

# **JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE AGENDA**

**4.00 pm**

**Tuesday  
2 October 2018**

**Council Chamber,  
Barking Town Hall, 1,  
Town Square, Barking,  
IG11 7LU**

**COUNCILLORS:**

**LONDON BOROUGH OF BARKING &  
DAGENHAM**

**Councillor Eileen Keller, London Borough of  
Barking & Dagenham  
Councillor Paul Robinson, London Borough of  
Barking & Dagenham  
Councillor Emily Rodwell, London Borough of  
Barking & Dagenham**

**LONDON BOROUGH OF  
WALTHAM FOREST**

**Councillor Richard Sweden  
Councillor Saima Mahmud  
Councillor Catherine Saumarez**

**LONDON BOROUGH OF HAVERING**

**Councillor Nic Dodin  
Councillor Nisha Patel  
Councillor Ciaran White**

**ESSEX COUNTY COUNCIL**

**Councillor Chris Pond**

**LONDON BOROUGH OF REDBRIDGE**

**Councillor Stuart Bellwood  
Councillor Beverley Brewer  
Councillor Neil Zammett**

**EPHING FOREST DISTRICT COUNCIL**

**Councillor Aniket Patel (Observer  
Member)**

**CO-OPTED MEMBERS:**

**Ian Buckmaster, Healthwatch Havering  
Mike New, Healthwatch Redbridge  
Richard Vann, Healthwatch Barking &  
Dagenham**

**For information about the meeting please contact:**

**Anthony Clements  
anthony.clements@oneSource.co.uk 01708 433065**

## **Protocol for members of the public wishing to report on meetings of the London Borough of Havering**

Members of the public are entitled to report on meetings of Council, Committees and Cabinet, except in circumstances where the public have been excluded as permitted by law.

Reporting means:-

- filming, photographing or making an audio recording of the proceedings of the meeting;
- using any other means for enabling persons not present to see or hear proceedings at a meeting as it takes place or later; or
- reporting or providing commentary on proceedings at a meeting, orally or in writing, so that the report or commentary is available as the meeting takes place or later if the person is not present.

Anyone present at a meeting as it takes place is not permitted to carry out an oral commentary or report. This is to prevent the business of the meeting being disrupted.

Anyone attending a meeting is asked to advise Democratic Services staff on 01708 433076 that they wish to report on the meeting and how they wish to do so. This is to enable employees to guide anyone choosing to report on proceedings to an appropriate place from which to be able to report effectively.

Members of the public are asked to remain seated throughout the meeting as standing up and walking around could distract from the business in hand.



Essex County Council



# NOTES ABOUT THE MEETING

## 1. HEALTH AND SAFETY

The Joint Committee is committed to protecting the health and safety of everyone who attends its meetings.

At the beginning of the meeting, there will be an announcement about what you should do if there is an emergency during its course. **For your own safety and that of others at the meeting, please comply with any instructions given to you about evacuation of the building, or any other safety related matters.**

## 2. CONDUCT AT THE MEETING

Although members of the public are welcome to attend meetings of the Joint Committee, they have no right to speak at them. Seating for the public is, however, limited and the Joint Committee cannot guarantee that everyone who wants to be present in the meeting room can be accommodated. When it is known in advance that there is likely to be particular public interest in an item the Joint Committee will endeavour to provide an overspill room in which, by use of television links, members of the public will be able to see and hear most of the proceedings.

The Chairman of the meeting has discretion, however, to invite members of the public to ask questions or to respond to points raised by Members. Those who wish to do that may find it helpful to advise the Clerk before the meeting so that the Chairman is aware that someone wishes to ask a question.

**PLEASE REMEMBER THAT THE CHAIRMAN MAY REQUIRE ANYONE WHO ACTS IN A DISRUPTIVE MANNER TO LEAVE THE MEETING AND THAT THE MEETING MAY BE ADJOURNED IF NECESSARY WHILE THAT IS ARRANGED.**

If you need to leave the meeting before its end, please remember that others present have the right to listen to the proceedings without disruption. Please leave quietly and do not engage others in conversation until you have left the meeting room.

## **AGENDA ITEMS**

### **1 CHAIRMAN'S ANNOUNCEMENTS** (Pages 1 - 2)

The Chairman will announce details of the arrangements in case of fire or other events that might require the meeting room or building's evacuation.

Directions to the venue are attached.

### **2 APOLOGIES FOR ABSENCE AND ANNOUNCEMENT OF SUBSTITUTE MEMBERS (IF ANY) - RECEIVE.**

### **3 DISCLOSURE OF INTERESTS**

Members are invited to disclose any interests in any of the items on the agenda at this point of the meeting. Members may still disclose an interest in an item at any point prior to the consideration of the matter.

### **4 MINUTES OF PREVIOUS MEETING** (Pages 3 - 10)

To agree as a correct record the minutes of the meeting held on 26 July 2018 (attached) and to authorise the Chairman to sign them.

### **5 BHRUT - IMPROVING CANCER CARE** (Pages 11 - 28)

Report attached.

### **6 HEALTH BASED PLACES OF SAFETY** (Pages 29 - 258)

Reports and information attached.

### **7 HEALTHWATCH HAVERING - SERVICES FOR PEOPLE WHO HAVE A VISUAL DISABILITY** (Pages 259 - 308)

Report attached.

### **8 JOINT COMMITTEE'S WORK PLAN** (Pages 309 - 310)

The Joint Committee is asked to suggest any further items for addition to its attached work programme.

**Anthony Clements**  
**Clerk to the Joint Committee**



## **Barking Town Hall**

### **Travel Directions**

Town Hall

1 Town Square

Barking

IG11 7LU

### **Public Transport**

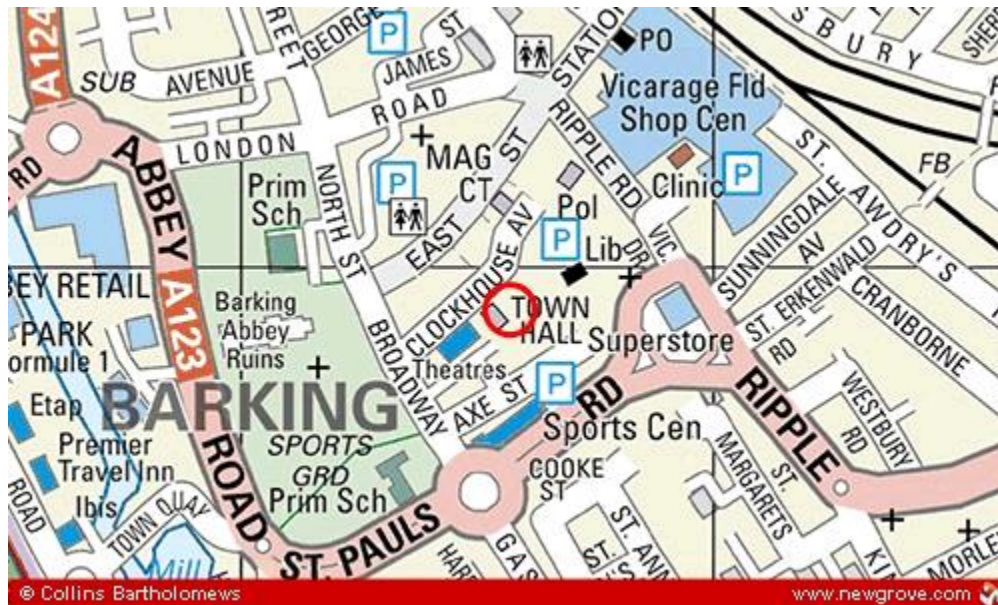
Bus: 5, 62, 169, 179, 238, 287, 368, 369, 387

Train: [Barking](#)

### **On arrival**

Please see reception inside the main entrance, who will let the person/s you are meeting know you have arrived.

## Location map



**MINUTES OF A MEETING OF THE  
JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE  
Council Chamber - Havering Town Hall  
26 July 2018 (4.00 - 6.02 pm)**

**Present:  
COUNCILLORS**

<b>London Borough of Barking &amp; Dagenham</b>	Paul Robinson
<b>London Borough of Havering</b>	Nic Dodin, Nisha Patel and Ciaran White
<b>London Borough of Redbridge</b>	Stuart Bellwood Muhammed Javed+ and Zammatt
<b>London Borough of Waltham Forest</b>	Richard Sweden, Saima Mahmud and Catherine Saumarez
<b>Epping Forest District</b>	Aniket Patel
<b>Co-opted Members</b>	Ian Buckmaster (Healthwatch Havering) and Richard Vann (Healthwatch Barking & Dagenham)

+ substituting for Councillor  
Beverley Brewer

**Also present:**

Sam Brooker, North East London  
Commissioning Support Unit  
(NELCSU)  
Carla Morgan, NELCSU  
Sharon Morrow, BHR Clinical  
Commissioning Groups (CCGs)  
Dr Arnold Fertig, BHR CCGs  
Dr Kate Adams, Clinical Lead,  
Urgent Care, North East London  
Commissioning Alliance  
Matthew Cole, Director of Public  
Health, Barking & Dagenham  
Mark Ansell, Director of Public  
Health, Havering  
Anthony Clements, Principal  
Democratic Services Officer,  
Havering  
Jilly Szymanski, Health Scrutiny  
Coordinator, Redbridge

One member of the public was also present.

All decisions were taken with no votes against.

**1 CHAIRMAN'S ANNOUNCEMENTS**

The Chairman gave details of the arrangements in case of fire or other events that might require the evacuation of the meeting room or building.

**2 APOLOGIES FOR ABSENCE AND ANNOUNCEMENT OF SUBSTITUTE MEMBERS (IF ANY) - RECEIVE.**

Apologies were received from Councillors Eileen Keller and Emily Rodwell, Barking and Dagenham, Beverley Brewer, Redbridge (Muhammed Javed substituting) and Chris Pond, Essex.

**3 DISCLOSURE OF INTERESTS**

There were no disclosures of interest.

**4 MINUTES OF PREVIOUS MEETING**

The minutes of the meeting of the Committee held on 13 February 2018 were agreed as a correct record and signed by the Chairman.

**5 BHR CCGS - COMMUNITY URGENT CARE SERVICES CONSULTATION**

With the agreement of the Chairman, a member of the public briefly addressed the Committee. The member of the public wished to raise what she considered the poor state of local health services, particularly in the Ilford South area. This area had the worst GP ratio of the three boroughs with, the member of the public contended, local residents waiting up to 11 weeks for a GP appointment.

It was felt that the urgent care consultation ignored this very serious situation and that the local CCGs did not know what was happening in the locality. Loxford polyclinic was not functioning as a walk-in centre and a lot of diagnostic equipment had been removed from the site.

In the view of the member of the public, there was not a GP hub at Loxford Polyclinic and appointments there could not be booked via NHS 111. Appointments could only be booked at the site and poor signage meant people did not know about the clinics available. It was felt that it should be noted that the Loxford area was the most deprived in Redbridge with many people for whom English was a second language and for whom it was therefore difficult to telephone for an appointment.

The member of the public felt that Loxford Polyclinic should be made an Urgent Treatment Centre in order to reduce the numbers of people attending A & E at King George Hospital.

Officers representing the Commissioning Support Unit confirmed that the public consultation period would close at 5 pm on 21 August 2018. Urgent care – care needed the same day for illness, cuts or minor injuries, was mainly delivered by GPs though also by community pharmacists. It was felt that there was a case for change in rationalising the way in which urgent care was delivered, particularly in the evenings or at weekends.

GP access hubs currently delivered urgent care at evenings and weekends via a separate telephone number from NHS 111. One third of these patients could be given advice by phone rather than needing to see a GP face to face and this was the same for walk-in centres. There were currently seven local GP hubs covering Barking & Dagenham, Havering and Redbridge and four walk-in centres.

It was felt that the best person to see for urgent care was a GP although officers accepted that it could be challenging to access GP services. GP services themselves were not being consulted upon. Officers felt that change was needed for a variety of reasons including public confusion over where best to go for treatment, national guidance on the need to improve facilities and the need to upgrade urgent care centres to urgent treatment centres, allowing x-rays, blood tests, diagnostics etc.

Officers felt that the NHS 111 service had improved over recent years and the new service provider starting on 1 August would increase to 50% the proportion of callers able to speak to a clinician. It was proposed that both options would allow a single phone number – 111 with which to speak to a clinician. GP and nurse appointments could also be booked via 111 and the overall number of locations at which people could be seen would not be reduced, being 12 under both options.

Under option 1, there would be four Urgent Treatments Centres (Queen's Hospital, King George Hospital, Harold Wood Polyclinic and Barking Community Hospital) with eight community locations for bookable appointments. The Urgent Treatment Centres would be walk-in but people would still be encouraged to phone or go on line first. Option 2 would provide two Urgent Treatment Centres – at Queen's and King George Hospitals and ten community locations.

Officers were aware of concerns around healthcare in South Ilford, including Loxford Polyclinic, and plans for primary care in the area had been brought to the Redbridge Overview and Scrutiny Committee. Barking Community Hospital already had an x-ray unit on site and parking was easier than at Loxford. Officers emphasised that it was not proposed to reduce capacity at Loxford and that it was wished to further develop facilities at Loxford.

It was felt that the current urgent care offer was too fragmented and that the proposals sought to simplify and standardise urgent care in line with the national strategy. Officers accepted that it could be challenging to communicate the detail of the proposals to the local community but translation services were available to people who contacted the consultation team by telephone.

Members felt that there was too much jargon in the consultation document and that terms such as GP hub should be more clearly defined. Members felt that issues such as making better use of Loxford Polyclinic should be included in the consultation response. A meeting during the consultation had been held in Loxford Polyclinic and it was emphasised that Redbridge Members in particular could not accept any watering down of services at the location.

It was felt that the underlying assumptions of the Pre-Consultation Business Case needed further discussion and the Committee therefore agreed to request that the consultation period be extended by a period of four weeks in order to facilitate this. Officers responded that they had offered to meet Redbridge Councillors on two further occasions during the consultation period. They were unable however to agree to any extension due to the requirements of the project procurement timetable.

A representative of Healthwatch Havering thanked the NHS officers for commissioning surveys on this issue by the three local Healthwatch organisations. These had shown that the public were confused by the terminology used and that people's perceptions had not changed. Some 75% of people had stated they understood the difference between urgent and emergency care although hardly any did in reality. It was also felt that there had been insufficient publicity about the new NHS 111 service and that the public consultation should not have been run over the summer holiday period.

Healthwatch Havering also raised concerns over the loss of the pharmacy at Harold Wood Polyclinic. Whilst accepting that this was a decision by NHS England, the Healthwatch representative felt that the lack of alternative out of hours pharmacies in the area meant that a pharmacy should be reinstated at the polyclinic.

Members also raised concerns over how the community locations had been chosen and if Council Local Plans and population growth had been taken into account. Issues such as the lack of parking at Urgent Treatment Centres and lack of progress at St George's Hospital (which was not part of the consultation) were also raised. Officers emphasised that the consultation was only on existing services. Services at Harold Wood Polyclinic were not being downgraded and discussions with Members could be held on this separately.

GP access hubs were available until 10 pm in the week and until 8 pm at weekends. Diagnostic tests could, if required, be arranged by NHS 111

direct at Urgent Treatments Centres. Members emphasised that they continued to find aspects of the proposals confusing and felt that terms such as GP hub or GP federation should be more clearly defined. Members added that, if it were not possible to extend the consultation beyond the summer holiday period, full details of the impact on any delay on the procurement timetable for the project should be supplied.

It was agreed that any individual borough responses should be supplied as part of the Joint Committee's response to the proposals and that the consultation document should be made easier to read.

The Committee agreed that the clerk should draft a response letter giving its views on the consultation, based on the discussions held at the meeting. This would allow a final response by the Committee to be submitted prior to the close of the consultation period.

## **6 NEW NHS 111 CONTRACT**

The Committee was advised that the new NHS 111 service would go live on 1 August 2018. The service, which had been procured jointly by the North East London CCGs, would be provided by London Ambulance Service. Competent health advice would be provided by phone or on line and callers could still be booked to see a clinician if necessary. Translators and Typetalk facilities for deaf callers would also be available.

Pathways had been developed to refer people back to their GP if necessary and a clinical assessment service would be based within NHS 111, comprising multi-disciplinary staff. It was planned that, shortly after the launch date, NHS 111 clinicians would have access to a patient's health care records (with a patient's consent). This would facilitate a quick transfer to a mental health assessment, should this be required.

The new system would allow consistency of approach through a single contact number. The service would be monitored closely with a patient participation group also being established. National metrics on e.g. rates of abandoned calls would be collected as would local metrics. Any instances of misdiagnosis would be monitored and investigated but it was felt that overall outcomes should improve under the new service.

A monthly Clinical Governance Group covered the whole of London and allowed learning to be shared and patient experience surveys would be undertaken.

The representative of Healthwatch Havering felt that views of NHS 111 differed across the local boroughs with, for example, lower use of the service being seen in Havering, where more people tended to present themselves at Queen's Hospital A&E. There was therefore a need to persuade more people in Havering to use NHS 111 and this did not seem to have been addressed thus far. Officers accepted that A&E departments

should advise people to call 111 where appropriate and the service would shortly be advertised in A&E.

Health advisors at NHS 111 undertook a six week training course and had their calls audited before being allowed to go live on the system. There had not been any instances at NHS 111 of missed cases of e.g. sepsis. Advisers were supported and calls could be referred on to the Clinical Assessment Service as required. It was possible that skype calls could be introduced to the service in the medium term. The clinical decision software used by the service would also be more sophisticated in the future.

Staff would be transferred from the current service provider under the TUPE regulations and it was noted that the London Ambulance Service already provided the NHS 111 service in South West London. The service call centre would be based in Barking. There would be a ratio of 1 clinician to four call handlers and this would include other clinicians such as pharmacists. This was considered an adequate level of cover and the processes for establishing this could be shared with the Committee.

It was agreed that an update on the performance of the NHS 111 service should be taken by the Committee in a year's time. It was further agreed that the clerk should seek to arrange a visit for the Committee to the NHS 111 call centre.

## **7 PROPOSED AMENDMENTS TO JOINT COMMITTEE'S TERMS OF REFERENCE**

A report of the clerk invited the Joint Committee to agree some minor changes to the Committee's Terms of Reference which sought to encompass how the Joint Committee and the relevant boroughs worked in practice and also reflect recent changes to NHS structures.

The recommendation of the report – that the changes to the Committee's Terms of Reference as shown in the report appendix be agreed was agreed unanimously with one further amendment that clause 6 of the Terms of Reference be amended to start as follows:

*If a member is unable to attend a particular meeting, he or she may arrange for any appropriate Member of the borough Council to attend as substitute, provided that a Member having executive responsibilities may not act as a substitute.*

## **8 JOINT COMMITTEE'S WORK PLAN 2018-19**

The initial work plan for the Joint Committee was agreed as shown in the report to the Committee. Additional items for inclusion on the work plan included proposed changes to cancer services in the locality.

## 9 **SCHEDULE OF FUTURE MEETINGS**

The schedule of meetings for the remainder of the 2018/19 municipal year was agreed as follows:

Tuesday 2 October 2018, 4 pm, Barking & Dagenham

Tuesday 15 January 2019, 4 pm, Waltham Forest

Tuesday 9 April 2019, 4 pm, Redbridge

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**Chairman**

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## OUTER NORTH EAST LONDON JOINT HEALTH OVERVIEW AND SCRUTINY SUB-COMMITTEE, 2 OCTOBER 2018

<b>Subject Heading:</b>	Improving Cancer Care
<b>Report Author and contact details:</b>	Liz Crees Cancer Speciality Manager, BHRUT
<b>Policy context:</b>	The information presented summarises work Barking, Havering and Redbridge University Hospitals NHS Trust is undertaking on cancer services.
<b>Financial summary:</b>	No impact of presenting information itself.

### SUMMARY

The attached presentation by BHRUT summarises a programme of changes to the Trust's cancer services.

### RECOMMENDATIONS

1. That the Joint Committee considers the information presented by BHRUT and takes any action it considers appropriate.

**REPORT DETAIL**

The attached presentation details the current situation as regards cancer services across the area served by BHRUT and gives details of the Trust's programme to change and improve these. This matter is not part of a formal consultation programme but is submitted for review and scrutiny by the Joint Committee.

**IMPLICATIONS AND RISKS**

**Financial implications and risks:** None of this covering report.

**Legal implications and risks:** None of this covering report.

**Human Resources implications and risks:** None of this covering report.

**Equalities implications and risks:** None of this covering report.

**BACKGROUND PAPERS**

None.

# IMPROVING CARE FOR OUR CANCER PATIENTS

Liz Crees

Cancer Specialty Manager

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# INTRODUCTION

- One of the busiest oncology departments in the country
- We are constantly focused on:
  - looking for new ways to improve our patients' care and experiences
  - improving efficiencies across the service
  - a holistic approach to caring for patients both during and after their treatment
- We must ensure we can meet the increasing demand now and into the future
- We believe we can best achieve this by:
  - creating a centre of excellence for cancer treatment at Queen's Hospital
  - creating a 'Living with and beyond cancer' hub



# WE'VE GOT A LOT TO BE PROUD OF...

- Met the national 62 day cancer standard for 13 months in a row
  - Only trust in London to have achieved this
- Member of the UCLH Cancer Collaborative
- Part of the BHR Cancer Collaborative Committee
- Enhanced Supportive Care team shortlisted for national Nursing Times award
- EMPOWER programme shortlisted for Nursing Times and Health Service Journal awards

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FOR HEALTHCARE LEADERS  
**HSJ** AWARDS  
**FINALIST**

**Nursing  
Times  
Awards**



# STATE OF THE ART RADIOTHERAPY...

- State of the art radiotherapy centre at Queen's Hospital
- Three brand new machines – Halcyon (x2) and the Edge (x1)
- First in world to have two Halcyon machines on one site
  - halves treatment times; more accurate; more comfortable
- The Edge – can treat much more complex cases



# CONTEXT

- Need to change how we deliver healthcare nationally
  - best use of resources (people, estate and finance)
  - deliver services in a way that meets changing demands of our population
- We serve more than 1million people from our three boroughs and across the whole of Essex (referred through our regional Neurosciences Centre)
- We expect a 6% increase year on year in patients requiring chemotherapy due to:
  - Population increase
  - Improvements in early diagnosis
  - State of the art treatments means people live longer
- Increases the need for services to be able to meet demand
- Increase in complexity in cases

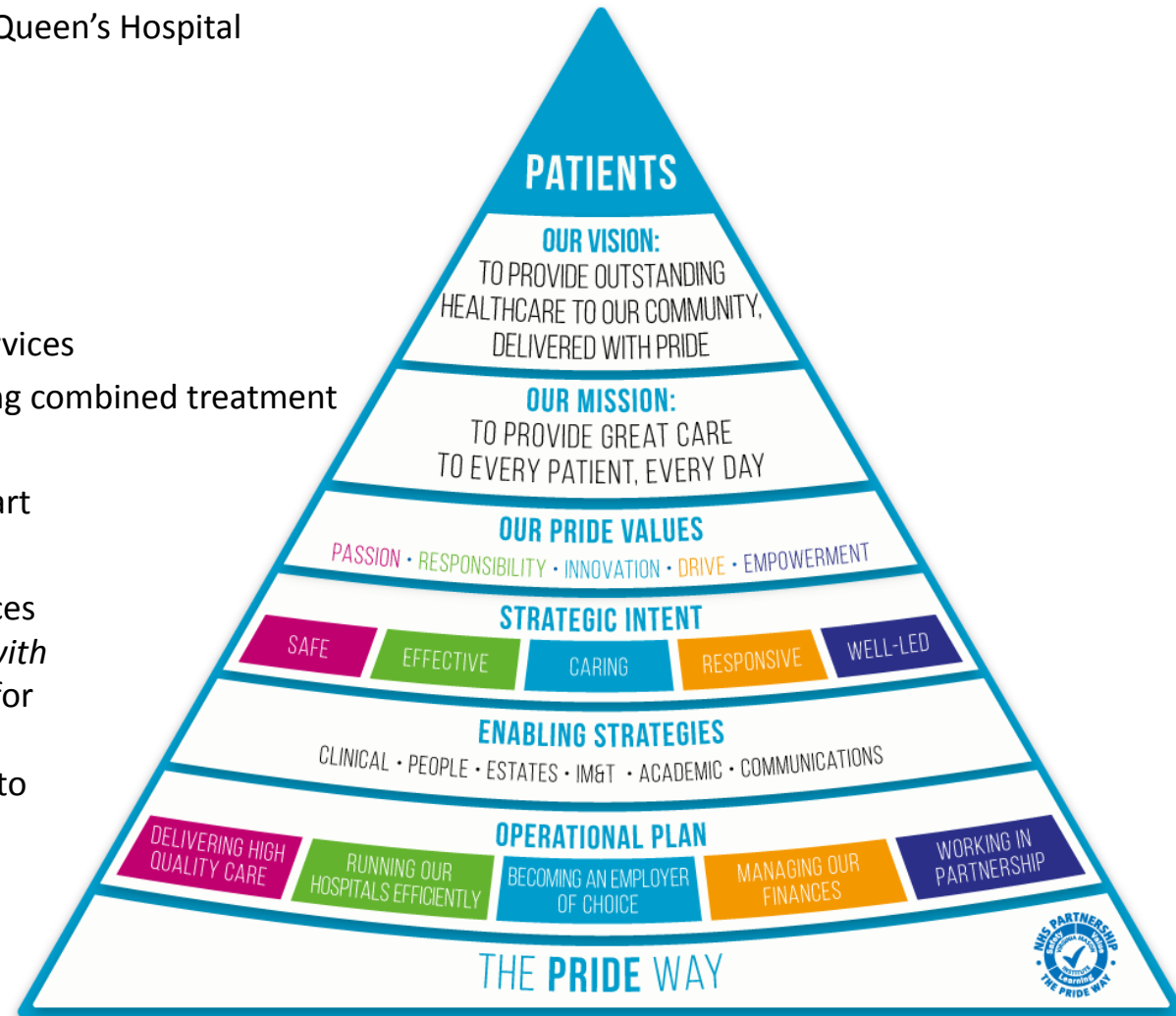
Year	Chemotherapy patients treated
2015/16	1,695
2016/17	1,809
2017/18	1,905

# OVERVIEW OF OUR SERVICES

- Provide treatment and health and wellbeing services across both King George and Queen's hospitals
- Essex Neurosciences Centre
- Cancer centre
  - Radiotherapy (Queen's)
  - Chemotherapy
  - 30 bed inpatient ward (Queen's)
  - Outpatient facilities
- Clinical trials unit (Queen's)

# OUR PROPOSAL TO IMPROVE CHEMOTHERAPY SERVICES

- Centralise chemotherapy services at Queen's Hospital
- Brings this on-site with:
  - specialised medical cover
  - inpatient services
  - outpatients services
  - state of the art radiotherapy services
    - easier for patients requiring combined treatment
  - cancer clinical trials
    - improved ability to take part
- Review of health and wellbeing services
  - exploring Cedar Centre as a *Living with and beyond cancer* hub as beneficial for patients to receive their health and wellbeing care at a different location to their treatment



# CURRENT TREATMENT PATHWAY

- All patients' pre-assessment at Queen's Hospital
- Treatment location decided by type of chemotherapy needed to give safest care
- Complex cases treated at Queen's – access to inpatient facilities and medical cancer specialists eg for drugs with high risk of anaphylactic shock; chemotherapy given together with radiotherapy
- Nursing staff rotate across both hospitals
- We treat on average 600 patients a month in Sunflower Suite at Queen's and average 150 per month in Cedar Centre at King George
  - Two years ago we saw on average 450 and 200 patients per month respectively
- Sunflower Suite – six day a week service
- Cedar Centre – consolidated treatments from four to two days a week due to lack of demand and increase in complex cases

# CLINICAL CASE FOR CHANGE

## Quality and safety

- King George Hospital – no medical cover in Cedar Centre
- Queen's Hospital– hub of medical expertise with facilities on one site
- Centralising nursing staff provides better training and mentoring; opportunity to 'grow our own' – staff prefer this approach

## Efficiency and productivity

- Our pharmacy teams make all cancer treatments at Queen's – then transport
  - This can cause delays at Queen's – reflected in patient feedback
  - Unable to fulfil additional prescriptions at King George
- New proposals mean Pharmacy can dispense drugs earlier – can start giving treatments earlier

## Future vision

- Centralising chemotherapy fits into our longer term ambitions to improve patient care
- Currently oncology patients who come in as emergencies go through our Emergency Department
- Longer term vision – telephone triage service as first port of call; ability to bring patients straight to acute oncology service to be cared for by our cancer team



# PATIENT EXPERIENCE CASE FOR CHANGE

## Patient feedback

- Negative feedback around waiting times and delays
- Reflected in Barking & Dagenham Healthwatch's Enter and View visit in September 2017 and in our Friends and Family Test

## Living with and beyond cancer

- Currently offer a range of health and wellbeing services across both sites
- Want to improve portfolio of services for patients living with and beyond cancer
- Fulfil National Cancer Strategy - provide required holistic care to our patients
- Moving chemotherapy to Queen's frees up Cedar Centre
- Exploring the possibility of using this space as a Living with and beyond cancer hub



# PATIENT NUMBERS

- 22% patients currently affected by the proposed change
- Expected to decrease over time due to increase in complex cases

CCG	QH	KGH	Total
Barking & Dagenham	433	149	582
Basildon & Brentwood	138	23	161
Barking & Havering	972	163	1135
Redbridge	314	167	481
W. Essex	45	22	67
Others	83	25	108
<b>Total</b>	<b>1,985</b>	<b>549</b>	<b>2,534</b>

Postcode	QH	KGH
IG1	128	72
IG4	26	4
IG5	44	30
<b>Total</b>	<b>198</b>	<b>106</b>

# IMPACT

## Travel

- Some impact on patients as reflected in numbers
- However reduced clinical risk, safer service, and improved care and experience
- Follows national practice for better outcomes eg stroke
- Consultants will continue to assess the need for patient transport
- Transport will continue to be provided wherever necessary, as is current practice

## Parking

- Dedicated oncology car park next to Sunflower
- Free parking during treatment; £2 at other times
- Capacity not anticipated to be an issue



# TIMELINES

- Implement improvements to delivery of chemotherapy services by end of October
- Allows us to be ready ahead of the increased demand of winter pressures
- Ongoing improvement of health and wellbeing services

# COMMUNICATIONS AND ENGAGEMENT

- Involve and engage our patients, public, partners and stakeholders throughout implementation and delivery
  - Messaging through range of channels eg website, plasma screens, stakeholder and GP newsletters
  - Comprehensive leaflet outlining plans available digitally (printable) and in hard copy across both our hospitals
- Work closely with partners eg local authorities and Healthwatch organisations to help inform and engage
- Dedicated patient partner to ensure information is relevant and easy to understand
- Feedback developed into FAQs and housed on our website
  - Dedicated email address for comments and queries
- Continue to listen to patient feedback and liaise with Cancer Patient and Public Advisory Group (CPPAG) post-implementation

healthwatch



# WHAT DO OUR PATIENTS THINK?

- Shared our proposals with our Patient Partnership Council (PPC) and CPPAG
  - All PPC members thought this would be a good idea to have the chemotherapy services on one site
  - It was queried if there would be sufficient capacity at Queen's – it was noted capacity will be available as treatments would be better spaced throughout the day and with potential treatments being delivered as part of a Saturday/Sunday for chemotherapy only
  - It was noted that PPC members were all in agreement with the proposed changes to our chemotherapy services

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**OUTER NORTH EAST LONDON JOINT HEALTH  
OVERVIEW AND SCRUTINY SUB-COMMITTEE, 2  
OCTOBER 2018**

**Subject Heading:**

Health Based Places of Safety

**Report Author and contact details:**

Glen Crosier,  
Programme Manager, East London Health  
and Care Partnership (ELHCP)

**Policy context:**

The information presented summarises  
work the ELHCP is undertaking  
concerning health based places of  
safety.

**Financial summary:**

No impact of presenting information  
itself.

**SUMMARY**

The attached documents by ELHCP officers summarises a programme of changes and improvements to the model of care for people in mental health crisis.

**RECOMMENDATIONS**

1. That the Joint Committee considers the information presented by the ELHCP and takes any action it considers appropriate.

**REPORT DETAIL**

The attached documents gives details of work on health based places of safety for people experiencing mental health crisis. This is presented to the Joint Committee for scrutiny as part of the ELHCP's engagement with key stakeholders.

**IMPLICATIONS AND RISKS**

**Financial implications and risks:** None of this covering report.

**Legal implications and risks:** None of this covering report.

**Human Resources implications and risks:** None of this covering report.

**Equalities implications and risks:** None of this covering report.

**BACKGROUND PAPERS**

None.

## Joint Health Overview and Scrutiny Committee: Health Based Places of Safety in Outer North East London

**Subject Heading:**

North East London CCGs – Health Based Places of Safety (HBPoS)

**Report Author and contact details:**

Dan Burningham, Mental Health Programme Director, City and Hackney CCG  
[dan.burningham@nhs.net](mailto:dan.burningham@nhs.net)  
Rory McMahon, Assistant Director of Transformation, North East London Commissioning Support Unit  
[Rory.McMahon1@nhs.net](mailto:Rory.McMahon1@nhs.net)

**Policy context:**

In 2017, the government formally announced changes to section 136 of the Mental Health Act 1983 (s136 MHA) through the Policing and Crime Act 2017. These came into effect on 11 December 2017. Under these amendments, CCGs must ensure plans for the designation, and appropriate staffing of CCG-commissioned health-based places of safety. In May 2018 HLP produced a pan-London business case for few better quality HBPoS.

## SUMMARY

A Health-Based Place of Safety (HBPoS) is a space where people can be detained under Section 136 of the Mental Health Act and assessed. Patients are typically detained under the Mental Health act under Section 136 by Police, then transported to a Section 136 Suite to be assessed.

Since 2015, Healthy London Partnership (HLP) has worked in partnership with London's health and care system to develop a Pan-London business case to inform a specification for a new model of care for individuals detained under Section 136.

The HLP business case proposes that the 20 existing dedicated HBPoS sites across London are reduced to nine hubs, each with better facilities and immediately available 24/7 staffing on site. This includes hubs within North East London.

The aim is to deliver:

- Better, quality, built environments that offer patients who are vulnerable or acutely unwell, the safety, privacy and dignity they deserve.
- Improved capacity with more rooms being added to fewer sites, to ensure blue light services are turned away less often.
- Trained and experienced dedicated staffing to improve the quality and efficiency of assessments and the relationships between services.

The HLP business case has been subject to a North East London STP options appraisal which was conducted by the STP Workstream 3, with stakeholders from each of the sites.

This paper details the options and recommendations arrived at as the result of this options appraisal, and the subsequent engagement process required for the reconfiguration of Health Based Places of Safety and Section 136 detentions, Pan-London and within the North East London STP.

## RECOMMENDATIONS

It is recommended that The North East London STP proceed with **Option 5**, a three site HBPoS option in the short term, located with three rooms each at Sunflower Court and Homerton Hospital, and one at the Newham Centre for Mental Health. This option is in line with the Transition Phase recommended in the HLP business case.

After a year of operation, the option will be assessed and a view taken on whether to keep the Newham HBPoS, or whether to re-divert the flows and move to a two site solution: Homerton and Sunflower Court.

## **Context**

Section 136 detainments give the police the power to remove a person from a public place when they appear to be suffering from a mental disorder to a place of safety. The person will be deemed by the police to be in immediate need of care and control as their behaviour is of concern. It is important to point out that a person is not under arrest when the decision is made to remove the person to a place of safety, where they can be assessed by relevant healthcare professionals. The police power is to facilitate assessment of their health and wellbeing as well as the safety of other people around them.

London's crisis care system is under significant pressure and does not have the services or infrastructure to ensure people experiencing a mental health crisis under a section 136 detainment receive timely, high-quality care that respects individual needs.

### **The Pan-London change and engagement process**

An HBPOS options appraisal in conjunction with an extensive engagement process, was undertaken by the Healthy London Partnership to identify how London's HBPOS sites could meet the developed specification. Over 400 Londoners with lived experience of Mental Health crisis and carers have been involved in developing the new model of care through an extensive engagement process.

Workshops, online surveys, and patient statements have been used in order to inform the Options Appraisal and recommendations.

The options appraisal identified several delivery options, with the aim of deciding on an optimal Pan-London place of safety configuration including:

- the required number of sites;
- optimal capacity; and
- optimal locations across London.

The output of this process was a nine-site model. This wider, pan-London process has then informed the development of a business case for HBPOS service change across the NEL STP.

### **Current Provision of Health-Based Places of Safety (HBPOS) in North East London**

There are currently four HBPOS sites operating in North East London:

- Sunflower Court, in Redbridge, provided by NELFT (2 assessment rooms)
- Newham Centre for Mental Health, in Newham provided by ELFT (one assessment room)
- Homerton Hospital, in Hackney provided by ELFT (one assessment room)
- Royal London, in Tower Hamlets, provided by ELFT (one assessment room)

**Figure 1 – Health Based Places of Safety within the North East London STP**



Key issues within the case for change can be summarised as follows:

- The HBPoS at the Royal London Hospital within Tower Hamlets is situated in a busy Accident and Emergency department, potentially compromising patient safety, privacy and dignity. The unit is also situated one mile away from mental health teams and wards, making an immediate transfer to patients problematic and drawing on staff support from mental health teams difficult. For these reasons the RLH is not considered an appropriate environment by CQC and HLP.
- The HBPoS at Royal London, Homerton and Newham have no dedicated staff and use staff from the wards. This makes it hard to ensure staff with sufficient experience and training are available. It therefore does not comply with the recommendations of HLP's business case that staff from wards are not used and that all staff are trained and experienced.
- The HBPoS at Homerton is situated in a rather public space and is not easily accessible.

### **Options for Service Delivery**

The following options for delivery of a new model of Health Based Places of Safety within the North East London STP were considered.

**Option 1:** Do nothing - Sunflower Court, Homerton, Royal London, Newham General all remain open.

**Option 2:** Develop an alternative HBPoS to Royal London at Mile End hospital; Homerton, Newham and Sunflower Court remain open.

**Option 3:** Two Sites - Sunflower Court & Homerton and Newham General HBPoS).

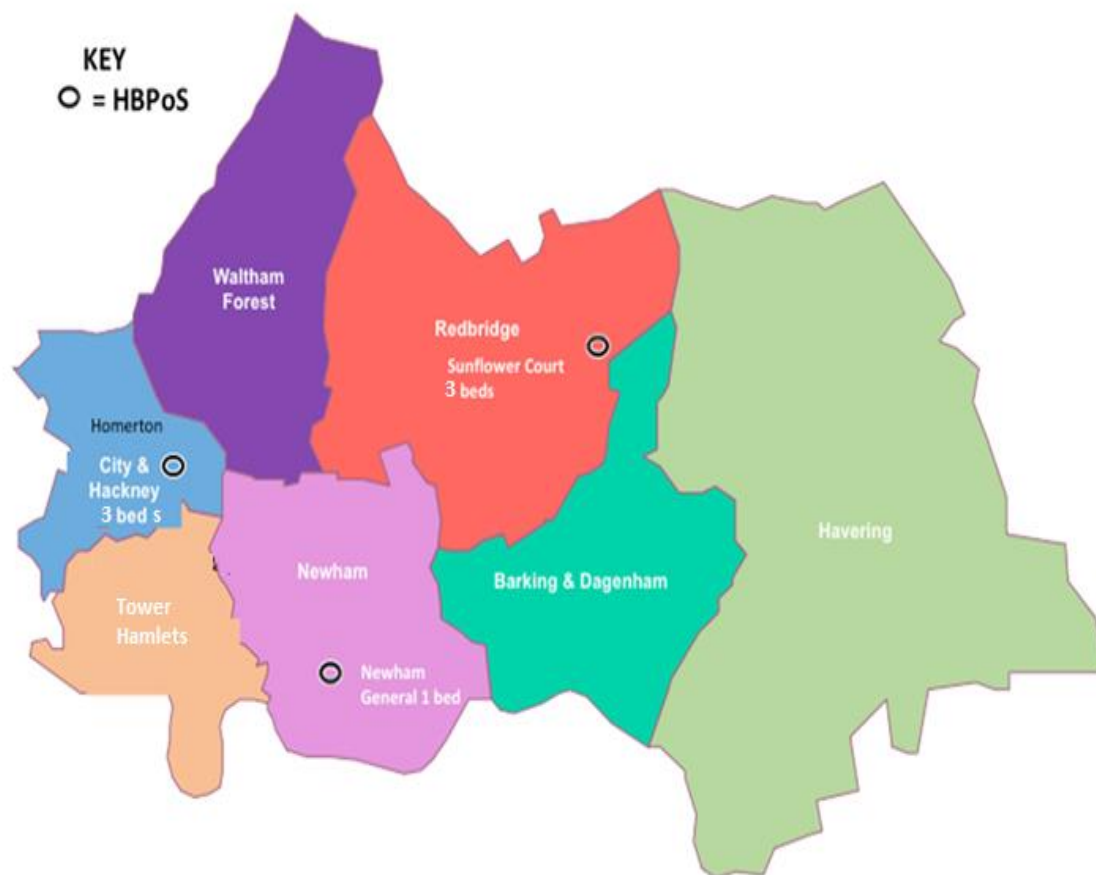
**Option 4:** Two Sites remain open - Newham and Sunflower Court.

**Option 5:** Three Sites remain - Homerton, Newham and Sunflower Court.

Based on the case for change and the options appraisal alongside an analysis of revenue costs, it is recommended that ELHCP proceed **with option 5**, a three site HBPoS option in the short term:

- **Sunflower Court** (3 rooms) with a dedicated core staff team
- **Homerton Hospital** (3 rooms) and re-located to offer better patient privacy and dignity and staffed with a dedicated core staff team
- **Newham Centre for Mental Health** (1 room).

**Figure 2 Option 5, HBPoS Three-Site Option**



This option expands the Homerton site's capacity to absorb the potential re-directed s136 flows from the Royal London.

Furthermore, the use of option 5 has the following advantages:

- More flexible facilities in terms of capacity in the short-term ,and allows time for further planning for a future two-site model if appropriate.
- Means reduced travel distances compared to Option 3.

- Enables experienced, qualified staff to be immediately available 24/7 on all sites.
- Incorporates capacity close to the City of London, which has a high number of section 136s.
- Facilitates better care for children and young people with two co-located CAMHS sites.
- Is in keeping with HLPs 13 site transition phase.

Option 4 (HLP's recommended final configuration), was rejected in the short-term because it was considered that re-directing flows from two sites at once was too risky. It was agreed that it would be better to close one site, map the flow, and then assess the case for closing a second site.

It was also agreed that Option 4 would be difficult to deliver in the short-term due to the higher revenue and capital cost implications. This could delay the re-diversion of flows from Royal London which does not meet standards of patient safety, privacy and dignity.

## IMPLICATIONS AND RISKS

### **Financial and Activity implications and risks:**

#### **a) Financial Implications**

- The Department of Health has funded a £388,200 capital development at Homerton (2-3 rooms) and £349,000 at Sunflower court (3 rooms). This element is thus cost-neutral to the local healthcare economy. Revenue costs are currently under negotiation with local CCGs.

#### **b) Activity:**

- The model predicts that the additional capacity from the closure of the Royal London site will be absorbed by the Homerton; any additional demand will be mitigated by the increased use of Street Triage and home treatment teams.

#### **c) Legal implications and risks:** Not applicable to this report.

#### **d) Human Resources implications and risks:** Not applicable to this report.

#### **e) Equalities implications and risks:** The preferred option is likely to improve the safety, privacy, and dignity of all service users through improved built environments and dedicated staffing teams. Older adults and people with disabilities may benefit from closer adjacencies to the wards. A dedicated and trained and qualified staff team is also more likely to have a better understanding of the needs of BME and LGBT patients and share this in good working relationships with the police.

**Appendices**

*London's Mental Health Crisis Care Programme, Stakeholder Engagement Summary, July 2018, Healthy London Partnership*

*Mental Health Crisis Care for Londoners, HBPOS Business Case, March 2018, Healthy London Partnership*

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# London's Mental Health Crisis Care Programme

## Stakeholder Engagement Summary

July 2018

## About Healthy London Partnership

Healthy London Partnership formed in 2015. Our aim is to make London the healthiest global city by working with partners to improve Londoners' health and wellbeing so everyone can live healthier lives.

Our partners are many and include London's NHS in London (Clinical Commissioning Groups, Health Education England, NHS England, NHS Digital, NHS Improvement, trusts and providers), the Greater London Authority, the Mayor of London, Public Health England and London Councils.

All our work is founded on common goals set out in [Better Health for London](#), [NHS Five Year Forward View](#) and the [Devolution Agreement](#).

## About this document

Since 2015, Healthy London Partnership (HLP) has worked in partnership with London's health and care system to develop a pan-London new model of care for individuals detained under Section 136 (s136). Continuous system wide engagement has been integral to the development of the new model of care. This document summarises the engagement in terms of activities undertaken, the stakeholders involved and how this has fed into the development of the new model of care. For further information on the proposed pan-London model of care for s136, please refer to the public engagement document.

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## Overview of the engagement process

It has long been recognised across London that mental health crisis care services often fall short in providing effective access, care and treatment for people who are among the most vulnerable in our society. London's crisis care system is under significant pressure and does not have the services or infrastructure to ensure people experiencing a mental health (MH) crisis receive timely, high-quality care that respects individual needs.

In 2015, HLP worked with stakeholders, including service users and carers, from across London's mental health crisis care system to identify key issues across the pathway and to develop a strong case for change.

A multi-agency group including service users, carers, frontline staff, MH and acute trusts, the London Ambulance Service, the three London police services and local authorities led the development of [London's s136 Pathway and HBPoS Specification](#), which outlines the minimum standard of care for HBPoS sites and the roles and responsibilities of all professionals in the pathway. Extensive engagement led to all partners formally endorsing this guidance, which was launched by the Mayor of London in December 2016.

The new model of care was developed from the principles laid out in the guidance. It was recognised across the system that in order to meet the specification standards, significant changes were needed to the current provision of services.

A HBPoS options appraisal was undertaken to identify how London's place of safety sites could meet the specification. The options appraisal identified the optimal pan-London place of safety configuration including the required number of sites, capacity and optimal locations across London. The output of this was a 9 site model with 5 of these sites as all-age provision. This then informed the development of a business case for service change.

HLP is now working with London's crisis care system and service users to support implementation of the model of care across London. Next steps include the development of business plans in each Sustainability and Transformation Partnership (STP) and for these to be taken through local decision making forums in order to progress implementation. As part of this process there will be further public engagement as further consideration is given at the STP level regarding plans for future HBPoS provision.

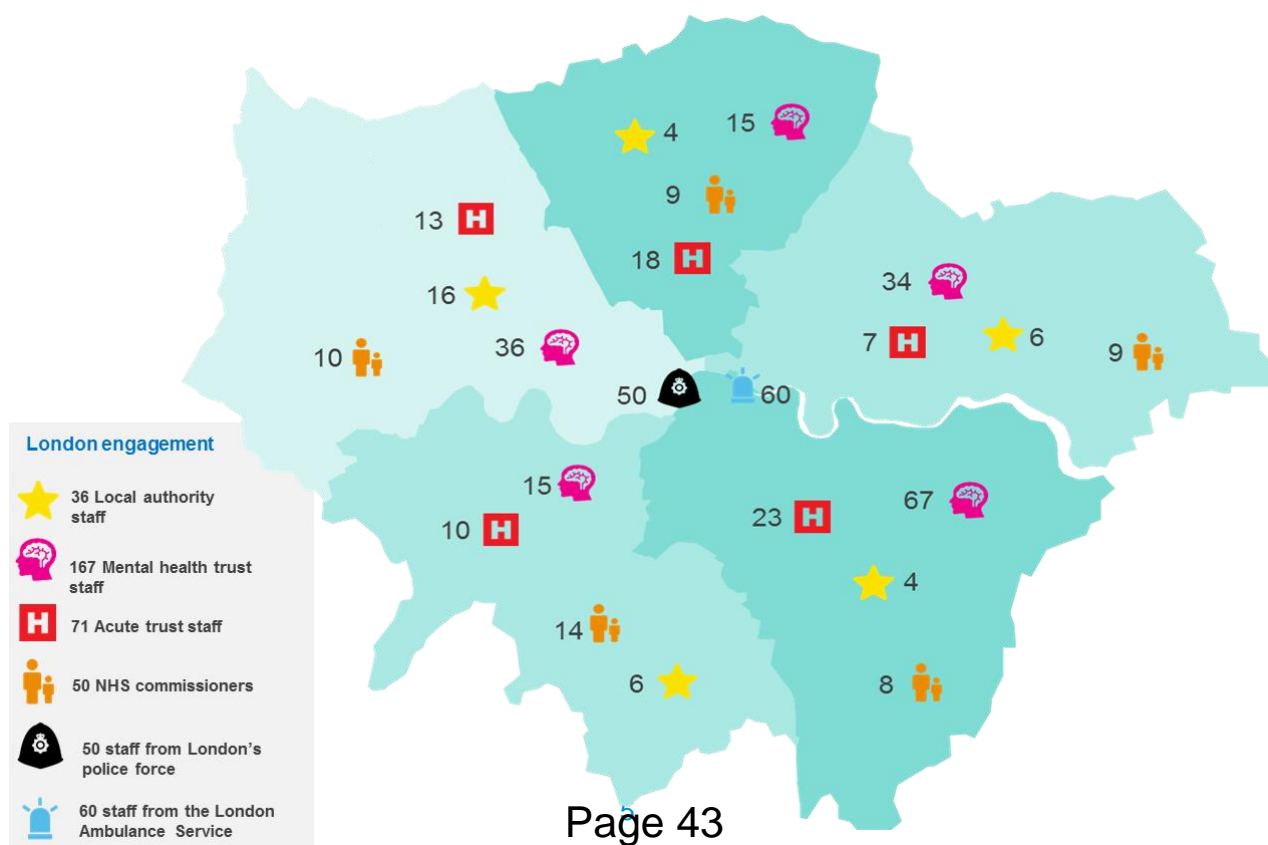
The voice of people with mental health problems has been at the heart of the programme. A section of this document has been dedicated to engagement with service users and carers, describing how they have been involved and how their experiences and views have shaped the development of the programme and the pan-London s136 model of care.

Figure 1 below includes the amount of engagement that has taken place throughout the life of the programme. Figure 2 provides an overview of staff that have been actively engaged more recently since the pan-London guidance has been developed. This includes those involved in specific activities to support implementation of the guidance throughout 2017 and 2018. Individual STP maps are available in appendix 1.

Figure 1: Summary of engagement throughout the programme



Figure 2: London engagement to implement the guidance throughout 2017 and 2018



## Key documents and dissemination

- [London's s136 pathway and HBPoS specification](#) (December 2016)
- [Evaluation of South London and Maudsley NHS Foundation Trust's Centralised HBPoS](#) (December 2017)
- [The business case for service change](#) (April 2018)
- S136 new model of care public engagement document

### 1. London's s136 pathway and HBPoS specification

Since 2015, Healthy London Partnership has worked with London's health and care system to develop a pan-London, new model of care for individuals detained under s136. Significant engagement at the outset of London's mental health crisis care (MHCC) programme determined that the s136 pathway was best focussed on at a pan-London level and that this would complement other local crisis care service development.

The pan-London s136 pathway and Health Based Place of Safety (HBPoS) specification, which outlines the minimum standard of care for HBPoS sites and the responsibilities of staff within the pathway, was developed through extensive engagement with London's crisis care system, including over 300 service users and carers and over 300 frontline staff from London Ambulance Service, London's police forces, mental health and acute trusts. Draft guidance was circulated to over 150 stakeholders for feedback prior to the final version being developed. An outline of the engagement is displayed in the figure below.

The pathway and specification was also formally endorsed by all NHS stakeholder organisations and pan-London forums, London's three Police forces, London Ambulance Service, the Royal College of Psychiatry, Mind and the National Crisis Care Concordat Initiative.

*Figure 3: Summary of engagement for development of London's s136 pathway and HBPOs specification.*

Formal endorsements from:



On the 12th of December 2016, Mayor of London Sadiq Khan launched London's s136 pathway and HBPOs Specification at an event at City Hall (see Events section for more details).

The document was uploaded to the HLP website in order to broaden its reach with 1863 page views since publication in October 2017. HLP also targeted specific stakeholders for distribution including:

- Metropolitan Police
- British Transport Police
- City of London Police
- London Ambulance Service
- Mental Health Trusts
- Local authorities, including London's AMHP services

- Acute Trusts
- Service users

## 2. Evaluation of South London and Maudsley NHS Foundation Trust's Centralised HBPoS

To understand the impact of SLaM's new centralised place of safety, piloting the pan-London s136 pathway and HBPoS specification, Healthy London Partnership worked with service users, SLaM staff, the police, the London Ambulance Service and AMHPs to evaluate the new service.

The evaluation report was circulated in November 2017 to stakeholders across London. Information and a link to the report was also included in the End of Year crisis care programme update distributed to over 450 stakeholders and in a news item on the HLP [website](#). The evaluation itself has also been available on the HLP [website](#) since November 2017, where so far it has had over 500 page views.

Since its launch, information from the evaluation has been included in numerous presentations and to share learning on the potential impacts of the pan-London new model of care. Crucially, the findings from the evaluation, including the service user and frontline staff feedback, were used to develop the business case for service case.

## 3. Business case for service change

The Business case for service change has been disseminated to a broad range of stakeholders via emails, events and meetings including:

- All 5 of London's Sustainable Transformation Partnerships (STPs): North Central London, North East London, North West London, South West London and South East London.
- London's Mental Health Trusts
- London's Acute Trusts
- Approved Mental Health Professional (AMHP)
- Local Authorities (LA)
- Clinical Commissioning Groups (CCGs)
- NHS England (London region)
- NHS Improvement (NHSI)

- Greater London Authority (GLA)
- London Ambulance Service (LAS)
- All 3 London police services (Metropolitan Police Service, British Transport Police and City of London Police)
- Mind charity
- Service users

The Business case for service change was presented to London's Crisis Care Implementation Steering Group for comment in mid-February 2018 and circulated for comment to the group members. This included feedback from service users and Mind. It was then taken to London's Mental Health Transformation Board and the Urgent and Emergency Care Transformation and Delivery Board for consideration in late March 2018 and the NHSE (London) Parity of Esteem Delivery Group in April 2018.

The Business case for service change was uploaded to the HLP website where it has had 157 page views since publication. A link to the document was provided in the April 2018 programme update distributed to over 450 stakeholders.

#### 4. Other documents and resources developed and disseminated via the HLP website and targeted emails to specific stakeholders include:

- Regular Programme updates, including a 2017 End of Year crisis care programme Report.
- [The Voluntary Handover Form](#) (April 2018): A process to support the safe and effective handover of patients attending emergency departments (EDs) accompanied by police.
- [The Mental Health Crisis Care Toolkit](#) (December 2017): Training slides developed by an independent legal expert support local training regarding the roles and responsibilities for s136 of the Mental Health Act, including legislation changes in which came into effect in December 2017.
- [Posters](#) detailing the roles and responsibilities of each agency involved in the s136 pathway as outlined in the new pan-London guidance developed by HLP. These were provided on request to MH Trusts, Acute Trusts, LAS and Police (December 2017)
- [Posters](#) from the 12 December 2016 launch event for the new London s136 pathway and HBPOS Specification (December 2016)

- [London s136 pathway: key principles](#) (December 2016)
- [S136 pathway service user scenarios](#) (December 2016)
- [Crisis care sustainability and transformation presentations](#) (December 2016)
- [Improving care for children and young people with mental health crisis in London](#) (October 2016)
- [The launch of London's s136 pathway learning report](#) (December 2016)
- [Improving care for children and young people in mental health crisis in London: Recommendations for transformation of services](#) (November 2015)

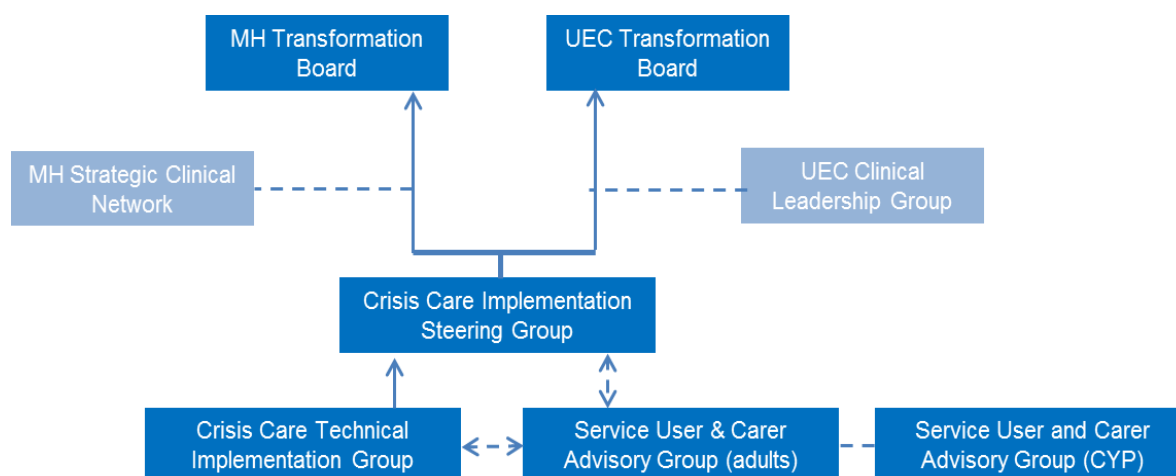
## Committees and boards

The following committees provide stewardship of the programme and expert input into the development of the s136 new model of care through various engagement activities including regular meetings and programme updates. The groups are made up of a range of key stakeholders from London's health and care system including mental health and acute trust staff, service users, representatives from all five STP areas, the police, LAS, local authorities and senior representatives from all partner organisations.

- London's Mental Health Transformation Board
- London's Urgent and Emergency Care Transformation & Delivery Board
- NHSE (London) Parity of Esteem Delivery Group
- Service User and Carer Advisory Group
- London's Crisis Care Implementation Steering Group
- London's Crisis Care Technical Implementation Group
- London s136 Commissioning and Payments Task & Finish Group
- London's Urgent & Emergency Care Clinical Leadership Group
- London's Mental Health Strategic Clinical Network

The governance structure for the programme is outlined in the figure below.

*Figure 4: Programme governance structure for London's Mental Health Crisis Care programme*



## Service user engagement

Over 400 Londoners with lived experience of MH crisis and carers have been involved in developing the new model of care through an extensive engagement process. Below we outline who we involved and why, how service users were involved, what we learned from our conversations and how this influenced the programme development. There are approximately 5000 s136 detentions in London per year; this includes multiple detentions for the same individuals.

### Who was involved and why

Over 400 Londoners have been involved in London's Mental Health crisis care programme, the majority of whom have lived experience of mental health crisis as a service user or carer. This has included those with specific experience of the s136 pathway, and those with experience of the wider crisis care in London. Representatives were sought from all areas of London, with black and ethnic minority communities and Children and Young people (CYP) also represented.

Through this, the programme endeavoured to include the input of both a large number of service users and to capture the experience in different areas of London and for particular groups. Where demographic information was asked for and provided, the proportion of white (65%) and BME (35%) represented in the service user engagement, reflects the proportion of these groups who are detained under s136 in London. A summary of service user and carer engagement and demographics for key events in development and implementation of London's s136 pathway and HBPOs specification is shown in the table below. Note that demographic information was not asked for in all cases.

Table 1: Service user demographics

	White	BME	Information not given
Online survey and focus group	70	23	61
CYP Focus Group for I statements	0	0	3
CYP Online survey for I statements	24	5	33
Crisis Care Summit	0	0	25
Mental Health Trust focus groups	5	10	32
Harrow in Mind (Somali group)	0	17	3
CYP workshop	2	0	0
Service user and carer advisory group			11
S136 Launch			10
Evaluation of SLAM's centralised place of safety			45
Technical Implementation Group and Implementation Steering Group			4
Mental Health Act Multiagency Training			8
London Ambulance Service patient forum			10

<b>Patient and public network meeting</b>	<b>4</b>
<b>Total</b>	<b>405</b>

## How service users have been involved

Engagement with service users and carers has taken place at each stage of the process from developing the case for change through to implementation.

### Workshops

Five workshops with over 50 service users and carers were held in each STP in London to look at a number of areas of the s136 pathway and HBPOs specification in more detail to ensure service user needs and expectations were met. Specific ideas were also tested with service users to support the implementation process. London's diverse population has been represented through these workshops including all ages and a range of ethnic groups, specific workshops were held for children and young people and individuals from BME communities.

### Online survey

In 2016, Healthy London Partnership's Mental Health Crisis Care programme undertook engagement with service-users and carers to further understand the experiences of people who have experienced a mental health crisis in London and find out what is important to them when they are in crisis.

Part of this work involved the charity, Mind, supporting the programme in developing an online survey, which focussed on the experiences of those whose crisis led to:

- attending an ED or
- being detained under section 135 or 136 of the Mental Health Act by the police

The survey was live online from 18 January to 24 February 2016 and was promoted by HLP, Mind, National Survivor User Network, Young Minds and other partners on social media. We received 104 responses by 29 January (the point at which HLP did the analysis to inform the I-statements) and 154 by 24 February when it closed. All except 6 people (29 January) rising to 10 (24 February) were from across London.

The service users and carers who took part in the online survey told us about their recent experiences of crisis care, including those in EDs and HBPOs sites. Service users told us what was good and what could have been better. They also told us what was most important to service users when helping to prevent a crisis, during a crisis and following a crisis.

The information gathered has been used to steer the development of London's new model of care to ensure that it meets the needs of service users.

Demographic information for those who took part in the survey can be found in Appendix 2.

### *I statements – focus group and online consultation*

A key output from the service user and carer involvement was the development of 'I statements'. These are first person statements setting out the expectations of how Londoners wish to be treated before, during and after a MH crisis. Over 200 service users co-produced a set of 'I' statements through online surveys and focus groups facilitated by Mind and YoungMinds. They were then refined through further online consultation (see appendix 3).

Further engagement was also undertaken with children and young people to better understand where their experiences and needs might differ from those of adults. HLP created an online survey to enable more children and young people to feed back on the draft 'I' statements. The survey was actively promoted on social media and featured on the YoungMinds online blog, which reaches thousands of young people across their network.

The survey was launched on 6<sup>th</sup> April 2016 and more than 60 young people completed it. Their responses were used to redraft the statements to ensure they reflect what is most important to Londoners who experience a mental health crisis as a young person. The CYP 'I' statements (see appendix 4) are to be read alongside and not instead of the other statements, which apply to Londoners of all ages.

The 'I' statements reflect service user needs and expectations of London's mental health crisis care and were used in the development of a case for change. The statements directly informed London's s136 pathway and HBPOS specification and the new model of care and will be crucial to the evaluation of the programme.

### *BME service user experience*

As part of HLP's continued service user engagement, in July 2016 a workshop was specifically arranged for members of BME communities to ensure that the needs of service users from BME communities were well represented within the new model of care. The workshop was co-facilitated by Mind and HLP. This was in addition to BME service users already represented in the other forums relating to the programme.

### *Expert by experience videos and stories*

In spring 2016, HLP filmed with a number of experts by experience to talk about their story and experience of being cared for under s136. In 2017, service user experiences were included on the Healthy London Partnership [website](#), a [Rethink blog](#) and were presented at MHCC summit in February 2016 as well. These

accounts of crisis care in London have been vital to inform the case for change and provide on-going drive for the programme.

### *London's crisis care summit*

London's crisis care summit was held in February 2016 and over 12% of delegates were service users from across London with experience of London's crisis care services. Service users were also involved in the event through presentations and co-facilitating workshops with clinical staff and key partners. The presentations from the service users highlighted examples of substandard crisis care while demonstrating an appetite to work together to improve the pathway for Londoners.

### *Pan-London s136 pathway launch*

On the 12th of December 2016, Mayor of London Sadiq Khan launched London's s136 pathway and HBPOS Specification at an event at City Hall. Over 10% of attendees were crisis care service users.

### *Place of safety options appraisal process*

Service users in each STP were engaged in the options appraisal to determine the best way to deliver crisis care services across London in order to meet the standards set out in London's s136 pathway and HBPOS specification.

### *Evaluation of SLAM's centralised place of safety*

The new model of care was piloted in South London and Maudsley NHS Foundation Trust (SLAM) in 2017, through the consolidation of 4 sites into 1 purpose built site with 24/7 dedicated staffing. The new purpose built facility was co-designed with service users to support delivery of safe, dignified care in a therapeutic setting and staff reported being able to use the facilities flexibly to better manage risk and respond to the changing needs of the individual in their care.

Service user surveys were carried out both before and after the centralised HBPOS opened. Under the new model, 76% of those surveys were positive about the support they received and 64% felt safe (compared with 36% in previous surveys of Londoners). Furthermore, 79% of service users reported being treated with respect and dignity by staff, 63% felt listened to by staff and 94% felt that they understood the next steps prior to leaving the unit.

Figure 5. Service user perceptions SLAM's centralised place of safety 2017



#### *Service User and Carer Advisory Group / committee representation*

Two service User and Carer Advisory Groups were formed (one for adults and one for CYP) to help ensure that service users had meaningful input into the stewardship of the programme. In addition to this service users also sit on London's Crisis Care Implementation Steering Group and the Crisis Care Technical Implementation Group.

#### *Other meetings:*

**London Ambulance Service (LAS) patient forum (August 2017):** Service users involved in the LAS patient forum were gathered to hear more about the London mental health crisis care programme and to provide feedback on the implementation plans across London.

**Urgent and emergency care patient and public network meeting (April 2018):** Programme updates were provided to members of London's patient and public care networks. Their role is to ensure there is patient input into London's wider UEC programme and ensure effective feedback links between local patient groups into London-wide work.

#### *Programme updates*

Regular programme updates every x month? have emailed to service users throughout the development of the new model to help keep them engaged and informed and to give them an opportunity to feedback to the programme team.

### *London's crisis care mailbox:*

The crisis care programme team set up a dedicated email address which is widely available and advertised on the Healthy London Partnership website and on programme updates to allow access to information directly from the programme team and to allow all stakeholders, including service users to provide feedback.

### **What was learned from the conversations**

A number of issues came out strongly from the surveys, focus group and online consultation when respondents were asked about their recent experiences in London's EDs and HBPOs sites.

These issues can be grouped under the follow themes: access and timeliness of care, attitudes and skills of staff, environment, and continuity of care.

We asked people what the most important thing to them was. The following were the most commonly identified areas of importance across the comments left by service users:

- being treated with compassion
- feeling safe
- being listened to

A number of respondents explicitly associated feeling safe with the appropriateness of the surroundings and the attitude of staff.

A significant number of respondents also raised the importance of being taken seriously, feeling respected and being able to access care quickly.

The following areas were identified through the engagement process as particularly important in the delivery of crisis care. The survey responses and focus group have helped to identify both the current problems across these areas and how service users think improvements could be achieved.

- **Access to the right help** – less than half of survey respondents knew how to access advice and support to get the help they needed when in crisis
- **Timeliness of care** – nearly 70% of survey respondents felt there were missed opportunities to prevent their mental health deteriorating to crisis point
- **Compassion** – only 34% who attended an ED and 27% who attended a place of safety agreed that staff had treated them with compassion
- **Choice and Involvement** – only 30% felt involved in discussions about their mental health problems

- **Staff attitudes and knowledge** – only 36% of those who attended an ED felt listened to and that their concerns were taken seriously
- **Environment** – 93% of respondents feel that being in an environment that suits their needs when in crisis is either important or very important
- **Continuity of care** – Over 95% said that receiving appropriate follow-up care after their crisis was either important or very important

### *Key messages from BME workshop*

- Service users said that HBPOS staff were often not very welcoming. It could seem like they were 'preparing for war', treating the individual as dangerous and showing fear of the individual in crisis. This demonstrated a lack of training and the stigma that currently exists.
- Service users often felt that there was not enough joined up thinking for the benefit of the individual in crisis.
- Staff should be mindful of the individuals' cultural and spiritual beliefs and do their best to provide culturally appropriate care.
- Those detained under s136 should be provided with a clear explanation of what is happening in their own language.
- Consideration should be given to ensure that those detained can be assessed by someone of their own gender if requested.
- Onward care plans should give consideration to an individual's social care needs, such as housing and employment, as well as addressing their mental health need.
- More information is needed on the voluntary and community services available including face-to-face and online support. Where possible, efforts should be made to find support groups that align with the individuals cultural and spiritual beliefs. Socialising is an important part of support and access to support groups and peer-support is needed.

### *Key messages from expert by experience videos*

- ED can be distressing and manic for an individual in crisis. ED members of staff do not always understand an individual's mental health need or treat it with the same importance as those with a physical health need.

- Individuals with mental health needs don't want to end up in ED but if they do they want to know physical and mental health staff are working together to coordinate their care.
- Waiting for long periods of time to access care or get a mental health assessment makes a crisis worse. They want to be seen quickly by skilled staff that can care for their mental and physical health needs.
- Individuals don't always know what is happening and members of staff don't always treat them with compassion. They want to be seen by skilled staff that understand mental health and listen to their needs.
- Suitable follow-up care not always available for individuals when they need it. Individuals want to know about all the services they can turn to in their community.
- A bad experience with the NHS means individuals can lose trust in health services and stop engaging in their care. They can then be extremely reluctant to seek help from the NHS when they need it.
- People are extremely hopeful things are going to change and it's a positive step that everyone has been working together to improve the care for patients detained under s136.

### *Key messages from the options appraisal process*

Service users involved in the optional appraisal process (service user and carer advisory groups and reps on the boards) were key to determining the criteria used in the process. The figure below shows the priorities for all age service users and CYP.

*Figure 6: Adult and CYP priorities for the pan-London S136 model of care.*

Adult priorities	Young people priorities
1 Staffing and care: Ensuring specialised skilled staff available to care for patients 24 hours a day.	1
2 Environment: Ensuring the Health Based Place of Safety environment promotes dignity, recovery, comfort and confidentiality for the patient. It offers a therapeutic environment that is safe, well maintained with good access to facilities e.g. washing and toilet.	1
3 Effective pathway with reduced delays: To have an effective pathway from the point of detention to acceptance in a place of safety meaning patients are not waiting in back of police cars or ambulances as well as a timely assessment once at the site.	1
4 Proximity to other health services (24/7 physical healthcare): The site is located close to an A&E to enable easy access to physical health care if required.	2
5 Proximity to other health services (mental health services): The site is located close to mental health services provided within a mental health trusts e.g. inpatient services or other mental health specialist services (not community mental health services).	2
6 The distance from pick up to the site where assessments take place: A close distance between where a service user is detained and where the mental health assessment takes place as well as proximity from the site to the patients place of residence to enable a short journey home following discharge.	3

## How feedback and involvement influenced programme development

**We were told:** People need timely access to care and effective pathways to reduce delays.

### *What is in progress and what has been done:*

London's s136 pathway and HBPoS specification provides an effective pathway which aims to reduce delays. Key standards that promote timely access to care include:

- Individuals detained under s136 must be taken to the closest HBPoS to the site of detention, regardless of where they are resident.
- If there is no capacity at the local HBPoS, it is that site's responsibility to ensure that the individual is received into a suitable place of safety.
- When the HBPoS states that it has capacity, this means it is able to receive the detained individual as soon as they arrive on site.
- When an individual under s136 presents to an ED, the ED cannot refuse access unless a formal escalation action has been enacted.

- The mental health assessment should be completed within 4 hours of the individual arriving at the HBPoS unless there are clinical grounds for delay.

Under the proposed London model, 88.5% of patients will be 45 minutes or less from an HBPoS which is able to provide specialist care through a 24/7 dedicated staffing team. Though the reconfiguration will mean that there are a smaller number of sites, those sites will have a higher capacity.

It is expected that access to care on arrival at the site will be quicker, with fewer incidences of individuals waiting outside HBPoS sites whilst staff are brought in from other areas of the trust to staff the unit. Furthermore, there will be fewer site closures and instances of individuals being transported from one trust to another due to insufficient capacity at an individual site.

By providing sufficient capacity at the HBPoS sites, the proposed option for the new model of care will reduce the average journey time from 64 minutes to 22 minutes for police vehicles and 24 minutes to 22 minutes for ambulance vehicles. This will ensure that patients receive emergency clinical care more quickly. Patient experience will improve as delays are minimised and they can be seen faster by clinical staff trained to care for their needs.

**We were told:** Specialised skilled staff must be available to care for patients 24 hours a day, and not pulled off inpatient wards

#### *What is in progress and what has been done:*

A key feature of London's s136 pathway and HBPoS specification is that all sites should have 24/7 dedicated staff teams to ensure that delays do not occur as staff are sought from other areas of the trust. Furthermore, there are clear expectation for the mental health and physical health competencies for all staff at the HBPoS.

The roles and responsibilities of all non-HBPoS staff e.g. police, paramedics, ED staff etc. are specified in the guidance to ensure clarity as to the expectation for all professionals involved in the pathway.

Under the proposed new model of care, the number of sites () will be reduce to 9 centres of excellence (however overall capacity will not change), this allows the 24/7 dedicated staffing to be feasible at all sites.

Multiagency training has taken place in all mental health trusts and for the London ambulance service in order to ensure that professionals involved in the s136 pathway are clear on their responsibilities under the guidance and the Mental Health Act legislation. Further training sessions will take place throughout 2018/19 with the focus on ED clinical and operational staff.

Furthermore, the programme has supported four of London's mental health trusts with existing dedicated staffing to secure funding from Health Education England and to begin setting up rotational nursing programmes to allow mental health nurses to develop physical health skills in EDs and ED nurses to develop mental health skills by spending time in the HBPOS. These programmes are on-going and hope to be implemented pan-London as centres of excellence develop.

**We were told:** The HBPOS environment must promote dignity, recovery, comfort and confidentiality for the patient.

*What is in progress and what has been done:*

This is achieved both through the physical design of an HBPOS site and staff factors: the training of the staff to use the environment effectively, the compassion and dignity afforded to patients by staff and the relationships within the staff team and with other professionals.

London's s136 pathway and HBPOS specification outlines the requirements for the facilities at an HBPOS. Where HBPOS environments have been co-designed with patients, this can ensure that the environment meets patient, as well as staff, needs. The guidance advises that there is significant service user and carer involvement in the governance and monitoring of HBPOS sites.

The crisis care programme has also supported London trusts to apply for capital funding to ensure facilities developed under the new model of care are fit for purpose with the right capacity.

**We were told:** Proximity to other health services is important, including mental health services and EDs to enable access to physical health care if required.

*What is in progress and what has been done:*

Whilst no EDs are dedicated HBPOS sites under the proposed pan-London s136 new model of care (under guidance from the Royal College of Psychiatry and the Royal College of Emergency Medicine) the options appraisal process ensured that close proximity to both mental health inpatient beds and 24/7 urgent physical care were key criteria points to determine the preferred location of sites in London.

**We were told:** Individuals with mental health problems do not want to end up in ED and if they do, but if they do they want to know ED and mental health staff are working together to coordinate their care.

*What is in progress and what has been done:*

Under the proposed pan-London s136 new model of care, no EDs are designated HBPOS sites (under guidance from the Royal College of Psychiatry and the Royal College of Emergency Medicine). In addition, London's s136 pathway and HBPOS

specification outlines physical health competencies for HBPOs staff to ensure that there are no unnecessary transfers to EDs for minor physical health problems. There is also a clear protocol to ensure that individuals under the influence of alcohol are not automatically transferred to ED including closer working with paramedics.

The rotational nursing programme and ED training sessions described above will support mental health and ED staff to work together and ED staff to clearly understand their role in the s136 pathway.

### How will London's crisis care programme engage with service users and carers in future?

The input of service users and their carers into the London's crisis care programme is vital for its future success and implementation of the pan-London new model of care. Service users continue to be valued members of the Crisis Care Implementation Steering Group and Technical Implementation Group. The London programme will continue to circulate programme updates and upload material to the crisis care pages on [www.healthylondon.org](http://www.healthylondon.org).

Whilst Healthy London Partnership continues to support the crisis care system on a pan-London basis, following the business case for service change outlining the proposed pan-London HBPOs configuration, STPs are taking ownership of planning and delivery at a local level. This will involve public engagement on local plans and taking these through decision making forum within the STP footprint.

London's crisis care programme has initiated work to develop a plan for evaluating the changes resulting from implementation of the new model of care and to collect baseline data for this evaluation. Service users and carers will have an important role, both by providing insight into current care through focus groups, and through input into the design of the evaluation.

## Key presentations and meetings

Throughout the programme information and updates have been given at a number of forums across London. These have been an opportunity to develop plans and receive feedback from a wide variety of stakeholders.

In the table below, a large number of small meetings (1-3 attendees), teleconferences and email exchanges have not been included as it is not practicable to detail such a significant number of interactions with senior stakeholders and frontline staff from police, LAS and NHS trusts.

Meeting	Date	Audience	Purpose
<b>London's Urgent and Emergency care Clinical Leadership Group</b>	Monthly	Urgent and emergency care clinical leads from London	Regular updates on the MHCC programme and securing feedback/ clinical input into the development of the s136 pathway and pan-London model of care; an opportunity to increase support and engagement for the programme to support implementation, particularly around ED issues.
<b>Mental Health London Transformation Board</b>	Regular attendance	Senior London Mental health care stakeholders	Formal reporting updates provided as this is a pan-London Board within HLP governance. This included the presentation of the final business case for endorsement. Feedback and input from the group sought to inform and steer development of the programme.
<b>London's Urgent and Emergency Care Transformation and Delivery board</b>	Regular attendance	Senior London urgent and emergency care stakeholders	Formal reporting updates provided as this is a pan-London Board within HLP governance. This included the presentation of the final business case for endorsement. Feedback and input from the group sought to inform and steer development of the programme.

<b>London Learning Disability and Mental Health Commissioners Network Meeting</b>	June 2018, February 2017	London Learning Disability and Mental Health Commissioners	General update on the MHCC programme ensuring links with MH and LD commissioning and increasing engagement efforts across London. Recent presentation of the business case and proposed London model of care. Feedback sought as well as understanding of any local issues to help inform development/ implementation.
<b>Association of Adult Directors of Social Services Meeting</b>	June 2018 and June 2016	Adult directors of social care London	The London ADASS lead has presented to ADASS colleagues on the MHCC programme over the past couple of years outlining new guidance and London proposals, the engagement with AMHPs and ensuring comments, feedback and potential challenges are fed into the programme.
<b>London Health Board</b>	June 2018, October 2017	The Mayor of London, leaders of London local authorities (LA) and senior representatives from the Health Sector in the capital.	Outline of MHCC programme implementation progress and a request for both the Board's and Mayor's continued support and input into the programme.
<b>NHSE (London) Parity of Esteem Delivery Group</b>	April 2018, September 2017		An overview of the case for change and pan-London model of care

			including the business case for service change. An opportunity to increase engagement and support from NHS London and to align the work with the PoE agenda/ discuss issues relating to this.
<b>MiCapacity workshop</b>	March 2018	MHCC stakeholders including MH Trust staff, the police, LAS and service users.	Linking the London s136 pathway with advances in the MiDOS MiCapacity tool which is looking at a pan-London live capacity tool for place of safety sites/ exploring synergies between the two programmes and opportunities for alignment.
<b>Health Education England - Delivering the Five Year Forward View: Caring for patients at the right time and in the right place</b>	March 2018	Various London NHS staff	An overview of the MHCC work to date with particular emphasis on the development of a rotational nursing programme between HBPOs and EDs; raising awareness of the work and an opportunity to hear feedback and explore synergies with other relevant projects at the event.
<b>London Security Management Specialists Managers Forum</b>	January 2018	Hospital security managers from across London	An introduction to pan-London transformation programmes, specifically what is happening in crisis care to increase understanding of the roles and responsibilities

			of all staff; understanding local issues relating to security and garnering support for and input into the implementation of the s136 pathway across London with these in mind.
<b>Approved Mental Health Professional (AMHP) London Leads Meeting</b>	Various dates- January 2018, March 2017, November 2016, May 2016, April 2016	London AMHP leads	Updates on the development of the MHCC programme with support from AMHP leads involved in the programme; an opportunity for AMHP feedback/ input into development of the pathway and implementation of the new model as well as to understand local issues/ barriers to implementation.
<b>London's Urgent and Emergency Care Improvement Collaborative Event</b>	December 2017	London's urgent and emergency care system stakeholders, including service users.	Workshop at the event dedicated to detailing the London guidance with a specific emphasis on mental health crisis care in ED's. Presentation included input from MHA legal expert. Aim was to understand issues and potential barriers to implementation and to increase awareness and support.
<b>London's Mental Health Trust Chairs meeting</b>	November 2017	Mental Health Trust chairs from across London	An update on the MHCC Programme of work to date; an opportunity to gain input/ feedback to

			inform delivery and to increase /sustain engagement, momentum & support for the work.
<b>Mind London CEO Network meeting</b>	November 2017	Mind charity CEOs London	Overview of the programme provided as well as asking for feedback and support to increase third sector and service user involvement in local implementation of the new model of care.
<b>London's Mental Health Trust Chief Operating Officers</b>	Various dates 2017	Mental Health Trust Chief Operating Officers	Regular updates provided to the London MH Trust COOs on the programmes' progress. Updates provided an opportunity to ask for feedback and continue engagement with senior leaders to ensure continued momentum and support.
<b>London Mental Health Trust Cavendish Square Group</b>	Various dates- November 2017, May 2017	Senior representatives from London's MH Trusts	Regular updates provided to the London MH Trust CE's on the programmes progress. Updates provided an opportunity to ask for expert feedback and continue engagement with senior leaders to ensure momentum and support.
<b>Meetings with CAMHS clinical leads at each MH trust</b>	August 2017	CAMHS clinical leads at each MH trust in London	Meetings to test possible options for CYP HBPOs provision. Feedback from these meetings steered programme towards having CYP HBPOs

			provision in each STP footprint
<b>London Clinical Senate Council Meeting</b>	May 2017, July 2017	Nominated representatives of the Patient & Public Voice, London's Clinical Commissioning Council, Academic Health Science Networks, Local Education and Training Boards, and Directors of Public Health Network and Social Care, and appointed senior health professionals.	Intro to HLP and the MHCC programme, an overview of the work undertaken to date and a request for specific advice and feedback from senate members around next steps in implementation incl. barrier and enablers such as financial challenges, buy-in at both a local and pan-London level.
<b>Metropolitan Police Service Mental Health Liaison Officers meeting</b>	May 2017	Metropolitan Police Service Mental Health Liaison Officers	An overview of the MHCC programme to date; opportunity to increase engagement, ask the officers for feedback/ input into the multi-agency training agenda and uncover local issues/ potential barriers to implementation.
<b>London's Mental Health Trust Directors of Nursing meeting</b>	May 2017	London's Mental Health Trust Directors of Nursing	An overview of the MHCC programme to date with particular emphasis on options appraisal & Pan-London configuration criteria; an opportunity to seek feedback, increase engagement/ support from the nurses and to understand if anything additional needs to be considered during

			development/ implementation.
<b>London's Mental Health Trust Medical Directors meeting</b>	May 2017; May 2016, May 2015	London's Mental Health Trust Medical Directors	An overview of the MHCC programme to date with particular emphasis on options appraisal & Pan-London configuration criteria; opportunity to increase engagement/ garner support from the MDs and their clinicians to ensure clinical input.
<b>London ED Consultants Network meeting</b>	May 2017	London ED consultants	An overview of the MHCC programme to date with a particular emphasis on the changes in legislation; opportunity to seek feedback and info on ED related issues/ potential barriers to implementation.
<b>London Care Quality Commission Mental Health Team meeting</b>	May 2017	Care Quality Commission London mental health team (30 attendees)	An overview of the MHCC programme to date with particular emphasis on comparison between RCPsych guidance and the London specification; a call for feedback /input to direct development and a call for support from the CQC.
<b>London Mental Health Senior Commissioners meeting</b>	Various dates- April 2017, February 2017	London's Mental Health senior commissioners	Regular updates on the progress of the MHCC programme and opportunity for feedback/ input from a commissioning perspective as well as support (e.g. explore

			local governance & nominate a member to join the MHCC Implementation Steering Group).
<b>London Clinical Commissioning Group Chief Officers meeting</b>	April 2017, July 2017	Chief officers London	Update on the progress of the MHCC programme; opportunity for feedback to inform development and a consultation on how the group would like to be engaged with /updated going forward.
<b>London Mental Health Clinical Network Leadership Group</b>	Various dates 2016		Regular updates and opportunities for feedback on the programme ensuring clinical input into the development of the s136 pathway and pan-London model of care. Also an opportunity to increase support/ engagement for the programme to support implementation
<b>London Directors of Nursing meeting (acute and mental health trusts)</b>	October 2016	Directors of nursing (45 attendees)	An update on the MHCC Programme to date and an opportunity to gain input/ feedback to inform deliver, increase engagement & support amongst nursing and to understand any issues pertaining to this group / potential barriers to implementation.
<b>Westminster briefing</b>	October 2016	25 attendees	Presentation on London's s136 pathway by Briony Sloper (LAS) and Dan

			Thorpe (Metropolitan police) to raise awareness and gain feedback.
<b>NHSE (London) Sustainability and Transformation Executive</b>	October 2016	Pan-London	An update on the MHCC programme and London's new model of care to raise awareness and gain feedback from NHSEL executives to inform implementation.
<b>S136 pathway scenario testing workshop</b>	September 2016	Multiagency s136 pathway stakeholders (14 attendees)	Testing of s136 patient scenario pathways with stakeholders to understand issues, barriers to implementation and to inform delivery of the programme.
<b>BEH Inter-Agency Mental Health Law Monitoring Group</b>	June 2016	Multi-agency stakeholders involved in MH law within BEH trust	An update on the MHCC programme to date and an opportunity to gain input, understand issues and increase engagement / support amongst this group.
<b>London Mental Health Partnership Board meetings</b>	Oct 2015; Jan & Apr 2016	Senior mental health crisis care stakeholders	An introduction to the pan-London MHCC programme including the scope of the programme and what it is proposed to cover in regards to s136, ensuring strong links and alignment with work that was being led by the Partnership Board.
<b>Mental Health</b>	Various (May,	London urgent and	The MHCC subgroup

<b>Crisis Care Subgroup meetings</b>	Jul, Sep, Nov Dec 2015; Jan; Mar, May, Jun 2016)	emergency care and MH crisis care stakeholders	was a precursor to the Implementation steering group (see below). Meetings were held to inform and progress the development of the case for change, as well as the scope, content and direction of the MHCC programme.
<b>London Nursing Leadership forum</b>	June 2016	Acute and mental health trust nurses (40 attendees)	An update on the MHCC Programme progress and an opportunity to gain input/ feedback to inform direction, hear about issues/ potential barriers and to increase engagement & support.
<b>London AMHP workshop discussing staffing models for AMHP options</b>	June 2016	London borough of Newham AMHPs (12 attendees)	Workshop facilitated by Simon Pearce (London ADASS lead) to discuss alternative staffing models for AMHPs to support implementation of the new model of care and to hear about challenges faced by this group that may hinder implementation as well as possible solutions.
<b>London borough Mental Health Officers meetings</b>	June 2016	Metropolitan police borough mental health officers (50 attendees)	Update provided to London's borough MH officers assigned to each Trust outlining details of the London pathway, asking for feedback and information on issues experienced / barriers faced as well as expectations from officers

			and other staff groups to inform development of the programme.
<b>St. Mary's Psychiatric Liaison team meeting</b>	April 2016	Psychiatric Liaison Team (8 attendees)	Engagement and feedback on the s136 pathway and HBPoS specification as well as understanding local issues and concerns/ potential barriers to implementation.
<b>ED mental health subgroup meeting (St. Mary's hospital)</b>	April 2016	ED staff members	Engagement and feedback on the s136 pathway and HBPoS specification as well as understanding local issues and concerns/ potential barriers to implementation.
<b>St. Thomas' ED Psychiatric Liaison team</b>	April 2016	Psychiatric Liaison Team (8 attendees)	Engagement and feedback on the s136 pathway and HBPoS specification as well as understanding local issues and concerns/ potential barriers to implementation.
<b>Camden and Islington MH Trust acute divisional meeting</b>	April 2016	Camden and Islington MH Trust Staff members	Engagement and feedback on the s136 pathway and HBPoS specification; understanding local issues and sharing the pathway development to date; call for input/ feedback to shape development.

<b>London Chief Executive Officers (CEO) Mental Health Trusts (Individual meetings)</b>	Various meetings throughout 2016	Individual meetings between programme team and each MH trust CEO in London	An update on the MHCC Programme progress; an opportunity to gain input / feedback to inform development and increase /sustain engagement, momentum & support. To explore local challenges and plans with the CEO.
<b>Implementing the Urgent and Emergency Care Vision in London</b>	November 2015	Broad range of London urgent and emergency care stakeholders	An update on the MHCC Programme progress; an opportunity to gain input / feedback to inform development and increase /sustain engagement, momentum & support.
<b>NHS England National Mental Health Team</b>	July 2015	NHS England national MH team members	An update on the MHCC Programme progress and a call for feedback; an opportunity to define the input & support this group has to offer in terms of informing development.
<b>South London and the Maudsley NHS Foundation Trust induction day</b>	May 2015	HBPoS new staff members	Supporting pilot site induction and its alignment with London's s136 pathway; helping staff understand what they are piloting and the expectations around the project.
<b>London Police Force s136 workshop</b>	May 2015	Police officers from all three of London's police forces (40 attendees)	Workshop lead by Chief Inspector from the Met Police to understand issues faced by front-line officers and to ensure

			they are addressed in the London s136 pathway guidance.
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## Events and workshops

This section outlines additional specific activities associated with programme stages

### London's Mental Health Crisis Care Summit

London's first Mental Health Crisis Care Summit was held at the KIA Oval on 25<sup>th</sup> February 2016 to share learning and best practice in crisis care and explore the changes required in order to meet the needs and expectations of Londoners facing a mental health crisis. The summit brought together multi-agency partners including local crisis concordat groups, the Urgent & Emergency Care networks and key partners such as the Police and London Ambulance Service, to promote partnership working and strategic alignment across national, London and local initiatives. The day comprised of three sessions that allowed delegates to hear from national and London mental health leaders, receive updates on different crisis care programmes and participate in 'share and learn' workshops that focussed on good practice and innovation.

200 delegates attended the day from numerous agencies across all five of London's UEC Networks. There was strong representation from commissioners, providers, clinicians, managers, local authorities and service users.

Feedback on the event received from delegates via evaluation forms and feedback cards was overall positive. Comments highlighted the multiple opportunities to learn from others and hear from service users, while suggestions for improvement included covering less content in the agenda and further involving service users in the design and delivery of the event.

Feedback and discussions from the event was used to inform the development of the programme.

### London's s136 pathway and HBPOS specification development

Over 50 meetings, workshops and pan-London forums took place to inform the case for change and the development of London's s136 pathway and HBPOS Specification, including:

- Service user and carer engagement (as outlined in separate section).

- Establishment of CYP working group (including CAMHS and commissioners)
- Site visits and meetings with pan London organisations including the London Ambulance Service and London's three police forces
- Engagement with acute trust and mental health trust staff including liaison psychiatry staff.
- MH liaison officer workshop
- Police frontline officer workshop
- Scenario testing workshop

### London's s136 pathway and HBPOS specification launch event

On the 12th of December 2016, Mayor of London Sadiq Khan launched [London's s136 pathway and HBPOS Specification](#) at an event at City Hall. The event brought together over 100 delegates from across London's crisis care system to recognise the significant partnership work undertaken and to build momentum to ensure the collaboration continued to implement the guidance. There was significant representation from service users, frontline and senior staff from Acute and Mental Health Trusts, commissioners, London's police forces, London Ambulance Service, Local Authorities and the voluntary sector. Over 10% of attendees were service users and all organisations that formally endorsed the guidance were present at the event.

The event offered a chance to hear from service users and leaders across London's crisis care system, and to provide facilitated multi-agency discussions to familiarise delegates with the new guidance, identify current blockers in the system and understand the further work required to ensure its successful implementation.

The event included presentations from an expert by experience and representative of the NSUN voluntary organisation, Sadiq Kahn (Mayor of London), John Brouder (Chief Executive of North East London Foundation Trust), Fionna Moore (former Chief Executive of London Ambulance Service) and Commander Christine Jones (Metropolitan Police and National Lead for Mental Health). Feedback and discussions from the event were used to inform the crisis care delivery plan to implement the guidance across London.

173 unique Twitter users used the event hash tag #crisiscare16 in 400 posts. These tweets were delivered to over 3 million users and to almost 20 million Twitter streams. The launch of the new guidance was picked up by BBC London News and featured on both the lunchtime and evening programmes. The item featured service user Pat Kenny and Dr Mary Docherty, a psychiatrist from SLaM involved in the

development of the guidance. Dr Marilyn Plant, clinical lead for the programme, was interviewed for BBC Radio London.

### Options appraisal workshops

In order to provide a viable solution to the existing issues, it was necessary to consider the full range of alternative delivery models for the s136 pathway and HBPOs specification. As such, a structured process made up of several steps was required to examine the options in order to identify the most desirable alternative to the status quo.

At each stage, a set of criteria was used to measure the different reconfiguration options in terms of patient experience and outcomes as well as efficiency improvements to the wider system. Before progressing to the next stage of the options appraisal process, the criteria was approved by the Crisis Care Implementation Steering Group, a group including members from the police, London ambulance service, mental health trusts, acute trusts and experts by experience.

Service user groups provided valuable input into the development of criteria and the options appraisal process, as described in the service user section. Frontline staff also had strong input into the options appraisal process, including outlining their priorities for a 'good' staff experience of the s136 pathway; this is shown in the figure below.

Specifically, in May 2017, an options appraisal evaluation workshop was held with senior staff from the different stakeholder groups as well as staff from London's mental health and acute trusts, and service users. At the workshop, pan-London configuration options were reviewed to provide recommendations for the optimal HBPOs configuration for London. The workshop representatives were able to use their experience and expertise to review and critique the options, and share opinions on the impact each option may have on patient experience, outcomes and the wider mental health and acute system. Recommended configuration options were then taken to a focussed testing workshop with mental health and urgent and emergency care clinical leads in June 2017.

At the multi-agency evaluation workshop, it was agreed that the assessment regarding CYP HBPOs sites should be completed in a more focussed session with Children and Adult Mental Health Services (CAMHS) clinicians and commissioners and needed to incorporate wider developments occurring across the CAMHS system. Therefore, a separate CYP options appraisal workshop was held in June 2017 which explored the HBPOs site configuration for CYP in the context of other CAMHS programmes in London. This workshop was supplemented by further engagement with CAMHS clinical leads from each Mental Health Trust which led to the notion that there should be one dedicated CYP HBPOs site in each STP to align

with local pathways; this was incorporated into the final proposed preferred pan-London configuration.

*Figure 7: Staff priorities*

- Staff are **part of a dedicated, skilled team** that have capacity to appropriately manage the service and able to deliver high quality care to those in crisis. Staff are able to maximise their skills due to enough throughput of activity through the site.
- Staff feel **supported in their role** and have access to the right tools and resources to carry out their responsibilities to deliver effective patient care.
- Staff have a **clear understanding of their roles and responsibilities** within the s136 pathway including the powers under the mental health act.
- The **physical environment** is pleasant, well equipped with good facilities and arranged in a way that supports staff to undertake their role.
- Staff **feel safe whilst carrying out their work** and should be supported by clear organisational procedures to reduce risk, and ensure appropriate response.
- Staff are **appropriately trained** to confidently carry out their role, e.g. training in the mental health act and de-escalation, and are provided with opportunity to learn and develop through their work.
- Staff have **positive working relationships** across the multi-agency pathway to allow effective cooperation and to improve morale.
- There are **clear, effective and timely escalation protocols** in place that ensure staff feel able to call on senior staff when necessary to provide additional support.
- There are **clear governance processes in place** for staff to feedback on the service and effectively manage quality, performance and risk.

Following the options appraisal workshops, a dedicated STP implementation workshop took place in mid-July 2017, with leads from each footprint. London's STP leads involved in the programme attended the workshop to discuss how to align outputs from the London-wide HBPOS options appraisal with local implementation and decision making processes. It was agreed at this workshop that more extensive testing with stakeholders would take place, as well as taking local Health Based Place of Safety configuration proposals through appropriate governance boards and forums. With the range of representatives in the room from different London STPs,

the group was able to define what needed to happen locally in order to get to the proposed configuration for HBPoS sites, including engagement methods and timeframes for implementation.

Programme STP leads tested the proposed short list of configuration options locally in late 2017 / early 2018, this included significant engagement with commissioners, Trust representatives, service users, Directors of Adult Social Services and Approved Mental Health Professionals as well as the London Ambulance Service and London's three police forces.

### AMHP workshop

An AMHP workshop was held in June 2017 led by Simon Pearce (Association of Directors of Adult Social Services (ADASS)), with representatives covering all nine of London's MH trusts; this group discussed the challenges that the current AMHP service could face with changes in the configuration of HBPoS sites across London. The group acknowledged that these challenges could be worked through, and proposed options for achieving this, including a pan-London agreement for cross-borough working and dedicated AMHPs to each HBPoS site.

### Physical health competencies workshop

A workshop was held in November 2017 between HLP and Health Education England (HEE) to scope existing opportunities to improve the physical health competencies of HBPoS staff. Discussions highlighted a particular interest in the development of rotational nursing programmes between EDs and HBPoS sites out of which came the HEE funded HBPoS/ED Rotational Nursing Programme (RNP). Twenty-four representatives from seven mental health trusts, four acute trusts (ED representatives), the Royal College of Nursing, Health Education England and the London Ambulance Service attended the workshop.

### Mental Health Act Multi-agency training

Engagement with frontline staff involved in the crisis care pathway was further strengthened by multiagency training developed by HLP. This training was facilitated by an independent legal expert and aimed to inform staff on their roles and responsibilities under the new guidance.

It was also designed to ensure awareness of the Mental Health Act legislation changes and provide an opportunity to discuss with professions from other agencies the challenges for the s136 pathway. They also provided the opportunity to distribute supporting material for the guidance e.g. roles and responsibility [posters](#) for displaying in workplaces.

Over 300 delegates attended the sessions including service users, and frontline staff from MH trusts, LAS, police and local authorities. A [training toolkit](#) was developed to

allow further training to take place locally. Further training sessions will take place in 2018, focussing on the ED role in crisis care.

## Marketing and media

To increase engagement in the development of the s136 new model of care HLP undertook a range of marketing activities including:

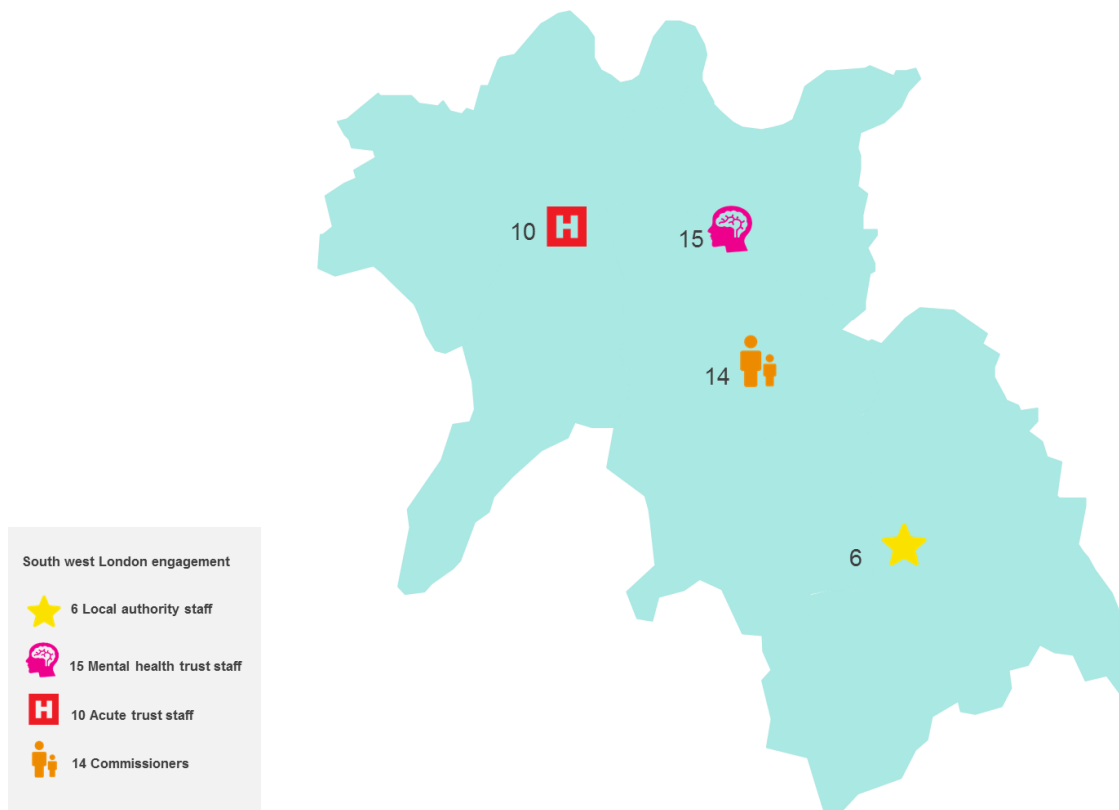
- Social media activity e.g. Twitter (50 HLP Tweets from January 2016 – May 2018)
- Blogs e.g. Mental Health Today; HSJ; [Rethink](#); and Taking the crisis out of mental health crisis care on the [HLP site](#)
- An improving crisis care for Londoners [video](#) outlining the success of the SLAM pilot evaluation (December 2017)
- [In focus briefing](#) - Healthy London Partnership London's s136 Pathway and HBPOS Specification (December 2017)
- [Online news piece](#) on new funding available to support crisis care (October 2017)
- [Online news piece](#) - Successful multiagency training for London's mental health crisis care professionals (July 2017)
- [In focus briefing](#) - Treat as One: Bridging the gap between mental and physical healthcare in general hospitals (April 2017)
- [Online news piece](#) - Specialist A&E mental health support around the clock 24/7 (April 2017)
- Award entries: Shortlisted for the Patient Safety Awards 2018; entered the HSJ awards 2017 and 2018; shortlisted for the Healthcare Transformation Awards 2018.

***London's crisis care programme would like to thank all those involved in the programme thus far and going forward for their hard work and support.***

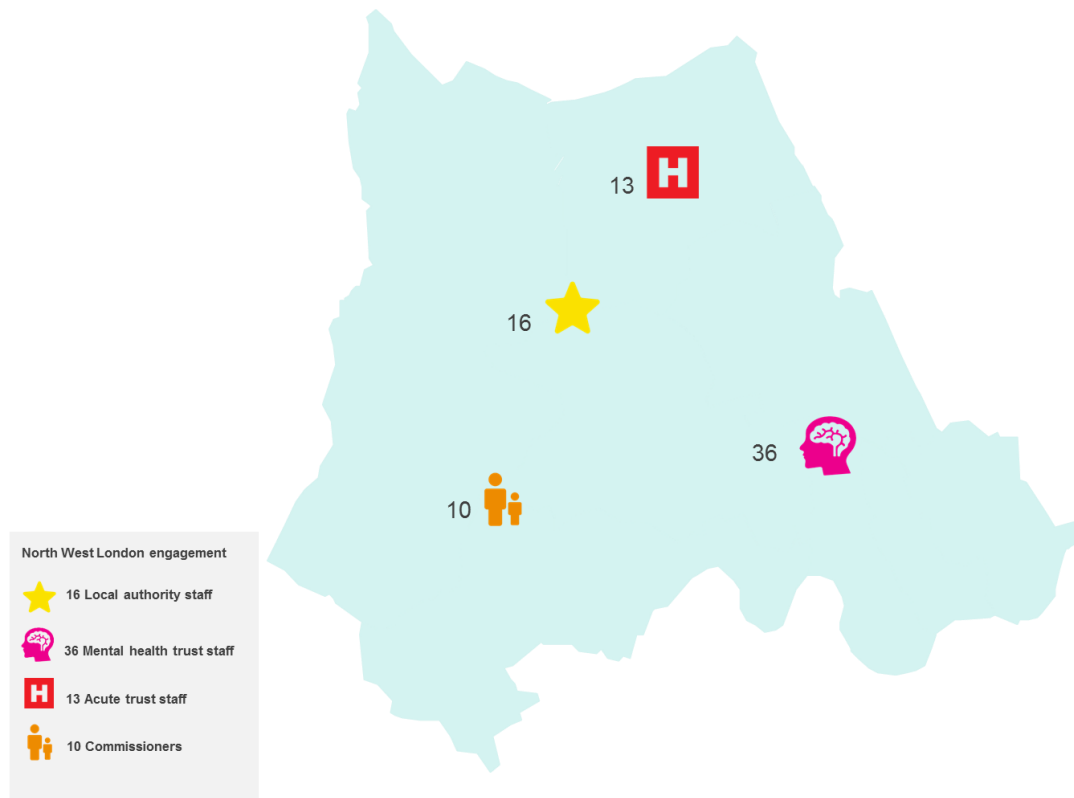
## Appendix 1: STP Engagement Maps

Individual STP maps to show engagement that has taken place more recently since the pan-London guidance has been developed, including activities to support implementation through 2017 and 2018.

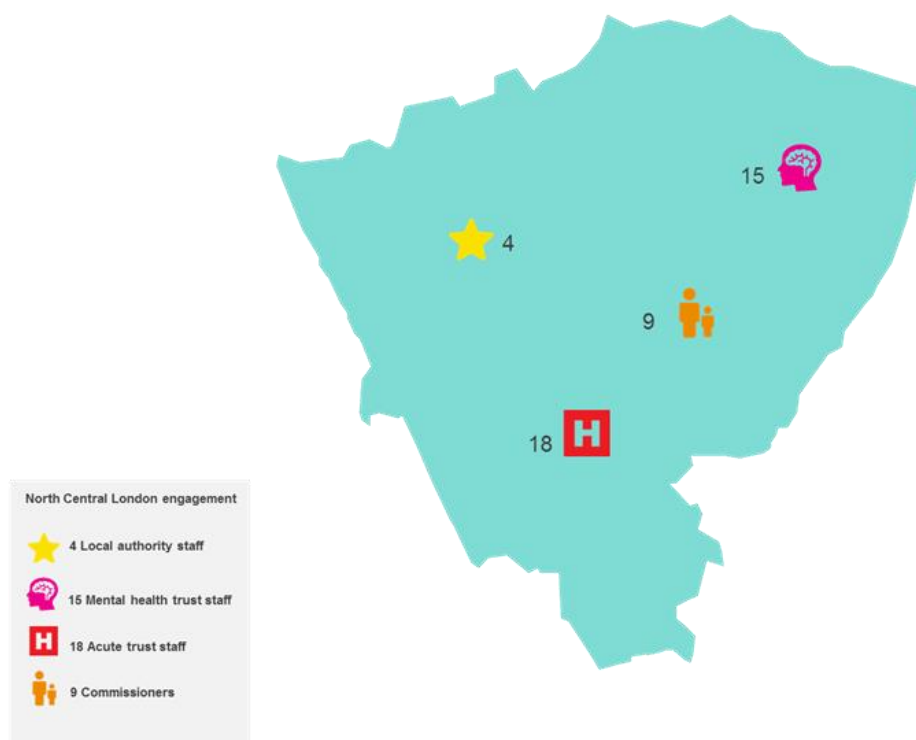
### South West London STP



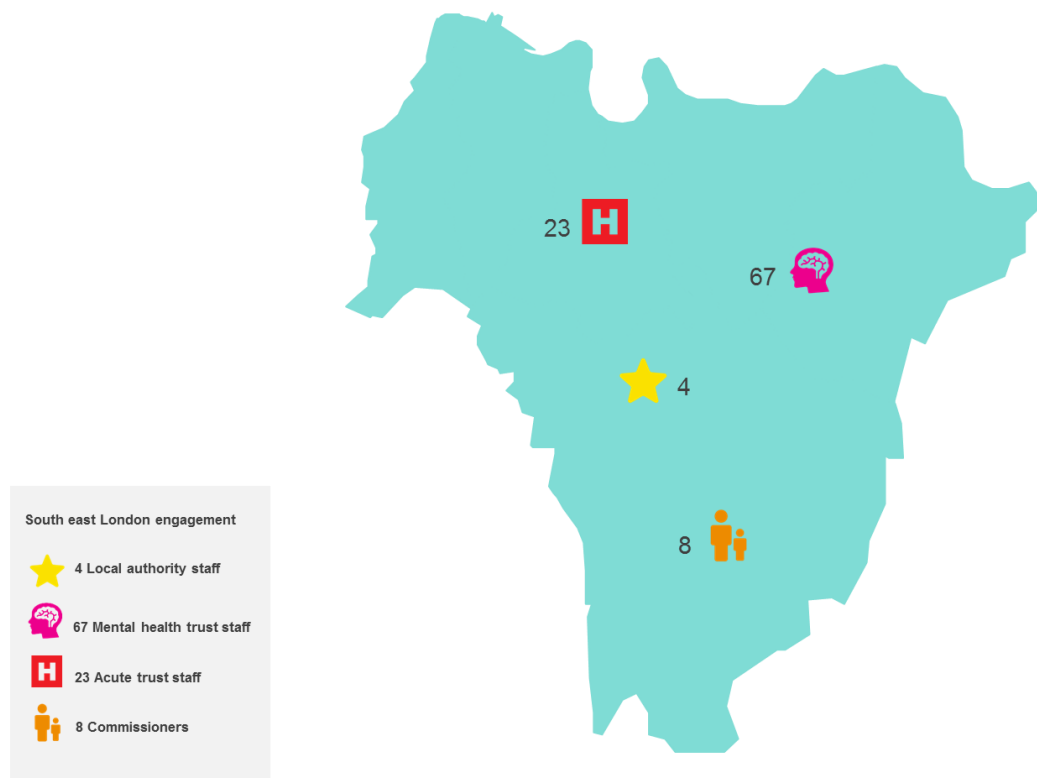
## North West London



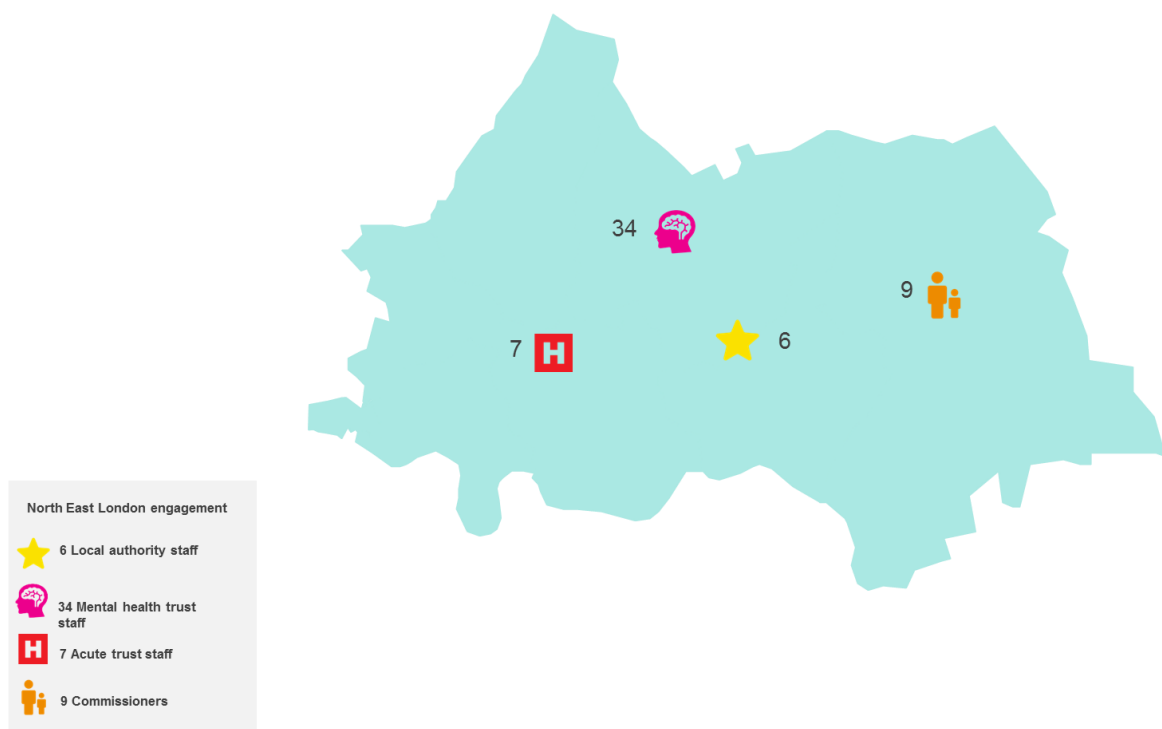
## North Central London STP



## South East London STP



## North East London STP



## Appendix 2: Online survey 2016 demographic information

The information below was collected at two points:

- 29<sup>th</sup> January – the point at which responses were analysed in order to develop initial drafts of the 'I' statements
- 24<sup>th</sup> February – the survey closure date

Characteristic	Online survey at 29/1/16 (104 responses)		Online survey when closed 24/2/16 (154 responses)	
Age				
12-17			3	3
18-24	7	11	12	13
25-34	14	22	16	17
35-44	10	16	17	18
45-54	23	36	31	33
55-64	9	14	12	13
65-74	1	1.5	2	2
75-84			-	-
85 and over			1	1
Gender				
Male	16	25	27	29
Female	48	75	66	70
Other			1	1
Transgender				
Yes	0	0	1	1
No	62	100	88	99
Sexuality				
Bisexual	10	16	13	14
Gay	3	5	4	4

<b>Heterosexual/straight</b>	<b>45</b>	<b>73</b>	<b>65</b>	<b>72</b>
<b>Lesbian</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>3</b>
<b>Other</b>	<b>3</b>	<b>5</b>	<b>5</b>	<b>6</b>
<b>Religion</b>				
No religion	<b>26</b>	<b>41</b>	<b>33</b>	<b>36</b>
Christian	<b>28</b>	<b>44</b>	<b>43</b>	<b>47</b>
Buddhist	<b>1</b>	<b>2</b>	<b>2</b>	<b>2</b>
Hindu	<b>2</b>	<b>3</b>	<b>3</b>	<b>3</b>
Jewish	<b>0</b>	<b>0</b>	<b>2</b>	<b>2</b>
Muslim	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
Sikh	<b>1</b>	<b>2</b>	<b>2</b>	<b>2</b>
Other	<b>5</b>	<b>8</b>	<b>7</b>	<b>8</b>
<b>Long term health condition or disability</b>				
Physical or sensory	<b>12</b>	<b>28</b>	<b>13</b>	<b>22</b>
Learning or developmental	<b>3</b>	<b>7</b>	<b>4</b>	<b>7</b>
Other (mainly mental health problems, also mental health problems with physical disability; diabetes; COPD; stroke survivor; chronic fatigue; asthma; vitamin and iron deficiency)	<b>28</b>	<b>65</b>	<b>43</b>	<b>72</b>
<b>Ethnic group (only groups represented are listed)</b>				
Asian or Asian British - Indian	<b>4</b>	<b>6</b>	<b>7</b>	<b>8</b>
Asian or Asian British – other Asian	<b>1</b>	<b>2</b>	<b>1</b>	<b>1</b>
Black or Black British - African	<b>1</b>	<b>2</b>	<b>4</b>	<b>4</b>
Mixed – White & Asian	<b>1</b>	<b>2</b>	<b>1</b>	<b>1</b>

Mixed – White & Black African	<b>2</b>	<b>3</b>	<b>2</b>	<b>2</b>
Mixed – White & Black Caribbean	<b>1</b>	<b>2</b>	<b>1</b>	<b>1</b>
Mixed – another mixed	<b>1</b>	<b>2</b>	<b>1</b>	<b>1</b>
White – White British	<b>43</b>	<b>69</b>	<b>61</b>	<b>66</b>
White – White Irish	<b>1</b>	<b>2</b>	<b>1</b>	<b>1</b>
White – another white background	<b>5</b>	<b>8</b>	<b>8</b>	<b>9</b>
Other ethnic group - Arab	<b>0</b>	<b>0</b>	<b>1</b>	<b>1</b>
Other ethnic group – another ethnic background	<b>3</b>	<b>5</b>	<b>5</b>	<b>5</b>

## Appendix 3: Service User 'I' statements



## Appendix 4: CYP 'I' statement

**Staff believe what I am saying and take my opinion seriously.** My voice is not ignored just because I have an adult with me and I am not spoken over or about just because I am young.

Those caring for me **involve me** in discussions about my care and listen to what I think works well.

Wherever possible **I am given options** in my care that recognise that I am an individual and that every situation is different

**I am never left waiting on my own without knowing what is going on** and I am always involved in making plans for what happens next.

Those involved in my care **make the effort to get to know me.** They understand that although I may be an adult legally, I may not always feel like one.

Those involved in my care are **always honest with me.** They support me to gain confidence in them when I am feeling vulnerable.

As far as possible **my confidentiality is respected** and only the friends, family and carers that I choose are involved in my care.

**I am supported to achieve my aspirations** for other areas of my life such as education, hobbies and relationships.

Those caring for me **take the time to find out about my fears.** They take them seriously and reassure me.

**I am prepared for the changes which are coming up** and not left feeling I am going into the unknown.



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# Mental Health Crisis Care for Londoners

HBPoS Business Case - DRAFT

March 2018

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# 1 Executive Summary

## 1.1.1 Introduction

The purpose of this document is to provide a business case to support implementation of London's section 136 (s136) new model of care and the proposed reconfiguration of Health Based Place of Safety (HBPoS) sites. This is to improve the efficiency and effectiveness of treatment and quality of care for people experiencing mental health crisis along the s136 pathway and the broader crisis care system.

To implement this innovative new model of care, bold action needs to be taken by London's crisis care system. Strong collaboration and new ways of working across healthcare, social care, police and third sector organisations are imperative, including breaking down the silos that exist between organisations and barriers between physical and mental healthcare. Whilst there must be an increased focus on local action to prevent crises occurring, when a crisis does happen, people experiencing mental health crisis need to have timely, high quality care, which respects individual needs, wherever they are in London.

The voice of people with mental health problems must be at the heart of the changes. Londoners say over and over again that their care whilst in crisis does not meet the basics of dignity, respect and high quality compassionate care. Services are often not delivered in the right environment to help people recover. Londoners are often denied access to HBPoS sites and Emergency Departments (EDs), left in the back of police cars and ambulances, or transferred unnecessarily between EDs and HBPoS sites due to a lack of appropriate and co-ordinated care. There is still not parity of esteem for mental health; as is clearly reflected in the disparity of care for people with mental health issues as opposed to physical ones. People with mental health problems and clinicians have recognised the opportunity to address a forgotten service and make s136 an active part of the crisis pathway.

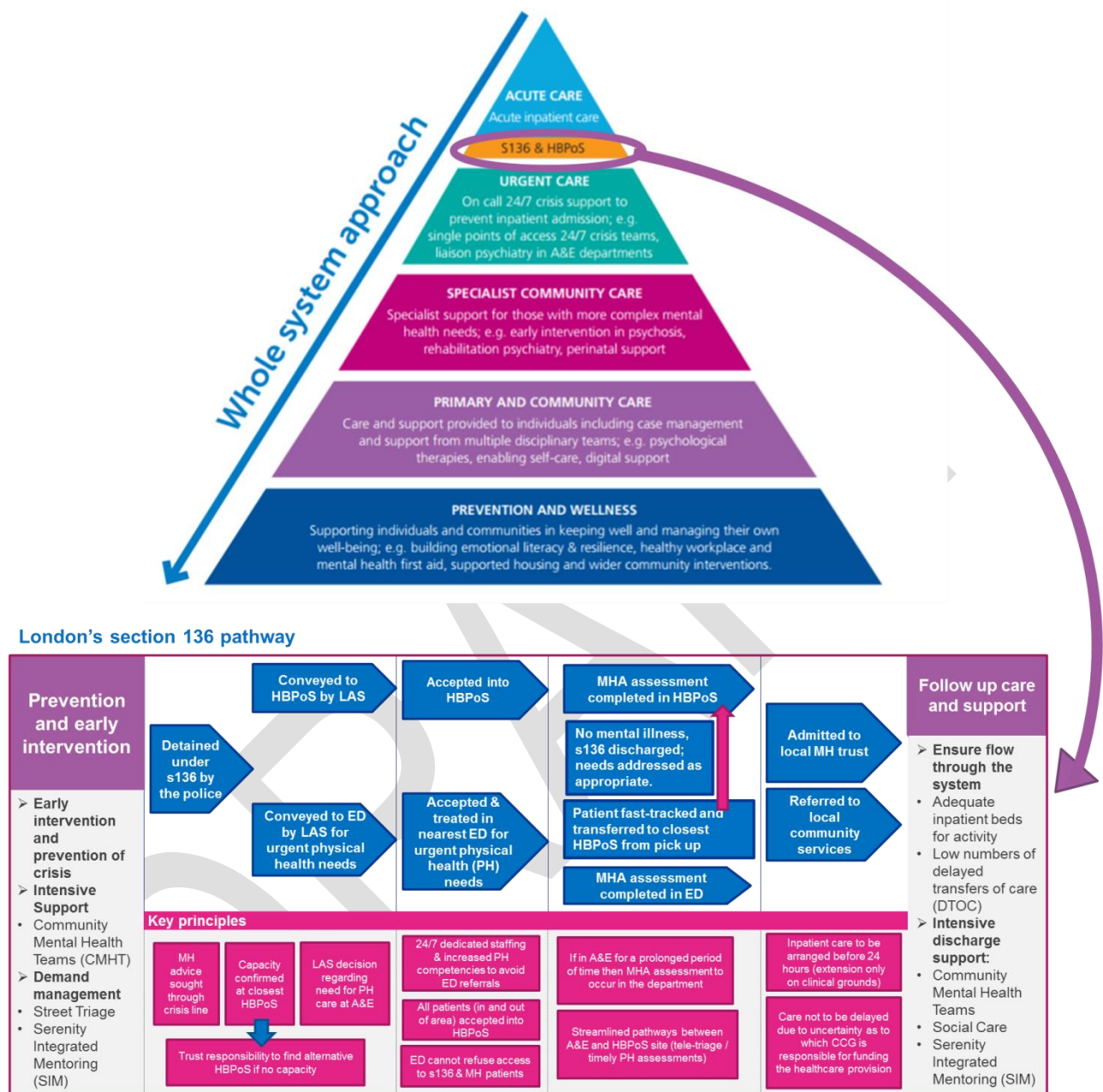
*"There is a stark disparity in the response from the health and social care system to people with mental health vs. physical health problems and this is unacceptable. People with mental health crisis needs are often denied access to care by the NHS in a way that is discriminatory and may have to be conveyed over many hours to multiple points of care in a police vehicle or ambulance in deeply distressing circumstances - sometimes even ending up detained in a police cell. It is unthinkable that this would be tolerated for a vulnerable individual who was physically in need of urgent care."* Mental health service user (2017)

Whilst the new model of care will have positive impacts on the crisis care system as a whole, it is also important to recognise that in order for it to be sustainable, all parts of the wider system need to be functioning well including: preventative initiatives which assist in demand management (such as Street Triage and Serenity Integrated Mentoring (SIM)), adequate flow through inpatient services including reduced delayed transfers of care (DTC), well-resourced and responsive community crisis response, and aftercare teams to support on discharge. The ideal pathway for a person in mental health crisis will involve positive, coordinated interactions with more than one of a range of services that will support them.

The optimal pathway for an individual detained under s136 is detailed below. The diagram shows the pathway is one element of the wider crisis care system; preventative and early

intervention services must be in place to prevent people from reaching crisis point as well as adequate follow up pathways once assessed at the HBPoS site.

**Figure 1: The pan-London's section 136 pathway**



This business case sets out the rationale for improving London's s136 pathway and for the HBPoS site reconfiguration to proceed, subject to completion of all recommendations herein and obtaining regulatory approval and funding.

## 1.1.2 Strategic Case

**London is currently facing significant challenges across the crisis care system owing to rising levels of mental ill health and challenges with current service provision. It is anticipated that services will be required to change to address these challenges and become sustainable in the medium term.**

- ▶ **The vision is to provide safety and high quality care and treatment to people detained under s136** by delivering the following six strategic objectives:
  - Enable the improvement in s136 patient outcomes
  - Facilitate access to 24/7 services
  - Ensure appropriate service provision for all ages
  - Concentrate staff expertise to enable a service suitable to patient needs
  - Ensure synergy with the wider crisis care system
  - Deliver value for money
- ▶ **Delays in accessing support and on-going treatment negatively impacts patient experience and outcomes.**
- ▶ **The new model of care provides the opportunity to achieve improved access and patients outcomes, higher levels of patient satisfaction, positive benefits to staff, deliver 24/7 services, reduce inequality and realise efficiencies** across the local health and care economy and wider society.
- ▶ **There is a continued drive for high quality sustainable care in the NHS.** People with mental health problems, carers, clinicians and regulatory bodies have highlighted that there is too much variation in both quality and access across different services.
- ▶ **Increasing financial and operational pressures** are being placed on mental health Trusts due to demand for services is increasing. Funding does not meet requirements to maintain standards of care; there is a need for all NHS organisations to engage in wider transformational change and service reconfiguration with other agencies towards highly responsive, effective and personalised services for people with urgent physical and mental health needs.
- ▶ **South London and Maudsley Mental Health Trust (SLAM) has piloted the new model of care at their centralised HBPoS site.**
  - An average of 15% more admissions are accepted.
  - Having a 24/7 dedicated team has meant there has been only one closure over the last year; sites were closed 279 times previously over a 12 month period;
  - The number of individuals taken to an ED before going to the centralised site has reduced;
  - 96% of individuals detained are being admitted to the HBPoS within 30 minutes of arrival;
  - The new purpose built facility provides a physical environment which is much more conducive to recovery;
  - 76% of service users provided positive feedback, finding the service more respectful and responsive;
  - The rate of admission to an inpatient bed has fallen by 13%.

## Mental health crisis care in London

London's mental health crisis care system is under significant pressure and simply does not have the services and infrastructure to ensure that people experiencing mental health crisis receive timely, high quality care that respects their individual needs. Across London's s136 pathway there are 20 designated HBPoS sites which vary in capacity, facilities, workforce and services. Most of the facilities are not fit-for-purpose and cannot handle current and future patient activity along the s136 pathway, let alone high quality, effective care.

There is a requirement for delivery of a new model which ensures that people experiencing a mental health crisis have the right care delivered at the right location, at the right time, by staff with the right skillset and in suitable facilities.

Moreover, the potential gains are clear for the NHS and wider public sector from intervening earlier, investing in effective, evidence-based care and integrating the care of people's mental and physical health. In addition to the moral imperative and the clear clinical and individual benefits, it is important to recognise that there is a financial necessity to manage the challenges of the years ahead.

The proposal is in line with wider policy goals relating to health and social care and particularly mental health care provision in England. Providing a better service to those detained under s136 will contribute to the aims and objectives outlined in the Crisis Care Concordat and the NHS Five Year Forward View. It also aligns to Mental Health and Urgent and Emergency Care (UEC) deliverables within London's STP plans and ensures the *pan-London s136 pathway and Health Based Place of Safety specification* (endorsed by all key stakeholders and launched by the Mayor of London in late 2016) is met.

### Issues across the s136 pathway and current HBPoS configuration

There are six key issues across London's s136 pathway and the current HBPoS configuration, which all play a role in affecting the experience of those in mental health crisis.

- **Inconsistent quality of care:** The care on offer at London's HBPoS sites can vary due to differing levels of staff training and skillsets of the staff allocated to HBPoS sites. London's service users and clinical staff have indicated the current 'ad-hoc' staffing model, where staff are pulled off wards when a person detained under s136 arrives, is not conducive to good patient care, both to those detained under s136 but also those on the ward where staffing numbers are depleted for a 12-24 hour period. Some sites across London also indicated that nursing and medical staff were not trained in de-escalation, which is recommended for managing those with disturbed behaviour.
- **Inappropriate provision for Children and Young People (CYP):** Patients who are under 18 require appropriate facilities and specialised staff that can respond to their specific needs. However, at present many of London's HBPoS sites have local protocols that restrict children and adolescents from the site. EDs are regularly used as the default position when HBPoS sites are unable to manage CYP detained under s136. When this occurs children can be in the ED for a 24-72 hour period due to lack of appropriate staffing but also the lack of Child and Adolescent Mental Health Services (CAMHS) beds available in London.

- **Delayed and unreliable access to care:** London's three police forces, the London Ambulance Service (LAS) and NHS Trusts continuously struggle to find capacity at HBPoS sites. This is primarily due to sites not having sufficient capacity to meet demand and because the absence of 24/7 staffing prevents effective patient flow, both in and out of hours. As the number of s136 detentions increase, this adds additional pressure to London's EDs and increases the length of time people are detained due to waiting in the back of a police van, ambulance vehicle or in ED.

A typical Emergency Department sees on average 300 patients a day who are in the department for an average of 2.5 hours. When an individual detained under s136 is in the department they spend on average 12 hours due to their complex health and social needs. This means that the care for one person detained under s136 is the equivalent of being able to treat ten other patients, based on the time s136 patient spend in department being five times that of other patients and requiring twice as much resource.

Treating a s136 patient in A&E takes on average the same resource as treating 10 physically ill patients and patients are significantly more likely to breach the A&E 4 hour standard and 12 hour standard. In an average A&E department, seeing 300 non-s136 patients a week, 10 patients equates to 3.3% of standard daily activity and therefore by treating s136 patients in a more appropriate environment frees up A&E resource and would positively impact on performance against the A&E standards.

Clinical staff have noted that delays in accessing support and on-going treatment negatively impacts patient experience and outcomes. Staff have stated that those who experience poor treatment at the start of the pathway are less likely to engage with health services, co-produced crisis plans are jeopardised and a lot of the trust between clinicians and the patient is lost.<sup>1</sup> This is illustrated by the fact that in 2015/2016 there were approximately 320 Londoner's who were detained again under s136 within two days.<sup>2</sup>

- **Challenging treatment environments:** A number of HBPoS sites were deemed not fit-for-purpose by the Care Quality Commission (CQC). It is important that during a mental health crisis, the treatment environment supports a good experience for those detained, staff efficiency and protects safety including that of staff. This problem in London is intensified by the fact that four of the designated HBPoS sites are EDs; whilst in some instances it is necessary for mental health crisis patients to attend an ED due to specific physical health needs e.g. overdose or self-harm, it is recognised that a busy ED is not always the most suitable environment for the care of patients in mental health crisis.
- **Funding issues:** Current funding arrangements do not promote Trusts to accept people into HBPoS sites based on need but rather a number of people are accepted and assessed based on their home address or registered GP. This causes delays and inconsistent and variable care across London; patients are denied access to urgent mental health care - something that does not happen to Londoner's who require urgent physical healthcare.

<sup>1</sup> NHS - Mental Health Crisis Care for Londoners: London's section 136 pathway and Health Based Place of Safety Specification

<sup>2</sup> NHS - Mental Health Crisis Care for Londoners: London's section 136 pathway and Health Based Place of Safety Specification

- **Inpatient bed availability:** The lack of inpatient beds in London impacts on the s136 pathway increasing the length of time patients spend at HBPoS sites. In line with the Mental Health Act, Approved Mental Health Professionals (AMHPs) cannot complete the Mental Health Act assessment until a bed is found. The lack of inpatient beds causes a delay in completing the assessment and there is now additional pressure given the recent changes to the Mental Health Act<sup>3</sup>. Currently, the London average is approximately 41% of those detained under s136 are admitted to an inpatient ward following assessment.

Evidence from elsewhere in the UK and in London (e.g. Birmingham and South London and Maudsley Mental Health Trust) suggests that confronting these issues can lead to improvements in patient experience and outcomes, reduced inpatient admissions and decreased readmissions. It is important that the rest of London follows suit.

### Pilot of London's s136 new model of care

South London and Maudsley Mental Health Trust is the first Trust in London to fully implement the London s136 pathway guidance and HBPoS specification to provide a 24/7 staffed place of safety for adults and children detained under s136. Healthy London Partnership with stakeholders from across the crisis care system have evaluated the new model of care which has received overwhelmingly positive feedback from service users as well as significant improvements in the pressure often experienced by the police, paramedics, EDs and the sites themselves. The key findings include:

- The site accepts on average 15% more admissions than previously across the four sites in that area. The activity increase represents the amount of patients turned away at previous single occupancy sites located in Croydon, Lambeth, Lewisham and Southwark;
- Having a dedicated team at the centralised site has meant that it has only been closed once over the past year - a stark improvement - sites were closed 279 times previously over a 12 month period;
- The number of individuals detained under s136 that have had to be taken to an ED before going to the centralised site has reduced - partly due to the fact that the staff based at the pilot site are better trained to address physical health issues;
- Individuals detained under section 136 are being admitted to the sites quicker, with 96% of cases being admitted within 30 minutes of arrival;
- The physical environment has been transformed through the new purpose built facility which is much more conducive to recovery;
- Service user's satisfaction with the centralised site has significantly improved with 76% of service users providing positive feedback;
- The rate of admission to an inpatient bed has fallen by 13% under the new model following comprehensive assessment by dedicated staff; and
- Improving flow will be important to reduce the time patients are detained at the suite in light of new legislation.

The feedback from service users is that they received a more respectful, more responsive and less fragmented experience from all agencies involved; from the police and ambulance services, to ED and social and mental health services.

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<sup>3</sup> Revisions to the MHA (1983) changed the length of time an individual can be detained under s136 from 72 to 24 hours.

### 1.1.3 Clinical Case

**London's mental health crisis system is facing a number of clinical challenges that have been identified through significant engagement with people with lived experience of mental health crisis, the LAS and clinical staff at both HBPoS sites and EDs and corroborated by the CQC, most recently in a report published in July 2017.**

The new model of care will contribute significantly to improving these challenges and help deliver better outcomes to Londoners:

1. **Improve the quality of care** by enabling more capacity across the system, better environment conditions and suitably trained and dedicated staff teams, enable the delivery of a consistent level of care for all, which support reduced inpatient admissions and readmissions.
2. **Improve the provision of care for CYP** by increasing the capacity of appropriate facilities for CYP with suitably trained staff.
3. **Improve access to care** by being better placed to accommodate capacity and demand, supporting reduced ED admissions, providing dedicated staffing 24/7, reducing conveyance time and enabling patients to be assessed and treated holistically and comprehensively.
4. **Improve the environment in which care is provided** by ensuring patients are treated with respect, comfort and dignity and feel safe at all times, in fit-for-purpose facilities.

Implementation will be carried out with strong clinical engagement and leadership to ensure clinical quality is maintained and improved at all sites throughout the transformation.

In the existing system, there are a number of clinical challenges along the s136 pathway which affect patient experiences and outcomes. These include:

- **Inconsistent quality of care** - Only 14% of people with experience of mental health crisis interviewed said that they had the support they needed in a crisis.<sup>4</sup> Issues within the crisis care system, such as the delays and unsuitable environments discussed above, contribute to potentially harmful patient experiences. Patients have also shown a clear preference for 24/7, dedicated crisis services even if that means travelling marginally further to access care. Patient experiences also vary due to differing levels of staff training and skillsets at the HBPoS sites and EDs. Staff who are not dedicated to treating mental health crisis patients feel less confident in their ability to contribute to mental health assessments;
- **Inappropriate provision for CYP** - In a survey by the Royal College of Psychiatrists, 79.1% of respondents reported safeguarding concerns while CYP waited for an inpatient bed; 61.9% reported young people being held in inappropriate settings such as paediatric and adult wards, police cells, and EDs.<sup>5</sup> The use of adult wards and EDs for managing

<sup>4</sup> Healthy London Partnership (2015) UEC Programme: 'I' statements

<sup>5</sup> Survey of in-patient admissions for children and young people with mental health problems. RCPsych, Faculty Report CAP/01

CYP has been described as problematic by stakeholders due to the perceived lack of staff expertise together with inappropriate facilities to care for CYP;

- **Delayed and unreliable access to care** - In 2015, over 100 issues related to HBPoS capacity and access across the s136 pathway were reported by frontline police officers.<sup>6</sup> This number increased in 2016 and 2017, with some instances of police officers and paramedics recording waits of over seven hours in accessing care, despite it being clear that without prompt intervention, a patient's mental health condition can deteriorate. A poor experience at the beginning of the s136 pathway can have traumatising effects for individuals, leading to worse clinical outcomes and a reluctance to seek professional help in the early stages of any future deterioration in mental health; and
- **Unsuitable treatment environments** - London's treatment environments for people experiencing mental health crisis vary, but often fail to provide a therapeutic setting for patients. In their most recent reports from 2016 and 2017, the CQC rated two London HBPoS sites as 'requires improvement' and one as 'inadequate'. The feedback is even worse for those that are transferred to Emergency Departments due to capacity issues; only 12% of those assessed in an ED thought their assessment rooms were pleasant, comfortable and welcoming.

**The reconfiguration of HBPoS sites seeks to address these challenges through:**

- Reducing delays throughout the pathway including improving the access to care, approximately 45% and 23% reduction in average police and ambulance conveyance times respectively and a 29% reduction in time spent at the HBPoS;
- Improving the treatment environment and staff expertise in both mental and physical health to support improved patient experience and outcomes.
- Reducing approximately 531 unnecessary ED attendances due to improved access and improved physical health competencies of HBPoS staff; this equates to resources for 5310 additional patients or 12,744 extra hours of patient care, which would become available to treat other patients.
- Each person detained under s136 attending ED accounts for 3.3 percentage points of activity (equivalent of 10 other patients) which if not seen will directly impact on performance against the four hour and twelve hour standard.
- Decreasing the overall rates of inpatient admissions and readmissions, 20% (1061 admissions) and 48% (2547 readmissions) respectively.
- Reduction in LAS handover time; LAS estimate a nine minute improvement in the handover of s136 patients, it is clear that this will have a positive impact on the majority of waiting and handover times across London.

These benefits have been demonstrated by models both nationally and in London that have made changes that reflect the new model of care.

<sup>6</sup> Metropolitan Police Mental Health Escalation Log (2015)

### 1.1.4 Economic Case

**The current configuration of HBPoS sites in London is not conducive to meeting the standards outlined in the pan-London s136 pathway and HBPoS specification.**

HBPoS sites are historically located where space has been available; however, capacity issues, a lack of dedicated, skilled resource (both in and out of hours) and lack of access predicated on geographic location of need are all drivers for a change of the current configuration.

- ▶ A robust options appraisal has demonstrated a reconfiguration of HBPoS sites is required to meet the new model of care. The options appraisal showed a preference of moving to:
  - **Nine site model for adults** with a combined workforce model (*further details on the workforce model is detailed in the workforce chapter*); and
  - **Five sites (one in each STP) within the nine site model that provide an all-age service.**
- ▶ The options appraisal represented the best option to address the mental health crisis care problems across London, bringing sustainable improvements and lasting benefits for patients, as well as driving improvements in the wider health economy.
- ▶ This option is the preferred state for London's future HBPoS site configuration; however a **transitional 13 site phase** has been developed following STP programme leads engaging locally on proposed configurations.
- ▶ The **indicative benefits** of the reconfiguration based on nine sites have been quantified by estimating the NHS financial savings as well as measuring the social impact of nine key outcomes.
  - NHS financial savings total £14,384k
    - £795k cashable / £13,589k non-cashable
  - Social impact savings (non-cashable) measured at £5,572k
- ▶ The **total baseline pathway cost is c. £20,632k p.a. (excluding activity growth).**
- ▶ The **total estimated cost of the reconfiguration is £23,744k** which includes the following:
  - Pathway cost £20,494k p.a.
  - Transition costs £1,000k
  - Capital costs £2,250k
- ▶ The **indicative net present benefit** of the reconfiguration over the five year period FY17/18 to FY21/22 is £73,927k which includes;
  - Net present value of non-cashable benefits (excluding non-pay costs) £66,174k
  - Net present value of the preferred option £7,753k

## Overview

A detailed options appraisal has been carried out in order to arrive at the preferred option, the 'consolidated model' of nine HBPoS sites. Within the nine site model the outcome of the options appraisal was that within each STP, one of the HBPoS sites should provide an all-age service with the appropriate facilities. This is to ensure those that are under 18 receive care in a suitable HBPoS site with adequate facilities and that EDs are not used.

Following the options appraisal, further engagement led by programme STP leads took place across the system on the preferred option. The engagement process resulted in some STPs confirming sites that would be included in a pan-London nine site model whilst others required more time to develop local plans, reflecting on other crisis care services and further understanding the impact of patient flow across local systems. This is particularly the case (but to varying degrees) in North West London (NWL), North East London (NEL) and South East London (SEL).

This resulted in a transitional stage of 13 HBPoS sites across London (including five sites that provide an all-age service). The 13 site transitional stage is referenced throughout the following chapters with further detail in the management case.

## Options appraisal

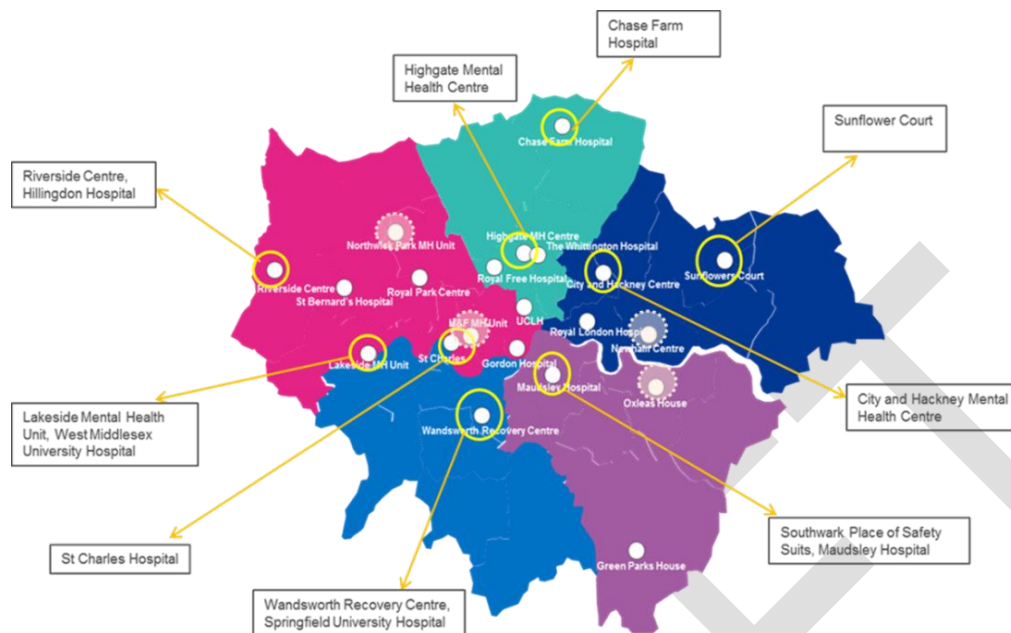
The options appraisal process comprised of three phases:

- Phase 1a: Site agnostic appraisal
- Phase 1b: Site specific appraisal
- Phase 2: Pan – London site configuration assessment
- Phase 3: Preferred option

At each phase, a set of criteria was used to reduce the millions of potential configurations to one preferred model. These criteria included quality, access to care, deliverability, strategic coherence and value for money. Figure 2 provides a map of the preferred 9 site configuration following the options appraisal as well as additional sites in the transitional phase (faded circles)<sup>7</sup>.

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<sup>7</sup> City and Hackney Centre for Mental Health received a marginally higher options appraisal score than Newham Centre for Mental Health. For this business case, the former is considered the preferred site, however as implementation plans progress the preferred site may change.

**Figure 2: Pan-London consolidated HBPoS site model**

All sites within the 9 and 13 site model are suited for adult provision, with one site per STP providing an all-age service. The preferred CYP sites in the transitional 9 and 13 site model are: The Wandsworth Recovery Centre (SWL), Maudsley Hospital (SEL), Highgate Mental Health Centre (NCL), and St. Charles (NWL). Newham Centre for Mental Health (NEL) is the preferred all-age site in the 13 site model; however, on transition to the 9 site model, the all-age provision will need to be reassessed as the Newham Centre is not included.

Some of the key attributes of the consolidated model are:

- The location is spread evenly across London, ensuring equity of inner and outer London, but also at an STP level. The consolidated approach, with dedicated staffing, also ensures that capacity is adequate to deal with fluctuations in demand at peak hours;
- Eight of the nine sites are within 0.5 miles<sup>8</sup> of an ED, ensuring that urgent physical care can be accessed if required;
- 100% of the sites are within 0.5 miles of an inpatient mental health bed (both adult and CYP);
- 88.5% of the s136 cohort will be 45mins<sup>9</sup> or less away from an HBPoS site. For the remainder of those detained under s136, the average time would be 53 minutes, with a range of 48 – 56 minutes. If patients were to be conveyed by blue light (only when suffering a life threatening clinical condition), 100% would be 45mins or less away; and

<sup>8</sup> 0.5 miles was agreed by service users, carers and operational staff to be the maximum distance HBPoS sites should be from inpatient and physical health services.

<sup>9</sup> 45 minutes travel time aligns to the timeframes used for London's stroke and trauma reconfiguration and is consistent with national and international good practice.

- The utilisation of facilities and staff will significantly improve, with an expected capacity utilisation of 58% and workforce utilisation of 62% across the nine sites. Based on 5,307 s136 patients equating to 58% utilisation, this would provide a range of 5,307-9,150 at peak capacity (100% utilisation), providing headroom to allow HBPoS sites to better manage peaks and troughs in activity.
- Furthermore, the experience from SLAM's centralised HBPoS illustrates that quieter periods give time for on-site training and for adequate breaks and reflection in what is on other occasions a high intensity environment; this has a positive impact on staff wellbeing and contributes to high retention rates.

## Economic costs and benefits

The Economic Case also outlines the indicative economic costs and benefits of the nine site model. This chapter focuses on the nine site model; further information on costs and benefits for the 13 site transitional phase is outlined in the management case.

The total estimated pathway cost of the preferred option is £20,494k p.a. giving a £138k saving on the baseline pathway cost of £20,632 p.a. (excluding impact of activity growth). In addition, the preferred option assumes transition and capital costs of £1,000k and £2,250k respectively will to be incurred through FY17/18 and FY18/19. In particular, the consolidation of HBPoS sites will require an increase in capacity for the majority of sites within the preferred option, for example through an increase in the number of assessment rooms, thereby necessitating capital investment. These costs are discussed in more detail in the financial case.

A range of benefits, which are designed to specifically enhance patient experience along the s136 pathway, include the financial, economic and social values which will be realised as a result of implementing the new model of care which includes the consolidation of HBPoS sites.

Table 1 below sets out the financial benefits totalling £14,384k which are estimated to be delivered, £795k of which is assumed to be cashable, £13,589k non-cashable. In addition, a further £5,572k social impact savings have been identified as part of the nine site option analysis. Table 2 sets out the indicative benefits per STP / HBPoS, both cashable and non-cashable, with the allocation calculated on a capitation basis; this will require further review and analysis at next business case stage.

**Table 1: Benefits overview**

No.	Outcome	Financial (cashable) benefit Value p.a (£000)	Financial (non-cashable) benefit Value p.a (£000)	Benefit of measuring social impact (non-cashable) - Value p.a (£000)	Total Value p.a (£000)
1a <sup>10</sup>	Reduced conveyance time (ambulance and police vehicle)	£498	-	£14	£512
2	Reduced ED admissions	£297	-	£60	£357
3	Reduced length of stay at HBPOs	-	-	£87	£87
4	Improved staff expertise	NA	-	NA	Qualitative
5	Improved HBPOs environment	-	-	£335	£335
6	Reduced non-pay costs	-	£5,542*	-	£5,542
7	Reduced inpatient admissions	-	£7,918**	£4,606	£12,524
8	Reduced HBPOs readmissions	-	£129**	£470	£598
9	Improving the wider crisis care system	NA	NA	NA	Qualitative
	<b>Total</b>	<b>£795*</b>	<b>£13,589</b>	<b>£5,572**</b>	<b>£19,956</b>

\* Financial benefits figures included in the preferred pathway costing analysis in section 5 of this business case

\*\* Total non-cashable benefits figure (£13,619k combined) included in indicative net benefits calculation in subsection 4.2.5 of this business case

**Table 2: Benefits overview by STP / HBPOs**

	STP	NCL		NWL			NEL		SEL	SWL	
	HBPoS	Chase Farm H	Highgate MHC	Lakeside MHU	Riverside C	St Charles	City & Hackney MHC	Sunflower Ct	Southwark	Wandsworth	
No.	Outcome	Indicative preferred option benefits (£'000s)									Total £'000s
1	Reduced conveyance time (ambulance vs. police vehicle)	£106		£103			£142		£111	£50	£512
2	Reduced ED admissions	£74		£72			£99		£78	£35	£357
3	Reduced length of stay at HBPoS	£5	£13	£9	£2	£6	£16	£8	£19	£8	£87
5	Reduced non-pay costs	£20	£50	£35	£9	£24	£61	£32	£73	£33	£335
6	Reduced inpatient admissions	£326	£824	£575	£141	£396	£1,014	£521	£1,205	£540	£5,542
7	Reduced HBPoS readmissions	£736	£1,862	£1,300	£319	£894	£2,292	£1,178	£2,723	£1,220	£12,524
8	Improving the wider crisis care system	£35	£89	£62	£15	£43	£109	£56	£130	£58	£598
	Total	£1,303	£2,838	£2,156	£486	£1,363	£3,733	£1,795	£4,339	£1,944	£19,956

In total, after considering financial and non-financial savings, the indicative net present value of the preferred option over the five year period FY17/18 to FY21/22 is estimated at approximately £70,931k which includes:

- Net present value of non-cashable benefits (excluding non-pay costs) £66,174k; and
- Net present value of the preferred option £4,757k.

<sup>10</sup> Combined benefit for LAS and Police

## Improving the wider crisis care system

The new model of care and reconfiguration of HBPoS sites across London will not only have a direct impact on the s136 pathway; it will have wider implications for the entire crisis care system in the capital:

- The first notable benefit is that the new model will future proof services. The reconfigured sites allow capacity to be utilised in a more sustainable manner, ensuring that infrastructure can better cope with volatility in demand and potential growth in coming years;
- Successful implementation of a pan-London model with improved facilities and a high quality standard of care will raise the profile of crisis care as a whole and is likely to encourage future service improvement in crisis care services, including potential expansion of other services and training;
- In addition, the new model of care will promote greater synergies between crisis care services and other physical and health services within the NHS and well as local demand management schemes that are emerging (e.g. Street Triage and the Serenity Integrated Mentoring (SIM) model). The specialised 24/7 staffed sites will lead to focal points for crisis care activity, providing the opportunity for a solid network of supporting services to be developed around the sites and bringing transparency and recognition to an often forgotten and 'ad hoc' service;
- The investment will support the broader objective of closing the financial gap between physical and mental health care funding. There are direct financial benefits to the reconfigured pathway as detailed in Section 5. Furthermore, the new model of care will provide a platform from which performance and trends can be appraised across the system, establishing the potential for further cost efficiencies; and
- The new model of care proposes a standardised, consistent s136 pathway across London. This presents an opportunity to collect and appraise standardised crisis care data. Using this as an initial platform to expand data collection across crisis care, will ensure that performance of the whole crisis care system can be effectively evaluated; this will support identification and sharing of best practice and identification of opportunities for wider service improvement and cost efficiencies.

### 1.1.5 Financial Case

**The current configuration of HBPoS sites in London, with a lack of dedicated, specialty skilled resource, results in a cost pressure for most MH Trusts, with staff diverted from other roles (often from inpatient facilities) to attend to s136 patients.**

The preferred **nine site option is estimated to cost c. £20.5m p.a.** compared to the baseline pathway cost of c. £20.6m p.a. (excluding impact of activity growth), a decrease of £0.1m

The interim stage of transition to the preferred option will involve a total of **13 sites at an estimated cost of c. £23.2m p.a.**

Over the five year period FY18/19 to FY22/23 total costs of the reconfiguration are estimated at c. £106.8m, compared to £111.7m per the baseline pathway. This gives a net savings of £4.9m, with a NPV of £4.8m.

The current plan is predicated on the following assumptions:

- ▶ Preferred option is implemented in FY19/20
- ▶ **Net activity growth** of 16.5% (allow for demographic growth and growth from recent statutory changes)
- ▶ Successful delivery of £6.3m financial savings (of which £795k are **cashable cost savings**)
- ▶ **£1m transition costs**; however, this is only an estimate and it is acknowledged that further analysis and refinement is required
- ▶ **£2.3m capital expenditure**; however, this is only an estimate and it is acknowledged that further analysis will be required during implementation planning, with capital requirements per site defined with local estates team. A transitional stage of 13 sites would require £450k less capital funding
- ▶ £3.3m funding being made available from CCGs / pooling of budgets across STP footprints

**Risks inherent to the financial analysis** of the s136 pathway and HBPoS specification include:

- ▶ Gaps in data collection
- ▶ Robustness of data
- ▶ Access to data

#### Financial costs

To understand the financial implications of the HBPoS reconfiguration, it is necessary to cost each step of the s136 pathway and determine the potential impact of the new model. However, there are a number of complications with trying to estimate a baseline cost for the s136 pathway, including inconsistent pathway practices and a lack of available data.

Nevertheless, pathway costs have been estimated by utilising existing secondary data sources provided by the LAS, Police and the NHS; supplemented through a series of data collection audits and surveys. The analysis considered the costs of conveyance, HBPoS sites and EDs

and determined a total saving of £138k per annum. This saving is primarily a result of non-pay savings, which result from a reduction in sites. Table 3 below summarises the annual variances.

**Table 3: Summary of cost variances**

Reference	Stakeholders	Baseline	Preferred Option	Variance
1a <sup>11</sup>	Police	£203k	£112k	(£91k)
1b <sup>11</sup>	Police (with LAS)	£435k	£333k	(£102k)
2 <sup>12</sup>	LAS	£1,310k	£1,004k	(£306k)
3	ED	£297k	£0k	(£297k)
4	AMHPs	£1,118k	£1,175k	£57k
5	Independent s12 Doctor	£378k	£302k	(£76k)
6	HBPoS: workforce	£5,417k	£11,636k	£6,219k
7	HBPoS: non-pay	£11,473k	£5,931k	(£5,542k)
	<b>Total</b>	<b>£20,632k</b>	<b>£20,494k</b>	<b>(£138k)</b>

### Transition costs

The reconfiguration of HBPoS sites across London will be a complex undertaking and as such, resources will be required to support in the transition.

It is proposed that implementation will be led locally and coordinated at an STP level. To this regard and with detailed implementation planning still to be undertaken, subject to the progression of this business case, it is difficult to provide a firm estimate of the level of resource required. However, it is acknowledged that resource will be required at both a local level and at a pan-London level to support the transition requirements.

For the purpose of the wider costing exercise it is proposed that £100k will be required per STP to support the transition. This establishes a total cost of £500k p.a. in FY18/19 and FY19/20 to support the transition. This is however, a high-level estimate and will require further refinement.

### Capital costs

The consolidation of HBPoS sites will require an increase in capacity for the majority of sites which are incorporated within the preferred option. As such, to support this increase in capacity, capital investment will be required at many HBPoS sites.

<sup>11</sup> 1a the cost of conveyance to police when conveying alone and 1b when conveying with LAS.

<sup>12</sup> The cost to LAS when they convey (always with police).

Aside from the increase in the number of assessment rooms, the degree to which an existing site can accommodate a larger HBPoS will vary. While analysis has been undertaken as part of the options appraisal process that considered the percentage of estates that are currently utilised for non-clinical purposes, further analysis is required during implementation planning to effectively deduce capital requirements per site in collaboration with local estate teams.

For the purpose of this financial analysis, an assumed capital cost of £150k is utilised per extra bed required. This figure is drawn from the Policing and Crime Bill – Amend Police Powers under the Mental Health Act 1983, which provides an indicative view of what may be required across London. This establishes that an assumed total level of capital investment required across London to support the configuration is £2.3m.

## Funding

At this early stage of the project, the exact funding arrangements for the costs outlined above have not been finalised and agreed. However, initial expectations about funding arrangements can be summarised as follows:

- It is likely that variances to pathway costs will be borne by the relevant stakeholders i.e. police forces, LAS, Mental Health Trusts;
- The pan-London transformation work programme has thus far been led by the Healthy London Partnership (HLP) in partnership with key stakeholders across London's crisis care system. Going forward, implementation and transition costs will require funding from local systems;
- Transition costs will likely be incurred by the CCGs within the relevant STPs as they transform the services at their HBPoS sites. It is important that additional funding is made available for this transition as there will be no equivalent income mechanism to support them; and
- The capital costs required to increase capacity at relevant HBPoS sites will likely be borne by the local STPs, however national capital funding available through bidding processes should be exploited.

Pooling budgets across CCGs within the relevant STPs, combining spending power, is expected to provide funding support for the new model of care.

### 1.1.6 Management Case

Current reconfiguration planning is based on a completion date of 2019/20, subject to agreement on financial support and regulatory and Board approvals. To reach the 9 site option the following measures are proposed:

- ▶ **A 13 site transitional phase has been supported by STPs in the shorter term as an interim measure to reach the preferred nine site option.**
- ▶ **A highly collaborative approach and governance structure, with robust governance arrangements** will be adopted to manage the reconfiguration and plan for the future implementation; key requirements have been identified.
- ▶ **A plan to continue engagement with key stakeholders including people with lived experience of mental health crisis and their carers** will be developed to ensure the transition into the new reconfiguration of HBPoS sites is successful.
- ▶ **A plan for proposed governance structure post implementation and performance management arrangements** will be developed; principles for governance have been identified and a suggested multi-agency group structure. Group roles and governance benefits have been identified.
- ▶ **A comprehensive risk assessment, escalation and mitigation process** will be developed and in place to support the reconfiguration, with risks identified both at a local and system wide level. Implementation risks will be identified and assessed using a four tiered matrix. Risks will be discussed during implementation and post implementation governance forums

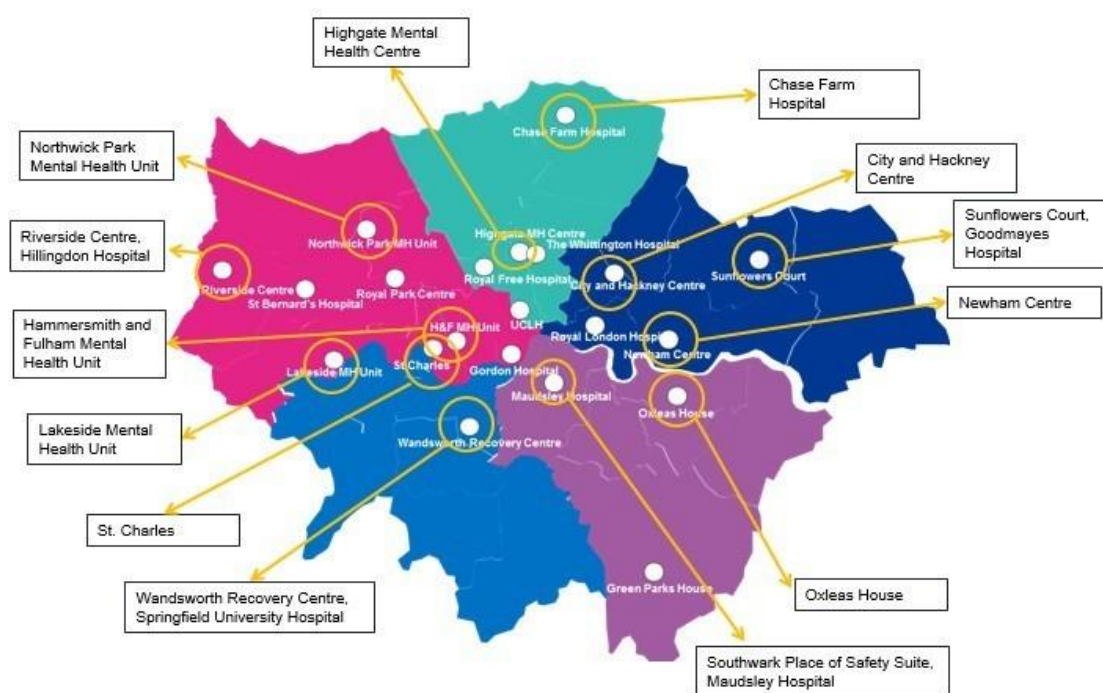
The implementation of a material reconfiguration of any clinical service must be undertaken in a robust and sensitive manner. As such, a number of priorities/principles have been proposed that should be adhered to during the course of implementation, ensuring that the process meets its objectives. These include:

- Ensuring patient safety;
- Profiling implementation and developing detailed implementation plans;
- Ratifying key protocols prior to go-live;
- Engaging with stakeholders;
- Aligning with wider crisis care transformation and;
- Maintaining clinical leadership.

#### Transition phase

As previously mentioned programme STP leads tested the nine site configuration locally through significant engagement across the system. From this it was recognised that the changes required for the nine site model would not be achievable locally in the short to medium term.

In light of this, the 13 site model is considered a transition stage to support STPs to implement the nine site preferred configuration. The resultant 13 site transition phase is shown below in Figure 3.

**Figure 3: HBPoS locations in the 13 site transition phase**

All sites within the 9 and 13 site model are suited for adult provision, with one site per STP providing an all-age service. The preferred CYP sites in the transitional 9 and 13 site model are: The Wandsworth Recovery Centre (SWL), Maudsley Hospital (SEL), Highgate Mental Health Centre (NCL), and St. Charles (NWL). Newham Centre for Mental Health (NEL) is the preferred all-age site in the 13 site model; however, on transition to the 9 site model, the all-age provision will need to be reassessed as the Newham Centre is not included.

The total estimated benefits of the transitional phase are marginally higher than the nine site model due to decreased travel times. This equates to an additional financial benefit to LAS and Police of c. £134k p.a. and an additional £3k p.a. social benefit (non-cashable) accruing to the patient due to a reduced travel time.

The overall costs however are more expensive with 13 sites largely due to 24/7 dedicated staffing at each site. The 13 site configuration is estimated to cost c. £23.2m p.a. compared to the baseline pathway cost of c. £20.6m p.a. and the nine site configuration of c. £20.5m p.a. (excluding impact of activity growth). Of the additional four sites not included in the nine site configuration, only two sites need additional capital funding to meet capacity requirements of an additional assessment room at each site. This capital investment will total c. £1.8m for the 13 site configuration, £450k less than the preferred nine site model.

The timelines for this transition are due to fall within the proposed two year process to move to the nine site model. As a result there no additional transition costs expected in addition to the £1.0m included as part of the preferred nine site option.

### Structures in place for implementation

The programme recognises the need for establishing robust governance procedures, risk management and a benefits realisation framework prior to implementation. This is to help manage key risks and issues that may arise, these include:

- Diversion and delays from the implementation plan;
- Lack of buy-in, scepticism and resistance to change;
- Impact on broader health and crisis care services;
- The requirement for formal new ways of working; and
- Availability of both capital and revenue funds.

Specific examples of implementation structures to consider for the next stage, in order to address the key risks and issues outlined above, will include establishing formal arrangements for AMHPs working outside of local authority boundaries, reaching an understanding on cross-charging arrangements for out of area patients, and understanding how this work interacts with other key mental health initiatives, such as ensuring adequate inpatient capacity and delayed transfers of care (DTC).

During and post implementation, a local multi-agency group led by the provider trust providing each of the HBPoS sites should exist and should be overseen by the respective UEC network in each STP. In addition, a post programme evaluation should be carried out. Due consideration should also be given to the pan-London position during implementation as it is important to ensure that there is pan-London oversight.

Post-implementation, in order to assess the impact of the programme at a pan-London level, a programme evaluation should take place. Appropriate key performance indicators (KPIs), which align with the objectives for the new model of care, would need to be established and agreed upon by stakeholders across the crisis care system.

### 1.1.7 Commercial Case

**The new model of care and reconfiguring HBPoS sites across London is the most effective option to address current issues across the s136 pathway.**

The new model will bring sustainable improvements and lasting benefits for patients, whilst in the medium to long term resulting in a local health economy that is both clinically and financially sustainable, delivering improved access, with 24/7 services and patient improved outcomes and provision of care.

**The reconfiguration will present an opportunity for broader transformation of the crisis care system, including a range of services; a robust commercial process is therefore required.**

- ▶ **With the complex network of stakeholders** involved in the reconfiguration, oversight of the commercial process is critical to the success of the new model of care
- ▶ Whilst it is early in the process to establish the exact service requirements, the **expectation is that services will be required for construction, programme support/implementation, recruitment and training**
- ▶ A commercial strategy supporting the reconfiguration will be developed in conjunction with proposed transformation plans on a STP basis

The requirement to develop a robust commercial strategy is particularly important for this transformation programme due to the breadth of stakeholders and delivering a pan-London model of care. At this early stage in the programme, it is difficult to predict which services will be required as part of the scheme. However, it is expected that services will be required for construction, programme support/implementation, recruitment and training.

A set of objectives have been developed which must be adhered to through development of procurement approach. This includes providing optimum value for money, the procurement is managed and governed in an open and transparent manner and there is careful planning and timing of procurement process.

In addition, the commercial strategy must recognise the opportunities related to synergies in the wider crisis care system. These involve joint investment, shared infrastructure and system wide data.

### 1.1.8 Workforce Case

Very few London HBPoS sites have dedicated trained staff and staffing levels are minimal out of hours; this is despite over 75% of s136 detentions occurring outside of regular working hours. Key components of the workforce model in each HBPoS site are:

- ▶ **Providing adequate, dedicated staffing 24/7 teams that are suitably skilled in both mental and physical health** at all HBPoS sites is expected to significantly improve patient experience and outcomes, staff experience and reduce cost pressures currently experienced from having to pull staff of inpatient wards.
- ▶ **Two dedicated specialty workforce models have been proposed: a combined staffing model** where the HBPoS is co-located with a crisis assessment unit or Psychiatric Decision Unit (as seen at South West London St. Georges Mental Health Trust), and a **stand-alone workforce model** (as seen at SLAM)
- ▶ **Three possible options have been identified to deliver AMHP services** following the reconfiguration of sites learning from different models across London; however, a more rigorous assessment is required to ensure challenges encountered by AMHPs are addressed and an efficient model is created.
- ▶ Greater transparency is needed to ensure **appropriate training standards have been met in relation to independent s12 doctors** and improved payment and administration protocols.
- ▶ The future operating model is expected to **minimise the number of ED presentations** due to capacity issues and improved physical healthcare provision in the HBPoS sites, both of which will reduce the strain currently experienced by London's Emergency Departments.
- ▶ **Development of a clear strategic direction and purpose** will facilitate transformation of the workforce model as well as a robust workforce strategy that includes staff engagement throughout implementation, robust workforce planning including network approaches across STPs, values based management and leadership and consistent London standards.

At present, staff across the crisis care system face a number of issues when it comes to the s136 pathway. The roles of the police and LAS, HBPoS staff, AMPHs, s12 doctors and ED staff are all affected by operational inconsistencies and efficiencies:

- **Conveyance staff:** London's police forces and LAS are hampered by delays in accessing HBPoS facilities, poor communication protocols between their staff and staff at HBPoS sites and Emergency Departments and lack of knowledge and clarity regarding the roles and responsibilities of each stakeholder group;
- **HBPoS staff:** Non-dedicated staffing can cause a number of issues for clinical staff and individuals undergoing Mental Health Act assessments at HBPoS sites. It detracts nurses and doctors from their substantive posts and leads to varying levels of competencies when treating s136 patients. It also leads to low staff satisfaction due to staff being pulled off wards and not feeling part of a dedicated, specialised team. A further important impact of a lack of dedicated staffing is that on downstream inpatient wards. When staff are brought in from other areas to staff the HBPoS, a reduction in staff in those clinical

areas will impact on quality of care for patients there, which effects patient experience and outcomes;

- **AMHP services:** Limited capacity, particularly out-of-hour AMHP availability, and inconsistent protocols across boroughs can delay mental health assessments. These issues are often amplified for out-of-borough presentations;
- **S12 doctor:** The lack of standardised processes for recruitment, administration and payment requirements can often delay independent s12 doctors, create a lack of transparency in the system, and lead to insufficient capacity and variable quality of assessments; and
- **ED staff:** Unclear policies and responsibilities for liaising and communicating with police and HBPoS staff, as well as lack of clarity of the role of EDs in the s136 pathway, can exacerbate delays to treatment. In addition, the limitations faced when accessing patient notes due to incompatible systems between Acute and Mental Health Trusts are challenging for good quality care.

The pan-London s136 pathway and HBPoS specification outlines key criteria that the future workforce model needs to meet. Once met the new model of care will have significant positive implications for staff in terms of safety, efficiency, utilisation and new ways of working. In addition, the improvements in staff training, communication protocols and multi-agency working that are expected will help to engage staff members from all parts of the pathway to help ensure successful implementation of the new model.

### Workforce model for HBPoS sites

During the options appraisal two staffing models were considered, a stand-alone workforce model (as seen at South London and Maudsley Mental Health Trust) or a combined workforce model where staff cover both an HBPoS and PDU (e.g. Psychiatric Decision Unit, seen at South West London St. Georges Mental Health Trust). In both models, the creation of a dedicated team has significant benefits through addressing some of the challenges related to access and quality of care. The dedicated, specialty trained workforce model is innovative and provides an opportunity to build a specialised workforce for this largely forgotten service, promoting the s136 pathway to an active part of the crisis care system.

The introduction of dedicated 24/7 staffing as part of the reconfiguration of the HBPoS sites will address current pressures experienced due to inadequate staffing and facilitate improved quality of assessments and resulting patient outcomes. The dedicated team will be able to work more closely with patients to understand their needs and identify the best course of action, with any plans developed handed over to the next team member on shift. At SLAM's centralised place of safety, which has piloted the new s136 model of care for London, the rate of admission has fallen by 13% following implementation of the new model. This has been attributed in large part to improved practice following the introduction of the dedicated staff team, together with a close working with the Trust's Acute Referral Centre.

The concept of the combined unit is to have a psychiatric decision unit and HBPoS co-located; this enables a joint workforce that can flex between the decision unit and the HBPoS increasing the utilisation of staff and benefitting from a model that provides a broader service to a wider range of patients (e.g. the assessment unit receives mental health crisis patients from liaison

psychiatry, crisis teams and street triage to carry out an informed, collaborative assessment in an appropriate mental health assessment facility). As noted above for SLAM however, periods of lower utilisation can have positive impacts on staff wellbeing and retention. Each area would need to consider the case for each model within their area.

The benefits of both models are a dedicated 24/7 specialised workforce and whilst it may be tempting to create an HBPoS team who have additional roles as supernumerary staff in other mental health teams, in the climate of overall low mental health workforce numbers, there is a real danger of reliance on these staff members thereby creating the situation where their immediate availability for a s136 patient is reduced, or those other areas of care are affected; this would mark a return to one of the key issues of the current model of care.

### Costing the 24/7 model

It is estimated that the preferred 9 site option with 24/7 dedicated workforce would cost £11.6m per year. The workforce model that is proposed is based on safe levels of staffing at the HBPoS.

Whilst the cost associated with providing dedicated 24/7 staffing with the new model of care at c. £11.6m p.a., is significantly higher than the staffing cost with the current 20 site model at £5.4m p.a., the cost associated with the preferred 9 site model is much more favourable than maintaining the current 20 site configuration and introducing 24/7 staffing at a cost of c. £14.7m p.a. (an additional £3.1m compared to the preferred option).

### HBPoS staff training and competencies

Irrespective of which workforce model, healthcare staff who work in an HBPoS should be sufficiently trained in mental and physical health to safely and effectively perform their role. The provision of a dedicated team allows for s136 specific training to be delivered to a dedicated workforce and for the on-going assessment of skills and training needs; this will improve the quality of care for individuals detained under s136.

As well as improving team skills and expertise, training initiatives for dedicated staff teams have a clear role in staff development and career progression. This will have positive impacts on recruitment and retention, both important issues to address across mental health, as highlighted in the Health Education England (HEE) Mental Health workforce plan<sup>13</sup>.

Furthermore, a dedicated workforce will allow development of relationships across the ED/Mental Health interface, leading to sharing of expertise, improved handover and the opportunity to develop novel approaches in partnership to support integrated mental and physical healthcare. It is anticipated that adherence to the physical health competencies set out in the pan-London guidance will reduce the need for physical health assessments or treatment in an ED prior to or during assessment at the HBPoS site. This will reduce the burden on EDs, improve the timeliness of assessments and reduce the use of further conveyance by LAS or police between HBPoS sites and EDs.

<sup>13</sup> Stepping Forward to 2020/21: Mental Health Workforce Plan for England (2017). Health Education England. Available at: <https://www.hee.nhs.uk/our-work/planning-commissioning/workforce-planning/mental-health-workforce-plan>

### 1.1.9 Recommendation and next steps

This business case sets out the rationale for a new model of care and consolidating HBPoS sites across London. The proposal contained herein demonstrates that such a reconfiguration can improve outcomes for patients, facilitate the availability of a 24/7 service, concentrate and enhance staff expertise, achieve value for money and ensure effective synergies between the s136 pathway and broader crisis care.

However, it is acknowledged that such an undertaking would be delivered in a complex, multi-stakeholder environment. Furthermore, it also requires an investment of resource, both in terms of finance and time. Therefore the steps that should be taken post the conclusion of this business case should be considered judiciously, ensuring that due diligence is taken in the commitment of further resource.

It is recommended that the proposal contained within this business case is progressed towards implementation, augmented with the following steps:

- Appropriate consultation is undertaken with key stakeholders as necessary;
- Each respective STP determines precise capital requirements particular to the sites within their jurisdiction;
- Sources of funding are determined, with relevant submissions made to secure such funding; and,
- The proposals contained within the Management Case are progressed; most notably, the establishment of effective implementation governance and the development of detailed implementation planning.

## 2 Introduction

This section sets out the context of the business case. It details the scope and purpose of the change and introduces the reader to the baseline pathway and preferred option. This section is structured as follows:

- Purpose of document
- Overview
- Mental Health Crisis Care for Londoners
- Current s136 pathway

## 2.1 Introduction and purpose of document

### 2.1.1 Purpose of this document

This document sets out the case for reconfiguring Health Based Place of safety (HBPoS) sites across London in order to improve the efficiency of treatment and quality of care for patients along the section 136 (s136) pathway. Specifically, it details how a consolidated nine-site model for adults, including an all-age site within each STP, will address the needs of patients and wider stakeholders in improving the s136 pathway and broader crisis care system.

The business case is intended to support the work carried out to date on mental health crisis care in London, specifically the s136 pathway and HBPoS specification. Moving to the 'consolidated model' will enable an improvement in the service provided to patients across the crisis care system and will facilitate future improvements to operations.

The business case follows HM Treasury Green Book guidance by outlining the strategic case, economic case, financial case, commercial case and management case for the reconfiguration. In addition, the business case specifically details the impacts for clinical outcomes and staff in the Clinical Case and Workforce Case respectively.

### 2.1.2 Overview

#### What is section 136?

Section 136 (s136) of the Mental Health Act 1983 is the power that allows a police officer to detain someone they believe to be mentally disordered and in need of urgent care or control. Either finding or being directed towards a person with mental disorder in a public place is not sufficient justification to detain under s136. The power requires the following conditions to be met:

- The individual must appear to the officer to be suffering from mental disorder;
- The individual must appear to the officer to be in immediate need of care or control;
- The officer must think that removing the individual is necessary in the individual's interests or for the protection of others;
- The individual must be found in a public place or anywhere that is not the house, flat or room where that person, or any other person, is living; and
- When practicable, the officer must consult a registered medical practitioner, a registered nurse, an Approved Mental Health Professional (AMHP) or a person of a description specified in regulations made by the Secretary of State.

#### What is a health based place of safety?

A HBPoS is used when an individual of any age has been detained under s135 or s136 of the Mental Health Act 1983. In law, the place of safety to which the person is taken can be residential accommodation provided by the Local Social Services Authority, a hospital as defined in the Act, a police station, an independent hospital or care home for mentally disordered

persons or any other suitable place where the occupier is willing to temporarily receive the person.

The Mental Health Act 1983: Code of Practice 2015 states that the preferred environment is a HBPoS where mental health services are provided<sup>14</sup>. Under the amended legislation of Section 136A of the Mental Health Act 1983 (which came into force from 11th December 2017), a child under 18 detained under s136 may not be removed to, kept at or taken to a place of safety that is a police station, and police stations should only be used for adults detained under s136 in exceptional circumstances<sup>15</sup>. Providing mental health assessments within healthcare settings improves access to care for patients and avoids the potential stresses associated with police stations. In practice, MH Trusts and hospital Emergency Departments are most commonly used.

### How can HBPoS sites be reconfigured?

To provide the quality of care which mental health crisis patients deserve, it is important that individuals are taken to the right environment, with the right staff, providing the right treatment that is tailored to their needs. As such, the HBPoS sites in London should meet certain standards in terms of infrastructure, workforce and practices.

At present, there are 20 HBPoS sites operating across London, the vast majority of which have 1-2 assessment suites. However, this number is not based on capacity requirements, the prevalence of s136 detentions in geographic areas or the availability of skilled staff across London. Instead, they are historically located where space has been available.

This historic configuration of sites, some with insufficient capacity and others with minimal utilisation, is not fit for purpose within London's crisis care service ambitions.

In choosing how many HBPoS sites should operate, in which locations and with what capacity, there are a multitude of initial options. However, by assessing the options based on access and quality of care, deliverability, value for money and strategic coherence, this list can be considerably refined. The options assessment in Section 4.1 details this process.

A final optimal model of nine adult sites, with a combined workforce was arrived at as the 'preferred option' for the reconfiguration. For CYP the change proposes that one site within each STP will have suitable facilities and staff expertise to provide an all-age service.

## 2.1.3 Mental Health Crisis Care for Londoners

This case builds on a series of reports over the past number of years which set out a clear and compelling case for transforming how mental health crisis care is delivered in London. The Crisis Care Concordat (2014)<sup>16</sup> and more recently The Five Year Forward View for Mental Health (2016)<sup>17</sup>, Next Steps on the NHS Five Year Forward View (2017)<sup>18</sup> and Implementing the Five

<sup>14</sup> Mental Health Act 1983: Code of Practice

<sup>15</sup> Section 136A of Mental Health Act 1983

<sup>16</sup> Mental Health Crisis Care Concordat. Improving Outcomes for People Experiencing Mental Health Crisis. HM Government (2014)

<sup>17</sup> The Five Year Forward View for Mental Health. Independent Mental Health Taskforce to the NHS in England (2016)

<sup>18</sup> Next Steps on the NHS Five Year Forward View. NHS (2017)

Year Forward View for Mental Health (2016)<sup>19</sup>, have put the spotlight on improving the quality and efficiency of crisis care in the UK.

More specifically, this document follows the recommendations and guidance set out in 'Mental Health Crisis Care for Londoners: London's section 136 pathway and Health Based Place of Safety specification'. The guidance document, developed in collaboration with partners across the crisis care system aligns with the overarching principle in the Crisis Care Concordat (2014)<sup>20</sup> of cooperation and collaboration:

*"We commit to work together to improve the system of care and support so people in crisis because of a mental health condition are kept safe and helped to find the support they need – whatever the circumstances in which they first need help – and from whichever service they turn to first."*

The key principles of the guidance are listed below and have been used to inform the options appraisal and business case process throughout:

- If there is no capacity at the local HBPoS when the police officer makes initial contact it is that *site's responsibility to ensure that the individual is received into a suitable place of safety*, through agreed escalation protocols or making alternative arrangements, whether the individual is from that area or not. When the HBPoS states that it has capacity, this means it is able to receive the detained individual as soon as they arrive on site;
- Under exceptional circumstances when an individual under s136 presents to an Emergency Department with no physical health needs (due to limited HBPoS capacity) the *Emergency Departments cannot refuse access* unless a formal escalation action has been enacted;
- If someone appears to be drunk and showing any 'aspect' of incapability (e.g. walking unaided or standing unaided) which is perceived to result from that drunkenness, then that person must be treated as drunk and incapable. *A person found to be drunk and incapable by the police should be treated as being in need of medical assistance at an Emergency Department* or other alcohol recovery service (where available);
- An Emergency Department can itself be a Place of Safety within the meaning of the Mental Health Act. Therefore, if protracted physical health treatment or care is required, where appropriate the *Acute Trust should accept the s136 papers* and take legal responsibility for custody of the individual for the purpose of the Mental Health assessment being carried out;
- Every HBPoS should have a designated s136 coordinator available 24/7 who is assigned to the HBPoS at all times. *Adequate, dedicated clinical staff must be available 24/7* to ensure staff members do not come off inpatient wards;
- HBPoS staff (including both nursing and medical staff) should have *adequate physical health competencies to prevent unnecessary Emergency Department referrals*;

<sup>19</sup> Implementing the Five Year Forward View for Mental Health (2016)

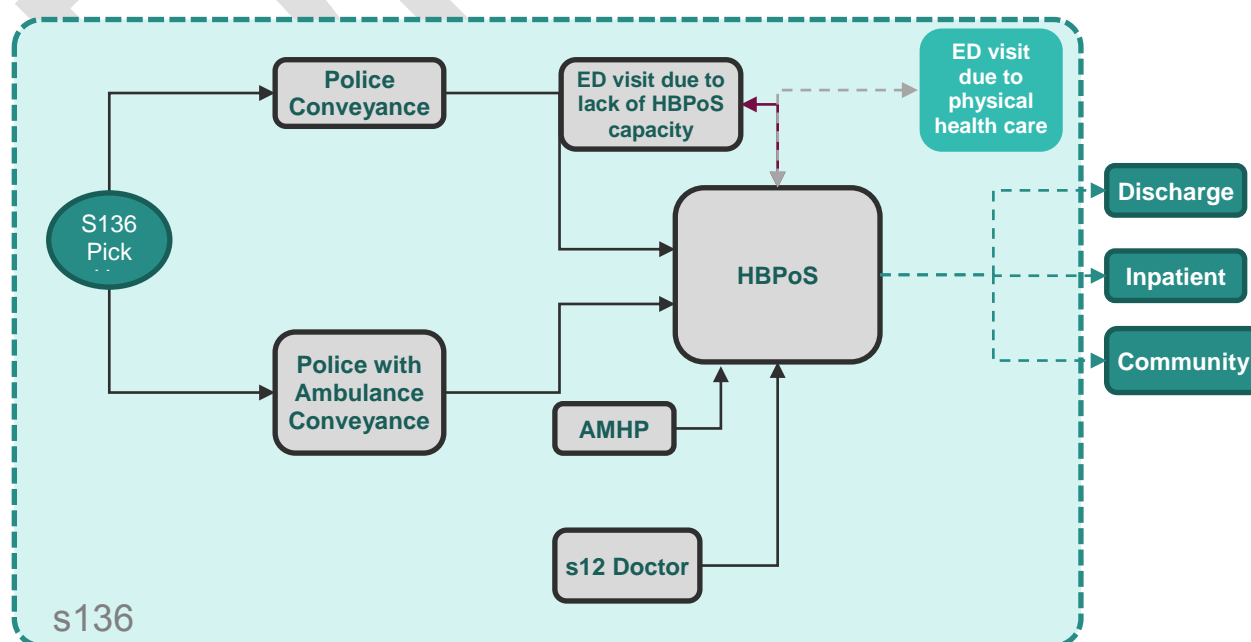
<sup>20</sup> Mental Health Crisis Care Concordat. Improving Outcomes for People Experiencing Mental Health Crisis. HM Government (2014)

- *HBPoS and local Acute Trusts should have clear pathways and protocols and the relationships to deliver these* for those with physical health problems but for whom urgent transfer to an ED is not the optimum course of action. These should include triage, advice and where possible outreach systems to support appropriate responsive and timely physical health care to those in a Health Based Place of Safety;
- While a police officer or an AMHP has the legal responsibility for authorising the transfer of the detained individual, coordinating the conveyance of individuals between HBPoS and Emergency Departments and vice versa should be undertaken by the Mental Health Trusts and Acute Trusts respectively, led by the s136 coordinator. *Coordinating and arranging transport is not the police's role* unless there is mutual agreement between parties that it is in the best interest of the individual and there is resource to provide support;
- If the s12 doctor (or in exceptional circumstances another doctor with adequate mental health experience) sees the individual before the AMHP and is satisfied that there is *no evidence of underlying mental disorder of any kind, the person can no longer be detained* and must be immediately released, even if not seen by an AMHP;
- When a Mental Health Assessment is required the *legal duty to assess falls upon the AMHP service for the area where the person is at the point when the assessment is needed*, in this case the borough in which they are currently being detained under s136; and
- *The mental health assessment should be completed within 4 hours* of the individual arriving at the HBPoS unless there are clinical grounds for delay.

### 2.1.4 Current s136 pathway

The s136 pathway is complex in nature, involving multiple stakeholders that varies across STPs. Figure 4 provides an illustration of the pathway, from pick up to decision to discharge.

Figure 4: s136 pathway



When a person is officially detained under s136 by the Police, the individual is taken to a place of safety by the LAS and police, unless they require physical health care, in which case, they are first taken to an Emergency Department and eventually transferred to the HBPoS. Under s136 of the MHA, the individual detained cannot leave until they have had a formal assessment of their mental health by a suitably trained doctor. If the individual is found to have no underlying mental disorder of any kind, the person is no longer within the scope of the MHA and is to be discharged at the earliest opportunity, even if the AMHP has not yet seen them.

However, if the individual is deemed to have an underlying mental disorder, they must also be assessed by an AMHP and a decision made regarding the care needed, for example an inpatient admission or community referral. Where the individual does not agree to an advised admission on an informal basis, in order that the AMHP can apply for MHA admission under section 2 or 3 of the MHA, medical recommendations for the admission are required from two medical professionals, one of whom must be an independent s12 doctor. The maximum detention period under s136 of the MHA is 24 hours from arrival at a place of safety.

### 3 Strategic case

This section sets out the strategic context and the case for change, together with the supporting investment objectives for the scheme. The section is structured as follows:

- Mental health crisis care in London
- Case for change
- Vision and objectives

DRAFT

**London is currently facing significant challenges across the crisis care system owing to rising levels of mental ill health and challenges with current service provision. It is anticipated that services will be required to change to address these challenges and become sustainable in the medium term.**

- ▶ **The vision is to provide safety and high quality care and treatment to people detained under s136** by delivering the following six strategic objectives:
  - Enable the improvement in s136 patient outcomes
  - Facilitate access to 24/7 services
  - Ensure appropriate service provision for all ages
  - Concentrate staff expertise to enable a service suitable to patient needs
  - Ensure synergy with the wider crisis care system
  - Deliver value for money
- ▶ **Delays in accessing support and on-going treatment negatively impacts patient experience and outcomes.**
- ▶ **The new model of care provides the opportunity to achieve improved access and patients outcomes, higher levels of patient satisfaction, positive benefits to staff, deliver 24/7 services, reduce inequality and realise efficiencies** across the local health and care economy and wider society.
- ▶ **There is a continued drive for high quality sustainable care in the NHS.** Service users, clinicians and regulatory bodies have highlighted that there is too much variation in both quality and access across different services.
- ▶ **Increasing financial and operational pressures** are being placed on mental health Trusts due to the demand for services increasing. Funding does not meet requirements to maintain standards of care; there is a need for all NHS organisations to engage in wider transformational change and service reconfiguration with other agencies towards highly responsive, effective and personalised services for people with urgent physical and mental health needs.
- ▶ **South London and Maudsley Mental Health Trust (SLAM) has piloted the new model of care at their centralised HBPoS site.**
  - An average of 15% more admissions are accepted.
  - Having a 24/7 dedicated team has meant there has been only one closure over the last year; sites were closed 279 times previously over a 12 month period;
  - The number of individuals taken to an ED before going to the centralised site has reduced;
  - 96% of individuals detained are being admitted to the HBPoS within 30 minutes of arrival;
  - The new purpose built facility provides a physical environment which is much more conducive to recovery;
  - 76% of service users provided positive feedback, finding the service more respectful and responsive;
  - The rate of admission to an inpatient bed has fallen by 13%.

## 3.1 Mental health crisis care in London

### 3.1.1 Overview

Mental illness is the single largest cause of disability in the UK and each year about one in four people suffer from a mental health problem. Yet despite its harmful physical and economic impacts, the response to mental health lags significantly behind physical health.

In London, mental health crisis care is an example of a system which does not meet the quality and efficiency standards of other services in the NHS. The treatment pathway for individuals detained due to mental disorder, which sits under s136 of the Mental Health Care Act 1983, has come under increasing pressure in recent years due to inadequate infrastructure and service provision as well as the increasing prevalence of mental health crises in the Capital.<sup>21</sup>

There are a number of cases which illustrate that timely, high quality care is not always available to individuals who are experiencing a mental health crisis. In surveys conducted by the Healthy London Partnership in 2016, only 14 per cent of people said they had the support they needed in a crisis.<sup>22</sup>

However, the challenges presented within this system are well recognised and significant progress has been made in recent years to improve the service. In 2014, the London Mental Health Crisis Commissioning Standards were agreed to ensure equity between physical and mental health. In addition, London's Mental Health Trusts and their key partners developed an action plan focused on s136 of the Mental Health Act. For example, the work of the Mental Health Partnership Board sought to reduce the use of police cells for those detained under s136 and since October 2016 the use of police cells in London has fallen below one per month.<sup>23</sup>

It was decided in 2015 that there should be a pan-London focus on the section 136 pathway and Health Based Place of Safety sites to improve the current inconsistencies across London and often inadequate care for those who are some of London's most vulnerable. This led to the development of London's s136 Pathway and HBPoS specification. Further detail on the development of this guidance is given below. Delivery of a new model of care, with a reconfiguration of HBPoS sites, the locations where detained individuals are transferred to by police officers under s136, is among the proposed changes which aims to improve quality and access for patients in mental health crisis care in London – and is the subject of this business case.

### 3.1.2 Model of care and stakeholder engagement

In 2015, a crisis care multiagency professional group was established with representation from Mental Health and Acute Trusts, the LAS, the Met Police, social services and general practice. This group led the development of the new model of care that includes the pan-London s136 pathway and a specification for HBPoS.

The new model of care was developed using a partnership model to ensure sufficient engagement with stakeholders across the system. This included active engagement with the following stakeholders:

<sup>21</sup> Mental Health Network NHS Confederation (2016): Is mental health crisis care in crisis?

<sup>22</sup> Healthy London Partnership (2016) UEC Programme: 'I' statements

<sup>23</sup> London Mental Health Partnership Board (2013-2016) Individuals under section 136 held in police cells

- **People with lived experience of mental health crisis and their carers:** Over 300 Londoners with lived experience of a mental health crisis were actively engaged to ensure that the guidance meets service user needs and expectations;
- **Police officers:** Over 70 police officers from London's three police forces (The Met Police, British Transport Police and the City of London Police Force) to ensure specific access and capacity issues were confronted;
- **Mental Health Trusts:** Over 150 front-line and senior staff from all nine of London's Mental Health Trusts were engaged with to inform capacity and infrastructure requirements;
- **Urgent and Emergency Care:** Over 200 ED staff and liaison psychiatry staff from ED's in each Urgent and Emergency Care (UEC) network were engaged in order to assess that equitable provision of care and patient outcomes across their footprint can be achieved;
- **Approved Mental Health Professionals (AMHPs) & Local Authorities:** Over 75 AMHPs and Local Authority representatives were consulted in developing the model of care; and
- **London Ambulance Service (LAS):** LAS paramedics, mental health nurses, and mental health operational staff were consulted and included in the multiagency professional group to ensure capacity and access issues during conveyance were addressed appropriately.

In addition, there was extensive engagement with the voluntary sector, particularly Mind, Rethink, NSUN and the National Crisis Care Concordat initiative. The Royal Colleges of Psychiatrists and Emergency Medicine and Pan-London forums, for example the Cavendish Square Group, also played important roles in the development of the new model of care.

## 3.2 Case for change

### 3.2.1 Overview

It has been said recently that London's crisis care system is itself in crisis. There are significant challenges across the system, due to inadequate care and services and also the level of mental ill health and crisis that the capital faces.

The disparity of care for people with mental health issues as opposed to physical ones is still disproportionate and all London's partners, including service users, realise that the status quo is not acceptable. Those detained under s136 are often denied access to Health Based Place of Safety sites and Emergency Departments (EDs), left in the back of police cars and ambulances, or transferred unnecessarily between an ED and mental health trusts due to a lack of appropriate and co-ordinated care. Londoners with experience of mental health crisis, together with London's clinicians, tell us over and over again that the care does not meet the basic expectations of dignity, respect and high quality compassionate care, and services are often not delivered in the right environment to help people recover. There is a real opportunity to address a forgotten service and make section 136 an active part of the crisis pathway.

#### Box 1: Case for Change

- Only 14% of Londoner's feel they have support when in a mental health crisis;
- Only 36% of patients felt safe in their surroundings in London's HBPoS sites;
- Recent LAS scene time data for section 136 patients has shown on average more than 35% of LAS callouts face significant access issues, averaging 2.5 hours from arrival at the hospital to being accepted into the site by staff;
- On average when section 136 patients present to the Emergency Department they remain in the department over 4 hours 70% of the time and nearly 50% are in the department for over 12 hours;
- Over 75% of section 136 detentions occur out of hours yet few sites in London have dedicated, appropriate 24/7 staffing to care for these patients

Whilst there must be an increased focus on local action to prevent crises occurring, when a crisis does happen service users need to have timely, high quality care, which respects individual needs, wherever they are in London. This is reiterated by service users who have told us they want crisis care that is always available, consistent and respectful across all stages of the pathway. There are still many cases which illustrate that this is not available, resulting in EDs being a regular default.

A reconfiguration of HBPoS sites is an important step towards overcoming the significant challenges and pressures in provision of mental health services and implementing the pan-London s136 model of care. This requires delivery of a new model which ensures that the right care is delivered at the right location, at the right time, by staff with the right skillset, in suitable facilities for patients during a mental health crisis. The status quo is not sufficient to provide this level of care to those in need and therefore a change is warranted. In addition, the reconfiguration will contribute towards the wider policy goal of embedding mental health care within the wider healthcare system, improving parity of esteem and integrating physical and mental health care.

The evidence is clear that improving outcomes for people with mental health problems supports them to achieve greater wellbeing, build resilience and independence and optimise life chances, as well as reducing premature mortality.

Moreover, the evidence is equally clear on the potential gain for the NHS and wider public sector from intervening earlier, investing in effective, evidence-based care and integrating the care of people's mental and physical health. In addition to the moral imperative and the clear clinical and individual benefits, it is important to recognise that there is a financial necessity to manage the challenges of the years ahead.

### 3.2.2 National Context

Historically, mental health has not had the priority awarded to physical health, has been short of qualified staff and deprived of funds. There is a need to provide equal status of mental and physical health, equal status to mental health staff and equal funding for mental health services.

The following paragraphs highlight four areas of the national context which drive the rationale for the reconfiguration of the HBPoS sites, which will support achievement of national objectives.

#### 1. Future direction of NHS

##### *NHS Five Year Forward Views*

The **NHS Five Year Forward View**, published in 2014, seeks to provide an equal response to mental and physical health and drive towards the two being treated together. It specifies the need to break down barriers across systems to integrate urgent and emergency care (UEC) services for people of all ages experiencing physical and mental health problems. This aligns with Sir Bruce Keogh's 2013 review of the NHS UEC system in England which highlighted the increasing unsustainable pressures on the current system, recommending system-wide transformation towards highly responsive, effective and personalised services for people with urgent physical and mental health needs. More recently, the **Next Steps on the Five Year Forward View**, published in 2017, outlines the key improvements required to be in place

through FY18 and FY19, including new specifications for mental health provision for people in secure and detained settings.

The **Five Year Forward View for Mental Health (FYFWMH)**, published in 2016, further emphasises the importance of having an effective, responsive UEC system and highlights the need to have mental health care accessible 24 hours a day, seven days a week – a key element in the s136 new specification. Implementing improved access to high quality care, more integrated services and early interventions will support establishment of services which are sustainable for the long term.

### **Future in Mind**

Future in Mind, a joint review by NHS England and the Department of Health, outlines the need to provide appropriate support to children in crisis in-hours and out-of-hours. In addition, the expertise and environment should be age-appropriate.

An important consideration in the reconfiguration of HBPoS sites is to ensure that CYP in crisis are transported to where they can receive the appropriate care, and that decisions are not related only to convenience of location.

### **Crisis Care Concordat**

The Crisis Care Concordat is a national agreement signed by 27 national bodies involved in health, policing, social care, housing, local government and the third sector. It sets out how organisations can work together to help people experiencing a mental health crisis get the help they need. The reconfiguration of HBPoS sites will facilitate organisations to work with each other by ensuring that a clear treatment pathway can be supported by appropriate facilities and expertise.

## **2. Quality expectations**

There is ever increasing scrutiny of mental health NHS providers, mental health independent providers, departments and individual healthcare professionals. Findings from the CQC's programme of comprehensive inspections of specialist mental health services 2014 to 2017 identified many examples of excellent care, but also found too much poor care and too much variation in both quality and access across different services. The pressure on services partly explains why, at 31 May 2017, 36% of NHS core services and 34% of independent mental health core services were rated as requires improvement for safe, with a further 4% of NHS and 5% of independent core services being rated as inadequate for safe. On too many wards, the combination of a concentration of detained patients with serious mental health conditions, old and unsuitable buildings, staff shortages and lack of basic training, make it more likely that patients and staff are at risk of suffering harm. In addition, people experienced difficulties in accessing services best equipped to their needs, there was persistence of restrictive practice and poor clinical information systems.<sup>24</sup>

## **3. Operational pressures**

One in four adults experience at least one diagnosable mental health problem in any given year. People in all walks of life can be affected and at any point in their lives, including new mothers, children, teenagers, adults and older people. Circa 1.8m people were in contact with adult mental health and disability services through FY16. From 2015/16 to 2016/17, s136 detentions

<sup>24</sup> CQC Report, "The state of care in mental health services 2014 to 2017"

have increased by 19%. Across England the increasing demand on mental health services, and the capacity constraints of these services, are contributing to escalating ED mental health presentations. The additional pressures on EDs contribute to Trusts breaching the four and twelve hour ED targets. CYP are also facing longer waits for treatment. Meanwhile, this is occurring whilst the mental health workforce has been in decline, with a 12% reduction in the number of mental health nurses from January 2010 to January 2017.

#### **4. Financial challenge**

The NHS is undergoing an unprecedented combination of rising demand with funding which falls short of what is estimated as required to maintain standards of care, requiring year on year efficiencies which are becoming increasingly difficult to deliver. In addition, short-term tactics to contain spending, such as holding down NHS staff pay and underinvesting in the NHS estate, have now more than run their course, whilst the introduction of access to mental health care 24 hours a day and the move to seven day working will present significantly higher costs. With the deficits across hospitals in England growing and a forecast deficit of £30bn by 2021<sup>25</sup>, all NHS organisations need to engage in wider transformational change and service reconfiguration with other agencies and providers and local government, housing, education, employment and the voluntary sector.

#### **3.2.3 London Context**

London faces many challenges across the crisis care system with services often falling short in providing effective access, care and treatment for the capital's most vulnerable. Whilst significant progress has been made in recent years to address these challenges, there is a requirement for a new model which ensures that the right care is delivered at the right location, at the right time, by staff with the right skillset. Current key issues with the s136 pathway, all of which impact patient experience, are detailed in the paragraphs which follow.

##### **3.2.3.1 Inconsistent quality of care**

The care on offer at London's HBPoS sites can vary due to differing levels of staff training and skillsets at the HBPoS sites and EDs. London's service users have indicated the current 'ad-hoc' staffing model, where staff are pulled off wards when an s136 patient arrives, is not conducive to good patient care, both to those detained under s136 but also to those on the ward where staffing numbers are depleted for a 12-24 hour period. Some sites across London also indicated that nursing and medical staff were not trained in de-escalation, which is recommended for managing those with disturbed behaviour. These inconsistencies in quality of care translate into poorer clinical outcomes.

##### **3.2.3.2 Inappropriate provision for Children and Young People (CYP)**

Patients who are under 18 require appropriate facilities and specialised staff that can respond to their specific needs. However, at present many of London's HBPoS sites have local protocols that restrict children from the site. Emergency Departments are regularly used as the default position when HBPoS sites are unable to manage CYP detained under s136. When this occurs children can be in the ED for a 24-72 hour period due to lack of appropriate staffing but also the lack of CAMHS Tier 4 beds available in London.

<sup>25</sup> NHS Five Year Forward View: <https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf>

### 3.2.3.3 Facilities

One of the primary objectives of the reconfiguration of HBPoS sites is to provide a standardised, high-quality treatment environment for individuals detained under s136. Evidence suggests that mental health facilities which are fit-for-purpose and meet the needs of service users improve patient outcomes and safety. Trends also lean towards reduced involuntary admissions and overall aggression levels.<sup>26</sup>

#### Overview of existing facilities

There are currently 20 ‘designated’ HBPS sites across London. Most can only see one patient at a time. Instead of their location being based on need or demand, sites are historically located where space has been available. This problem in London is intensified by the fact that four of the designated HBPoS sites are EDs; whilst in some instances it is necessary for mental health crisis patients to attend ED due to specific physical health needs e.g. such as overdose or self-harm, it is recognised that a busy ED is not always the most suitable environment for the care of patients in mental health crisis.

London’s HBPoS sites have had varying Care Quality Commission (CQC) ratings. In the most recent CQC reports from 2016 and 2017, two Trusts received ‘needs improvement’ ratings, while another was rated ‘inadequate’. Key themes from the CQC reports include the lack of dignity, comfort and confidentiality; inadequate processes regarding the Mental Health Act; staff levels and training; and information recording. These themes correspond with national issues. It was recently reported that 39% of crisis care services, including HBPoS sites were rated as ‘requires improvement’ or ‘inadequate’ for safety.<sup>27</sup> This needs to change.

#### Service user experiences

Londoners with lived experience have also expressed concerns about the quality of the treatment environments. Only 36 per cent of Londoner’s detained under s136 said they felt safe in an HBPoS.<sup>28</sup> In London’s EDs, only 12 per cent of those assessed thought their assessment rooms were pleasant, comfortable and welcoming. These assessment rooms have been described as “like a police cell”; “padded cell”; “interrogation room”; “bunker”; and “glorified storage room”.<sup>29</sup>

*“I’ve been sectioned before and held in a police cell before and that was bad, it was cold and dark and miserable and I just curled up on those bunks and cried my eyes out. The place they take you now is only a little bit better, and I mean only little bit better, it’s not as cold and they don’t make you wear those paper suits but it’s still like a police interrogation room than a place where you should be getting better.”*

Person detained under Section 136

#### CYP environments

In addition, a number of stakeholders interviewed have stated that the HBPoS environment is not appropriate for CYP in general and especially for those with learning difficulties.<sup>30</sup> One issue was that there was limited access to any information at the HBPoS that would help to explain the

<sup>26</sup> Hughes, R. (2008) Patient Safety and Quality: An Evidence-Based Handbook for Nurses. Agency for Healthcare Research and Quality (US)

<sup>27</sup> [https://www.cqc.org.uk/sites/default/files/20170720\\_stateofmh\\_report.pdf](https://www.cqc.org.uk/sites/default/files/20170720_stateofmh_report.pdf)

<sup>28</sup> Healthy London Partnership (2015) UEC Programme: ‘I’ statements

<sup>29</sup> Therapeutic Solutions: Section 136 and Mental Health Crisis Presentations in Emergency Departments in London

<sup>30</sup> Ibid

reason for their detention and the process that would follow. This was linked to the non-therapeutic nature of the environment.

### 3.2.3.4 Capacity and delays

The ability of a pan-London system of HBPoS sites to perform its function relies on its ability to provide adequate access to care; this is achieved primarily by ensuring that there is suitable capacity, but also by ensuring that there are minimal delays in the pathway. In the existing system, capacity issues and delays are negatively impacting those detained under s136 and wider stakeholders, such as police forces and EDs.

#### Current capacity

From interviews conducted, it has been deduced that police forces, the LAS and NHS Trusts struggle to find capacity at London HBPoS sites.

In 2015, over 210 issues were reported by frontline police officers in London; half of these were specifically related to capacity and access across the s136 pathway<sup>31</sup>. Monthly comparisons of issues logged between 2015 and 2016 show a 30 per cent increase in reports due to delays in accessing sites. Similar issues have continued throughout 2017 into 2018.

The reasons behind these capacity limitations are manifold:

- **Staff availability:** Very few London HBPoS sites have dedicated staff and staffing levels are generally minimal out of hours - despite over 75% of s136 detentions occurring outside of regular working hours (11pm -7am);
- **Temporary closures:** While it is rare that an emergency care service for physical health shuts down, there has been numerous occasions of temporary closures of HBPoS sites due to the lack of dedicated staff and/or damaged facilities; and
- **Low individual site capacity:** the dispersed HBPoS sites across London tend to predominantly have low capacity. A number of existing sites have a capacity of 1. This results in binary utilisation, whereby sites are either completely empty or at capacity at any given point in time.

These capacity issues are exacerbated by a rising number of s136 detentions, as well as London's unique capacity limitations. Whereas police in other parts of the UK can offer support to people in crisis beyond detainment, London is limited in its alternatives. This means the number of s136 detentions persist, adding increased pressure to London's HBPoS sites and Emergency Departments.

#### Impact on the system and patient outcomes

Access issues and delays along the pathway have wider implications for the range of stakeholders involved during an s136 detention.

Clinical staff have noted that delays in accessing support and on-going treatment negatively impacts patient experience and outcomes. Staff have stated that those who experience poor treatment at the start of the pathway are less likely to engage with health services, co-produced

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<sup>31</sup> Metropolitan Police Mental Health Escalation Log (2015)

crisis plans are jeopardised and trust between clinicians and the patient is lost.<sup>32</sup> This is illustrated by the fact that in 2015/2016 there were approximately 320 Londoners who were detained again under s136 within two days.<sup>33</sup>

Both national (including MHA legislation) and London policy prevent the use of police cells for those detained under s136 which has resulted in a 94% decrease in the use of cells. However, the knock on effect has been additional pressure on HBPoS sites and EDs.

Capacity issues at HBPoS sites have harmful impacts for EDs. As places of safety by law, the Met Police instructs all officers to go to the nearest ED when capacity issues arise at HBPoS sites. Evidence suggests that prolonged ED stays are associated with increased risk of symptom exacerbation and absconson for those with mental health issues.<sup>34</sup> The delays have a strong link with poor patient experience leading to increased hospital readmissions and poorer clinical outcomes.

EDs are also experiencing escalating demand from all attendances, and significant resources are needed in order to manage the care of those under s136 in the department. Individuals detained under s136 spend five times as long in EDs, with over 40% of those in mental health crisis in ED breaching the four hour target. A typical emergency department sees on average 300 patients a day who are in the department for an average of 2.5 hours. When an individual detained under s136 is in the department, they spend on average 12 hours due to their complex health and social needs. This means that the care for one person detained under s136 is the equivalent of being able to treat ten other patients, based on the time s136 patient spend in department being five times that of other patients and requiring twice as much resource.

Treating a s136 patient in A&E takes on average the same resource as treating 10 physically ill patients and patients are significantly more likely to breach the A&E 4 hour standard and 12 hour standard. In an average A&E department, seeing 300 non-s136 patients a week, 10 patients equates to 3.3% of standard daily activity and therefore by treating s136 patients in a more appropriate environment frees up A&E resource and would positively impact on performance against the A&E standards.

National policy direction states that long delays in handing patients over from the care of ambulance crews to that of the ED staff, not only result in breaches of the 15 minute handover target, but are detrimental to clinical quality and patient experience and costly to the NHS. Under the current HBPoS configuration, police and ambulance staff often face long delays accessing place of safety sites whilst staff are pulled from other wards, often with the individual detained having to wait in an ambulance or police van. Furthermore, the time taken to convene the assessing team and arrange onward care following assessment also contributes to delays; with lengthy place of safety admissions impacting patient experience and limiting patient flow, contributing to capacity issues.

The benefits of the new model and reliable access to care will provide the Police and LAS with access to the right medical staff to consult with prior to detention, the confidence to take the patient to the nearest HBPoS to receive high quality care as well as the opportunity to build

<sup>32</sup> NHS - Mental Health Crisis Care for Londoners: London's section 136 pathway and Health Based Place of Safety Specification

<sup>33</sup> NHS - Mental Health Crisis Care for Londoners: London's section 136 pathway and Health Based Place of Safety Specification

<sup>34</sup> NHS - Mental Health Crisis Care for Londoners: London's section 136 pathway and Health Based Place of Safety Specification

better working relationships with staff at the sites. All of this will contribute significantly to admission avoidance, improved patient flow throughout the system and a better quality service; driving a positive impact on the 15 minute ambulance handover time target as well as both the four and twelve hour performance across the capital.

### Monitoring and oversight

There is a role for commissioners and providers to have better oversight when capacity issues occur. It was recorded in 2016 that only 32 per cent of London CCGs were using provider, police and local authority data to monitor and understand the demand for HBPOs sites (as well as outcomes for those detained under s136).<sup>35</sup> Over 62 per cent thought they were not compliant in instigating joint incident reviews when someone detained under s136 has been refused access to a HBPOs, or taken into police custody, or both.

#### 3.2.3.5 Funding issues

Current funding arrangements do not promote Trusts to accept patients into HBPOs sites based on need, but rather a number of patients instead are accepted and assessed based on their home address or registered GP. This causes delays and inconsistent and variable care across London; patients are denied access to urgent mental health care - something that does not happen to Londoner's who require urgent physical healthcare.

#### 3.2.3.6 Inpatient bed availability

The lack of inpatient beds in London impacts on the s136 pathway increasing the length of time patients spend at HBPOs sites. In line with the Mental Health Act, AMHPs cannot complete the mental health assessment until a bed is found. The lack of inpatient beds causes a delay in completing the assessment and there is now additional pressure given the recent changes to the Mental Health Act<sup>36</sup>. The London average used for this business case is 41% of those detained under s136 are admitted to an inpatient ward following assessment<sup>37</sup>.

Evidence from elsewhere in the UK and in London (e.g. Birmingham and South London and Maudsley Mental Health Trust) suggests that confronting these issues can lead to improvements in patient experience and outcomes, reduced inpatient admissions and decreased readmissions. It is important that the rest of London follows suit.

### 3.2.4 Patient volumes and trends

At present, London's HBPOs sites provide care for approximately 5,307 s136 patients per annum. Given demographic projections, and increasing trends in demand over the past number of years, patient volumes are estimated to grow by approximately 16.5% for adults and 17.5% of CYP between 2015/16 and 2020/21.

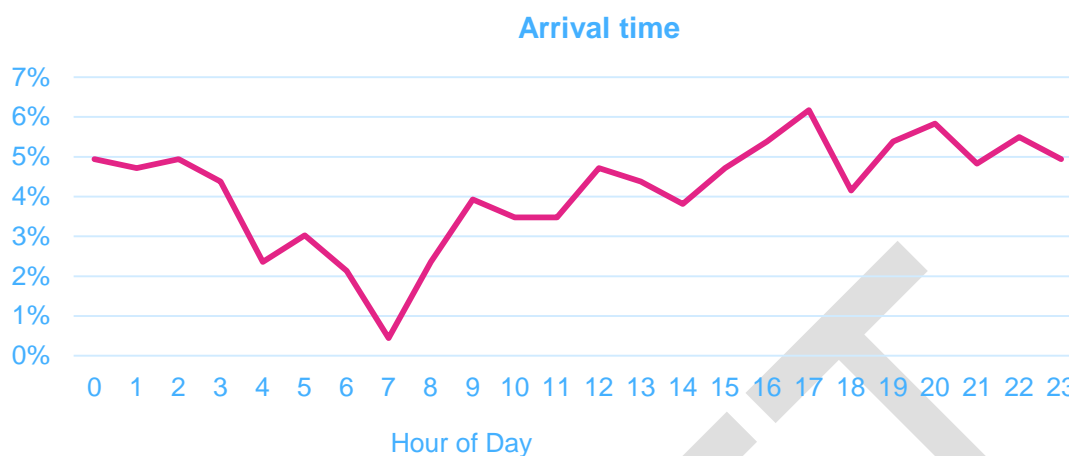
Of these detentions, over 75 per cent occur out of hours.<sup>38</sup> This is illustrated in Figure 5, which details the proportion of arrivals by hour of day.

<sup>35</sup> CCG Improvement and Assessment Framework report (September, 2016)

<sup>36</sup> Revisions to the MHA (1983) changed the length of time an individual can be detained under s136 from 72 to 24 hours.

<sup>37</sup> Mental Health and Learning Disability dataset (MHLDDS) from July – December 2015

<sup>38</sup> Healthy London Partnership (2015) UEC Programme: HBPOs audit

**Figure 5: proportion of activity by time of arrival**

The hours of arrival, together with the expected growth in patient volumes puts significant stress on the current configuration. The majority of sites do not have dedicated 24/7 staffing, and therefore cannot respond to patient needs appropriately.

### 3.2.5 Learning from elsewhere

#### Leveraging London's own expertise

There are two HBPOs sites within London with dedicated 24/7 staffing, South London and Maudsley (SLAM) and South West London and St. George's (SWLSTGs). The experience from these sites has been used to inform the s136 new model of care and reconfiguration of HBPOs sites.

During the options appraisal process and beyond, frontline staff and management from SLAM and SWLSTGs have helped to inform the analysis and assumptions supporting this business case.

Below are some of the key advantages and the learning from SLAM and SWLSTG.

#### *South London and Maudsley (SLAM)*

SLAM's centralised place of safety is a purpose-built facility, which meets the NHS estates standard and is staffed with a specialist team dedicated to providing speedy and expert assessments on 24/7 basis. It currently holds four assessment rooms, and two further step-down units. One of the two high dependency units has an attached private lounge area and was designed to accommodate those under the age of 18, making SLAM's centralised HBPOs one of the few sites across London that has a designated assessment room for this purpose.

Key advantages:

- Access to a HBPOs has improved, with the new site accepting an average of 13% more s136 referrals each month than across the four sites under the old model;

- Frequent place of safety closures that were experienced in the past due to staffing issues and damaged facilities have not been a problem disruption to services due to closures reduced from 279 incidents across 4 sites in 2016 to 1 closure in 2017;
- A dedicated team on site 24/7 has facilitated quicker acceptance of patients into the site, with 96% of patients admitted within 30 minutes of arrival; the time which police officers have to remain at the place of safety has also improved;
- Improved physical health capabilities of staff has facilitated a decrease in the number of patients going to an ED prior to admission to the HBPoS;
- Dedicated specialist staffing has facilitated improvement in service user experience, quality of assessment provided and interagency working across the s136 pathway;
- The new purpose built facility, co-designed with service users, has transformed the physical environment. The unit has been designed to support delivery of safe and dignified care to patients in a therapeutic setting; and
- The admission rate has decreased by 13% under the new model, with improved practice of a dedicated team and close working with the Trust's acute referral team (equates 8 fewer admissions per month for the trust via the centralised place of safety).

#### Key Learning:

- Further work is required to improve patient flow and ensure patients are always assessed and discharged from the site quickly;
- The availability of inpatient beds for onward admission remains an issue (length of stay for individuals requiring admission is on average 10 hours longer than those discharged into the community); and
- Now there is a better understanding of the fluctuations in demand, plans for managing both periods of high and low demand, including managing capacity issues and reviewing staff utilisation are in progress.

#### *South West London and St. George's (SWLSTGs)*

The SWLSTGs model is based on the Birmingham Psychiatric Decision Unit (PDU), which plays an important role in the urgent care pathway and has demonstrated significant benefits in reducing inpatient admissions and diverting people from the ED. SWLSTGs is a 24-hour mental health acute assessment unit that enables more in-depth assessments. It currently has two s136 assessment rooms and an adjacent psychiatric decision unit with a bed capacity of 5 units.

#### Key Advantages:

- There was a 26% decrease in informal admissions, a 17% reduction in 0-5 day admissions and 8.4 fewer occupied beds per day through November 2016 to February 2017.
- There has been an improvement in service user experience due to the nature of the PDU's calm and relaxing environment that reduces anxiety levels;

- A more dynamic workforce model with the ability to interchange staff between the s136 assessment rooms and the PDU, which reduces down-time for staff;
- All service users transferred to the suite are supported to develop a collaborative crisis plan to keep on discharge; this has been met positively by service users; and
- The service has supported the professional development of nursing assessment skills resulting in a clear pathway for role progression.

Key Learning:

- On-going learning will continue to take place from adverse incidents, assessment time breaches and advice from regulators, in order to ensure safety and high quality care in the unit. As with SLAM, fluctuations in demand need to be understood to ensure staff can operate effectively when the unit is at maximum capacity.

## 3.3 Vision and objectives

### 3.3.1 Improving London's section 136 pathway

Transforming the s136 pathway and HBPoS service sites requires a shared vision across London's crisis care system. As such, all partners involved in this transformation have agreed to work in line with the main principle of cooperation and collaboration underpinning the crisis care concordat<sup>39</sup>.

This overarching vision to provide safety and support to people in mental health crisis is underpinned by a number of guiding principles which informed the specification of London's s136 pathway. In addition, it is important that this vision enables the development of strategic objectives for the reconfiguration of HBPoS.

### 3.3.2 Strategic objectives

The strategic objectives outlined below highlight the list of aims which the reconfiguration of HBPoS sites is trying to achieve and/or contribute to. By setting out a list of objectives, decision makers can assess whether the programme's objectives are in line with wider policy interests and also evaluate the programme post-implementation. These objectives will inform the range of economic and clinical benefits identified in this business case and further benefits realisation activities thereafter.

#### Objective 1: Enable the improvement in patient outcomes

- The reconfiguration of HBPoS sites should assist all stakeholders in the s136 pathway in delivering better patient experiences
- This includes ensuring that adequate conveyance times, facilities and services on arrival are provided to enable better care to those in crisis

#### Objective 2: Facilitate access to 24/7 services

- The reconfiguration should allow those experiencing a mental health crisis to have specialist treatment available to them 24/7
- In addition, the reconfiguration should seek to minimise delays in specialist treatment and transport for the benefit of people in mental health crisis, police forces, Emergency Departments and clinical staff

#### Objective 3: Concentrate staff expertise to enable a service suitable to patient needs

- The reconfiguration should allow individuals to have access to the expertise required to enable better outcomes no matter which HBPoS they are transported to
- Staff should also have adequate physical health competencies to prevent unnecessary ED referrals and provide a better experience for those detained under s136 through more holistic care.

<sup>39</sup> Mental Health Crisis Care Concordat. Improving Outcomes for People Experiencing Mental Health Crisis. HM Government (2014)

### Objective 4: Deliver value for money

- The reconfiguration should be delivered in the context of existing financial constraints and funding availability within the UK's health system
- This involves minimising the level of capital investment required to deliver the improved s136 pathway
- In addition, the reconfiguration should seek to have sufficient throughput of patient activity so that desirable staff utilisation levels are maintained

### Objective 5: Ensure synergy with the wider crisis care system

- The preferred HBPoS configuration should fit within the wider crisis care system in a way which enables other services to benefit from the proposed change
- An example of these synergies is from future-proofing i.e. the new configuration allows for the expansion and/or improvement in the system in the medium to long term

### Objective 6: Ensure appropriate service provision for all ages

- The reconfiguration should ensure that the specific needs of CYP can be met in a suitable care environment.
- As a result, there will be one HBPoS within each STP that provides services for all ages, with appropriate facilities available for CYP patients and sufficient capacity and staff skills to provide a 24/7 service.

### 3.3.3 Appraisal framework

In order to appraise options in the Economic Case, and to subsequently evaluate the preferred option against the do-nothing alternative, it is necessary that the framework utilised to appraise potential options aligns with the broader strategic objectives of the programme. Table 4 sets this out in detail.

**Table 4: Appraisal framework**

Objectives	Appraisal criteria
<b>Objective 1:</b> Enable the improvement in s136 patient outcomes	Ensure that the preferred configuration of HBPoS sites can best deliver the proposals set out in the Specification
<b>Objective 2:</b> Facilitate access to 24/7 services	Determine what configuration would establish sufficiently constant demand to warrant 24/7 services across all sites
<b>Objective 3:</b> Concentrate staff expertise to enable a service suitable to patient needs	Ensure that the preferred configuration can maintain the skills required to deliver a high-quality 24/7 service Ensure that the preferred configuration supports sufficient utilisation of resource to warrant dedicated HBPoS staff
<b>Objective 4:</b> Deliver value for money	Consider a configuration which makes best use of existing infrastructure and ensures an efficient use of resources per patient
<b>Objective 5:</b> Ensure synergy with the wider crisis care system	Configuration allows for enhancement of other services through HBPoS and the potential for future proofing
<b>Objective 6:</b> Ensure a distinction between the service provided to adults and the service provided to CYP	Ensure that the resource and infrastructure requirements for adults and CYP are considered separately

## 4 Clinical case

This chapter provides an added focus on the clinical challenges that exist with the existing configuration of HBPoS sites, along with an appraisal of proposed clinical benefits that may be derived through the proposed reconfiguration.

This chapter is structured as follows:

- Existing clinical challenges
- Clinical benefits of the preferred option

**have been identified through significant engagement with people with lived experience of mental health crisis, the LAS and clinical staff at both HBPoS sites and EDs and corroborated by the CQC, most recently in a report published in July 2017.**

The new model of care will contribute significantly to improving these challenges and help deliver better outcomes to Londoners:

1. **Improve the quality of care** by enabling more capacity across the system, better environment conditions and suitably trained and dedicated staff teams, enable the delivery of a consistent level of care for all, which support reduced inpatient admissions and readmissions.
2. **Improve the provision of care for CYP** by increasing the capacity of appropriate facilities for CYP with suitably trained staff.
3. **Improve access to care** by being better placed to accommodate capacity and demand, supporting reduced ED admissions, providing dedicated staffing 24/7, reducing conveyance time and enabling patients to be assessed and treated holistically and comprehensively.
4. **Improve the environment in which care is provided** by ensuring patients are treated with respect, comfort and dignity and feel safe at all times, in fit-for-purpose facilities.

Implementation will be carried out with strong clinical engagement and leadership to ensure clinical quality is maintained and improved at all sites throughout the transformation.

## 4.1 Existing clinical challenges

### 4.1.1 Overview

London's current s136 pathway and HBPoS specification does not adequately and consistently deliver the quality of care that patients deserve. Stakeholders across the crisis care system acknowledge that there are a number of challenges which need to be addressed in order to provide patients with timely, high quality care which respects individual needs.

This section sets out the existing clinical challenges in London's mental health crisis care system. These challenges have been identified through continued engagement and interviews with London's police forces, the LAS, clinical staff and patients with experience of the s136 pathway and HBPoS sites. The challenges identified are:

- Delayed and unreliable access to care;
- Unsuitable treatment environment;
- Inconsistent quality of care; and
- Inappropriate provision for CYP.

In the Financial Case and Economic Case, a number of these challenges are discussed in terms of their financial, economic and social impacts. The purpose of the Clinical Case, however, is to outline how the existing inefficiencies and inconsistencies along the pathway can be addressed through the reconfiguration of HBPoS sites.

### 4.1.2 Delayed and unreliable access to care

Insufficient site capacity, together with non-dedicated staffing, can cause significant delays to treatment for patients detained under s136 of the Mental Health Act.

#### Delays to care

A number of stakeholders involved with the s136 pathway have noted continued delays in accessing sites, as police forces and LAS struggle to secure capacity at HBPoS sites. In 2015, over 100 issues related to capacity and access across the s136 pathway were reported by frontline police officers.<sup>40</sup> This number increased in 2016, with some instances of police officers and paramedics recording waits of over seven hours in accessing care. Box 2 provides an example of difficulties police forces have faced in accessing care for individuals detained under s136.

#### Box 2: Capacity and delays in existing system

Police request access to a Health Based Place of Safety but were denied as the site was full, staff at the site refused to facilitate arranging elsewhere for the patient to go. Eight hours later officers had the patient assessed at a London Emergency Department, following assessment the patient was then transferred back to the original site where the Place of Safety was situated to be admitted into an inpatient psychiatric bed.

<sup>40</sup> Metropolitan Police Mental Health Escalation Log (2015)

There are two primary reasons for these difficulties in accessing care:

- Individual site capacity; and
- Insufficient staff availability.

Many of the current HBPoS sites have minimal capacity, with some only capable of holding one individual under s136 at any point in time. The current configuration of sites and their capacity is not modelled according to demand and therefore when the volumes of patients presented at HBPoS sites exceed the available number of suites, long delays can occur in terms of waiting times and travelling times to other sites.

As the majority of sites do not currently have dedicated staffing, this situation is exacerbated outside of regular working hours. Over 75% of s136 detentions occur during this time period, yet minimal staffing levels restrict the ability to provide a responsive service.

Together, these bottlenecks and operational inefficiencies increase conveyance times and lengths of stay at HBPoS sites, ultimately delaying patient assessments and elongating the service.

### Impact on patients

For patients, delays in time to assessment can lead to:

- Increased emotional distress;
- A delay in receiving appropriate medication; and
- A breakdown in trust with mental health services.

Without prompt intervention, a patient's mental health condition can deteriorate. A poor experience at the beginning of the s136 pathway can have traumatising effects for individuals, leading to worse clinical outcomes and reluctance to seek professional help in the event of another crisis. Unplanned delays can also have a catastrophic impact on a person's pre-admission functional ability. In a mental health setting, extended length of stay can lead to deconditioning, functional relapse and a loss of confidence.<sup>41</sup>

In interviews, clinical staff at London's HBPoS sites have also noted that these delays in accessing support and on-going treatment negatively impacts patient experience and outcomes. Staff have stated that those who experience poor treatment at the start of the pathway are less likely to engage with health services, co-produced crisis plans are jeopardised and much of the trust between clinicians and the patient is lost. This is illustrated by the fact that in 2015/2016 there were approximately 320 Londoners who were detained again under s136 within two days.

#### 4.1.3 Unsuitable treatment environment

London's treatment environments for mental health crisis patients vary, but often fail to provide a therapeutic setting for patients. In the most recent reports from 2016 and 2017, the CQC rated two Mental Health Trusts as 'needing improvement' and one as 'inadequate'.

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<sup>41</sup> Right place, right time, better transfers of care, NHS Providers, 2015

Londoners with lived experiences of the s136 pathway have also expressed concerns about the comfort and safety of HBPoS sites. Only 36 per cent of Londoner's detained under s136 said they felt safe in an HBPoS.<sup>42</sup> The feedback is even worse for patients that are transferred to EDs due to capacity issues. In London's EDs, only 12 per cent of those assessed thought their assessment rooms were pleasant, comfortable and welcoming.<sup>43</sup>

It is important that London's crisis care services can provide patients with the respect, comfort and dignity that they deserve during difficult moments in their lives. Poor physical environments can make a patient feel intimidated, scared and less likely to engage with treatment during and after the intervention.

#### 4.1.4 Inconsistent quality of care

Only 14% of patients interviewed say that they had the support they needed in a crisis.<sup>44</sup> Issues within the crisis care system, such as the delays and unsuitable environment discussed above, contribute to potentially harmful patient experiences. Patients have also shown a clear preference for 24/7, dedicated crisis services even if that means travelling further to access the care. Patient experience also varies due to differing levels of staff training and skillsets at the HBPoS sites and EDs.

The CQC report indicated that nearly a third of nursing and medical staff training was 'on the job' rather than before they started work in the place of safety. Furthermore, five per cent of places of safety indicated that nursing and medical staff were not trained in de-escalation, which is recommended for managing disturbed behaviour.<sup>45</sup>

On occasion, staff who do not have a dedicated role in treating mental health crisis patients can feel less confident in their ability to contribute to mental health assessments.

#### 4.1.5 Inappropriate service provision for CYP

CYP suffering a mental health crisis have different needs to adults, which should be reflected in the care and environment provided to them.

However, many CYP patients are not receiving the care that they need in mental health facilities. In a survey by the Royal College of Psychiatrists, 79.1% of respondents reported safeguarding concerns while CYP were waiting for an inpatient bed; 76.5% reported young people with unacceptably high risk profiles having to be managed in the community because of a lack of beds; 61.9% reported young people being held in inappropriate settings such as paediatric and adult wards, police cells, s136 suites and Emergency Departments.<sup>46</sup>

The use of adult wards for managing CYP detained under s136 has been described as problematic by stakeholders interviewed as part of the Health Needs Assessment.<sup>47</sup> This is due to the perceived lack of staff expertise in care for CYP at a number of sites.

<sup>42</sup> Healthy London Partnership (2015) UEC Programme: 'I' statements

<sup>43</sup> Ibid

<sup>44</sup> Healthy London Partnership (2015) UEC Programme: 'I' statements

<sup>45</sup> Care quality Commission: A safer place to be

<sup>46</sup> Survey of in-patient admissions for children and young people with mental health problems. RCPsych, Faculty Report CAP/01

<sup>47</sup> Section 136 and mental Health Crisis Presentations in Emergency Departments in London, 2016

This issue in the quality of care for CYP patients is exacerbated by London's current configuration of HBPoS sites, as many instruct that children detained under s136 should instead go to the nearest Emergency Department. Over the past two years, one London ED has seen an 82% increase in the number of CYP patients requiring a mental health assessment. As discussed previously, treating anyone detained under s136 in an Emergency Department is not appropriate and has a strong link with poor patient experiences, higher readmission rates and less desirable clinical outcomes.

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## 4.2 Clinical benefits of the preferred option

### 4.2.1 Overview

A primary purpose of the reconfiguration of HBPoS sites is to address the existing clinical challenges along the s136 pathway and within the wider crisis care system in order to deliver high-quality, coordinated care for some of the most vulnerable Londoners. By improving access to care, providing suitable treatment environments and ensuring a consistent quality of care at HBPoS sites, the preferred option will help to deliver better outcomes for those detained under s136 in future. In addition, the provision of an all-age HBPoS site in each STP will ensure that CYP are provided with appropriate care according to their needs.

This section outlines how the preferred option will address the current clinical challenges identified within the crisis care system. Table 5 maps out how the outcomes of the preferred option will address the existing challenges, and lead to clinical benefits.

**Table 5: Clinical benefits map**

Existing challenge	Preferred option outcome(s)	Clinical benefit(s)
Delayed and unreliable access to care	<ul style="list-style-type: none"> <li>Reduced conveyance time</li> <li>Reduced HBPoS length of stay</li> </ul>	<ul style="list-style-type: none"> <li>Patients experiencing a crisis are treated quicker</li> </ul>
Unsuitable treatment environment	<ul style="list-style-type: none"> <li>Improved HBPoS environment</li> <li>Reduced ED admissions</li> </ul>	<ul style="list-style-type: none"> <li>Fit-for-purpose facilities improve patient outcomes and reduce aggression levels</li> </ul>
Inconsistent quality of care	<ul style="list-style-type: none"> <li>Improved staff expertise</li> <li>Reduced inpatient admissions</li> <li>Reduced readmissions</li> </ul>	<ul style="list-style-type: none"> <li>Patients receive better quality treatment during HBPoS stay</li> <li>Reduction in variation</li> </ul>
Inappropriate provision for CYP	<ul style="list-style-type: none"> <li>Improved staff expertise</li> </ul>	<ul style="list-style-type: none"> <li>CYP patients are treated by paediatric professionals with appropriate skills</li> </ul>

### 4.2.2 Clinical outcomes and benefits

In addressing the challenges discussed previously, the reconfiguration of HBPoS sites will produce a number of benefits for patients. The outcomes listed below are also included in the Economic Case, however they are discussed in this section purely in terms of their clinical benefits.

#### Reduced conveyance time

By providing sufficient capacity at the HBPoS sites, the preferred option will reduce the average journey time from 64 minutes to 22 minutes for police vehicles and 24 minutes to 22 minutes for ambulance vehicles.

This will ensure that patients receive emergency clinical care more quickly whilst also denoting a time saving for police, ambulance and patients. Patient experience will improve as delays are minimised and they can be seen faster by clinical staff trained to care for their needs.

Furthermore, by reducing the conveyance time for patients, the reconfiguration will contribute towards the wider aim of urgent and emergency access to crisis care – making sure that a mental health crisis is treated with the same urgency as a physical health emergency; this is vital step towards achieving parity of esteem for mental and physical health.<sup>48</sup>

### Reduced length of stay at HBPoS

Through dedicated staffing and minimised delays, it is expected that the average length of stay at an HBPoS site will reduce slightly from 17.5 hours to 16 hours. This is partially because the new configuration seeks to limit the number of assessments which last more than 24 hours to zero.

Where this represents a reduction in waiting time, there is an improvement in patient experience as they are seen by a mental health professional and admitted to an inpatient bed, where necessary, more rapidly.

The National Institute for Health and Care Excellence (NICE) note that it is important to start building therapeutic relationships as early as possible in order to:

- Lessen the person's sense of being coerced;
- Encourage the person to engage with treatment and recovery programmes and collaborative decision-making;
- Create a safe, contained environment; and
- Reduce the risk of suicide, which is high during the first 7 days after admission.

This is particularly important for people who have been admitted in crisis.<sup>49</sup>

### Improved HBPoS environment

It is a national objective for mental health services in London that people are treated with dignity and respect when in crisis, within a therapeutic environment.<sup>50</sup> A soothing environment can de-escalate patients and make them feel safer during treatment. Importantly, it also demonstrates to patients that they are respected and cared for by those seeking to help them. This is achieved both through the physical design of an HBPoS site and staff factors: the training of the staff to use the environment effectively, the compassion and dignity afforded to patients by staff and the relationships within the staff team and with other professionals. Where HBPoS environments have been co-designed with patients, this can ensure that the environment meets patient, as well as staff, needs.

<sup>48</sup> Achieving Better Access to Mental Health Services by 2020. DH, 2014

<sup>49</sup> Transition between inpatient mental health settings and community or care home settings (NG53). NICE, 2016

<sup>50</sup> Department for Health, 2014 - Achieving Better Access to Mental Health Services by 2020

### Box 3: HBPoS environment

“We’re starting to learn how to use the environment in a really positive way in terms of managing risk. We use the rooms to step people down and step people up according to their need. That works really well for us in terms of managing risk, and it ties in with other initiatives we use in the Trust, like the four steps to safety which is a violence and aggression tool.”

#### SLAM Centralised Place of Safety Nurse, 2017

Evidence suggests that mental health facilities that are fit-for-purpose and meet the needs of service users improve patient outcomes and safety. Trends also lean towards reduced involuntary admissions and overall aggression levels.<sup>51</sup> Staff at the SLAM Centralised Place of Safety have experienced that the design of the built environment has supported safety, improved dignity and privacy and quality of assessments.

**Figure 6: Service user perceptions of the SLAM centralised HBPoS, 2017**



In the Economic Case, this benefit has been quantified and a monetary value of £335k per annum has been estimated using the Social Value Bank methodology.

<sup>51</sup> Hughes, R. (2008) Patient Safety and Quality: An Evidence-Based Handbook for Nurses. Agency for Healthcare Research and Quality (US)

## Reduced Emergency Department admissions

In the preferred option, it is anticipated that the number of patients sent to ED due to insufficient capacity will reduce from 4.5% to zero.

ED admissions are associated with poor patient experiences, leading to less desirable clinical outcomes. As a result, diverting individuals away from Emergency Departments will have clinical benefits in terms of reduced hospital readmissions and improved patient experiences.

If ED admissions due to insufficient capacity are reduced to zero, approximately 200 patients will benefit from the improvement in experience. This has been calculated using the Social Value Bank's value for relief from depression/anxiety and is calculated at approximately £10k per annum.

## Improved staff expertise

The reconfiguration of HBPoS sites will concentrate staff expertise at the 9 sites.

The provision of 24/7 dedicated staffing, together with more focused staff training, will ensure that all patients receive a high quality of care upon arriving at an HBPoS site. Furthermore, by training staff to contribute to mental health assessments, a sense of ownership and responsibility can be fostered within the dedicated sites.

This improvement in care has not been quantified for the purpose of this business case; however, it can be expected that it contributes to the reduction in inpatient admissions and reduced repeat presentations which are discussed below.

## Reduced inpatient admissions

Past case studies, from Birmingham, SLAM and South West London have shown that the combination of dedicated staffing, improved facilities and minimised delays in care can lead to a significant reduction in inpatient admissions. The reconfiguration of HBPoS sites in London, together with a combined workforce model, could reduce inpatient admissions by between 20% and 26% if results from elsewhere are achieved.

The reduction in inpatient admissions as a result of the improved s136 pathway and HBPoS specification will itself represent a clinical benefit. Avoiding unnecessary admissions to mental health inpatient wards illustrates the efficacy of the clinical interventions at the HBPoS site.

## Reduced repeat presentations

At present, approximately 19.2% of sections are repeat presentations from patients that are readmitted through the s136 pathway within six months.<sup>52</sup> However, from discussions with key stakeholders in the system it is estimated that a reduction to 10% is possible under the preferred option.

As above, the reduction in readmissions as a result of the improved s136 pathway and HBPoS specification will itself represent a clinical benefit. Avoiding reoccurrences of mental health crises illustrates the efficacy of the clinical interventions at the HBPoS site.

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<sup>52</sup> Therapeutic Solutions: Section 136 and Mental Health Crisis Presentations in Emergency Departments in London

## 5 Economic case

This section sets out the Economic case for reconfiguring HBPoS sites in London. It outlines the process for arriving at the preferred option and outlines the indicative costs and benefits of the reconfiguration against the do-nothing baseline scenario.

This chapter is structured as follows:

- Options assessment
- Indicative economic costs and benefits

**The current configuration of HBPoS sites in London is not conducive to meeting the standards outlined in the pan-London s136 pathway and HBPoS specification.**

HBPoS sites are historically located where space has been available; however, capacity issues, a lack of dedicated, skilled resource (both in and out of hours) and lack of access predicated on geographic location of need are all drivers for a change of the current configuration.

- ▶ A robust options appraisal has demonstrated a reconfiguration of HBPoS sites is required to meet the new model of care. The options appraisal showed a preference of moving to:
  - **Nine site model for adults** with a combined workforce model (*further details on the workforce model is detailed in the workforce chapter*); and
  - **Five sites (one in each STP) within the nine site model that provide an all-age service.**
- ▶ The options appraisal represented the best option to address the mental health crisis care problems across London, bringing sustainable improvements and lasting benefits for patients, as well as driving improvements in the wider health economy.
- ▶ This option is the preferred state for London's future HBPoS site configuration; however a **transitional 13 site phase** has been developed following STP programme leads engaging locally on proposed configurations.
- ▶ The **indicative benefits** of the reconfiguration based on nine sites have been quantified by estimating the NHS financial savings as well as measuring the social impact of nine key outcomes.
  - NHS financial savings total £14,384k
    - £795k cashable / £13,589k non-cashable
  - Social impact savings (non-cashable) measured at £5,572k
- ▶ The **total baseline pathway cost is c. £20,632k p.a. (excluding activity growth).**
- ▶ The **total estimated cost of the reconfiguration is £23,744k** which includes the following:
  - Pathway cost £20,494k p.a.
  - Transition costs £1,000k
  - Capital costs £2,250k
- ▶ The **indicative net present benefit** of the reconfiguration over the five year period FY17/18 to FY21/22 is £73,927k which includes;
  - Net present value of non-cashable benefits (excluding non-pay costs) £66,174k
  - Net present value of the preferred option £7,753k

## 5.1 Options assessment

### 5.1.1 Overview

As expressed in Section 3, there is a clear case for a new model of care, changing the configuration of HBPoS sites alongside the development of the new s136 pathway. Stakeholders from across the crisis care system have articulated that the care and treatment service that users experience throughout different points of the pathway is variable and often inadequate.

In order to provide a viable solution to the existing issues, it is necessary to consider the full range of alternative delivery models for the s136 pathway and HBPoS specification. This section describes the process undertaken to evaluate the site configuration options for mental health crisis care for London.

The reconfiguration of HBPoS sites in London requires a more complicated and thorough options appraisal process than most public spending proposals. This is because, in theory, there are a vast number of potential configurations into which HBPoS sites could be organised across London:

- There could be any number of sites in an option ranging from one site for London to 20 sites (current state)<sup>53</sup>;
- Each site could be designated as a HBPoS; or
- There could be multiple combinations of sites to form a single service.

As such, a structured process made up of several steps was required to scrutinise the alternatives in order to identify the most desirable alternative to the status quo. In order to provide a structured, logical and objective approach towards arriving at a preferred option for reconfiguration, a three stage process was designed:

- Phase 1a: Site agnostic appraisal;
- Phase 1b: Site specific appraisal;
- Phase 2: Pan – London configuration assessment; and
- Phase 3: Preferred option.

At each stage, a set of criteria was used to measure the different reconfiguration options in terms of patient experience and outcomes as well as improve wider system efficiencies. Before progressing to the next stage, approval was required from the Crisis Care Implementation Steering Group.

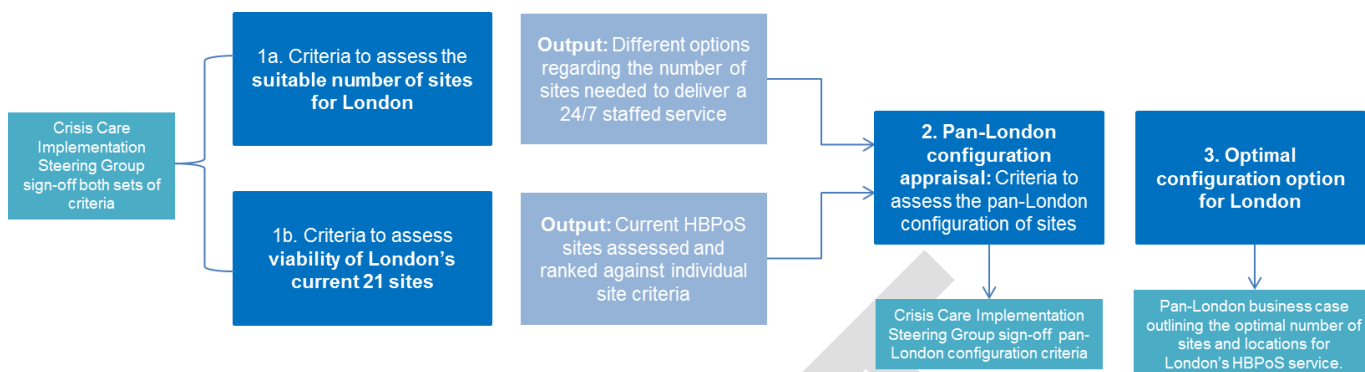
As described throughout the following sections, appraisal was undertaken separately for adult and CYP groups, with a final subjective assessment carried out in the final steps of the analysis.

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<sup>53</sup> At present, there are 20 HBPoS sites in operation across London. However, a HBPoS in Highgate is currently proposed for development and has therefore been considered as an option for the purpose of this appraisal

Figure 7 below provides a high-level overview of the appraisal process outlining the key outputs delivered at each stage.

**Figure 7: London's HBPoS options appraisal exercise**



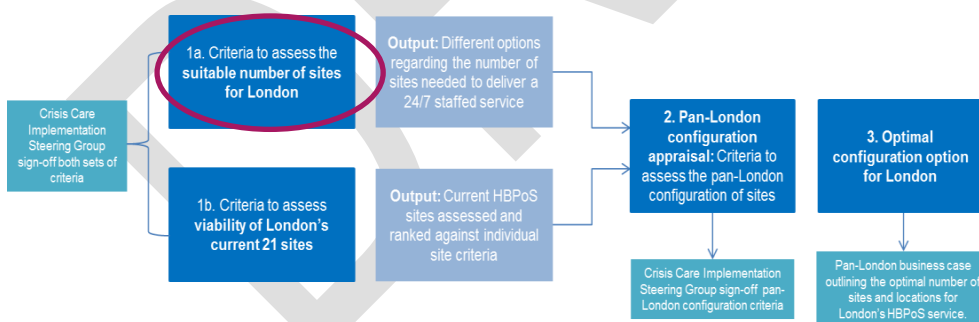
Source: Healthy London Partnership

Following the options appraisal, further engagement led by programme STP leads took place across the system on the preferred option. The engagement process resulted in some STPs confirming sites that would be included in a pan-London nine site model whilst others required more time to develop local plans, reflecting on other crisis care services and further understanding the impact of patient flow across local systems. This is particularly the case (but to varying degrees) in North West London (NWL), North East London (NEL) and South East London (SEL).

This resulted in a transitional stage being developed. The transitional stage is referenced throughout this business case with further detail in the Management Case.

## 5.1.2 Phase 1a – site agnostic appraisal

**Figure 8: London's HBPoS options appraisal step 1a**



### Overview

The first step in the options appraisal process was to identify the optimum number of HBPoS sites irrespective of the location and/or quality of the sites themselves. However, rather than arrive at a specific number of sites, and limit later stages of the analysis, the site agnostic appraisal provided a view as to the range within which the optimum number of sites exists.

The results of this stage of the options assessment have been used to help shape the Pan London assessment in phase 2. In addition, the hurdle process helps to reduce the millions of alternatives for reconfiguration down to a long list of options.

## Criteria

The criteria utilised during this stage of the assessment aim to test the degree to which a set number of sites can support the core principles within London's section 136 pathway and Health Based Place of Safety specification, namely the provision of a 24/7 service, minimising potential capital expenditure investment, effectively utilising capacity and resources and providing an equitable coverage across London. This produced four hurdle questions to employ as criteria:

- Does the configuration effectively utilise staff skills?
- Does the configuration effectively utilise capacity?
- Does the configuration provide equitable coverage across London?
- Does the configuration minimise capital expenditure investments?

## Results

The analysis established that between five and 13 HBPoS sites would be the optimal range for adults in London. A configuration with under 5 sites would not provide equitable coverage and would require significant capital investment. On the other hand, a configuration with more than 13 sites would not effectively utilise workforce and capacity and thereby struggle to justify the establishment of a 24/7 service.

**Figure 9: Hurdle analysis – adult HBPoS sites**

	No. of sites in the configuration																				
Hurdle questions	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21
Does the configuration effectively utilise workforce	Green	Green	Green	Green	Green	Diagonal	Diagonal	Diagonal	Diagonal	Diagonal	Green	Diagonal	Diagonal	Red	Red	Red	Red	Red	Red	Red	Red
Does the configuration effectively utilise capacity	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Red	Red	Red	Red	Red	Red
Does the configuration provide equitable coverage across London	Red	Red	Red	Red	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green
Does the configuration minimise capital expenditure investments	Red	Red	Red	Red	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green

### Optimal Range

This analysis establishes that the range deemed to be optimal for the number of HBPoS sites in London serving adult patients is between 5 and 13



a number of sites that is considered to have passed a given criteria test



a number of sites that is considered not to have passed a given criteria test



a number of sites that is considered to have passed a given criteria test for one workforce model, but not the other

Source: Healthy London Partnership

For CYP, the same process was undertaken in the site agnostic appraisal. At this stage, the optimal number of HBPoS sites for CYP in London was found to be between 1 and 2 sites. A larger number of sites would not effectively utilise workforce or capacity in the system and importantly, the option to have one or two sites allowed for an optimal concentration of appropriate skills.

**Figure 10: Hurdle analysis – CYP HBPoS sites**

Hurdle questions	No. of sites																				
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21
Does the configuration effectively utilise workforce																					
Does the configuration effectively utilise capacity																					
Does the configuration provide equitable converge across London																					
Does the configuration minimise capital expenditure investments																					

### Optimal Range

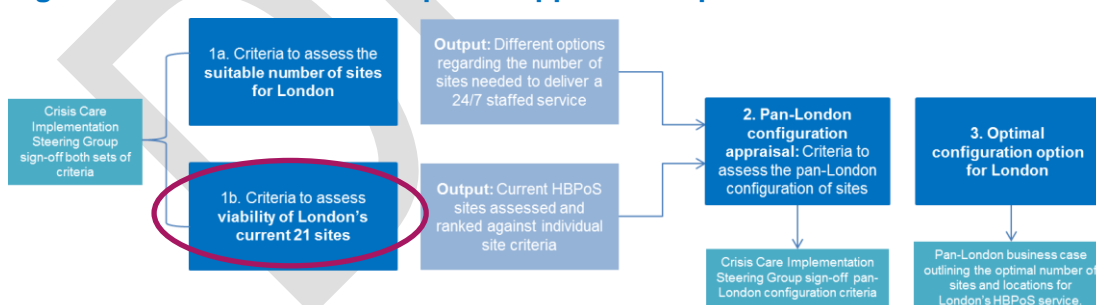
This analysis establishes that the range deemed to be optimal for the number of HBPoS sites in London serving CYP patients is between 1 and 2

- a number of sites that is considered to have passed a given criteria test
- a number of sites that is considered not to have passed a given criteria test

Source: Healthy London Partnership

## 5.1.3 Phase 1b – site specific appraisal

**Figure 11: London's HBPoS options appraisal step 1b**



### Overview

In parallel to determining the optimal number of sites for the configuration, individual HBPoS sites were also assessed against a set of criteria in order to determine London's most viable sites for the reconfiguration.

This objective assessment of individual sites enabled a ranking of the full range of HBPoS sites across London and within their respective sustainability and transformation partnerships (STPs), which was subsequently utilised in the pan-London appraisal.

## Criteria

Six criteria have been used to assess the HBPoS sites on an individual basis:

- Proximity to occurrences of s136 detentions (based on pick up locations and areas of prevalence);
- Proximity to inpatient beds;
- Deliverability (designated HBPoS sites at Emergency Departments are deemed not viable);
- Proximity to 24/7 urgent physical care<sup>54</sup>;
- % of non-clinical space to total space available; and
- Current capacity of the HBPoS site.

This set of criteria for individual sites has been tested with individual members from both the Crisis Care Implementation Steering Group and the Technical Implementation Group meeting along with representatives from the STPs, people with lived experience and their carers. Table 6 illustrates the criteria that has been utilised to rank each of the sites. Each option is scored using either a tiered (each option is placed on a 0-1 scale for achievement of goal) or binary (each option is given a value of 0 or 1, reflecting yes/no answer) method. High, medium and low weightings are provided in order to prioritise the importance of certain criteria.

**Table 6: Site-specific appraisal criteria**

Type	Criteria	Rationale	Weighting
Access to care	Areas where there are high presentations of section 136 detentions	Given the challenges with current service provision there is a need to improve the access of care, particularly in areas of high s136 activity. It is also well known that a good proportion of s136 patients are picked-up near large transportation hubs in London.	High
Deliverability	Emergency Departments that are 'designated' HBPoS are deemed unviable to be further developed	Royal College of Psychiatry and the Royal College of Emergency Medicine both recommend EDs should only be used as an HBPoS where medical problems need urgent assessment and management, this has been supported by London service users and stakeholders across the system.	High
Access to care	Proximity to mental health inpatient beds (adults - general acute wards and PICU wards, CYP – CAMHS beds and CAMHS workforce)	There is a need to be close to other mental health services, particularly inpatient beds. For adults this is general inpatient beds and Psychiatric Intensive Care Units (PICU), for CYP this is more CAMHS Tier 4 and the CAMHS workforce.	High

<sup>54</sup> In some cases, individuals detained under s136 require urgent physical care. This is typically delivered at an Emergency Department, and this arrangement is expected to continue in the new configuration.

Access to care	Proximity to 24/7 urgent physical care	Feedback throughout the engagement period outlined that robust acute and mental health pathways are vital to ensure an effective s136 pathway. It is acknowledged that sites that are in close proximity to an ED are more likely to have well developed pathways and have more effective, joint working between physical and mental health staff.	Medium
Deliverability	% of non-clinical space to total space available	This measure looks at the possibility of increasing capacity at HBPoS sites, the assumption being that non-clinical areas can more readily be used to increase capacity at sites.	Low
Deliverability	Current capacity at HBPoS	This criteria measures the current capacity at each site, with the rationale being to minimise the amount of capital investment required.	Low

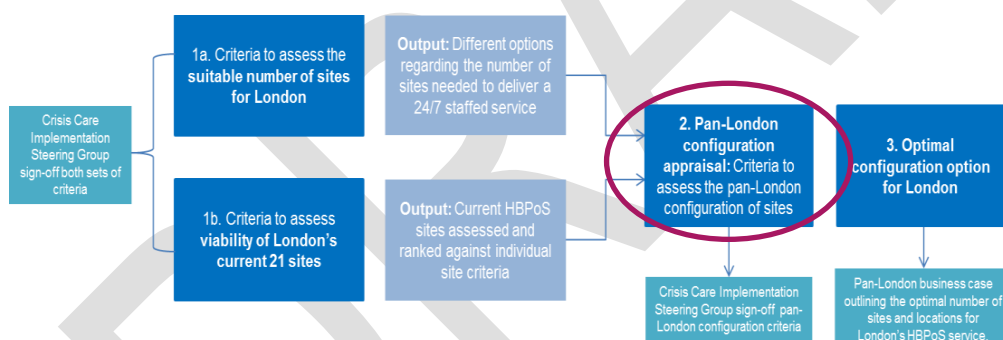
Source: Healthy London Partnership

## Results

The full suite of HBPoS sites were ranked according to each criteria. Please see Appendix A for detail on the rankings of HBPoS sites.

### 5.1.4 Phase 2: Pan – London configuration assessment

Figure 12: London's HBPoS options appraisal step 2



## Overview

Following the site agnostic appraisal and site-specific appraisal, an objective pan-London configuration appraisal was undertaken in order to arrive at a shortlist of options.

The first step involved at this stage of the process was to establish a long list of configuration options based on the highest scoring configurations from the site specific analysis undertaken in step 1b. The long list of configurations was then assessed in two ways:

- Individual site appraisal criteria that are relevant on a pan-London level and hence aggregated to provide an appraisal of a given configuration; and
- Specific pan-London criteria.

## Criteria

The pan-London configuration criteria used at this stage in the assessment are outlined in Table 7 below. This set of criteria was tested with individual members from both the Implementation Steering Group and the Technical Implementation Group along with representatives from the STPs, people with lived experience and their carers. The criteria are both objective and subjective in nature, and build on the analysis undertaken in Phase 1a and Phase 1b. Each option is scored against the baseline model, which is scored as zero; the scoring framework interprets whether the new model is an improvement on the current model or not, with the scores weighted based on the agreed weighting of that criteria point. High, medium and low weightings are provided in order to prioritise the importance of certain criteria.

**Table 7: Pan-London configuration criteria**

Type	Configuration criteria	Weighting
Quality	Pan-London configuration option delivers London's HBPoS specification (a key component being a 24/7 staffed service)	High
Quality	Pan-London configuration option maximises service user experience	High
Quality	Pan-London configuration option maximises staff experience (acknowledging multi agencies)	High
Quality	Pan-London configuration option ensures improved patient outcomes	High
Access to care	Option ensures adequate HBPoS capacity to meet peak demands and future growth in activity	High
Access to care	Option ensures appropriate distance between mental health inpatient service and HBPoS site	High
Access to care	Option ensures minimal conveyance time from pick up to the HBPoS site	High
Access to care	Option ensures appropriate distance between Emergency Department and HBPoS site	Medium
Access to care	Option ensures equitable coverage between sites (distance between each HBPoS site in the configuration)	Low
Value for money	Option provides value for money for London	Medium
Value for money	Option minimises overall capex investment	Low
Deliverability	Option ensures all estates are fit-for purpose and viable to deliver an improved service	Medium
Strategic coherence	Option aligns to STP wider crisis care visions	High

Strategic coherence	Option aligns with current agreed acute reconfigurations/mental health reconfigurations or service developments across wider health and social care.	Medium
Strategic coherence	Option ensures comprehensive coverage across London	Medium

## Results

Based on the criteria above, the objective pan-London assessment recommended a 9 site configuration of HBPoS sites for adults, with a combined workforce model. The results are provided in Table 8 below.

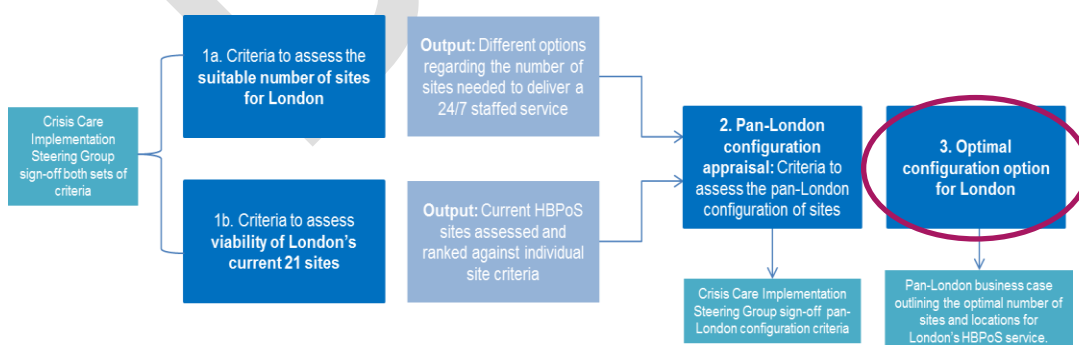
**Table 8: Pan-London appraisal results**

	5 Site Model		9 Site Model		13 Site Model	
	Stand-alone	Combined	Stand-alone	Combined	Stand-alone	Combined
Objective analysis	-9	-5	-3	1	-5	1
Subjective analysis	15	15	18	18	12	12
<b>Total</b>	<b>6</b>	<b>10</b>	<b>15</b>	<b>19</b>	<b>7</b>	<b>13</b>

For CYP, the same process was undertaken, which included further engagement across London with CAMHS clinical leads. A 2-site model with a combined workforce scored high in the objective analysis; however, it was not supported by both service users and clinicians.

### 5.1.5 Phase 3: preferred option

**Figure 13: London's HBPoS options appraisal step 3**



## Overview

In order to arrive at a preferred option, the subjective input of various stakeholders was sought in order to ensure that the output from the pan-London assessment in phase 2 proposed a realistic and viable alternative to the current configuration.

This step in the process ensured that appropriate engagement and insights were sought from the organisations and individuals which would be directly and indirectly affected by the change. It also allowed for a more strategic evaluation of options, with a consideration of other potential alternatives for the delivery of crisis care.

To inform the stakeholders involved in this phase of the assessment, the short list of options, including the supporting pan-London appraisal and individual site appraisal scores were circulated to the Crisis Care Implementation Steering Group and the Technical Implementation Group. This was followed by an evaluation workshop, which gained stakeholder input against a list of set focus points.

Finally, to arrive at the exact configuration of sites, a meeting was held between strategic leads in the relevant stakeholder groups. This considered a shortlist of 3 options for the preferred 9-site, with an HBPoS within each STP providing an all-age service with the appropriate facilities.

Rather than supersede the objective analysis undertaken in Phases 1 and 2, this subjective element of the appraisal process was used to supplement the analysis in order to arrive at the correct determination of the preferred option for London.

## Criteria

Each of the short listed configuration options were subjectively appraised against the pan-London criteria shown in Table 9 below.

**Table 9: Preferred option decision criteria**

Type	Criteria	Weighting
Quality	Pan-London configuration option maximises service user experience	High
Quality	Pan-London configuration option maximises staff experience (acknowledging multi agencies)	High
Quality	Pan-London configuration option ensures improved patient outcomes	High
Deliverability	Option ensures all estates are fit-for purpose and viable to deliver an improved service	Medium
Strategic coherence	Option aligns to STP wider crisis care visions	High
Strategic coherence	Option aligns with current agreed acute reconfigurations/mental health reconfigurations or service developments across wider health and social	Medium

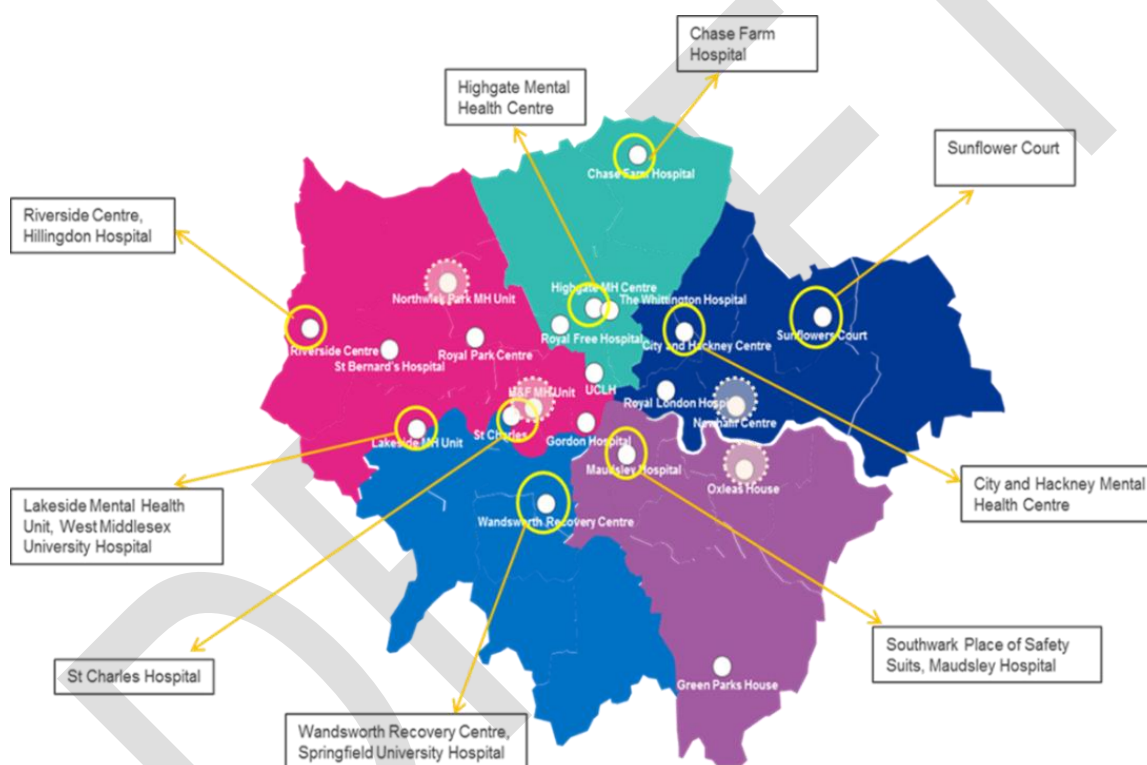
	care.	
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Source: Healthy London Partnership

## Results

The subjective assessment of sites, through two evaluation workshops (one for CYP, the other for adults), aligned with the results from Phase 2 above – indicating that a nine site combined model would be preferred for the HBPOs reconfiguration, with 5 sites (one in each STP) providing an all age service, with appropriate facilities<sup>55</sup>. A shortlist of 3 options were presented to the strategic leads, with the final configuration chosen as the preferred option illustrated in Figure 14 below (sites in the transitional phase are identified by faded circles).

**Figure 14: Pan-London consolidated HBPOs site model**



## Transitional stage

Following the options appraisal, further engagement led by programme STP leads took place across the system on the preferred option. The engagement process resulted in some STPs confirming sites that would be included in a pan-London nine site model whilst others required more time to develop local plans, reflecting on other crisis care services and further understanding the impact of patient flow across local systems. This is particularly the case (but to varying degrees) in North West London (NWL), North East London (NEL) and South East London (SEL).

<sup>55</sup> The preferred CYP sites in the 9 site model include: The Wandsworth Recovery Centre (SWL), Maudsley Hospital (SEL), Highgate Mental Health Centre (NCL) and St. Charles (NWL). The site of the CYP all-age service for NEL in the final 9 site model will require further discussion as the preferred CYP site is one of the transitional sites.

This resulted in a transitional stage of 13 HBPoS sites across London (including five sites that provide an all-age service). The additional sites are highlighted in Figure 13 above by faded circles. Further detail of the 13 site transitional stage is referenced in the Management Case.

DRAFT

## 5.2 Indicative economic costs and benefits

### 5.2.1 Overview

To deliver the new model of care, the reconfiguration of HBPoS sites in London will have direct and indirect impacts for service users, staff, the NHS and London's wider society and economy. The direct financial implications of the proposed nine site model are outlined in detail in Section 5, the Financial Case. However, the direct financial costs and savings do not fully account for the full range of impacts which will result from the reconfiguration. Instead, to determine the full set of costs and benefits of the proposal, a wider consideration of economic and social impacts is encouraged by the HM Treasury Green Book. This chapter focuses on the nine site proposal; further information on costs and benefits for the 13 site transitional phase are outlined in the Management Case.

The consideration of wider benefits is particularly important for this proposal, as the changes to London's mental health crisis care system are intended to primarily address quality issues and because mental health is an investment area for the government. As a result, the case for reconfiguration may be primarily grounded on the social and economic benefits discussed in this section.

This section begins by outlining the methodology for identifying and measuring the economic and social impacts of this proposal. Where possible, the benefits have been quantified with reference to EY's Social Return on Investment (SROI) methodology, using sources of information which are supported by the HM Treasury Green Book.

It then discusses the benefits identified for this proposal, both qualitative and quantitative, based on 9 key outcomes which will result from the reconfiguration of HBPoS sites, namely:

1. Reduced conveyance time;
2. Reduced ED admissions;
3. Reduced length of stay at HBPoS;
4. Improved staff expertise;
5. Improved HBPoS environment;
6. Reduced non-pay costs;
7. Reduced inpatient admissions;
8. Reduced readmissions; and
9. Improving the wider crisis care system.

These outcomes result in benefits across a range of stakeholders and are monetised where possible so that a comparison with the costs of the proposal can be carried out.

While some fiscal savings to the NHS are discussed in this section, the detailed analysis of the financial costs and savings along the s136 pathway are presented in Section 5, the Financial Case.

## 5.2.2 Benefits Methodology

The proposed new model will have positive impacts for a range of stakeholders across the crisis care system in London. These benefits may be through financial savings, economic impacts or positive social externalities.

In order to capture the broad and varied range of benefits appropriately, we have referred to EY's approach to calculating society's return on investment (SROI). This methodology has been specifically tailored to the s136 pathway and HBPoS reconfiguration by utilising the detailed analysis and audit which was undertaken as part of the options appraisal process described in the section above.

The SROI methodology has been broadly divided into three steps, are discussed in turn below:

1. Defining and classifying the costs and benefits for each potential initiative;
2. Researching likely efficacy and impact of each intervention; and
3. Applying the costs and benefits across the relevant population to understand society's return on investment in aggregate.

### Step 1: Defining the costs and benefits

#### *Identifying benefits: pathway based outcomes*

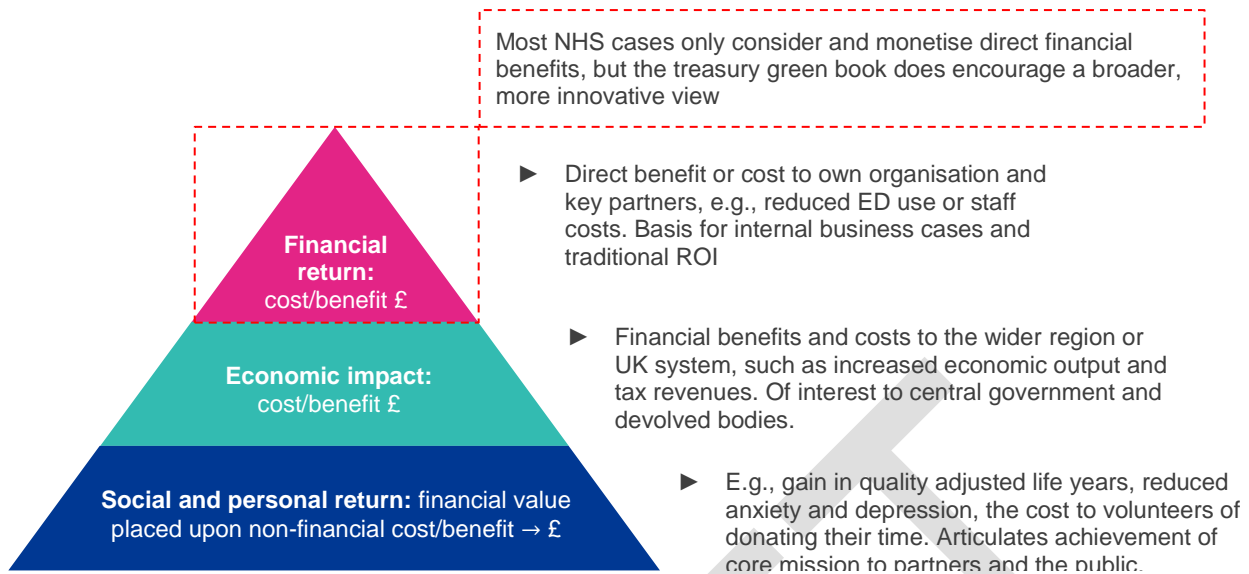
To align our approach to benefits with the financial case and options assessment, the methodology employed has focused on the outcomes resulting from the HBPoS reconfiguration both on the s136 pathway, for example conveyance times, ED admissions and the HBPoS facilities and staff.

However, in addition to these outcomes, a wider set of implications outside of the s136 pathway have also been considered in order to understand the full footprint of the proposed change. These outcomes outside of the pathway include reduced inpatient admissions, reduced readmissions and a broader objective of improving the wider crisis care system.

To identify the full suite of outcomes and benefits, a workshop was held with key stakeholders and health consultants with experience in this area. This allowed a categorisation and assignment of benefits as discussed below.

#### *Categorising benefits*

The first step in identifying the benefits of the reconfiguration was to seek to understand the financial, economic and social impacts of the proposed model. Figure 15 provides an illustration to demonstrate the potential benefits of health care projects.

**Figure 15: Benefits categorisation**

### Stakeholder benefits

The benefits realised from the outcomes above can further be categorised into the following stakeholder groups:

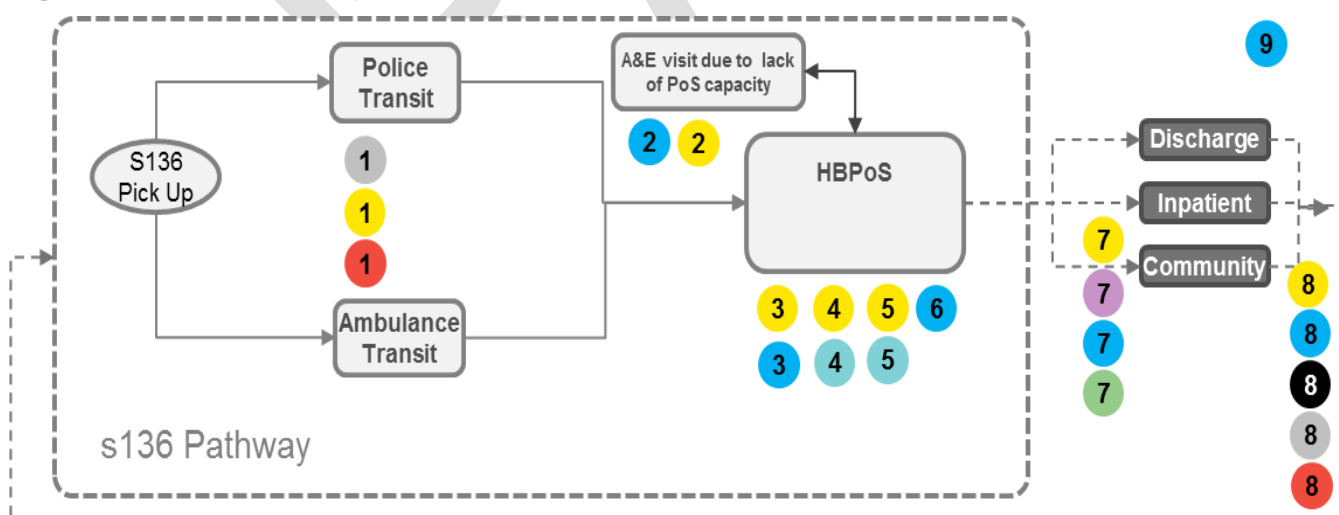
- Service Users;
- Relatives and carers of the service users;
- HBPoS staff;
- LAS;
- Police forces;
- Local authorities;
- The NHS; and
- The wider economy.

### Outcomes mapping

The table and diagram below illustrates how the new model outcomes can be mapped along the pathway and assigned to the stakeholder groups. The numbers denote the outcome listed below, while the colours indicate which stakeholder groups are affected.

**Table 10: Outcomes map**

Outcome	Patients	Family/ Carers	Wider economy	LAS	NHS	HBPoS staff	Police	Local Authorities
1. Reduced conveyance time	✓			✓			✓	
2. Reduced ED admissions	✓				✓			
3. Reduced length of stay at HBPoS	✓				✓			
4. Improved staff expertise	✓					✓		
5. Improved HBPoS environment	✓					✓		
6. Reduced non-pay costs					✓			
7. Reduced inpatient admissions	✓	✓	✓		✓			
8. Reduced readmissions	✓			✓	✓		✓	✓
9. Improving the wider crisis care system					✓			

**Figure 16: Outcomes map****Step 2: Researching impact and efficacy**

Once we have understood the types of cost and benefit expected to result from each initiative, the next step is attaching a financial value to them as accurately as possible. This involves research into the likely efficacy, impact and resource requirements of the interventions under consideration using the best sources available.

### **Transparency**

As the level of evidence related to each of the benefits will be variable, it is important that the research method is rigorous and systematic and that the findings are presented in a transparent and consistent manner. This means actively identifying any weaknesses or gaps in the evidence base.

There are known limitations to data availability for mental health crisis care in London and as a result, we have required the use of external sources and a number of agreed assumptions.

### **Credibility and proximity of evidence**

To ensure that the value of this proposal is estimated in a robust, verifiable manner, the most reputable sources of information available have been used when quantifying benefits.

The most credible sources of information are considered in this context to be governmental or peer reviewed academic sources – while grey literature and one-off case studies are relatively weaker.

In addition, we have leveraged the audits and modelling work undertaken to date, which has provided us with robust assumptions about the cost and time of resources along the baseline pathway. Further information on the sources of information utilised in the quantification of benefits are provided in Box 4 below.

#### **Box 4: Information sources for benefits quantification**

##### **Primary sources of information**

The primary sources used for quantifying benefits for the HBPOs reconfiguration were the UK social value bank and the New Economy CBA model - both of which are endorsed by the HM Treasury Green Book.

HACT is the housing sectors ideas and innovation agency. Together with a social impact analysis and policy evaluation specialist, HACT have created the largest bank of methodologically consistent and robust social values. These values provide an initial assessment of social impact, providing evidence of value for money which can be used in full SROI or cost-benefit analyses. This represents a significant step forward in the quality of available resources to enable placing social value on qualitative outcomes.

In a similar fashion, New Economy, in conjunction with central government, have formulated a cost database, comprising of more than 600 cost estimates, largely derived from government reports and academic studies and cover areas from crime, to education, skills and employment. These costs have been quality-assured by HM Government. The database therefore allows for informing proposals for implementing new interventions and redesigning or evaluating public services.

### **Step 3: Application to population or programme**

For ease of comprehension, the values derived in step 2 are often best presented at the level of each intervention applied to a single suitable individual. However, when developing a business case it is important to think about the population an intervention or package of interventions will actually be applied to. This will drive the overall levels of cost and benefit experienced by society.

### **Patient volumes**

To aggregate the benefits, we have used the estimated number of individuals per year who are detained under s136:

- A total of 5307 people detained under s136 are estimated to go through the pathway each year;
- There were 219 CYP detentions between April 2015 and March 2016, leaving an estimated balance of 5088 adults detained under s136 per annum.

### **Time estimates**

The patient volumes are combined with the estimates of time spent per patient at each stage of the pathway to determine a final cost. These time estimates have been derived from the baseline audits conducted and using assumptions from prior case studies in Birmingham, Yorkshire and South West London. Details of each time-based assumption are provided in the following section.

## **5.2.3 Indicative benefits**

### **Overview**

To discuss and where possible, quantify the list of benefits resulting from the new model of care and reconfiguration of HBPoS sites, each benefit has been mapped against the list of outcomes discussed previously in this section.

A number of the benefits identified have been quantified and monetised using the Social Value Bank, New Economy Model or audit data collected during the options appraisal process. In addition, as shown in the outcomes map in Figure 16 these benefits have been mapped to the stakeholders at key points along the pathway.

Table 11 outlines the list of benefits identified for the new model of care, following reconfiguration of HBPoS sites for both adults and CYP. The total values are presented per outcome and are discussed in the following sub-sections. Table 12 sets out the indicative cashable and non-cashable benefits per STP / HBPoS, with the allocation calculated on a capitation basis. This will require further review and analysis at the next business case stage.

**Table 11: Benefits overview**

No.	Outcome	Financial (cashable) benefit Value p.a (£000)	Financial (non-cashable) benefit Value p.a (£000)	Benefit of measuring social impact (non-cashable) - Value p.a (£000)	Total Value p.a (£000)
1	Reduced conveyance time (ambulance and police vehicle)	£498	-	£14	£512
2	Reduced ED admissions	£297	-	£60	£357
3	Reduced length of stay at HBPOs	-	-	£87	£87
4	Improved staff expertise	NA	NA	NA	Qualitative
5	Improved HBPOs environment	-	-	£335	£335
6	Reduced non-pay costs	-	£5,542*	-	£5,542
7	Reduced inpatient admissions	-	£7,918**	£4,606	£12,524
8	Reduced repeat presentations	-	£129**	£470	£599
9	Improving the wider crisis care system	NA	NA	NA	Qualitative
	<b>Total</b>	<b>£795*</b>	<b>£13,589</b>	<b>£5,572**</b>	<b>£19,956</b>

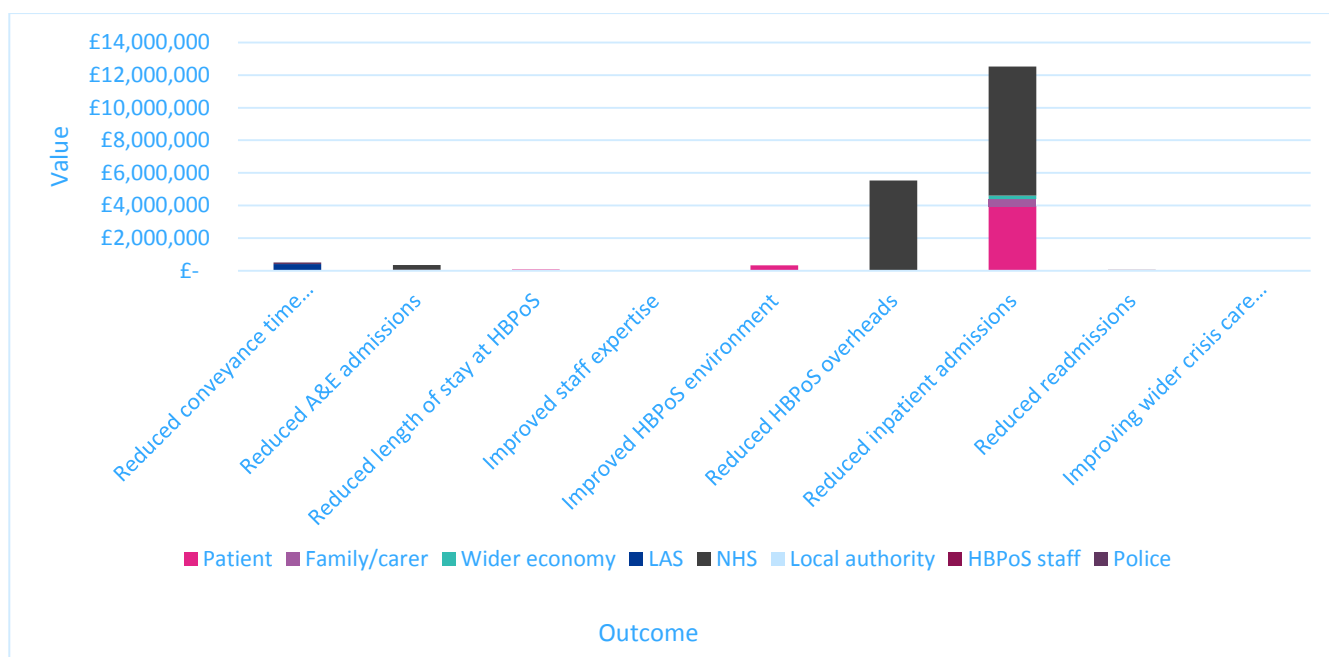
\*Financial benefits figures included in the preferred pathway costing analysis in section 5 of this business case

\*\*Total non-cashable benefits figure (£13,619k combined) included in indicative net benefits calculation in subsection 4.2.5 of this business case

**Table 12: Benefits overview by STP and HBPOs**

STP		NCL		NWL			NEL		SEL	SWL	Total £'000s
HBPOs		Chase Farm H	Highgate MHC	Lakeside MHU	Riverside C	St Charles	City & Hackney MHC	Sunflower Ct	Southwark	Wandsworth	
No.	Outcome	Indicative preferred option benefits (£'000s)									Total £'000s
1	Reduced conveyance time (ambulance vs. police vehicle)	£106		£103			£142		£111	£50	£512
2	Reduced ED admissions	£74		£72			£99		£78	£35	£357
3	Reduced length of stay at HBPOs	£5	£13	£9	£2	£6	£16	£8	£19	£8	£87
5	Reduced non-pay costs	£20	£50	£35	£9	£24	£61	£32	£73	£33	£335
6	Reduced inpatient admissions	£326	£824	£575	£141	£396	£1,014	£521	£1,205	£540	£5,542
7	Reduced HBPOs readmissions	£736	£1,862	£1,300	£319	£894	£2,292	£1,178	£2,723	£1,220	£12,524
8	Improving the wider crisis care system	£35	£89	£62	£15	£43	£109	£56	£130	£58	£598
	<b>Total</b>	<b>£1,303</b>	<b>£2,838</b>	<b>£2,156</b>	<b>£486</b>	<b>£1,363</b>	<b>£3,733</b>	<b>£1,795</b>	<b>£4,339</b>	<b>£1,944</b>	<b>£19,956</b>

Figure 17 below illustrates the breakdown of benefits per stakeholder. It is clear that reduced inpatient admissions are a key driver of benefits, while both patients and the NHS are main beneficiaries.

**Figure 17: Benefits by stakeholder**

## 1. Reduced conveyance time

The total conveyance social savings are set out in Table 13 below and described in more detail in the paragraphs which follow.

**Table 13: Conveyance savings**

Stakeholder	Conveyance %	Base case	9 site model with same conveyance %	Financial Saving (cashable)	Social Saving (non-cashable)	Total Saving
Police <sup>56</sup>	21%	£203,235	£112,428	£90,807	-	£90,807
Police (with LAS) <sup>57</sup>	79%	£435,143	£333,474	£101,669	-	£101,669
Ambulance <sup>58</sup>	79%	£1,309,914	£1,003,859	£306,055	-	£306,055
Patient				-	£13,197	£13,197
<b>Total</b>				<b>£498,531</b>	<b>£13,197</b>	<b>£512,448</b>

The first step along the s136 pathway is the detention and conveyance (transport) of the individual to the HBPoS site.

At present, there are significant inefficiencies in the system due to insufficient capacity causing delays in conveyance. There are a number of statements from police officers and LAS staff which highlight the issues in “bouncing around” the system due to insufficient capacity at individual sites. Box 5 provides an example.

<sup>56</sup> The cost of conveyance to police when conveying alone.

<sup>57</sup> The cost of conveyance to police when conveying with LAS.

<sup>58</sup> The cost of conveyance to LAS; this is always with police.

### Box 5: Delays in conveyance

“There was no S136 Suite available across [HBPoS] or neighbouring Trusts. After 2 hours in the van and no sign of a S136 suite becoming available, male was taken to custody suite”

“Police detain the male under S136 MHA and attend ED for physical health clearance. Officers are told by a nurse that there is a bed at [HBPoS] reserved for him. Officers attend the HBPoS with the male but are met by a nurse who states that there are no beds available”

These issues are addressed in the new model by ensuring appropriate capacity at the individual HBPoS sites. This reduces the average journey from 64 minutes to 22 minutes for police vehicles and 107 minutes to 82 minutes for ambulance vehicles (which are accompanied by police vehicles). Please see Financial Case for more detail.

This estimated reduction in conveyance time will have benefits for the police forces, LAS and patients. For LAS and the police forces, the time spent conveying those detained under s136 represents an opportunity cost to the public service staff's time. This is estimated at £0.97 and £2.92 per minute for police officers and LAS staff respectively.<sup>59</sup> Given a 21:79 split in volume for police forces and LAS, the total savings per annum are estimated at £192,476 (combines £90,807 and £101,669 in Table 12 above) and £306,055 respectively.

In addition to police and LAS benefits, the reduction in conveyance time represents a partial reduction in the total time that the individual spends on the s136 pathway. As a result, the individual receives a time saving of 21.6 minutes on average. The value of this time is calculated using the Department for Transport's Transport Appraisal Guidance (TAG), which values non-working time (leisure) at £5.51 per hour.<sup>60</sup> Aggregating this for patient volumes provides a total benefit of £13,917 for patients due to conveyance.

In total, taking LAS, police and patient benefits together, the social benefit of this outcome is estimated at £512,448.

## 2. Reduced ED admissions

A typical emergency department sees on average 300 patients a day who are in the department for an average of 2.5 hours. When an individual detained under s136 is in the department they spend on average 12 hours due to their complex health and social needs. This means that the care for one person detained under s136 is the equivalent of being able to treat ten other patients, based on the time s136 patient spend in department being five times that of other patients and requiring twice as much resource.

Treating a s136 patient in A&E takes on average the same resource as treating 10 physically ill patients and patients are significantly more likely to breach the A&E 4 hour standard and 12 hour standard. In an average A&E department, seeing 300 non-s136 patients a week, 10 patients equates to 3.3% of standard daily activity and therefore by treating s136 patients in a more appropriate environment frees up A&E resource and would positively impact on performance against the A&E standards.

<sup>59</sup> These resource costs have been estimated from audit data from the HBPoS sites

<sup>60</sup> The use of non-working time is considered to be a conservative approach, as it assumes that 100% of those detained are experiencing crisis outside of their own working hours.

It is estimated that the current number of ED attendances as a result of capacity constraints will reduce from 6% to zero with the new model of care, with a further 4% reduction driven by the impact of improved physical health competencies amongst place of safety staff. This equates to 531 patients who will not present to London EDs as a result of the new model. Taking the 531 s136 patients identified, the current additional resource requirement equates to 5310 patients being seen, or 12,744 extra hours of patient care, which will become available to treat other patients and contribute to improving performance against the 4 and 12 hour ED targets across the system in London.

As quantified above the impact on the department of a person detained under s136 attending will be felt by the majority of patients attending at the time of or even after a s136 patient has been treated, given the knock on impact the event will have on resources and patient flow. This reduction of available resources will constrain the flow of patients through the department which quickly starts to back up to the front door where ambulance handovers will be impacted. Therefore, in addition to the LAS estimate of a nine minute improvement in the handover of s136 patients, it is clear that the new model of care will have a positive impact on the majority of waiting and handover times across London.

The total savings from reduced ED admissions are set out in Table 14 below and described in more detail in the paragraphs which follow.

**Table 14: ED savings**

Stakeholder	Financial Saving (cashable)	Social Saving (non-cashable)	Total Saving
NHS	£297,134	-	£297,134
Patient (time and experience)	-	£60,207	£60,207
Total	£297,134	£60,207	£357,341

There is a financial benefit to the NHS from this reduction in ED attendances. The average cost of an ED attendance is £117.<sup>61</sup> However, this is based on an average duration of just 2.5 hours.<sup>62</sup> However, as audit data shows that those detained under s136 spend an average of 12 hours at ED, this is uplifted in order to take account of the added resource costs. As a result, the total annual estimate for the NHS financial savings from reduced ED attendances is £297,134, and is also included in the Financial Case.

In addition to the financial savings, the 531 service users who will not attend ED as a result of the capacity or physical health conditions in the reconfigured model will realise both time and experiential benefits.

*“In London’s EDs, only 12 per cent of those assessed thought their assessment rooms were pleasant, comfortable and welcoming”<sup>63</sup>*

The value of time is calculated as per outcome 1 above, while the experiential benefit is calculated using the Social Value Bank’s value for relief from depression/anxiety for the 12 hours. The total patient savings are estimated at £60,207.

<sup>61</sup> Manchester New Economy Model, 2016 - <http://neweconomymanchester.com/our-work/research-evaluation-cost-benefit-analysis/cost-benefit-analysis/unit-cost-database>

<sup>62</sup> <http://www.content.digital.nhs.uk/catalogue/PUB23070>

<sup>63</sup> Healthy London Partnership (2015) UEC Programme: ‘I’ statements

In total, taking both NHS savings and patient savings together, the benefit of this outcome is estimated at £357,341.

### 3. Reduced length of stay at HBPoS

The total savings from reduced length of stay (LoS) are set out in Table 15 below and described in more detail in the paragraphs which follow.

**Table 15: LoS savings**

Stakeholder	Financial Saving (cashable)	Social Saving (non-cashable)	Total Saving
Patient (time and experience)	-	£86,673	£86,673
Total	-	£86,673	£86,673

At present, the average length of stay at an HBPoS site is approximately 17.5 hours. Through dedicated staffing and minimised delays, it is expected that this will reduce slightly to 16 hours. While this is a minimal change, it denotes time savings for each patient. This is valued as per Outcomes 1 and 2 above and is estimated at £86,673 per annum.

It is assumed that there is no saving to the NHS from this reduced LoS as AMPHs and s12 doctors both charge fixed fees. In addition, HBPoS staff will be dedicated 24/7 and as a result there will be no additional saving in resource in costs. However, the reduced LoS will improve access to HBPoS sites, thereby reducing conveyance and acceptance times for police and LAS, and reducing the use of ED for capacity reasons.

### 4. Improved staff expertise

The new model of care and reconfiguration of HBPoS sites will concentrate staff expertise at 9 sites with one HBPoS within each STP providing an all-age service with the appropriate facilities. In the current model, staff are often pulled from wards and do not have the appropriate capabilities to treat mental health crisis patients. See Box 6 below for an example.

#### Box 6: AMHP staff interview

“The suite is staffed but not by a dedicated team. There is a manager, but the team consists of rotating staff from the wards so they’re a team of people, some of whom know what the role is and are very good at the role, some of whom are very disinterested in the role in the suite and don’t really understand the role particularly or aren’t that interested, so you’ve got a mixed bag of staff”

#### AMHP Staff Interview

This improvement in staff expertise will undoubtedly have an effect on a service user’s short term and long term outcomes. However, the size of this impact is uncertain and has not been measured as part of this business case. Instead, it can be included in the benefit service users receive from experience an improved HBPoS setting. It may be argued that a significant qualitative benefit will be realised by CYP, as they will receive a more appropriate and focused treatment under the new model.

In addition, the improvement in staff expertise will have benefits for the staff members themselves. The dedicated HBPoS staff will feel more confident in their ability to treat people detained under s136, which will add to satisfaction levels. This benefit has not been quantified for the purposes of this business case, but for reference purposes, the SVB estimates that a feeling of greater confidence can be attributed to approximately £13k per year. It is anticipated that there will be benefits in terms of recruitment and retention, which will lead to savings, particularly through a reduction in the use of agency staff.

## 5. Improved HBPoS environment

The total savings from an improved environment are set out in Table 16 below and described in more detail in the paragraphs which follow.

**Table 16: Improved environment savings**

Stakeholder	Financial Saving (cashable)	Social Saving (non-cashable)	Total Saving
Patient (experience)	-	£335,123	£335,123
Total	-	£335,123	£335,123

The new model will ensure that all infrastructure for those detained under s136 at the sites is fit for purpose. At present there are notable issues with the facilities, which have negative impacts for patients and staff, see Box 7 for details.

### Box 7: HBPoS environment

"I've been sectioned before and held in a police cell before and that was bad, it was cold and dark and miserable and I just curled up on those bunks and cried my eyes out. The place they take you now is only a little bit better, and I mean only little bit better, it's not as cold and they don't make you wear those paper suits but it's still like a police interrogation room than a place where you should be getting better."

**London Mental Health Crisis Care Service User**

For patients, ensuring that HBPoS sites are fit for purpose, together with improved staffing levels and expertise, will lead to a more therapeutic health care setting. Using the social bank measure for relief from depression/anxiety, we have estimated this benefit at £288,485 per annum.

In addition, the improved HBPoS facilities will help to relieve safety concerns at the sites. These themes correspond with national issues. As of 31<sup>st</sup> May 2017, 36% of NHS and 34% of independent core services were rated by CQC as requires improvement for 'safe'. A further 4% of NHS core services and 5% of independent services were rated as inadequate for 'safe'.<sup>64</sup>

## 6. Reduced non-pay costs

The total non-pay cost savings are set out in Table 17 below and described in more detail in the paragraph which follows.

**Table 17: Non-pay cost savings**

<sup>64</sup> CQC report, The state of care in mental health services 2014 to 2017

Stakeholder	Financial Saving (cashable)	Social Saving (non-cashable)	Total Saving
NHS	£5,541,837	-	£5,541,837
Total	£5,541,837	-	£5,541,837

As discussed in detail in Section 5, the Financial Case, the new model of care and reconfiguration of HBPOs sites will induce a saving in non-pay cost such as corporate overheads, cleaning and estate charges. These costs are primarily driven by the scale of facilities with the consolidation in the number of facilities expected to create a financial saving for the NHS of £5,541,837.

## 7. Reduced inpatient admissions

The total savings from reduced inpatient admissions are set out in Table 18 below and described in more detail in the paragraphs which follow.

**Table 18: Reduced inpatient admission savings**

Stakeholder	Financial Saving (cashable)	Social Saving (non-cashable)	Total Saving
NHS	-	£7,918,089	£7,918,089
Patient (time and experience)	-	£3,960,176	£3,960,176
Family/carers (time)	-	£437,350	£437,350
Wider economy	-	£208,861	£208,861
Total	-	£12,524,476	£12,524,476

Past case studies have shown that the combination of dedicated staffing, improved facilities and minimised delays in care can lead to a significant reduction in inpatient admissions. Examples include:

- **Birmingham and Solihull Mental Health NHS Foundation Trust Psychiatry Decision Unit (PDU):** An evaluation of the service showed a 26% decrease in inpatient bed admissions, saving 6,900 bed days in total<sup>65</sup>
- **South London and the Maudsley Centralised Place of Safety:** The evaluation showed a 13% reduction in admissions<sup>66</sup>.
- **South West London and St. George's:** The PDU established at SWLSTG saw a reduction in inpatient admissions of 25%<sup>67</sup>

In order to not overstate the potential benefits from this outcome, we have assumed that inpatient admissions would reduce by 20%. This accounts for an approximate decrease of 356 admissions, equivalent to 14,850 bed days given an average length of stay of 41.7 days.<sup>68</sup>

This reduction in inpatient admissions will have benefits for a wide range of stakeholders, including service users and their families, the NHS and the wider economy.

<sup>65</sup> Mental Health Crisis Care for Londoners: London's Section 136 pathway and HBPOs specification

<sup>66</sup> Evaluation of South London and Maudsley NHS Foundation Trust's Centralised Health Based Place of Safety. Healthy London Partnership (2017).

<sup>67</sup> South West London and St. Georges: Lotus Assessment Suite (Psychiatric Decision Unit) Report

<sup>68</sup> British Journal of Psychiatry, <http://bjp.rcpsych.org/content/210/2/157.full-text.pdf+html>

For individuals in mental health crisis, avoiding admission to an inpatient ward generates significant time savings and experience savings. These are valued using the Social Value Bank and TAG values described in Outcomes 1 and 2 above and are estimated at £3,960,176 per annum.

In addition, the relatives and/or carers of service users typically suffer an opportunity cost of time from visiting patients during inpatient admission periods. This, as for patients, is estimated using DfT's TAG value for non-working time, with an assumed loss of 8 days.<sup>69</sup>

A major financial benefit results from avoided inpatient admissions for the NHS. The Manchester New Economy Model provides an estimate of £459 for the fiscal cost of mental health inpatient cost per bed day, providing a total saving of £7,918,089.<sup>70</sup>

Finally, there may be benefits to the wider economy from reduced readmissions. Employers will gain if more individuals become available to work as a result of the proposed changes. This positive labour intervention will therefore have an overall impact on productivity in the economy. The Manchester New Economy Model values the economic costs of service provision for those suffering from mental health disorders at £4,420 per year. Given the average length of stay and patient volume assumptions, this saving is estimated at £208,861 per annum.

## 8. Reduced repeat presentations

The total savings from reduced repeat presentations are set out in Table 19 below and described in more detail in the paragraphs which follow.

**Table 19: Reduced repeat presentations savings**

Stakeholder	Financial Saving (cashable)	Social Saving (non-cashable)	Total Saving
NHS	£128,631	-	£128,631
Patient (time and experience)	-	£46,213	£46,213
Local authority	-	£164,580	£164,580
Wider economy	-	£3,94829	£3,948
LAS	-	£132,039	£132,039
Police	-	£122,780	£122,780
Total	£128,631	£469,559	£598,191

At present, approximately 19.2% of sections are repeat presentations from individuals are readmitted through the s136 pathway within six months.<sup>71</sup> However, from discussions with key stakeholders in the system it is estimated that a reduction to 10% is possible under the preferred option. For the entirety of London, this would represent a 489 fewer episodes of individuals being detained under s136 per year when compared to the current model. In addition, it is expected that implementation of new models such as Serenity Integrated Mentoring (SIM) will have a positive impact on repeat admissions.

The entire costs of the pathway, financial, social and economic are therefore saved with respect to these 489 patients. The total saving is estimated at £598,191 per annum.

<sup>69</sup> The use of non-working time is conservative as it assumes that 100% of relatives/carers visit outside of working hours

<sup>70</sup> Manchester New Economy Model, 2016 - <http://neweconomymanchester.com/our-work/research-evaluation-cost-benefit-analysis/cost-benefit-analysis/unit-cost-database>

<sup>71</sup> Therapeutic Solutions: Section 136 and Mental Health Crisis Presentations in Emergency Departments in London

## 9. Improving the wider crisis care system

The new model of care and reconfiguration of HBPOs sites across London will not only have a direct impact on the s136 pathway; it will also have wider implications for the entire crisis care system in the capital:

- The first notable benefit is the new model will future proof services. The reconfigured sites allow capacity to be utilised in a more sustainable manner, ensuring that infrastructure can better cope with volatility in demand and potential growth in coming years;
- Successful implementation of a pan-London model with improve facilities and a high quality standard of care will raise the profile of crisis care as a whole and is likely to encourage future service improvement in crisis care services including potential expansion of other services and training;
- In addition, the new model of care will promote greater synergies between crisis care services and other physical and health services within the NHS and well as local demand management schemes that are emerging (e.g. Street Triage and the Serenity Integrated Mentoring (SIM) model). The specialised 24/7 staffed sites will lead to focal points for crisis care activity, providing the opportunity for a solid network of supporting services to be developed around the sites and bringing transparency and recognition to an often forgotten and 'ad hoc' service;
- The investment will support the broader objective of closing the financial gap between physical and mental health care funding. There are direct financial benefits to the reconfigured pathway as detailed in Section 5. Furthermore, the new model of care will provide a platform from which performance and trends can be appraised across the system, establishing the potential for further cost efficiencies; and
- The new model of care proposes a standardised, consistent s136 pathway across London. This presents an opportunity to collect and appraise standardised crisis care data. Using this as an initial platform to expand data collection across crisis care, will ensure that performance of the whole crisis care system can be effectively evaluated; this will support identification and sharing of best practice and identification of opportunities for wider service improvement and cost efficiencies.

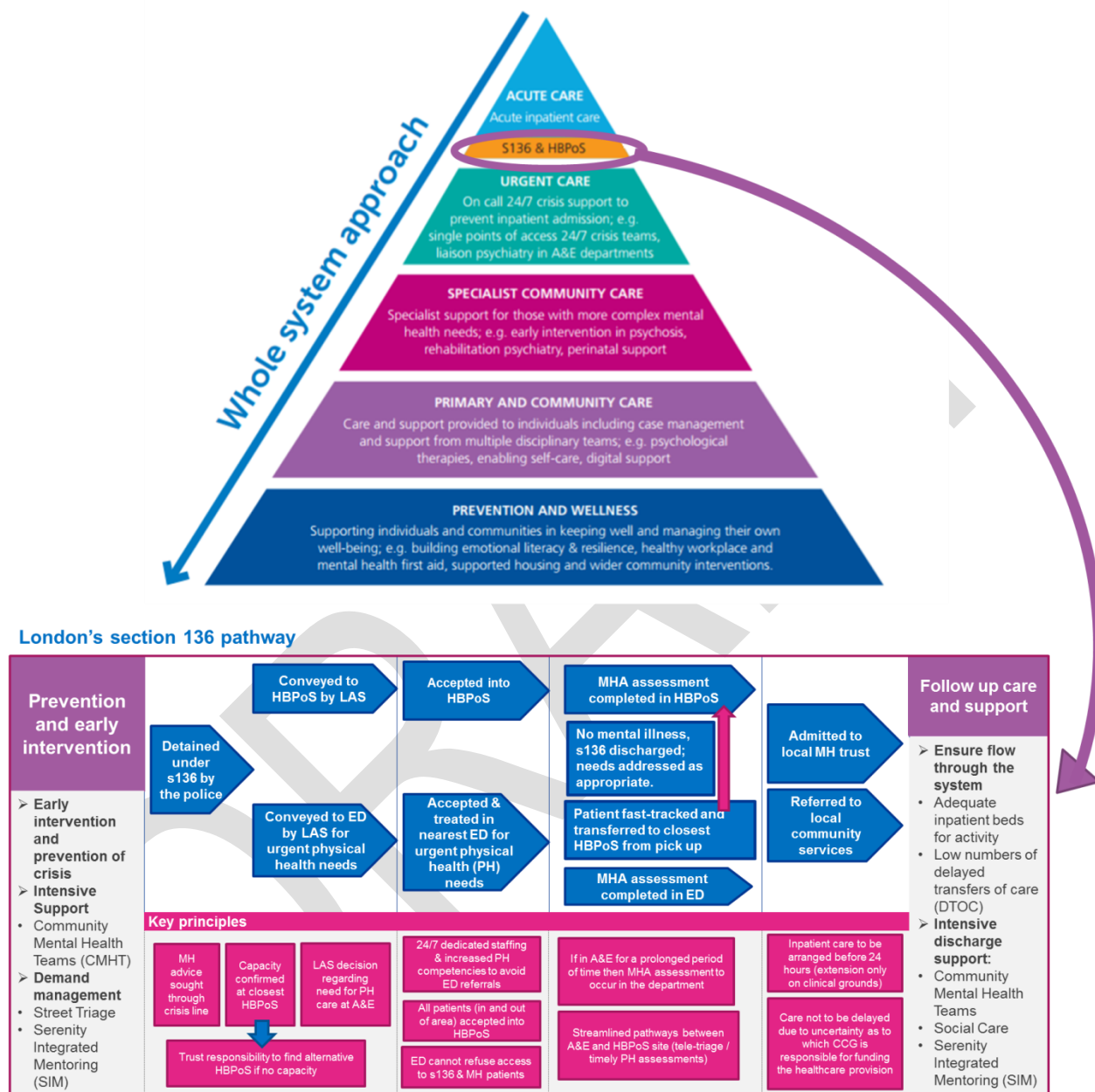
Whilst the new model of care will have positive impacts on the crisis care system as a whole, it is also important to recognise that in order for it to be sustainable, all parts of the wider system need to be functioning well including:

- Preventative initiatives which assist in demand management (such as Street Triage)
- Flow through inpatient services with adequate beds and low numbers of delayed transfers of care (DTOC)
- Well-resourced and responsive community and crisis response teams for prevention of admission and intensive discharge support.
- S117 aftercare support from social services
- New initiatives, such as the Serenity Integrated Mentoring (SIM) model to provide targeted support to those frequently detained.

The ideal pathway for a patient in crisis will involve positive interactions with more than one of a range of services that will support them. It is also these services, particularly

demand management initiatives such as street triage and crisis resolution teams that will protect against the presence of a well-functioning s136 pathway driving further increasing demand.

**Figure 18: The ideal journey of a person in mental health crisis on the pan-London s136 pathway.**



The pathway is one element of a wider crisis care system; preventative and early intervention services must be in place to prevent people from reaching crisis point as well as adequate follow up pathways once assessed at the HBPoS site.

## 5.2.4 Indicative costs

The cost of the new model of care and reconfiguration of London's HBPoS sites is outlined in detail in Section 5, the Financial Case and includes the following expenditure items:

- Transition costs;

- Capital costs; and
- Section 136 pathway variances as a result of the reconfiguration.

The total estimated cost of the reconfiguration, including total indicative transition and capital costs as well as estimated pathway costs for a given year, is £23.7m and is broken down as shown in the table below. The costs of the preferred option include the financial savings gained along the pathway from LAS and police time savings, together with the NHS savings from reduced ED admissions due to capacity issues and lower overheads.

**Table 20: Costs overview**

Type	Baseline cost for 20 sites (£000)	Preferred option (£000)	Variance (£000)
Pathway (per annum)	£20,632	£20,494	£138
Transition	£0	£1,000	(£1,000)
Capital	£0	£2,250	(£2,250)
<b>Total</b>	<b>£20,632</b>	<b>£23,744</b>	<b>(£3,112)</b>

## 5.2.5 Indicative net benefits and NPV

The potential value of the new model of care and reconfiguration of HBPoS sites in London can only be understood through comparing the full range of costs and benefits of the scheme. This includes each of the financial, economic and social impacts which affect the broad range of stakeholders involved within and outside of the s136 pathway. To determine the profitability of the proposed reconfiguration the Net Present Value (NPV) is calculated. The NPV is described as the difference between the present value of cash inflows (benefits) and the present value of cash outflows (costs) over a period of time. A positive NPV indicates a profitable investment.

Tables 21 and 22 below consider the net benefits and costs of the scheme for the period FY18/19 to FY22/23. To avoid double counting, the financial savings from reduced overheads (non-cashable), lower ED admissions and LAS and police resource costs (latter two both cashable) are not included in the benefits identified.

Whilst the current analysis assumes that all benefits will be delivered in full from year 1 (FY18/19), there is recognition that the benefits will accrue over time as the new model of care is implemented. Furthermore, it is acknowledged that additional costs may arise as a result of phased implementation (two sites FY18/19, three sites FY19/20). Further detail will be developed to capture the estimated financial impact at the next business case stage. This will be dependent on the implementation plans by STP.

This indicative analysis of costs and associated non-cashable benefits suggests a net present value (NPV) of non-cashable benefits of £66.2m over the five year period. The NPV has been calculated on the future cash flow over 5 years discounted at 3.5% per annum.

**Table 21: Net present benefits**

	FY18/19	FY19/20	FY20/21	FY21/22	FY22/23
Benefits (excl. pathway financial savings)	£13,619k	£14,156k	£14,693k	£15,230k	£15,768k
Discount factor (3.5%)	0.966	0.934	0.902	0.871	0.842
Discounted benefits	£13,158k	£13,215k	£13,252k	£3,272k	£13,276k
<b>Net present non-financial benefits</b>	<b>£66,174k</b>				

The indicative analysis of the variance in costs between the baseline pathway and preferred option pathway suggests a NPV of £4.8m over the five year period. The NPV has been calculated on future cash flow over 5 years discounted at 3.5% per annum.

**Table 22: Net present savings/costs**

	FY 18/19	FY 19/20	FY 20/21	FY 21/22	FY 22/23
Variance (cost)/saving	(£500k)	(£2,750k)	£2,154k	£3,005k	£3,856k
Discount factor	0.966	0.934	0.902	0.871	0.842
Discounted (cost)/ Saving (£,000)	(£483k)	(£2,567k)	£1,942k	£2,618k	£3,246k
<b>Net present financial savings</b>	<b>£4,757k</b>				

Together, Table 19 and Table 20 illustrate that the indicative net present value of the reconfiguration is approximately £71m (including both cashable and non-cashable benefits). It is therefore recommended that the proposal is approved for funding.

## 6 Financial case

This section of the business case describes the financial implications of the preferred nine site option for the new model of care and reconfiguration of HBPoS sites in London. As indicated

previously, further information on costs and benefits for the 13 site transitional phase is outlined in the Management Case. The starting point for the analysis is to identify the costs of the current s136 pathway to the range of stakeholders within the crisis care system. To determine the cost variances as a result of the reconfiguration, this analysis is followed by a breakdown of the costs of the preferred option, which is supported by a new model of care for people detained under s136.

This chapter is structured as follows:

- Baseline 'do nothing' pathway costs
- Preferred option pathway costs
- Variance in pathway costs
- Transition costs
- Capital costs
- Summary and funding arrangements
- Risks to financial assessment

**The current configuration of HBPOs sites in London, with a lack of dedicated, specialty skilled resource, results in a cost pressure for most MH Trusts, with staff diverted from other roles (often from inpatient facilities) to attend to s136 patients.**

The preferred **nine site option is estimated to cost c. £20.5m p.a.** compared to the baseline pathway cost of c. £20.6m p.a. (excluding impact of activity growth), a decrease of £0.1m

The interim stage of transition to the preferred option will involve a total of **13 sites at an estimated cost of c. £23.2m p.a.**

Over the five year period FY18/19 to FY22/23 total costs of the reconfiguration are estimated at c. £106.8m, compared to £111.7m per the baseline pathway. This gives a net savings of £4.9m, with a NPV of £4.8m.

The current plan is predicated on the following assumptions:

- ▶ Preferred option is implemented in FY19/20
- ▶ **Net activity growth** of 16.5% (allow for demographic growth and growth from recent statutory changes)
- ▶ Successful delivery of £6.3m financial savings (of which £795k are **cashable cost savings**)
- ▶ **£1m transition costs**; however, this is only an estimate and it is acknowledged that further analysis and refinement is required
- ▶ **£2.3m capital expenditure**; however, this is only an estimate and it is acknowledged that further analysis will be required during implementation planning, with capital requirements per site defined with local estates team. A transitional stage of 13 sites would require £450k less capital funding
- ▶ £3.3m funding being made available from CCGs / pooling of budgets across STP footprints

**Risks inherent to the financial analysis** of the s136 pathway and HBPOs specification include:

- ▶ Gaps in data collection
- ▶ Robustness of data
- ▶ Access to data

## 6.1 Baseline ‘do nothing’ pathway costs

### 6.1.1 Overview

To provide a financial case for the new model of care and reconfiguration of HBPoS sites in London, there is a clear requirement to provide robust costing for the base case, the ‘do-nothing’ option. This enables a greater understanding of the cost impacts along various sections of the s136 pathway and allows a further examination of how the proposed changes will be realised financially.

However, there are numerous challenges in trying to estimate a baseline cost for the s136 pathway:

- The pathway is inconsistent across the system;
- There is lack of consistent data, as no pan-London consistent data collection methodology exists across what is a complex, multi-stakeholder environment; and
- Data can be misinterpreted due to the complexity of the pathway with multiple interfaces with various stakeholders.

During the options evaluation process, a mapping exercise was carried out, where the journey of an individual detained under Section 136 was recorded from the point of detention to their arrival at an HBPoS and subsequent discharge. There can be up to seven different agencies involved in this process for an adult and the number is even greater for a child or young person. All of these agencies have their own policies, cultures, information/communication requirements (e.g. assessments), processes and attitudes towards risk. These agencies include:

- i. The police (including the Metropolitan Police, The City of London Police and British Transport Police);
- ii. LAS;
- iii. EDs;
- iv. Mental health trusts (MHTs);
- v. AMHPs;
- vi. Emergency duty teams (EDTs), which may be different organisationally from day services; and
- vii. Crisis resolution and home treatment teams (or other referral agencies).

As a consequence, providing an accurate assessment of cost for the baseline is complex in nature. Furthermore, this complexity is exacerbated by the lack of robust data in this area of the UK’s health service. Recent literature has identified the need to enhance the robustness of existing data for the s136 pathway and related crisis care services. For example, the Royal College of Psychiatrists’ ‘Guidance for commissioners’ document (2013), emphasised core standards in service provision from initial detention, including the need to establish multi-agency groups that will monitor data to develop, implement and assure quality of service. Similarly, the

Care Quality Commission (2014) undertook a national survey of providers and found that there was a lack of an appropriate data capture mechanism to inform the monitoring of service provision.<sup>72</sup>

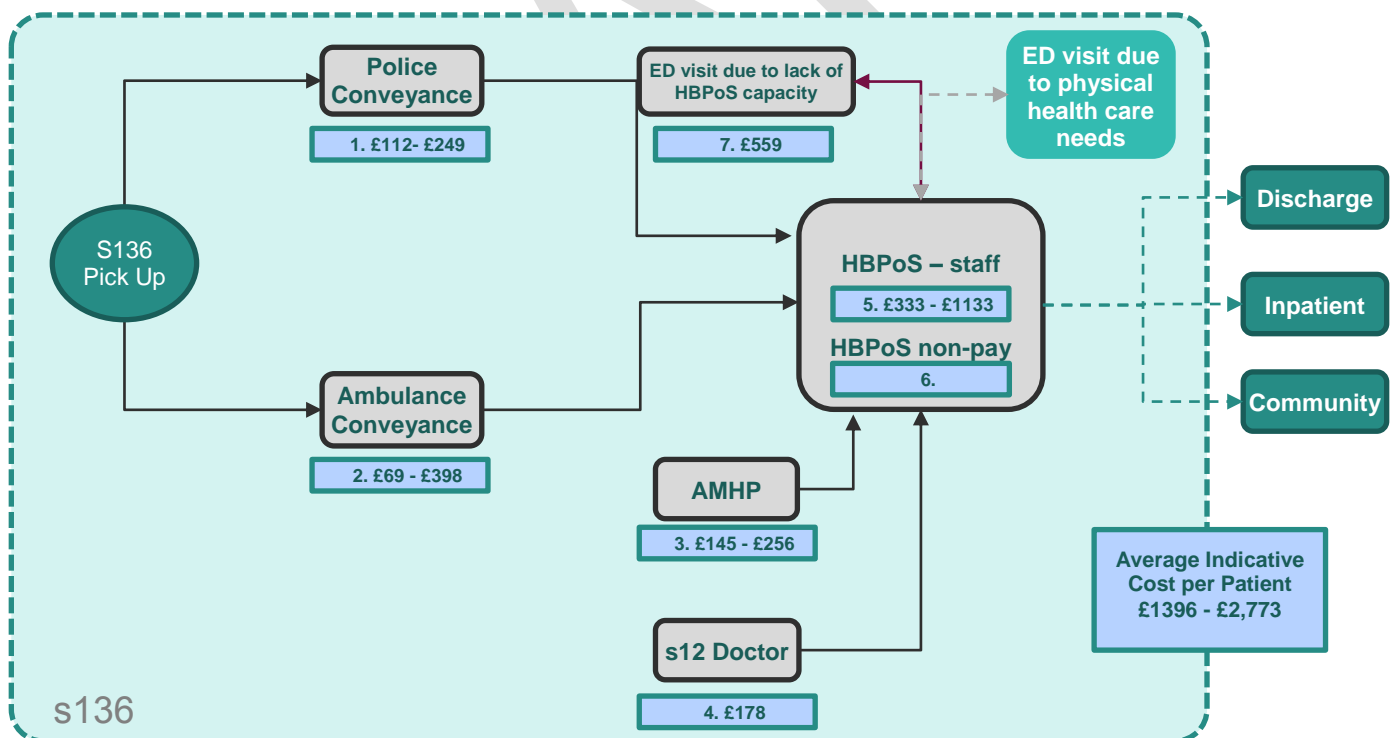
Given such data limitations, the costs of the s136 pathway have been estimated by utilising existing secondary data sources provided by the LAS, Police and the NHS; supplemented through a series of data collection audits and surveys.

The baseline pathway costs have been grouped into the following key steps along the s136 pathway:

- Cost of Conveyance;
- HBPoS costs, including the cost of AMHPs, s12 Doctors and assumed overhead costs; and
- ED costs, where an ED is utilised due to lack of capacity at an HBPoS.

The remainder of this subsection and the following subsection is organised according to these headings. Underneath each of these key steps, the cost of specific stakeholder involvement can be calculated. Figure 19 below provides a summary of the scope and costs estimates of the s136 pathway.

**Figure 19: Summary and scope of baseline costs**



<sup>72</sup> CQC national survey of providers 2014

## 6.1.2 Summary of baseline pathway costs

It is estimated that on average, the baseline s136 pathway costs are circa £20.6 million per year. Table 23 below provides a summary of the average cost range associated with the s136 pathway components. The paragraphs which follow describe each component cost in more detail.

**Table 23: Baseline pathway costs**

Ref	Pathway Component	Indicative annual activity	Indicative unit cost per patient	Indicative baseline cost
1a	Police Conveyance <sup>73</sup>	1,114	£182.36	£203k
1b	Police Conveyance (with LAS) <sup>60</sup>	4,193	£103.79	£435K
2	Ambulance <sup>74</sup>	4,193	£312.44	£1,310k
3	AMHP	5,307	£210.75	£1,118k
4	Independent s12 Doctor	2,123	£178	£378k
5	HBPoS: Staff	Standalone – 617 Combined – 373 The remainder – 4,317	IP - £843 Discharge -£458 Community - £513 SLAM – £1,512k PDU - £1,151k	£5,418k
6	HBPoS: non-Pay			£11,473k
7	ED	531	£559	£297k
	<b>Total</b>			<b>£20,632k</b>

<sup>73</sup> 1a refers to conveyance activity and costs when police only when conveying alone and 1b when conveying with LAS.

<sup>74</sup> The activity and cost to LAS when they convey; this is always with police.

### 6.1.3 Cost of Conveyance

The total costs of conveyance are set out in Table 24 below and described in more detail in the paragraphs which follow.

**Table 24: Cost of Conveyance**

Stakeholder	Indicative per patient	Indicative per annum
Police costs <sup>75</sup>	£112-£249	£203,235
Police conveyance costs (with LAS) <sup>76</sup>	£81-£141	£435,143
Ambulance conveyance costs <sup>77</sup>	£327-£564	£1,309,914

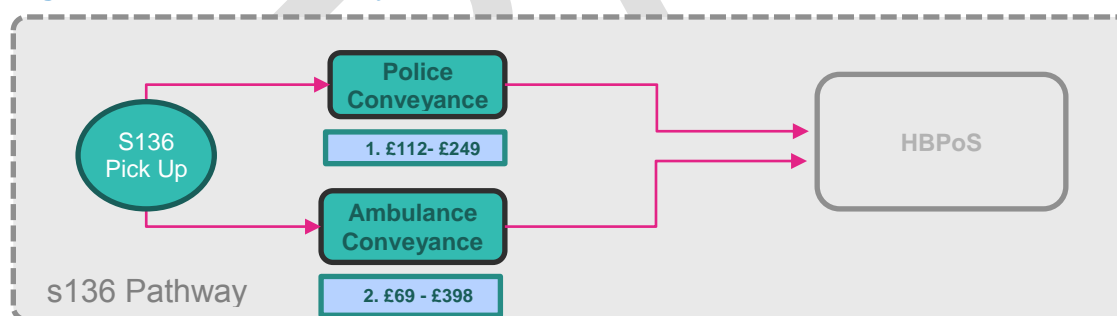
At present, there are two modes of conveyance by which an individual detained under s136 arrives at an HBPoS site after initial detention:

- Either via the LAS
- via police vehicle (if LAS is not available within an adequate timeframe)

Note that the police retain legal responsibility for the patient during conveyance and therefore will always accompany LAS.

.Figure 20 provides a snapshot of this step along the s136 pathway.

**Figure 20: Baseline conveyance costs**



For both modes of travel, there are three major cost drivers for this step in the pathway:

- The travel time/distance from initial detention to HBPoS;
- The frequency of conveyance; and
- The unit cost of conveyance.

<sup>75</sup> The cost of conveyance to police when conveying alone.

<sup>76</sup> The cost of conveyance to police when conveying with LAS

<sup>77</sup> The cost of conveyance to LAS; this is always with police.

The total costs per patient and per annum for conveyance by police conveyance and ambulance conveyance are discussed below. Ranges are given for costs per patient, while for the purposes of this financial analysis, median figures have been used to aggregate this to an annual amount.

## 1. Police conveyance

### a) Without LAS

- Indicative per patient police conveyance costs: £112 - £249
- Indicative per annum police conveyance costs: £203k

Using the cost per patient and the average travel times from detention to HBPoS, it has been estimated that conveyance by a police officer in London costs between £112 and £249 per person detained. After taking patient activity into account, the cost of conveyances of s136 patients via the police force is estimated at approximately £203k per annum. This cost includes both adult and CYP conveyances. The assumptions used for travel time, activity and unit costs are discussed in turn below.

### Travel time

To determine the baseline travel time for Police conveyances, one year's worth of data (from April '15 to March '16) submitted from the British Transport Police has been utilised. The data, direct from stakeholder sources, established that Police conveyance ranged on average from 40 minutes to 84 minutes with a median conveyance of 64 minutes.

### Activity

To determine activity, an estimate was required of the percentage of activity conveyed via the Police alone vs. LAS (with police). Historic trajectories have been analysed to understand how the proportion of various means of conveyance has changed. These trajectories have demonstrated that the proportion of conveyance by police alone is decreasing; this is in line with London's s136 guidance which states that an ambulance with police support should always be used to convey the individual under s136 to a HBPoS. Combining conveyance data from London's three police forces, it has been estimated that conveyance by police alone represents approximately 21% of all conveyances, with LAS conveyance (with police) representing the remaining 79%. These figures have been used for the baseline calculations.

### Unit costs

To establish the unit cost of conveyance via Police, the unit cost is drawn from the National Policing Guidelines on Charging for Police Services 2016. This provides a cost figure of £58.20 per hour and incorporates both direct costs as well as an apportionment of overhead costs including equipment and vehicle costs, building costs and back office costs.

### b) With LAS

- Indicative per patient police conveyance costs: £81 - £141
- Indicative per annum police conveyance costs: £435k

Using the cost per patient and the average travel times from detention to HBPoS, it has been estimated that conveyance by a police officer in London, whilst accompanying the LAS, costs between £81 and £141 per individual detained under s136. After taking patient activity into

account, the cost of conveyances of s136 patients via the police force, whilst accompanying the LAS, is estimated at approximately £435k per annum. This cost includes both adult and CYP conveyances. The assumptions used for unit costs are discussed above, whilst the assumptions used for travel time and activity are the same as that used for ambulance conveyance, discussed in turn below.

The combined total police conveyance costs in the baseline option are therefore estimated at £638k per annum.

## 2. Ambulance conveyance

- Indicative per patient ambulance conveyance costs: £245 - £423
- Indicative per annum ambulance conveyance costs: £1,310k

Using the cost per patient and the average travel times from detention to HBPOs, it has been estimated that conveyance by an ambulance ranges between £245 and £423 per individual detained under s136. After taking patient activity into account, the cost of conveyances of s136 patients via LAS is estimated at approximately £1,310k per annum. This cost includes both adult and CYP conveyances. The assumptions used for travel time, activity and unit costs are discussed in turn below.

### Travel time

To determine the baseline travel time for ambulance conveyances, information was drawn from six months' worth of LAS data (from Aug '16 to Jan '17). The data, direct from stakeholder sources, established that Ambulance conveyance ranged on average from 84 minutes to 145 min, with a median conveyance of 107 minutes.

### Activity

As discussed above for police conveyance, it has been estimated that ambulance conveyance represents approximately 79% of all conveyances.

### Unit costs

LAS provided an estimate of the average cost per minute of £2.92 to See, Treat and Convey. This is based on reference costs and the average job cycle time.

## 6.1.4 Health Based Place of Safety

The total HBPOs costs are set out in Table 25 below and described in more detail in the paragraphs which follow.

**Table 25: HBPOs costs**

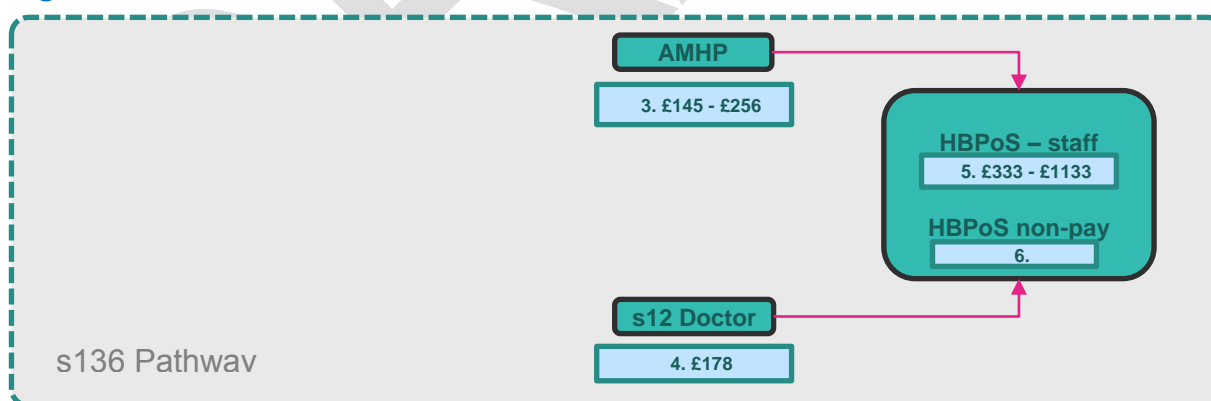
Stakeholder	Indicative per patient	Indicative per annum
AMHP	£145-£256	£1,118,450
Independent s12 doctor	£178	£377,858
Staff costs	£333-£1,133	£5,417,486
Non-pay costs	NA	£11,472,647

Once the individual detained under s136 arrives at the HBPoS, there are three key areas of activity that can occur:

- **Activities carried out by HBPoS staff:** After the handover that occurs between the police/ambulance at the place of safety, the person's immediate needs are assessed by the duty doctor; usually a junior doctor. A full mental state examination is carried out by a more senior doctor - a Specialist Registrar (SpR), or Consultant Psychiatrist, who will either be called to the suite from their normal place of work or, if outside of normal office hours, called in from home. If the SpR or Consultant is of the view that the patient is not suffering from a mental disorder, they can be discharged directly after this initial assessment.
- **Activities carried out by the AMHPs:** If the doctor sees the person first and concludes that they have a mental disorder, the person must be seen by an AMHP who will interview them. The AMHP is a duty social worker with specialist mental health training, who is available 24/7 in each borough. If an admission is not required, they will decide what (if anything) the person needs in the community, for example a community team referral. The patient may agree to informal (voluntary) admission, in which case assessment by the section 12 doctor as described below is not required..
- **Activities carried out by the independent s12 doctor:** If the SpR or Consultant feels that admission is required but the patient does not consent to this, a second Section 12 approved doctor and an AMHP will complete a MHA assessment and make a decision following that assessment.

In addition to these activities which drive pay costs, there are non-pay costs such as corporate and management overheads which need to be factored into our analysis. Figure 21 below provides a snapshot of this step along the s136 pathway.

**Figure 21: HBPoS baseline costs**



The total costs per patient and per annum for AMHPs, s12 doctors, HBPoS staff and HBPoS non-pay expenses are discussed in turn below.

### 3. AMHP costs

- Indicative per patient AMHP costs: £145 - £256
- Indicative per annum AMHP costs: £1,118k

The provision of AMHP services varies significantly across each of London's boroughs. This variation not only affects patient services, but also impacts on data collection at each HBPoS site. A range of data collection methods such as monitoring or audit forms, log-sheets, paper-based staff records, and bespoke spread sheets have been utilised by different HBPoS sites, with little consistency. As a result, it is difficult to compare AMHP costs across services. To solve this issue, a survey was conducted with various boroughs to estimate the cost of an AMHP in dealing with a section 136 patient.

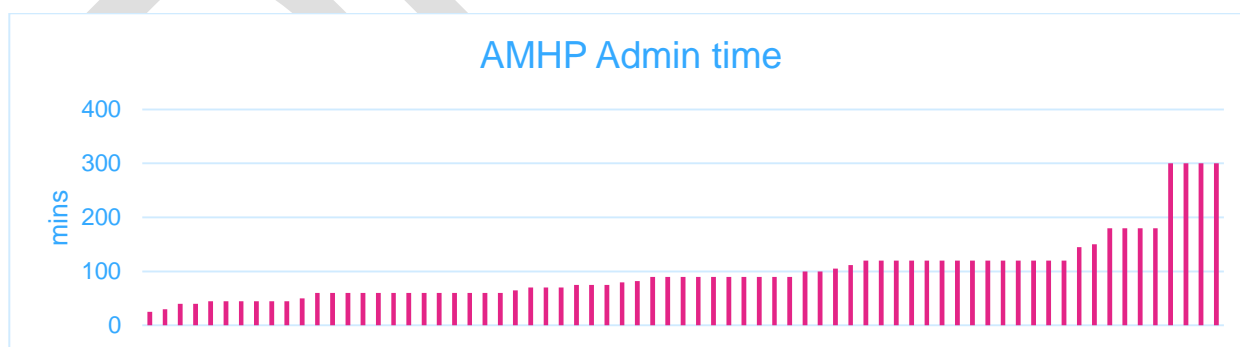
From the analysis, it is estimated the average cost of an AMHP assessment can range between £145 and £256 per assessment. When aggregated, the estimated baseline cost for AMHPs is £1,118k per year. This cost includes AMHP services to both adult and CYP individuals.

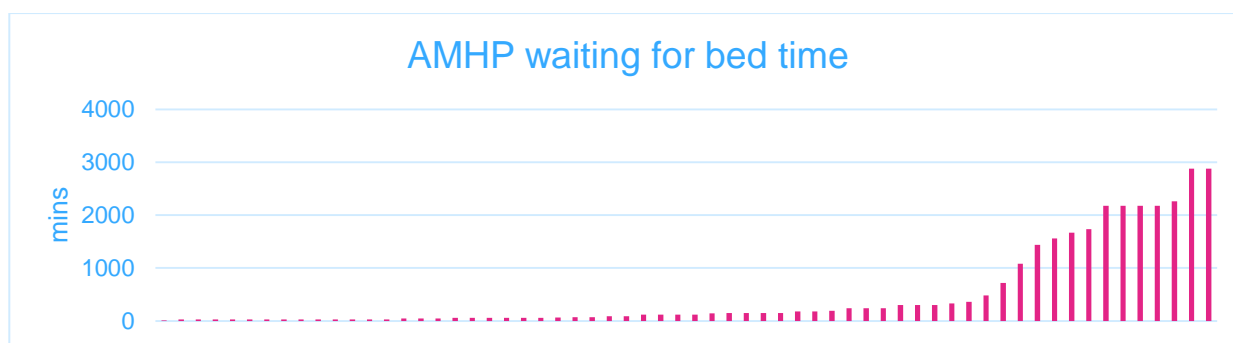
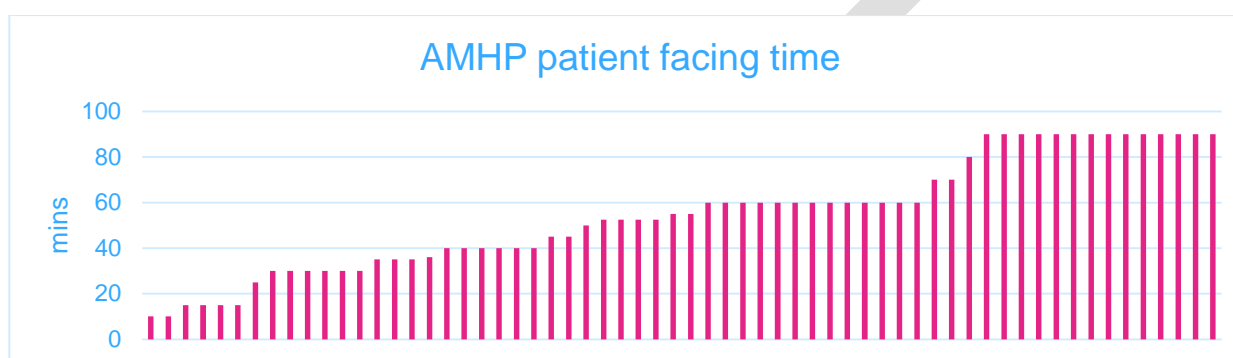
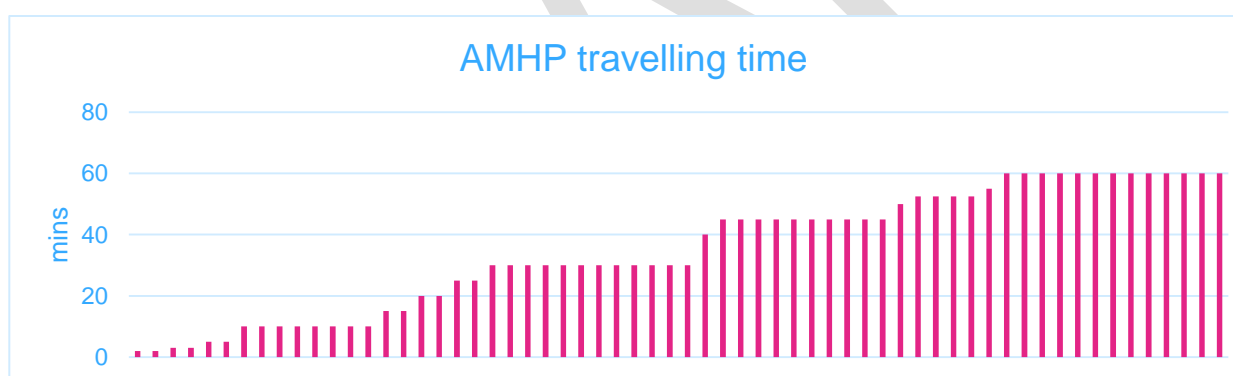
For the purposes of the financial analysis, it is assumed that 100% of the patients are seen by an AMHP based on the specification. From Police and LAS data, the annual s136 activity across London is 5307 is estimated from Jan 16 to Dec 17.

The unit cost figures were sourced through research into the contracted hourly rate for AMHPs across London. This research determined that the contracted hourly rates varied from approximately £28 per hour to £32 per hour. For this business case, a mid-point of £30 per hour has been used. It is acknowledged that this figure solely considers the direct cost of contractor AMHP activity and does not incorporate an apportionment of overheads. Furthermore, while it is noted that there is a greater prevalence of contracted AMHP resources in London, some of these resources will be operating via a substantive permanent post.

To estimate the time spent by AMHPs within the s136 pathway, a data collection exercise was undertaken by HLP. The exercise focused on collating data to inform average times spent within the pathway. This included average administrative time, travel time to the assessment and the actual time required to undertake the mental health assessment. This determined that AMHPs on average spend between 292 minutes and 514 minutes on s136 activities per patient. The distribution of data collected against each of these time categories is displayed in Figures 22 to 25 below.

**Figure 22: Distribution of AMHP admin time**



**Figure 23: Distribution of AMHP waiting for bed time****Figure 24: Distribution of AMHP patient facing time****Figure 25: Distribution of AMHP travelling time****Table 26: Baseline AMHP resource time**

AMHPs (time in mins)	Admin	Waiting Time	Patient Facing	Travel time	Total time	Total Cost
Baseline	92	231	61	38	422	£1,118k

For the purposes of costing, 422 minutes has been used, a sum of median travel time, patient facing, admin and waiting time for AMHPs was used. Using this information, it has been estimated the cost of the baseline to be £1,118k.

#### 4. Independent s12 doctor costs

- Indicative per patient s12 doctor costs: £178

- Indicative per annum s12 doctor costs: £378k (assumed call out rate 40%)

An independent s12 doctor is called if the SpR or Consultant feel that admission is required but the patient does not consent to admission. The s12 doctor cost for the pathway is therefore influenced by two factors:

- **The frequency in which the s12 doctor is called:** The major driver for this cost category is the frequency of the s12 doctor call out. However, there is no robust data that clearly establishes this figure. From data analysis, it is estimated that 20% of patients are informally admitted, while 21% are detained formally. The data is sourced from Mental Health and Learning Disability dataset (MHLDDS) from July – December 2015. From this data, it can be assumed the s12 doctor was called at least 21% of the time, since 21% of the patients got formally admitted. However, a proportion of patients seen by the s12 doctor will be eventually admitted informally or discharged. As an estimate, 40% independent s12 call out rate for the baseline is assumed.
- **The cost charged by the independent s12 doctor:** The cost of an s12 doctor is based on a fixed fee that is charged for every s12 call out. It is a fixed fee of £178, which is standard across England.

Assuming a 40% call out rate, together with the fixed fee of £178, a baseline cost of £378k per annum for s12 doctors has been estimated. This cost includes s12 services provided to both adult and CYP individuals.

## 5. HBPoS staff costs

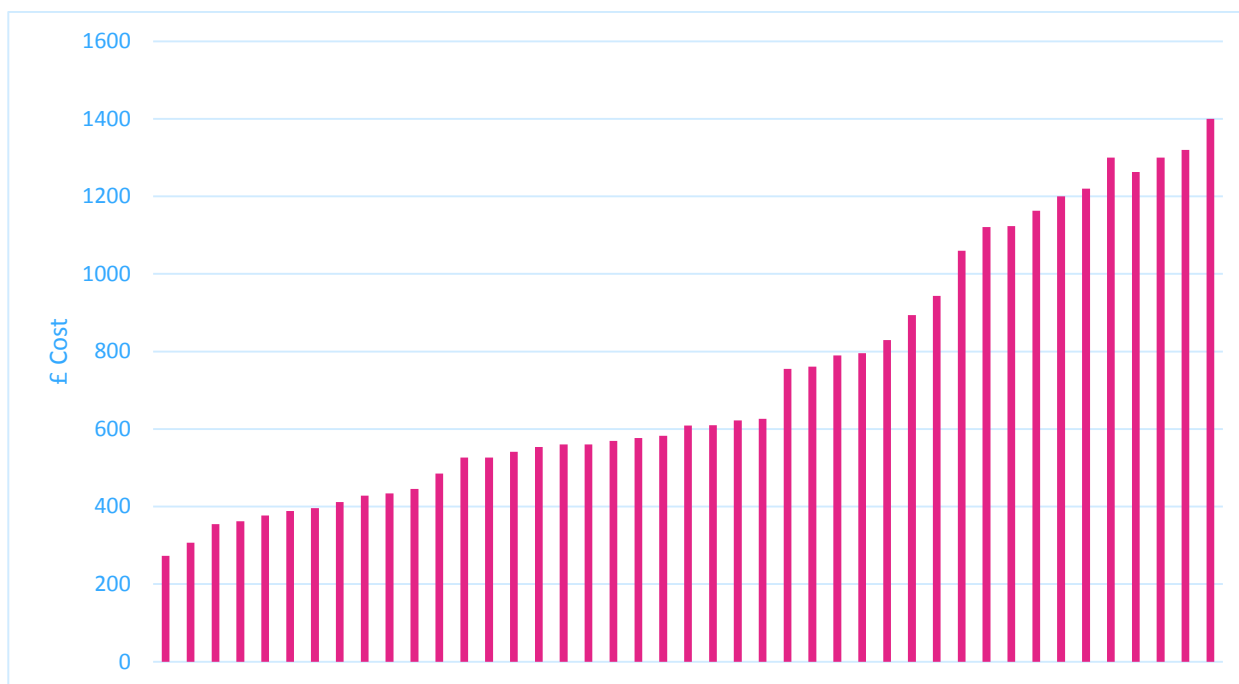
- Indicative per patient HBPoS staff costs: £333 - £1,133
- Indicative per annum HBPoS staff costs: £5,417k

As the majority of the HBPoS sites do not have any dedicated staffing arrangements, the traditional method of costing the pathway, by adding the whole time equivalent and multiplying by their respective unit cost is not possible.

As an alternative, a time and motion study was undertaken to determine the time that non-dedicated staff typically spend dealing with a person detained under s136. Excluding places of safety<sup>78</sup> with dedicated staffing, the average cost of staff per service user ranges from between £333 and £1,133. The major drivers for this cost are the length of stay at the HBPoS, the various staffing models and the pay band at each of the sites. It is estimated that the indicative cost of staff directly involved in the provision of care within HBPoS sites across London is approximately £5.4m per year. This includes those sites that have established dedicated staffing and includes HBPoS services provided to both adult and CYP individuals.

Whilst the cost associated with providing dedicated 24/7 staffing with the new model of care at c. £11.6m p.a., is significantly higher than the staffing cost with the current 20 site model at £5.4m p.a., the cost associated with the preferred 9 site model is much more favourable than maintaining the current 20 site configuration and introducing 24/7 staffing at a cost of c. £14.7m p.a. (an additional £3.1m compared to the preferred option).

<sup>78</sup> SWLSTGs, and SLAM are excluded when calculating cost per individual detained under s136; however, the cost of £4.9m does include SWLSTGs and SLAM staff costs.

**Figure 26: Distribution of cost per individual detained under s136**

## 6. HBPoS non-pay costs

- Indicative per annum HBPoS non-pay costs: £11,473k

As with pay costs, attempting to establish the proposed non-pay cost of HBPoS sites across London is challenging. Multiple stakeholders have iterated the complexity of costing the non-staff running costs such as drugs, medications, and estimating capital overheads and estate charges. This is, to some degree, driven by the lack of formal data capture undertaken within the pathway. Box 8 provides an example of these difficulties.

### Box 8: Non-pay cost identification difficulties

“The two suites are part of PFIs which are managed by acute trust partners and both the non-staffing running costs (utilities, medication, phones, stationary etc ) and capital overheads are integrated within the overall fabric of the building. At this stage we don't have a dedicated staffing team for the suites and delegate staffing from our wards and Pre Admission Suite when required.”

**Finance Manager**

While it is difficult to estimate the various non-pay costs such as management overheads and estate charges, it is prudent to assume that HBPoS sites draw on overhead resources. As a proxy, data associated with SLAM's non-pay costs have been tested with finance directors from London's Mental Health Trusts and utilised to estimate a baseline non-pay cost across London. This dataset was utilised due to it being the most detailed breakdown of non-pay costs available. These non-pay costs are assumed to be driven both on a per site basis and a per patient basis; a summary of the non-pay cost of HBPoS across London is provided below.

### Table 27: Baseline non-pay costs

Non-pay costs		Baseline Non-Pay Cost of HBPoS sites across London	
Drugs	£	40k	
Medical Purchases	£	160k	
Transport costs	£	1,037k	
Cleaning	£	700k	
Pharmacy Overhead Allocation	£	160k	
Corporate Overhead Allocation	£	5,142k	
Management Overhead Allocation	£	1,512k	
Estate charges	£	2,722k	
Total	£	11,473k	

### 6.1.5 Emergency Department (ED)

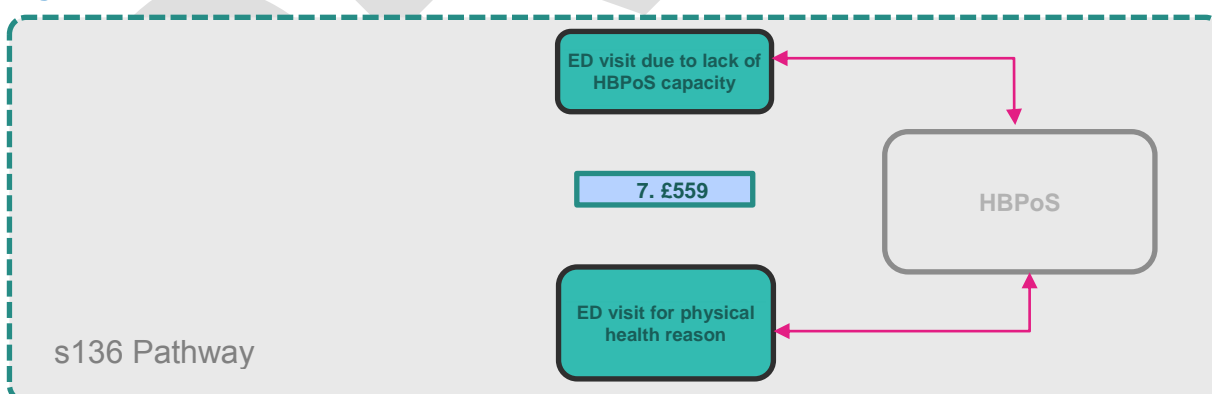
The total ED costs are set out in Table 28 below and described in more detail in the paragraphs which follow.

**Table 28: ED costs**

Stakeholder	Indicative per patient	Indicative per annum
NHS	£559	£297,134

At present, it is estimated that 6% of people detained under s136 are sent to the ED due to insufficient capacity in the current configuration of HBPoS sites.<sup>79</sup> In addition, a further 4% are estimated to attend with other physical health conditions. This adds increased pressure to EDs and leads to worse treatment experiences for the individual. Figure 27 below provides a snapshot of this step in the pathway.

**Figure 27: ED baseline costs**



The average cost of an ED attendance is £117.<sup>80</sup> However, this is based on an average duration of just 2.5 hours.<sup>81</sup> However, as audit data shows that individuals detained under s136 spend an average of 12 hours at an ED, this is uplifted in order to take account of the added resource costs. As a result, the total annual estimate for the NHS cost of s136 attending the ED is £297k.

<sup>79</sup> This estimate has been calculated from audit data from the HBPoS sites

<sup>80</sup> Manchester New Economy Model, 2016 - <http://neweconomymanchester.com/our-work/research-evaluation-cost-benefit-analysis/cost-benefit-analysis/unit-cost-database>

<sup>81</sup> <http://www.content.digital.nhs.uk/catalogue/PUB23070>

## 6.2 Preferred option pathway costs

### 6.2.1 Overview

Following the detailed analysis undertaken to assess the baseline costs of the s136 pathway discussed in the previous subsection, this subsection focuses on assessing the cost of the preferred nine site option across the patient pathway. This incorporates understanding the cost impact of the consolidation of the existing HBPoS sites into nine sites. Furthermore, it considers a dedicated, combined workforce model, consistently applied across all sites in London.

As in the previous subsection on baseline costs, this section describes the cost associated with the reconfiguration of HBPoS sites at each step of the s136 journey. The pathway is divided into two parts:

- The conveyance from initial detention to the HBPoS; and
- The critical steps that occur at the HBPoS.

For the cost associated at each of these steps of the pathway, an indicative cost range is provided where applicable, along with an estimated overall cost per annum.

### 6.2.2 Summary of preferred option pathway costs

It is estimated that on average, the s136 pathway costs for the preferred option are circa £20.5million per year. Table 29 below provides a summary of the average cost associated with the s136 pathway components. The paragraphs which follow describe each component cost in more detail. Table 30 sets out the indicative pathway component costs per STP / HBPoS, with the allocation calculated on a capitation basis. This will require further review and analysis at the next business case stage.

**Table 29: Preferred option pathway costs**

Ref	Pathway Component	Indicative annual activity	Indicative unit cost per patient	Indicative preferred option cost
1a <sup>82</sup>	Police Conveyance	1,114	£101	£112k
1b <sup>69</sup>	Police Conveyance (with LAS)	4,193	£80	£333k
2 <sup>83</sup>	Ambulance	4,193	£239	£1,004k
3	AMHP	5,307	£222	£1,176k

82 1a the cost of conveyance to police when conveying alone and 1b when conveying with LAS.

83 The cost to LAS when they convey; this is always with police.

4	Independent s12 Doctor	1,698	£178	£302k
5	HBPoS – Staff	5,307	£2,192	£11,636k
6	HBPoS – non-pay			£5,931k
7	ED	0	£0	£0k
	<b>Total</b>			<b>£20,494k</b>

Table 30: Preferred option pathway costs per STP and HBPoS

Ref	STP	NCL		NWL			NEL		SEL	SWL	Total
	HBPoS	Chase Farm	Highgate MHC	Lakeside MHU	Riverside	St. Charles	City and Hackney MHC	Sunflower Court	Southwark	Wandsworth	Total £'000s
	Pathway Component	Indicative preferred option costs (£'000s)									
1a	Police <sup>84</sup>	£23		£23			£31		£24	£11	£112
1b	Police (with LAS) <sup>71</sup>	£69		£67			£92		£73	£32	£333
2	LAS <sup>85</sup>	£208		£201			£278		£218	£98	£1,004
	<b>Total</b>	<b>£300</b>		<b>£291</b>			<b>£401</b>		<b>£315</b>	<b>£141</b>	<b>£1,449</b>
3	AMHP	£69	£175	£122	£30	£84	£215	£111	£256	£115	£1,176
4	Independent s12 doctor	£18	£45	£31	£8	£22	£55	£28	£66	£29	£302
5	HBPoS-Staff	£858	£1,512	£1,185	£858	£858	£1,840	£1,185	£2,155	£1,185	£11,636
6	HBPoS – Non pay	£349	£882	£616	£151	£424	£1,085	£558	£1,290	£578	£5,931
	<b>Total</b>	<b>£1,294</b>	<b>£2,614</b>	<b>£1,954</b>	<b>£1,047</b>	<b>£1,388</b>	<b>£3,195</b>	<b>£1,882</b>	<b>£3,767</b>	<b>£1,907</b>	<b>£20,494</b>

## 6.2.3 Cost of Conveyance

As noted, there are two major routes in which an individual arrives from initial detention to the HBPoS; either via a police vehicle or via an ambulance with police support.

<sup>84</sup> 1a gives the cost of conveyance to police when conveying alone and 1b when conveying with LAS

<sup>85</sup> The cost to LAS when they convey; this is always with police.

The total costs of conveyance are set out in Table 31 below and described in more detail in the paragraphs which follow.

**Table 31: Cost of Conveyance**

Stakeholder	Indicative per patient	Indicative per annum
Police conveyance costs <sup>86</sup>	£101	£112,427
Police conveyance costs <sup>83</sup> (with LAS)	£80	£333,474
Ambulance conveyance costs <sup>87</sup>	£239	£1,003,859

### 1. Police conveyance

#### a) Without LAS

- Indicative per patient police conveyance costs: £101
- Indicative per annum police conveyance costs: £112k

The total cost for police conveyance (not accompanying the LAS) in the preferred option has been estimated at £112k per annum. This cost includes both adult and CYP conveyances. The assumptions used for travel time, activity and unit costs are discussed in turn below.

#### Travel time

To assess the impact on conveyance time of the preferred option, data was utilised that detailed the pick-up location of historic s136 pan-London activity. This data was overlaid onto the location of HBPoS sites within the preferred option, allowing an assessment to be made of average conveyance time between the pick-up locations and the location of the consolidated HBPoS sites.

This determined that average conveyances times within the preferred option were between 16 and 32 minutes, with a median of 22 minutes. For the purpose of this analysis, it is assumed that travel time differential between the Police and the Ambulance does not exist, as Ambulance vehicles are not allowed to blue light while conveying mental health patients to the HBPoS, although this may change in the future.

#### Activity

As stated in Section 5.1.3, the proportion of individuals detained under s136 conveyed by police, is decreasing relative to LAS conveyance. Using mathematical prediction, an indicative estimate is that 87% of those detained will be conveyed by LAS by 2020, compared to 13% by police vehicle. As it is not possible to determine conclusively that the past trend will continue at the same pace in the future, the preferred option uses the same conveyance percentages that is seen in the baseline - an ambulance conveyance of 79% and a police conveyance of 21%.

It is noted that there is a risk to increasing activity at HBPoS sites that border London where police detention takes place in the outer areas of London. Further investigation into this shows there are two Health Based Place of Safety sites that lie within ten miles of the London boundary that could be affected by the nine site option. Conveyance to these sites outside of London is likely to primarily come from the

<sup>86</sup> 1a the cost of conveyance to police when conveying alone and 1b when conveying with LAS.

<sup>87</sup> The cost to LAS when they convey; this is always with police.

outer London boroughs in NWL and SEL. To give an indicative estimation of the potential impact, it is estimated that activity levels diverted to these sites would be no higher than 10% of activity in the affected areas, using current figures this would be 20-23 patients per annum as a result of London's new model of care. However, improved access at HBPoS sites within the London boundary is likely to limit the conveyance of those sectioned to sites outside the city. Nonetheless, during and post implementation it will be important to be aware of this potential unintended consequence and be open to communication with areas outside London in order to monitor and mitigate this risk.

### *Unit costs*

As per the baseline costs, the preferred option unit cost per minute is assumed to be £58.2 per hour for police forces.

#### **b) With LAS**

- Indicative per patient police conveyance costs: £80
- Indicative per annum police conveyance costs: £333k

The total cost for police conveyance, accompanying the LAS, in the preferred option has been estimated at £333k per annum. This cost includes both adult and CYP conveyances. The unit cost assumptions are discussed above, whilst the assumptions used for travel time and activity are the same as that used for ambulance conveyance, discussed in turn below.

The combined total police conveyance costs in the preferred option are therefore estimated at £446k per annum.

## **2. Ambulance conveyance**

- Indicative per patient ambulance conveyance costs: £239
- Indicative per annum ambulance conveyance costs: £1,004k

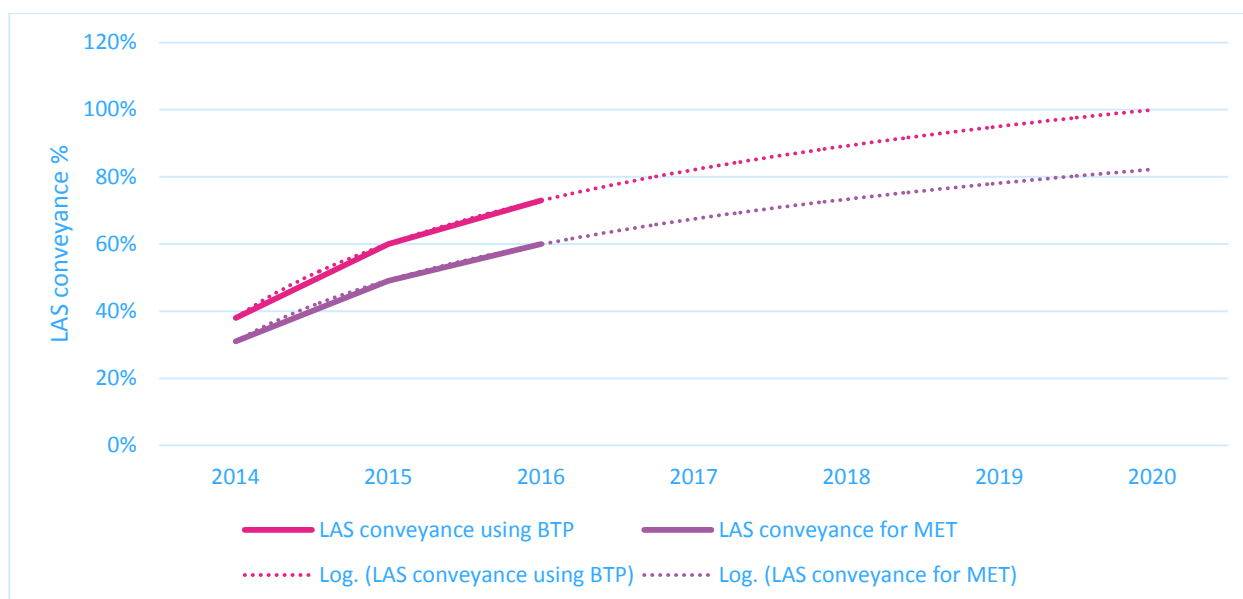
The total cost for ambulance conveyance in the preferred option has been estimated at £1,004k per annum. This cost includes both adult and CYP conveyances. The assumptions used for travel time, activity and unit costs are discussed in turn below.

### *Travel time*

As noted above, the average conveyance time assumed for the preferred option is between 64 and 111 minutes, with a median of 82 minutes. For the purpose of this analysis, it is assumed that travel time differential between the Police and the Ambulance does not exist, as Ambulance vehicles are not allowed to blue light while conveying mental health patients to the HBPoS, although this may change in the future.

### *Activity*

As stated above, we have assumed that the preferred option uses the same conveyance percentages that are seen in the baseline - an ambulance conveyance of 79% and a police conveyance of 21%. However, it is important to note that the proportion of those detained who are conveyed via ambulance may increase in the future. Figure 28 provides an illustration of a projected increase in LAS conveyance, although this has not been incorporated in our financial analysis.

**Figure 28: Projection of LAS conveyance %**

If these projections are accurate, the anticipated shorter journey times, together with the increased frequency of usage for ambulance and a decreased usage of police conveyance, will require local ambulance services to have more staff and more ambulance vehicles, potentially inducing cost increases during conveyance.

#### Unit costs

As per the baseline costs, the preferred option unit cost per minute is assumed to be £2.92 for LAS.

### 6.2.4 Health Based Place of Safety

The total HBPoS costs are set out in Table 32 below and described in more detail in the paragraphs which follow.

**Table 32: HBPoS costs**

Stakeholder	Indicative per patient	Indicative per annum
AMHP	£222	£1,175,501
Independent s12 doctor	£178	£302,287
Staff costs	£2,192	£11,636
Non-pay costs	NA	£5,830,810

### 3. AMHP costs

- Indicative per patient AMHP costs: £222
- Indicative per annum AMHP costs: £1,176k

It is estimated that the AMHP cost associated with s136 activity across London is £1,176k per annum for the preferred option, which includes AMHP activity for adults only.

There are three drivers that will impact the AMHPs cost for the preferred option, which are as follows:

- **Activity** - For the preferred option, it is also assumed that 100% of the patients are seen by an AMHP, as this is outlined in the s136 specification.
- **Unit cost** - It is assumed that hourly rate of AMHPs across London does not change between the baseline and the preferred option, and therefore, £30 per hour was utilised for the preferred option.
- **Time spent (travel/admin/assessing patient)** - As a result of the consolidation of HBPoS sites, AMHPs travel time would increase. Given the location associated with the 9 site model, it is estimated that travel time would increase by 57% from 38 minutes to 59 minutes on average. The % increase is calculated by the time differential of travelling between the baseline case and the preferred option, where AMHPs are travelling from their home borough to the closest HBPoS located within their STP, within the reconfigured model.

**Table 33: AMHP resource time**

AMHPs (time in mins)	Travel time	Patient Facing	Admin	Waiting Time	Total time	Total Cost
Preferred option	59	61	92	231	443	£1,176k

#### 4. Independent s12 Doctor costs

- Indicative per patient s12 doctor costs: £178
- Indicative per annum s12 doctor costs: £302k

The cost of the s12 doctor for the pathway is influenced by two factors in the preferred option:

- **Frequency:** With a 24/7 dedicated speciality workforce, it is envisioned that admission to inpatient beds will reduce. Given limited data on s12 doctor call-out rates, the % change of the s12 doctor call-out rate is required be estimated. Both SLAM Centralised Place of Safety and SWLSTG PDU, with their dedicated 24/7 staffing teams, have seen a decrease in admissions following assessment. Using the SWLSTG PDU as a proxy, a 20% drop in inpatient admission was evidenced. Using the equivalent % change, it is possible to estimate the callout % for an independent s12 doctor. Using this as a basis, independent s12 callout % in the preferred option is estimated to be 32%.
- **Cost:** The cost of the independent s12 doctor is based on a fixed fee, which is standard across England at £178 and therefore is proposed not to change in the preferred option.

Utilising this information, it is estimated that the cost of s12 activity in the preferred option will cost £302k. This cost includes s12 activity for both adult and CYP individuals.

#### 5. HBPoS staff costs

- Indicative per patient HBPoS staff costs: £2,192  
Indicative per annum HBPoS staff costs: £11,636k

The 9 site preferred option is moving away from the predominant existing model of taking staff from wards to deliver the service, to a model that provides 24/7 dedicated specialised staff.

It is estimated that the preferred 9 site option with 24/7 dedicated workforce would cost £11.6m per year. The workforce model that is proposed is based on safe levels of staffing at the HBPoS. Table 32 below shows an assumed workforce requirement for HBPoS at various bed capacity levels.

Whilst the cost associated with providing dedicated 24/7 staffing with the new model of care at c. £11.6m p.a., is significantly higher than the staffing cost with the current 20 site model at £5.4m p.a., the cost associated with the preferred 9 site model is much more favourable than maintaining the current 20 site configuration and introducing 24/7 staffing at a cost of c. £14.7m p.a. (an additional £3.1m compared to the preferred option).

**Table 34: WTE requirement by capacity levels**

Bed Capacity	1	2	3	4	5	6
	WTE					
New Speciality Doctor Grade	1.0	1.0	1.0	1.0	1.0	1.0
Consultant's Post	0.5	0.5	0.5	0.6	0.7	0.7
Nursing Band 03	3.0	6.0	9.0	12.0	15.0	18.0
Nursing Band 05	3.0	6.0	9.0	12.0	15.0	18.0
Nursing Band 06	1.5	3.0	4.5	6.0	7.5	18.0
Nursing Band 07	1.0	1.0	1.0	1.0	1.0	1.0
Admin & Clerical Band 04	1.0	1.0	1.0	1.0	1.0	1.0

Similarly, Table 35 below shows the assumed cost of workforce for HBPoS sites of various capacity levels.

**Table 35: Pay costs by capacity levels**

Capacity	1	2	3	4	5	6
New Speciality Doctor Grade	£74k	£74k	£74k	£74k	£74k	£74k
Consultant's Post	£68k	£63k	£73k	£82k	£91k	£89k
Nursing Band 03	£104k	£208k	£312k	£416k	£520k	£624k
Nursing Band 05	£130k	£259k	£389k	£519k	£649k	£778k
Nursing Band 06	£84k	£168k	£253k	£337k	£421k	£505k
Nursing Band 07	£54k	£54k	£54k	£54k	£54k	£54k
Admin & Clerical Band 04	£31k	£31k	£31k	£31k	£31k	£31k
Total	£545k	£858k	£1,185k	£1,512k	£1,840k	£2,155k

Once the cost associated with each capacity level at an HBPoS is determined, it is important to understand the capacity required for the preferred option.

Analysing activity flows from the baseline to the preferred option, accounting for demand patterns and growth, capacity requirement at each of the consolidated sites was determined for the preferred option. Table 36 below shows the capacity and workforce cost breakdown by the HBPoS for the preferred option for the adult population only. This only includes the s136 staff, without any wrap around service cost included, noting that some places of safety which already have dedicated staff members might have a different workforce mix.

**Table 36: Preferred option HBPoS staff costs**

STP	HBPoS	Capacity	Workforce cost
North Central London	Chase Building, Chase Farm Hospital	2	£858k
North Central London	Highgate Mental Health Centre	4	£1,512k
North East London	City and Hackney Centre for Mental Health	5	£1,840k
North East London	Sunflowers Court, Goodmayes Hospital	3	£1,185k
North West London	St. Charles	2	£858k
North West London	Riverside Centre, Hillingdon Hospital	2	£858k
South East London	Lakeside Mental Health Unit - West Middlesex University Hospital	3	£1,185k
South East London	Southwark Place of Safety Suite, ES1 Ward, Maudsley Hospital (new centralised site)	6	£2,155k
South West London	Wandsworth Recovery Centre, Section 136 Suite, Springfield University Hospital	3	£1,185k
Total			£11,636k

## 6. HBPoS non-pay costs

- Indicative per annum HBPoS non-pay costs: £5,931k

The consolidation of sites will impact non-pay costs at the selected HBPoS sites. It is expected that the consolidation will not only reduce costs, but also that the larger sites will individually gain from economies of scale.

Table 37 below provides an assumed breakdown of non-pay costs associated with the preferred option. The basis of non-pay costs is drawn from the SLAM HBPoS and the table below is an extrapolation of the non-pay costs for the preferred 9 site model.

**Table 37: Preferred option non-pay costs**

Non-pay costs	Preferred Option
Drugs	£40k
Medical Purchases	£160k
Transport costs	£1,037k
Cleaning	£315k
Pharmacy Overhead Allocation	£160k
Corporate Overhead Allocation	£2,314k
Management Overhead Allocation	£680k
Estate charges	£1,225k
Total	£5,931k

## 6.2.5 Emergency Department (ED)

From the Strategic Case, it has been made clear that an ED is not the right environment for an s136 patient to be treated, in the absence of urgent physical health needs that cannot be address in the HBPoS.

The total ED costs are set out in Table 38 below and described in more detail in the paragraph which follows.

**Table 38: ED costs**

Stakeholder	Indicative per patient	Indicative per annum
NHS	£559	£0

It is proposed that the preferred option for HBPoS reconfiguration will reduce the number of ED visits due to lack of capacity at the HBPoS. To this end, the preferred option will have adequate capacity to deal with s136 demand, where growth and hourly demand pattern is accounted for. It is therefore estimated that all pathway costs associated with ED activity due to lack of capacity to reduce to zero.

## 6.3 Variance in pathway costs

### 6.3.1 Overview

Following the detailed analysis undertaken to assess the current costs of s136 services across the patient pathway discussed in section 3.1 and subsequently the cost of the preferred option in section 3.2, the next step is to understand and highlight any cost differentials between the baseline and the preferred option. This section discusses the incremental costs or savings related to delivering the preferred option and whether these savings are cashable for the NHS.

The pathway is divided into two parts, as follows:

- The conveyance from initial detention to the HBPoS; and
- The critical steps that occur at the HBPoS.

For the cost variance at each step of the journey, consideration is made to the variance drivers and alternative scenario's considered for the preferred option.

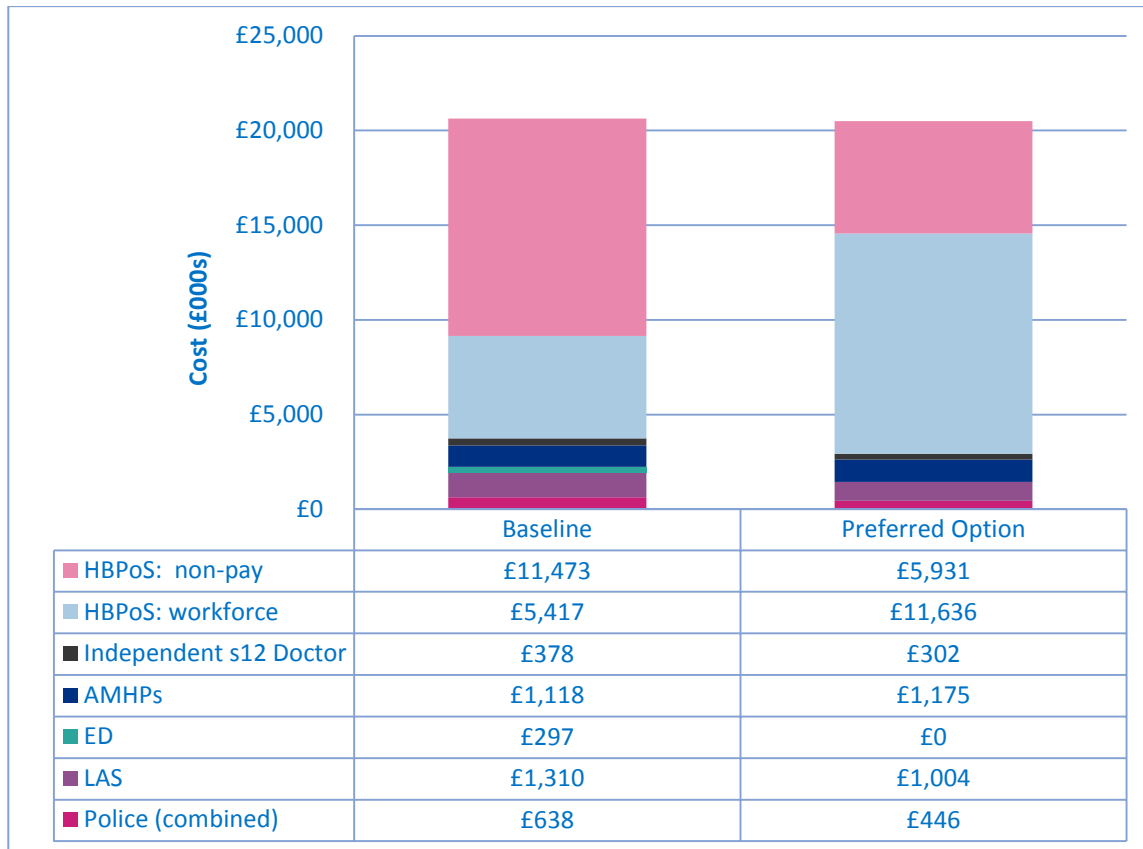
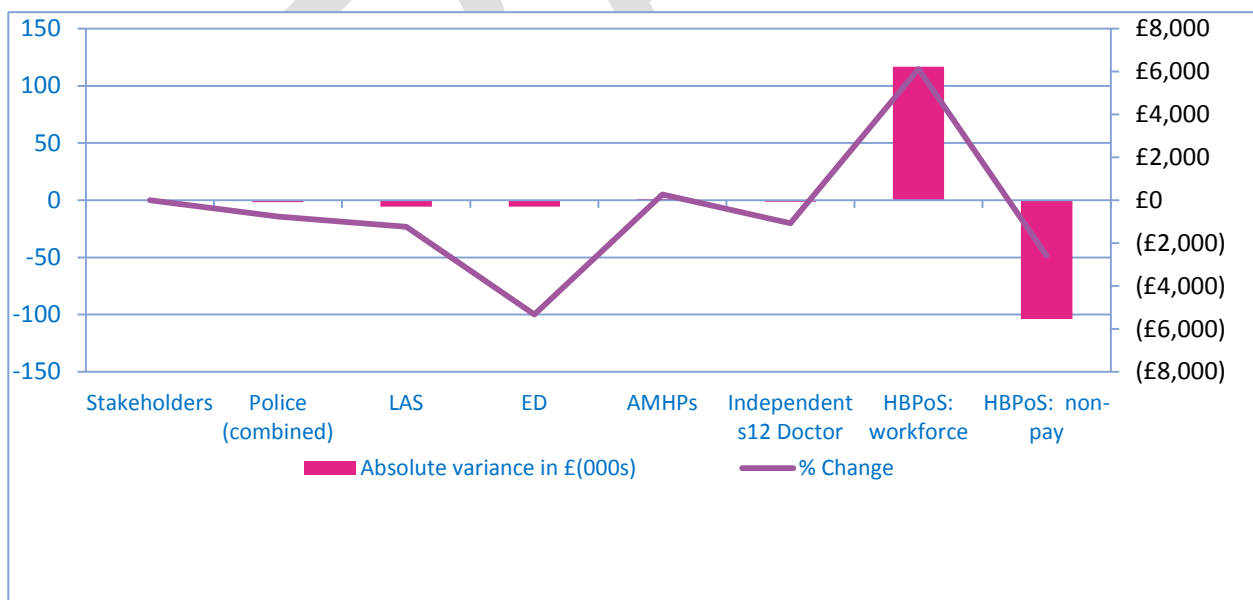
### 6.3.2 Summary of pathway cost variances

It is estimated that on average, the s136 pathway cost for the preferred option induces a net saving of £138k per annum. This is primarily driven by non-pay costs which are expected to be non-cashable. It should be noted however, that if the non-pay costs are excluded, the preferred option would induce an incremental cost of £5.4m above the baseline.

Table 39 provides a summary of the variance associated the s136 pathway estimates. The paragraphs which follow describe each component cost in more detail.

**Table 39: Pathway cost variances**

Stakeholders	Baseline	Preferred Option	Variance
Police	£203k	£112k	(£91k)
Police (with LAS)	£435k	£333k	(£102k)
LAS	£1,310k	£1,004k	(£306k)
ED	£297k	£0k	(£297k)
AMHPs	£1,118k	£1,175k	£57k
Independent s12 Doctor	£378k	£302k	(£76k)
HBPoS: workforce	£5,417k	£11,636k	£6,219k
HBPoS: non-pay	£11,473k	£5,931k	(£5,542k)
Total	£20,632k	£20,494k	(£138k)

**Figure 29: Cost differential for baseline and preferred option broken by stakeholders****Figure 30: Absolute cost variance from base case to preferred option by stakeholder**

## 6.3.3 Cost of Conveyance

### 1. Police conveyance

#### a) Without LAS

Table 40 illustrates the cost variance of the base case with the preferred option for police conveyance, not accompanying the LAS.

**Table 40: Police conveyance cost variance**

Conveyance type	Base case	Preferred Option	Variance
Police	£203k	£112k	(£91k)

#### b) With LAS

Table 41 illustrates the cost variance of the base case with the preferred option for police conveyance, accompanying the LAS.

**Table 41: Police conveyance cost variance accompanying the LAS**

Conveyance type	Base case	Preferred Option	Variance
Police <sup>88</sup>	£435k	£333k	(£102k)

### 2. Ambulance conveyance

Table 42 illustrates the cost variance of the base case with the preferred option for ambulance conveyance.

**Table 42: Ambulance conveyance cost variance**

Conveyance type	Base case	Preferred Option	Variance
Ambulance <sup>89</sup>	£ 1,310k	£ 1,004k	(£306k)

The assumptions behind these variances are described below.

#### Cost per unit

There is no difference in the cost per minute from the baseline to the preferred option.

#### Conveyance time

Through the consolidation of sites established by the preferred option, it is expected that, with fewer HBPOs sites in London, initial conveyance time will increase. However, it is also acknowledged that, through improved capacity within the consolidated sites, the number of incidents where further conveyance is required due to an individual detained under s136 arriving

<sup>88</sup> This is the cost to police only. The cost to the LAS is given in table 40.

<sup>89</sup> This is the cost to LAS only. The cost to the police is given in table 39.

at a site which is at capacity, will reduce. Box 9 provides an example from the Metropolitan Police escalation log which illustrates the type of delays faced within the current s136 pathway.

### Box 9: Delays current s136 pathway

“There was no S136 Suite available across [HBPoS] or neighbouring Trusts. After 2 hours in the van and no sign of a S136 suite becoming available, male was taken to custody suite”

“Police detain the male under S136 MHA and attend ED for physical health clearance. Officers are told by a nurse that there is a bed at [HBPoS] reserved for him. Officers attend the HBPoS with the male but are met by a nurse who states that there is no beds available”

Figure 30 below depicts the conveyance time from the base case scenario to the preferred 9 site option for Police conveyance. The base case of 20<sup>90</sup> sites includes inefficiencies in the system driven by the police conveying an individual to a site which is then found to be at capacity. This results in either further conveyance time to an alternate place of safety or waiting at the place of safety.

Moving from the inefficient model, to the efficient 20<sup>91</sup> site model, where patients are taken to the closest HBPoS without any bottleneck or operational inefficiency reduces the average travel time significantly. However, the travel time increases as the number of sites decrease from the 21 efficient site model to the preferred 9 site model, as expected.

**Figure 31: Police conveyance time from base case to preferred option**

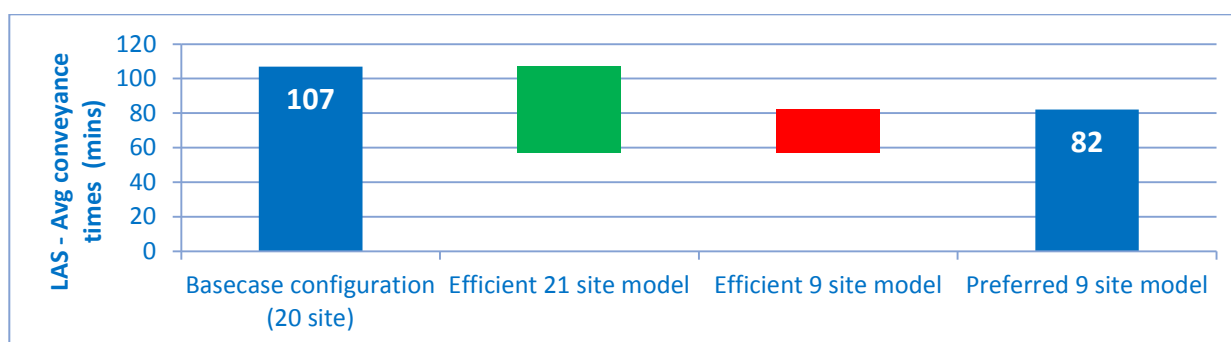


Similarly, the conveyance time for the ambulance from the base case scenario to the 9 site model will influence the pathway cost for the conveyance of the preferred option.

**Figure 32: LAS conveyance time from base case to preferred option**

<sup>90</sup> Because the calculation of travel time utilises actual data, Highgate Mental health trust has been excluded, as this site currently does not exist, and therefore, a 20 site for the base case. However, when calculating the travel time in the efficient site model, Highgate mental health trust is included in the calculation.

<sup>91</sup> The 21 site does include Highgate mental health trust



Therefore, there is a 42 minute time differential for the Police and a 25 minute time differential for the ambulance conveyance from the base case to the preferred option, which is the main driver for the cost variance between the baseline and the preferred option.

### Activity

There is no difference in the proportion of patients conveyed via an ambulance and police from the baseline to the preferred option. The same conveyance proportions are assumed, 79% of conveyance via the ambulance and 21% conveyance via Police.

## 6.3.4 HBPOs

In this pathway, the four main components that drive a cost variance between the preferred option and the base case within the s136 pathway are:

- AMHPs;
- Independent s12 doctor;
- HBPOs staff; and
- HBPOs non-pay costs.

### 3. AMHP costs

The preferred option for AMHPs costs £1,118k, compared to the base case of £1,175k, representing an increased cost of £57k. The main driver for this cost is caused by an increase in travel time in the preferred option compared to the baseline. As noted in the baseline analysis, the proportion of AMHP time which is dedicated towards travelling represents a relatively small proportion of total AMHP activity.

**Table 43: AMHP cost variance**

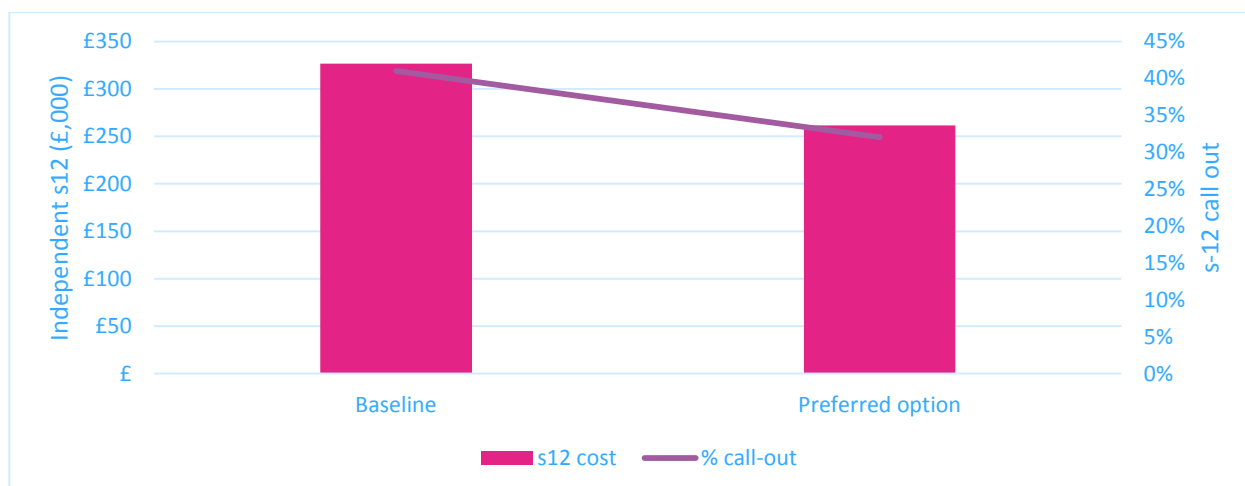
AMHPs (time in mins)	Travel time	Patient Facing	Admin	Waiting Time	Total time	Total Cost	% change from baseline
Baseline	38	61	92	231	422	£1,175k	0%
Preferred option	59	61	92	231	443	£1,118k	5.1%

It is assumed that patient facing time, admin time, and waiting time remain the same for the baseline and preferred option.

#### 4. Independent s12 costs

The cost of an independent s12 doctor for the preferred option is estimated to be £302k, compared to the baseline of £378k, a decrease in cost from the baseline of £76k, which is cashable. The main driver for this change is driven by lower call-out frequencies for the s12 doctor in the preferred option compared to the baseline.

**Figure 33: Difference in cost of s12 doctor from base case to preferred option**



#### 5. HBPOs staff costs

The staff cost of HBPOs sites for the preferred option is estimated to be £11.6m, compared to the baseline of £5.4m, an increase in cost from the baseline of £6.2m. The main driver for this cost is having 24/7 dedicated staffing at each of the HBPOs sites.

**Table 44: HBPOs staff cost variance**

	Baseline	Preferred Option	Variance
<b>Staff costs</b>	£5.4m	£11.6m	115%

#### 6. HBPOs non-pay costs

The non-pay cost of HBPOs staff for the preferred option is estimated to be £5.9m, compared to the baseline of £11.5m, a decrease in cost from the baseline of £5.6m. The majority of this is driven by non-pay costs that are assumed to be driven by the number of HBPOs sites such as cleaning, corporate overhead allocation, and management overhead allocation and estate charges. It is assumed that the majority of these are non-cashable. Table 45 summarises the cost differential between the baseline and the preferred option for non-pay costs.

**Table 45: HBPOs non-pay cost variance**

	Baseline	Preferred Option	Variance
Drugs	£ 40k	£ 40k	£ 0
Medical Purchases	£ 160k	£ 160k	£ 0
Transport costs	£ 1,037k	£ 1,037k	£ 0
Cleaning	£ 700k	£ 315k	(£ 385k)
Pharmacy Overhead Allocation	£ 160k	£ 160k	£ 0
Corporate Overhead Allocation	£ 5,142k	£ 2,314k	(£ 2,828k)

Management Overhead Allocation	£ 1,512k	£ 680k	(£ 832k)
Estate charges	£ 2,722k	£ 1,224k	(£ 1,497k)
Total	£ 11,473k	£ 5,931k	(£ 5,542)

### 6.3.5 Emergency Department

#### 7. Emergency Department costs

The cost of an unwarranted visit of an s136 patient to an ED is zero in the preferred option, compared to the base case of £297k. This is because we assume that the preferred option will have adequate capacity and protocols in place, with suitably trained staff, to avoid ED presentations of this nature.

**Table 46: ED cost variance**

	Referred to ED baseline	Baseline Cost	Referred to ED for the preferred option	Preferred option cost	Variance
ED referrals	10%*	£297k	0%	£0	(£ 297k)

*\*includes 6% due to capacity issues and 4% for other physical conditions*

## 6.4 Transition costs

Table 47 below summarises the assumptions included for the purpose of the wider costing exercise. Specifically, it is proposed that a figure of £100k will be required per STP to support the transition. This establishes a total cost of £500k p.a. in FY18/19 and FY19/20 to support the transition. This is however, a high-level estimate and will require further refinement.

**Table 47: Transition costs**

	Cost
STPs	£500k
Total	£500k

The new model of care and reconfiguration of HBPoS sites across London will be a complex undertaking and as such, resources will be required to support in the transition.

It is proposed that implementation will be led locally and coordinated at an STP level. To this regard and with detailed implementation planning still to be undertaken, subject to the progression of this business case, it is difficult to provide a firm estimate of the level of resource required. However, it is acknowledged that resource will be required at both a local level and at a pan-London level to support the transition requirements.

These resources may be required to support a number of activities, including:

- Programme and project management;
- Internal and public communications;
- Site assessments and subsequent non-capital development costs; and
- Development and further refinement of appropriate protocols and ways of working.

Further details about the proposed requirements are provided in the Management Case.

## 6.5 Capital costs

The new model of care and consolidation of HBPoS sites will require an increase in capacity for the majority of sites which are incorporated within the preferred option. As such, to support this increase in capacity, capital investment will be required at many HBPoS sites.

Aside from the increase in the number of beds, the degree to which an existing site can accommodate a larger HBPoS will vary. While analysis has been undertaken as part of the options appraisal process that considered the percentage of estates that are currently utilised for non-clinical purposes, further analysis is required during implementation planning to effectively deduce capital requirements per site in collaboration with local estate teams.

For the purpose of this financial analysis, an assumed capital cost of £150k is utilised per extra bed required. This figure is drawn from the Policing and Crime Bill – Amend Police Powers under the Mental Health Act 1983, which provides an indicative view of what may be required across London. This establishes that an assumed total level of capital investment required across London to support the configuration is £2.3m.

**Table 48: Indicative capital costs**

STP	HBPoS	Baseline capacity	Capacity requirement	Capital cost at £150k per bed *
North Central London	Chase Building, Chase Farm Hospital	2	2	N/A
North Central London	Highgate Mental Health Centre	0	4	£600k
North East London	City and Hackney Centre for Mental Health	1	5	£600k
North East London	Sunflowers Court, Good mayes Hospital	2	3	£150k
North West London	St. Charles	1	2	£150k
North West London	Riverside Centre, Hillingdon Hospital	2	2	N/A
South East London	Lakeside Mental Health Unit - West Middlesex University Hospital	1	3	£300k
South East London	Southwark Place of Safety	4	6	£300k
South West London	Wandsworth Recovery	2	3	£150k
Total				£2,250k

\* Further analysis and refinement required with local estate teams during implementation planning, to identify actual capital requirements per site location

## 6.6 Summary and funding arrangements

In order to assess the long term financial impact of the implementation of the proposal, a net present value of the financial implications has been calculated. This does not include the economic and social benefits discussed in the Economic Case. The net present value calculation assesses the long term financial impact by adding together the anticipated cost savings over the life of the project and deducting all the costs involved, discounting both the future costs and savings as an appropriate rate. The discount rate, equal to 3.5%, is used to convert the future costs and benefits to the “present value”, so that they can be compared.

### 6.6.1 Summary of financial impact and NPV

Table 47 below summarises the baseline pathway cost, whilst Table 48 summarises the preferred pathway cost, the high-level transition and capital costs associated with the preferred option.

This assumes that implementation planning and subsequent transition will be spread across FY18/19 and FY19/20. The costs associated with capital development have been assumed to fall in FY19/20.

For the modelling purpose, it is assumed that the preferred option is implemented in FY 19/20. Table 49 illustrates the base case – do nothing scenario. The total cost over the five year period to FY22/23 is £111.7m.

**Table 49: Baseline pathway costs – 5 year view**

	FY 18/19	FY 19/20	FY 20/21	FY 21/22	FY 22/23
<b>Baseline - Pathway cost</b>	£20,632k	£21,483k	£22,334k	£23,185k	£24,036k

Table 50 illustrates the costs of implementing the preferred option.

**Table 50: Preferred option costs – 5 year view**

	FY 18/19	FY 19/20	FY 20/21	FY 21/22	FY 22/23
<b>Pathway cost</b>	£20,632k	£21,483k	£20,494k	£20,494k	£20,494k
<b>Transition cost</b>	£500k	£500k	£0k	£0k	£0k
<b>Capital</b>	£0k	£2,250k	£0k	£0k	£0k
<b>Total</b>	£21,132	£24,233k	£20,494k	£20,494k	£20,494k

Under proposed plans for the preferred nine site model, the five year cost of the project will be approximately £106.8m.

Table 51 sets out the variances in costs/savings of the base case pathway compared to the preferred nine site option.

**Table 51: Net present value (financial only)**

	FY 18/19	FY 19/20	FY 20/21	FY 21/22	FY 22/23
<b>Variance (cost)/saving</b>	(£500k)	(£2,750k)	£2,154k	£3,005k	£3,856k
<b>Discount factor</b>	3.5%	3.5%	3.5%	3.5%	3.5%
<b>Discounted (cost)/ Saving (£,000)</b>	(£483k)	(£2,567k)	£1,942k	£2,618k	£3,246k
<b>NPV</b>	£4,757k				

There is a net saving of £4.9m with the preferred nine site option, with a positive net present value (NPV) of £4.8m.

However, as discussed in the Economic Case in Section 4, the financial impact of the reconfiguration should not be viewed in isolation. Instead, it is important to consider the range of clinical, economic and societal benefits which will be enabled by the scheme. The total net benefit from the new model of care, consolidating HBPOs sites in London, is estimated at £20m per year (financial and non-financial).

## 6.6.2 Funding arrangements

At this early stage of the project, the exact funding arrangements for the costs outlined above have not been finalised and agreed. However, initial expectations about funding arrangements can be summarised as follows:

- It is likely that variances to pathway costs will be borne by the relevant stakeholders i.e. police forces, ambulance services, Mental Health Trusts;
- The work programme has thus far been led by the Healthy London Partnership (HLP), which is funded by all 32 CCGs and NHSE. However, when HLP have finished their programme of work, the continued implementation and transition costs will require funding;
- Transition costs will likely be incurred by the CCGs within the relevant local STPs as they transform the services at their HBPOs sites. It is important that additional funding is made available for this transition as there will be no equivalent income mechanism to support them; and
- The capital costs required to increase capacity at relevant HBPOs sites will likely be borne by the local STPs.

Pooling budgets across CCGs within the relevant STPs, combining spending power, is expected to provide funding support for the reconfiguration.

## 6.7 Risks to financial assessment

The consolidation of HBPoS sites requires a complex programme of change, and in order to model the financial implications, a number of assumptions have been made. To test the validity of the results, an initial high-level assessment of key sensitivities has been carried out.

Below are the key risks inherent to the financial analysis of the s136 pathway and HBPoS specification.

### *Gaps in the data collection*

A literature review to aid this analysis identified that there were a relatively small field of academic, peer-reviewed papers (which were mainly highly localised, small-scale and dated studies) from which conclusions could be drawn.

The ad-hoc evidence base which currently exists means that there is a limited knowledge of trends or changing patterns in the area, as well as limited 'service user' involvement. There are few outcome studies other than those that measure the result of a clinical decision to admit an individual to an inpatient bed or, otherwise, re-presentation levels.

A major gap in the literature relates to understanding longer-term outcome measurements, including changes in morbidity and mortality rates. Gaps also exist in data collection with EDs, as there was very limited robust information on issues such as secondary presentations, including dual diagnosis needs.

### *Robustness of data*

The scoping component and analysis of all the datasets also identified issues with the robustness of the quantitative data collected.

- Discussions with police leads highlighted coverage and completeness issues with some of the data held across the three police forces and for the Mental Health Service Dataset (MHSDS) there were coverage issues that resulted in some areas presenting no data (e.g. some EDs did not contribute to the system at all).
- Similar problems were found with the secondary analysis of the HES information derived from EDs.
- Similar issues were identified with other datasets, including data capture issues in the MHSDS as a consequence of migration to a new data platform, which resulted in a noticeable drop in returns to the system.

### *Access to data*

It was not possible to access the primary data sources of any clinical dataset for a number of reasons including the following:

- Concerns over confidentiality;
- Proprietary ownership of confidential information, including concerns over second-party interpretation of data;

- Manual recording of some data items;
- The technical aspects of extracting data; and
- The resource implications of developing systematic downloads to make them available for secondary analysis.

As a result, for this analysis, access to the MHSDS was derived through extracts of clinical data as part of a pre-existing pan-London performance monitoring arrangement. As part of this 'piggy-back' arrangement, the data available was limited to the information routinely used to form performance monitoring arrangements – for example, one quarter's data only. As a result, it was not possible to further analyse the data to understand trends or changes in the patterns of mental health presentation.

Data was also supplied on an ad-hoc basis across the London networks by MHTs and AMHPs. These covered a number of approaches including

- The use of bespoke spread sheets encompassing clinical audit data;
- Logbooks; and
- Stakeholders' own analyses of data.

This pragmatic approach allowed for often complex information to be collected, but this was at the expense of developing a consistent, systematic and robust methodology across the whole of London. The reports received from across the networks varied in terms of what and when data was collected and used different methodologies encompassing various definitions (e.g. the definition of 'repeat presentations' varied hugely across the data received). Few of the reports received defined the counting rules used to analyse data that would allow us to interpret the findings presented. These were further compounded by varying definitions of when the 'clock' started and stopped in relation to the measurement of process times.

## 7 Management case

This section of the Business Case describes the transitional stage of 13 HBPoS sites across London (including five sites that provide an all-age service), detailing associated indicative costs and benefits against the baseline/preferred option scenario. The section also addresses the ‘achievability’ of the scheme. Its purpose, therefore, is to consider the key considerations and governance that will be required to achieve successful implementation along with the actions required to transition to an effective governance environment post implementation.

This chapter is structured as follows:

- Transitional phase
- Implementation
- Post-implementation

Current reconfiguration planning is based on a completion date of 2019/20, subject to agreement on financial support and regulatory and Board approvals. To reach the 9 site option the following measures are proposed:

- ▶ **A 13 site transitional phase has been supported by STPs in the shorter term as an interim measure to reach the preferred nine site option.**
- ▶ **A highly collaborative approach and governance structure, with robust governance arrangements** will be adopted to manage the reconfiguration and plan for the future implementation; key requirements have been identified.
- ▶ **A plan to continue engagement with key stakeholders, including people with lived experience of mental health crisis and their carers,** will be developed to ensure the transition into the new reconfiguration of HBPoS sites is successful.
- ▶ **A plan for proposed governance structure post implementation and performance management arrangements** will be developed; principles for governance have been identified and a suggested multi-agency group structure. Group roles and governance benefits have been identified.
- ▶ **A comprehensive risk assessment, escalation and mitigation process** will be developed and in place to support the reconfiguration, with risks identified both at a local and system wide level. Implementation risks will be identified and assessed using a four tiered matrix. Risks will be discussed during implementation and post implementation governance forums.

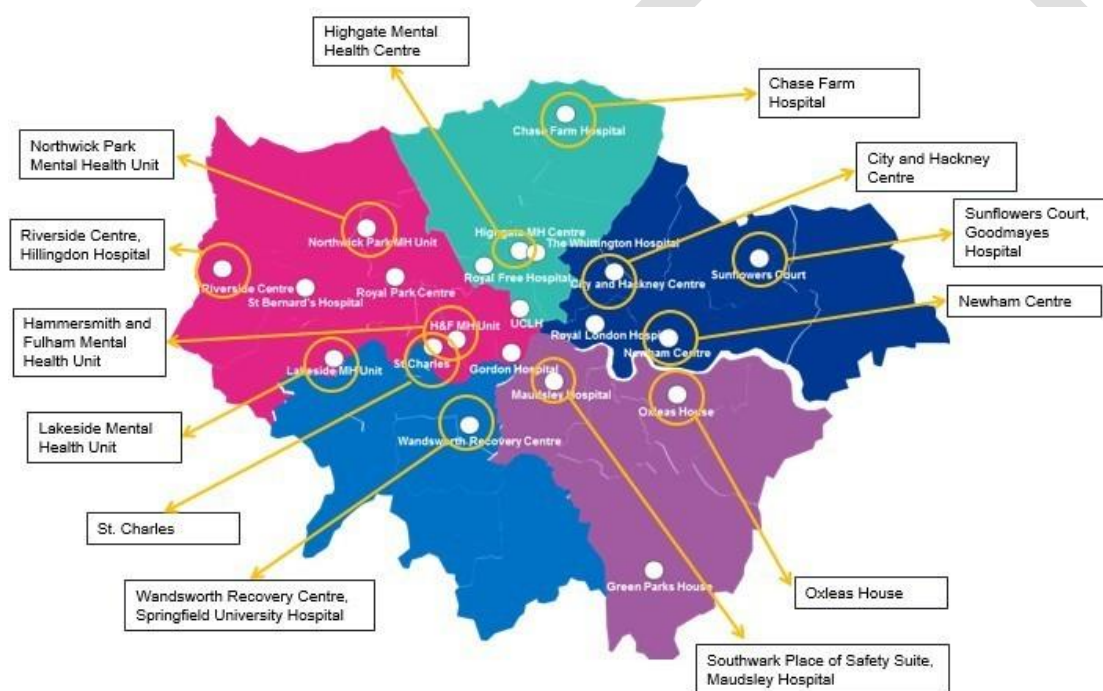
## 7.1 Transitional phase

### 7.1.1 Overview

As previously mentioned in the Business Case, following the options appraisal, further engagement led by programme STP leads took place across the system on the preferred option. The engagement process resulted in some STPs confirming sites that would be included in a pan-London nine site model whilst others required more time to develop local plans reflecting on other crisis care services and further understanding the impact of patient flow across local systems. This is particularly the case (but to varying degrees) in North West London (NWL), North East London (NEL) and South East London (SEL).

In light of this, the 13 site model is considered a transition stage (including five sites that provide an all-age service) to support STPs to implement the nine site preferred configuration. The resultant 13 site transition phase is shown below in Figure 34.

**Figure 34: HBPoS locations in the 13 site transition phase**



All sites within the 9 and 13 site model are suited for adult provision, with one site per STP providing an all-age service. The preferred CYP sites in the transitional 9 and 13 site model are: The Wandsworth Recovery Centre (SWL), Maudsley Hospital (SEL), Highgate Mental Health Centre (NCL), and St. Charles (NWL). Newham Centre for Mental Health (NEL) is the preferred all-age site in the 13 site model; however, on transition to the 9 site model, the all-age provision will need to be reassessed as the Newham Centre is not included.

### 7.1.2 Thirteen site transitional phase pathway benefits

Following the detailed analysis undertaken to assess the benefits of the preferred option s136 pathway discussed in section 4, this subsection focuses on assessing the benefits of the 13 site transitional stage model across the patient pathway. This incorporates the financial, economic and social impacts.

The same methodology and approach was applied to identify benefits of the 13 site model, as was followed for the preferred option cost benefit analysis, detailed in section 4 of this business case. Table 52 below, sets out the financial benefits totalling £20,074k which are estimated to be delivered, £930k of which is assumed to be cashable, £13,589k non-cashable. In addition, a further £5,555k social impact savings have been identified as part of the thirteen site transitional phase option analysis.

**Table 52: Thirteen site transitional stage benefits overview**

No.	Outcome	Financial (cashable) benefit Value p.a (£000)	Financial (non-cashable) benefit Value p.a (£000)	Benefit of measuring social impact (non-cashable) - Value p.a (£000)	Total Value p.a (£000)
1	Reduced conveyance time (ambulance vs. police vehicle)	£633 (vs £498)	-	£17 (vs £14)	£650 (vs£512)
2	Reduced ED admissions	£297	-	£60	£357
3	Reduced length of stay at HBPoS	-	-	£87	£87
4	Improved staff expertise	NA		NA	Qualitative
5	Improved HBPoS environment	-	-	£335	£335
6	Reduced non-pay costs	-	£5,542	-	£5,542
7	Reduced inpatient admissions	-	£7,918	£4,606	£12,524
8	Reduced repeat presentations	-	£129	£450 (vs £470)	£579 (vs £599)
9	Improving the wider crisis care system	NA	NA	NA	Qualitative
		<b>£930</b>	<b>£13,589</b>	<b>£5,555</b>	<b>£20,074</b>

The total estimated benefits of the transitional phase are marginally higher than the preferred option nine site model (c. £118k higher, which equates to a 1% increase) due to the following:

- **Reduced conveyance times** – There are decreases of 69% (from 64 minutes to 20 minutes) and 31% (from 107 minutes to 74 minutes) in the average journey times for police vehicles and LAS (accompanied by police) respectively (this compares to 45% and 23% for the preferred nine site model), which generates an additional combined financial benefit to the Police and LAS of c.£135k p.a. and an additional £3k p.a. social benefit (non-cashable) accruing to the patient due to a reduced travel time; and
- **Reduced repeat presentations** – There is a decrease in the average travel time for repeat presentations for police vehicles and LAS combined from 69 minutes to 63 minutes from the preferred option nine site model to 13 site transitional phase, which generates a decrease of c. £20k social benefit (non-cashable).

All other benefits remain unchanged between the preferred option nine site model and the 13 site transitional phase option.

### 7.1.3 Thirteen site transitional phase pathway costs

Following the detailed analysis undertaken to assess the baseline and preferred option costs of the s136 pathway discussed in section 5, this subsection focuses on assessing the cost of the 13 site transitional stage model across the patient pathway. This incorporates understanding the cost impact of the consolidation of the existing HBPOs sites into thirteen sites. Furthermore, it considers a dedicated combined workforce model, consistently applied across all sites.

The same methodology and approach was applied to identify costs of the 13 site model, as was followed for the baseline and preferred option costing analysis, detailed in section 5 of this business case. Table 53 below, sets out the estimated average pathway cost for the 13 site transitional phase at £23.2m p.a., compared to the baseline and preferred option pathway costs of £20.6m p.a. and £20.5m p.a. (excluding impact of activity growth) respectively.

**Table 53: Pathway costs**

Stakeholders	Baseline	Preferred Option	Transitional phase
Police	£203k	£112k	£108k
Police (with LAS)	£435k	£333k	£300k
LAS	£1,310k	£1,004k	£903k
ED	£297k	£0k	£0k
AMHPs	£1,118k	£1,175k	£1,176k
Independent s12 Doctor	£378k	£302k	£302k
HBPOs: workforce	£5,417k	£11,636k	£12,502k
HBPOs: non-pay	£11,473k	£5,931k	£7,946k
<b>Total</b>	<b>£20,632k</b>	<b>£20,494k</b>	<b>£23,237k</b>

The costs are more expensive for the 13 site transitional phase largely due to 24/7 dedicated staffing at each site and additional non-pay costs associated with the increased number of sites (i.e. estate charges, management/corporate overheads and cleaning costs).

#### 7.1.4 Transition costs

The timelines for this transition are due to fall within the proposed two year process to move to the nine site model. As a result there no additional transition costs expected in addition to the £1.0m included as part of the preferred nine site option.

#### 7.1.5 Capital costs

Of the additional four sites not included in the nine site configuration, only two sites require additional capital funding to meet the capacity requirements of an additional assessment room at each site. As illustrated in Table 52, this capital investment will total c. £1.8m for the 13 site configuration, £450k less than the preferred nine site model.

**Table 54: Indicative capital costs for 13 site transitional phase**

STP	HBPoS	Baseline capacity	Capacity requirement	Capital cost at £150k per bed *
North Central London	Chase Building, Chase Farm Hospital	2	2	N/A
North Central London	Highgate Mental Health Centre	0	4	£600k
North East London	City and Hackney Centre for Mental Health	1	2	£150k
North East London	Sunflowers Court, Good mayes Hospital	2	3	£150k
North West London	St. Charles	1	2	£150k
North West London	Riverside Centre, Hillingdon Hospital	2	3	£150k
South East London	Oxleas House	1	2	£150k
South East London	Southwark Place of Safety	4	5	£150k
South West London	Wandsworth Recovery	2	2	N/A
<b>Total (9 sites)</b>				<b>£1,500K</b>
NWL	Hammersmith and Fulham	1	1	N/A
NWL	Lakeside Mental Health Unit	1	2	£150k
NWL	Northwick Park	1	1	N/A
NEL	Newham	1	2	£150k
<b>Total (13 sites)</b>				<b>£1,800k</b>

\* Further analysis and refinement required with local estate teams during implementation planning, to identify actual capital requirements per site location

## 7.2 Implementation

### 7.2.1 Overview

This section discusses the steps that need to be taken in order to put in place the processes, workforce and facilities that can deliver London's s136 pathway and reconfigured HBPoS sites.

In order to deliver the strategic objectives set out in Section 3, a joined up approach to implementation will be required by all stakeholders across the pathway. Establishing a clear plan for implementation, together with appropriate governance structures is therefore critical to the success of the programme.

This section sets out the following important considerations for implementing the reconfigured HBPoS sites:

- Priorities for implementation;
- Options for implementation;
- Requirements pre-implementation;
- Governance;
- Benefits management; and
- Risks.

### 7.2.2 Priorities for implementation

The implementation of a material reconfiguration of any clinical service must be undertaken in a robust and sensitive manner. As such, a number of priorities/principles have been proposed that should be adhered to during the course of implementation, ensuring that the process meets its objectives.

- **Ensuring patient safety**

The consolidation of HBPoS sites across London inherently requires the closure of some existing sites as the reconfiguration is established. This must be undertaken in a manner which ensures patient safety throughout. Any decisions associated with implementation and transition should consider potential service impact and ensure that plans are put in place to transition in a safe manner. Further considerations as to how patient safety can be maintained during implementation are proposed later in this section.

- **Profiling of Implementation**

With respect towards the complexity and multi-stakeholder nature of the s136 pathway, careful consideration should be applied to the profiling of implementation. Shadow running of services is proposed to help mitigate the complexity of implementation, with further details around implementation options proposed later in this section.

- **Development of detailed implementation plans**

Following consideration of this business case, focus should be applied to the development of detailed implementation plans. It is proposed that these are established at an STP level. However, it is essential that key stakeholders, including the Police, Local Authorities and the LAS, are sufficiently involved in the development of these plans, clearly identifying any dependencies. Furthermore, due to the pan-London nature of the reconfiguration, pan-London oversight would be required.

- **Key protocols require ratification prior to go-live**

The specification detailed a standard of care, which the reconfiguration of HBPoS sites will help deliver. However, during the course of implementation, there is a need to ensure a number of pivotal protocols are established at the point of 'go-live'. Such consideration needs to be applied to:

- ▶ Site capacity breach – whilst the reconfiguration of HBPoS sites is proposed to better ensure that capacity can deal with peaks in demand, it should be acknowledged that there will be occasions where capacity is reached at a given site due to abnormal demand. The pan-London pathway (in addition to the NHSE (London) compact) outlines a clear escalation protocol that should be followed in these instances;
- ▶ Clarity over geographic working – the impact of consolidating HBPoS sites will mean that a number of arrangements for working will change. This includes the impact on AMHPs who may have to travel further to assess patients, there is a need to establish how resources can best be managed and funded within the system prior to go-live; and
- ▶ Financial impact – whilst the reconfiguration has very much been proposed to benefit the service user and the system as a whole, the complex multi-stakeholder and commissioning system at it stands may mean financial flows benefit some parts of the system more than others. The commissioning and payment flows will need to be adjusted to support implementation of this new model of care.

- **Continued stakeholder engagement**

Due to the multi-stakeholder nature of the reconfiguration, it is recommended that comprehensive stakeholder engagement is continued throughout implementation. This should ensure that appropriate forums are established to allow stakeholders including commissioners, providers, local authorities and service users to be provided with a platform to input into and refine plans as they develop.

- **Alignment with wider Crisis Care transformation**

Whilst the focus of consideration here is the reconfiguration of HBPoS sites to support implementation of the London s136 pathway, it should be acknowledged that this pathway is heavily intertwined with the broader crisis care system. The implementation of the pathway and reconfiguration of sites must be undertaken in synergy with changes across the broader crisis care system, ensuring that collaborative benefits are realised and that any system risks are mitigated.

- **Maintain clinical leadership**

The options appraisal process undertaken in support of the proposed reconfiguration has ensured firm clinical leadership throughout. This has helped evolve and refine the approach, ensuring that the preferred option has been shaped and approved by clinicians. Similarly, clinical leadership must play an integral role in the implementation of the reconfiguration.

### 7.2.3 Implementation approach

In transitioning to the new reconfiguration of HBPoS sites, it is proposed that there is a phased implementation across London. Sites within the preferred configuration would be geared up to deliver the proposed capacity and service before other sites are formally stood down. Key protocols can then be phased in, providing an opportunity for systems and resources to accommodate new ways of working, prior to formal go-live. The benefits of this approach are set out below, along with some risks, which would need to be managed.

The benefits of a phased implementation are:

- ✓ Implementation risk can be minimised through ensuring that existing infrastructure is not decommissioned before the reconfigured infrastructure is ready to accommodate new levels of service and new ways of working;
- ✓ In a multi-stakeholder implementation such as this, a phased implementation can effectively accommodate variance in readiness of stakeholders to change;
- ✓ The phased approach gives the flexibility to test processes and plans prior to formal go-live and provides a possibility to learn lessons from these experiences; and
- ✓ This flexible approach allows focus towards those areas/sites which require the most significant change as a result of the proposal.

The risks of a phased implementation are:

- ✗ A phased implementation is likely to incur higher cost of implementation, as there will be an element of dual running of resources during the phasing;
- ✗ The process of phasing will likely mean that the implementation process will be longer than other alternative models of implementation; and
- ✗ During the phased implementation, there is a risk that sufficient resources are not available consistently throughout the course of the process.

This approach should be tested and verified during implementation planning as more detail is developed. Particular attention may be required with regards to how cross boundary flows of activity are managed during a phased implementation approach.

## 7.2.4 Requirements pre-implementation

Consideration needs to be applied to the requirements prior to implementing the reconfiguration of HBPoS sites in London. These should be progressed post the submission of this business case.

It is acknowledged that each respective STP should confirm its willingness to embark upon the reconfiguration proposed within this business case, subject to more detailed implementation planning. The development of detailed implementation planning should be STP led but with full engagement and involvement from all key organisational stakeholders involved in the pathway, including relevant local authorities, Mental Health and Acute Trusts, the LAS and London's three police forces.

Whilst due care is required to ensure that the implementation occurs in an effective and safe manner, it is also acknowledged that there is an imperative to change the current s136 pathway across London. Focus should be applied to ensure that progress is made towards implementation at pace for the benefit of London's service users.

No definitive view is provided here as to when implementation can take place, as this is very much dependent on the individual STP's requirements and associated readiness for change. However, there are a number of considerations that play an integral part in the timeline towards implementation and these are summarised below:

- Detailed implementation planning – implementation plans need to be developed at an STP level. These will need to be overseen at a pan-London level to determine synergy and coordination between the various plans. These plans need to incorporate a range of activities, including estate development requirements, workforce impact assessments, communications, capability training, and plans to transition services;
- Public consultation – it is likely that some areas may be required to publically consult on plans prior to progressing towards implementation;
- Finance and funding approval – due consideration is required towards the requirements for funding to support both the transition and operating costs of the reconfigured sites. Whilst further details about the specific financial impact across all stakeholders is discussed in the Financial Case, the following principles should make up part of the implementation planning:
  - **Transition Costs** – one off transition costs are required to support the implementation activities of the reconfiguration. It is proposed that these are administered at an STP level. However, some resources will be required at an organisational level, especially with respect to resource costs associated with shadow operation of services during implementation;
  - **Capital Costs** – the development of enhanced HBPoS sites require capital expenditure to support both increased capacity as well as other refurbishments required to bring sites in line with the requirements of the specification. It is acknowledged that each STP and those Mental Health Trusts with a requirement to develop sites will be doing so from varied bases. Therefore, it is proposed, that as part of the STP led implementation planning, Mental Health Trusts, with the support

of their STPs, develop business cases that detail and substantiate capital requirements. This can be supported by the upcoming Department of Health 'beyond places of safety' capital funding process; and

- **Transformed Pathway Costs** – as detailed in the financial case, there may be some higher costs of operation for some stakeholders. These costs will need to be factored into revenue budgeting for the period post implementation.

## 7.2.5 Implementation governance

Transitioning to the new model of care is a complex task, which needs to be carefully managed across a range of stakeholders. To enable effective programme management, a governance structure is required which facilitates monitoring and decision making throughout the duration of the implementation.

Some of the key requirements and components for effective implementation programme management include:

- **Programme Management Office**

Implementation would be required to be led locally, within existing PMO structures at STP level. The PMO should be tasked with developing and administering the specific implementation plans, as well as maintaining project management assets. The pan-London oversight will continue to support local implementation, local PMOs should ensure a clear path of communication to the pan-London programme, thereby ensuring there is clarity over both local and pan-London progress.

- **RACI Matrix**

Due to the complexity of the stakeholder environment within which implementation will need to take place, it is proposed that a matrix, defining who should be responsible, accountable, consulted and informed should be established and effectively maintained.

- **Change Management**

The complexity of the programme within which there are key stakeholders with conflicting priorities, a clear protocol, defining robust escalation policies should be established for tracking and enforcing programme change. These protocols and enforcing programme change should be co-produced with the local governance structures including key stakeholders from across the pathway.

- **Communications Plan**

Since the programme of change involves multiple stakeholders, a detailed system and public communication plan must be created to ensure all parties are informed of critical decision making. A dedicated team should be in place to communicate relevant information to all stakeholders to ensure stakeholders are sign-posted of relevant information.

- **Risk Management Framework**

With any programme of change of such scale, a dedicated resource and frame work, focused on proactive risk identification, management and mitigation, is required. It is not enough to identify the risks, but equally important to facilitate mitigation strategies to resolve any issues that might arise.

- **Project Performance Reporting**

Given the complexity of the programme within which there are multiple stakeholders, a clear reporting mechanism, with clear content for the audience is required. The reporting mechanism should be streamlined, with key performance indicators and rhetoric's tested with stakeholders before distribution.

- **Off Target Delivery Mechanism**

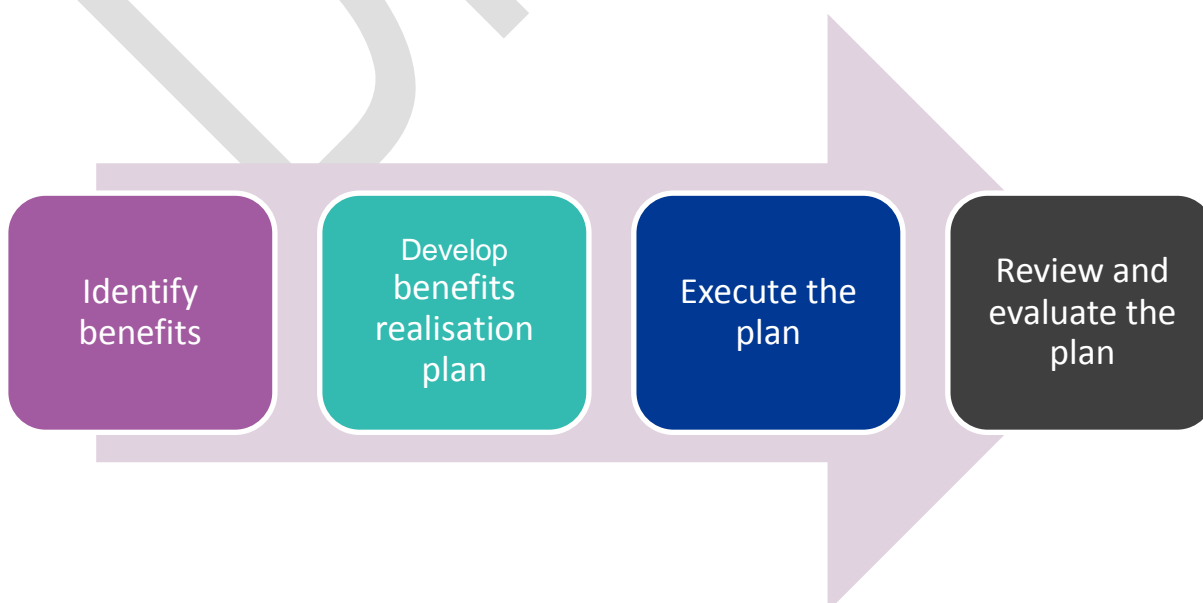
No matter the amount of planning, there are likely to be unseen obstacles that will risk the delivery of this programme. In such instances, an agreed protocol to mitigate off target delivery should be in place. This should be agreed and tested with local governance structures and clear escalation procedures should be in place when such protocols are to be enforced.

## 7.2.6 Benefits management

Benefits management allows a structured approach towards achieving outcomes as a result of change, and involves identifying, planning, measuring and tracking benefits from the start of the programme until realisation of the final desired objective.

A clear approach toward benefits realisation will help ensure maximum value is driven from implementing the s136 pathway and should be incorporated into further work undertaken towards implementation. A proposed summary of the benefits management approach is provided in figure 34 below.

**Figure 35: Benefits management approach**



**Identify Benefits** – the identification of benefits should draw from those proposed in the Economic Case. A means through which these can be appraised and measured should be established. The degree to which various stakeholders are able to influence and drive these benefits should also be established across the system.

**Develop benefits realisation plan** – having determined where influence and accountability lies for the various benefits, detailed planning should establish milestones and schedules for these benefits that considers the dependencies on the achievement of these benefits. This plan should be agile and should evolve as implementation progresses.

**Execute the plan** – the benefits realisation plan should be executed, with management of the plan being led by the implementation PMO and subsequently transferred into the post-implementation governance framework.

**Review and evaluate the plan** – at a reasonable point, it is considered good practice to review the progress made against the plan and share achievements as well as lessons learnt. It is recommended that this is undertaken as part of the post-implementation governance framework.

## 7.2.7 Risks and mitigations

Effective risk management is an integral element of the programme to implement the s136 pathway and reconfigure HBPoS sites. This will help to mitigate against any potential internal or external threats to successful delivery of the strategic objectives.

### Identifying risks

Risks should be identified at both a local and system wide level, effectively logged and discussed as part of a standing agenda item during implementation and post-implementation governance forums.

### Monitoring and reporting

A standardised risk register should be utilised to monitor and report risks. This should effectively track the probability and impact of risks both pre and post mitigation as well as identifying a risk owner.

The risk assessment utilises a four tiered matrix assessing likelihood and impact of any proposed risk, as follows:

#### Likelihood

1. Low – the event is highly unlikely to occur
2. Medium – the event is likely to occur
3. High – the event is highly likely to occur
4. Very High – the event is almost certain to occur

#### Impact

1. Low – the event will have minimal impact on the programme's plans or objectives

2. Medium – the event will have a reasonable impact on the programme’s plans or objectives
3. High – the event will have a large impact on the programme’s plans or objectives
4. Very high – the event will have a catastrophic impact on the programme’s plans or objectives

Consideration of risks have been summarised in Table 55.

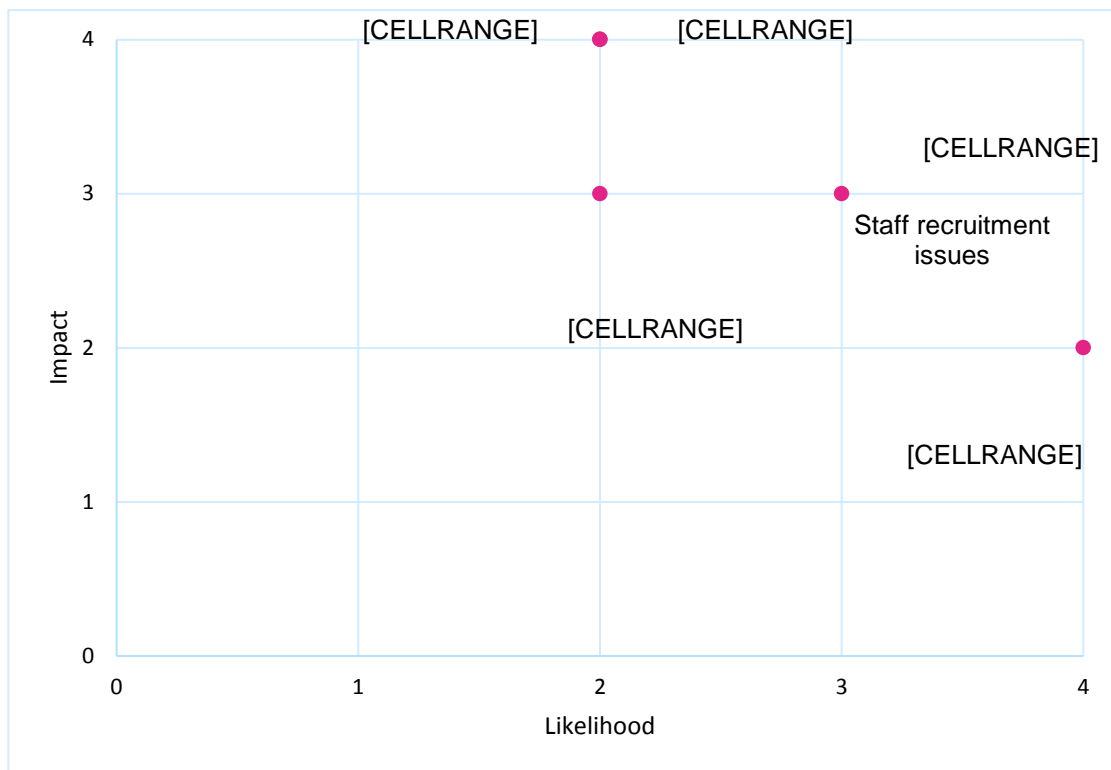
**Table 55: Implementation risks**

Ref	Risk	Likelihood	Impact	Rating	Mitigation
1	<b>Diversion from implementation plan</b>  The required implementation is a complex multi-stakeholder undertaking and milestones or timelines may be missed.	3	3	9	A detailed implementation plan needs to be shared and signed up to by all responsible stakeholders. Furthermore, a clear off-target delivery plan needs to be established to provide clear direction as to how stakeholders should react should a milestone is missed, thereby minimising the impact on overall programme objectives.
2	<b>Lack of buy-in, scepticism and resistance to change</b>  The required implementation of consolidated HBPOs sites will likely be a long process and therefore a degree of change fatigue is likely. Furthermore, challenges are likely to emerge which may lead to change resistance.	4	2	8	Engagement should be monitored throughout implementation in the form of surveys to track any degree of change fatigue and/or resistance. The overarching vision of what is attempting to be achieved should also be at the forefront of any work associated with the change.
3	<b>Impact on broader health and crisis care services</b>  A number of the proposed benefits rely on broader care services to be achievable. A number of the benefits may not be realised if broader resources are not sufficiently prepared to support this change.	2	3	6	As part of implementation planning, it is recommended that readiness checks are undertaken across all services that may be impacted by the proposed change. These include LAS, Emergency Departments AMHP services and mental health inpatient wards.

4	<b>The requirement for formal new ways of working</b>  The consolidation will require a number of new ways of working which will require formal agreement prior to implementation. Should these new ways of working not be established it may result in benefits not being effectively realised or service quality issues emerging.	2	4	8	Clarity over the protocols and processes that require new ways of working should be established and stakeholders required to come to agreement identified. Formal agreement should be seen as a key dependency prior to go-live.
5	<b>Availability of funds</b>  This proposal is reliant on capital investment which will enable sufficient capacity at each of the selected HBPoS sites. However, there is a risk that funds may not be made available for one or more of London's STPs	2	4	8	Sufficient engagement across partners to ensure sufficient funding is allocated to the model and clarity over the expected benefits and any cost savings from implementation of the new model.
6	<b>Staff recruitment issues</b>  Given the scale of recruitment that may be required in the consolidated model, it may be challenging to attract and retain staff during the implementation period.	3	3	9	In line with national priorities, funding needs to be made available to recruit staff for mental health services. Staff engagement and recruitment plan to be developed.

Figure 35 below illustrates these primary risks based on the ratings in the table above.

**Figure 35: Implementation risks**



## 7.3 Post implementation

### 7.3.1 Overview

During the planning and implementation stages for the reconfiguration of HBPoS sites, it is necessary to consider the future governance model to ensure that the appropriate structures and decision making units are established and maintained. In addition, a post programme evaluation should be carried out to ensure that objectives are delivered and lessons are learned for service transformation and investments.

### 7.3.2 Post implementation governance

The future governance of the pan-London s136 model of care should draw from existing governance and best practice principles from other health services. Such governance should be embedded within broader crisis care governance arrangements to enable system wide oversight. Whilst it is noted that London's Urgent and Emergency Care (UEC) Networks are established in different forms across London, it is proposed that they have collective oversight for the equitable provision of care across this pathway.

#### Principles for governance

Decisions for the programme following implementation should be driven through business as usual commissioning arrangements wherever possible, and should be built on the current arrangements to manage this process.

The proposed principles for governance should include:

- Sufficient representation from the breadth of stakeholders involved in the s136 pathway;
- Effective alignment with broader crisis care governance arrangements;
- A balance of pan-London system oversight with focused local decision making;
- Clear lines of accountability and escalation; and
- A decision making framework effectively supplied with accurate, relevant and timely data.

#### Proposed governance – multi-agency group

A local multi-agency group led by the provider trust providing the HBPoS site should exist and should be overseen by the respective UEC network. Each group should be positioned within the local governance system and have appropriate representation to ensure that there is adequate oversight and accountability.

The multi-agency group must be attended by senior representatives from the HBPoS, local Emergency Departments, other Mental Health Trusts in the STP, AMHPs, the Police, LAS and Healthwatch (or other patient representatives). The group should ensure membership represents all ages.

The group should perform the following roles:

- Measure and analyse current performance at the HBPoS;
- The continuation of the implementation benefits realisation process, ensuring that activities are focused on achieving the proposed benefits of reconfiguration;

- Understand the contact those detained under s136 have had with mental health services previously and what alternative pathways or interventions could have been applied to prevent the use of s136;
- Discuss specific case studies where issues have occurred across the pathway to ensure learning across the system from these specific cases;
- Facilitate training initiatives on local policies and protocols which include key partners and local Acute trusts;
- Network with other local multiagency groups across London to ensure consistency of service across the s136 pathway; and
- Ensure the Directory of Services is regularly updated showing the accurate up-to-date information regarding the HBPoS.
- Furthermore, the requirement for pan-London oversight is necessary and will be supported through the implementation of the NHSE (London region) compact.

### 7.3.3 Governance benefits

Significant benefits may be derived through the establishment of an effective post-implementation s136/HBPoS governance framework. A number of the issues identified in the implementation process could be mitigated through the establishment of such a framework. Such benefits include:

- Effective asset utilisation – ensuring that London's resources and infrastructure are utilised in the most effective manner possible in the provision of care;
- Consistency of service – facilitating a consistently high quality service for those detained under s136, regardless of where that service is being delivered in London;
- Proactive risk mitigation – ensuring that data is effectively utilised to support the analysis of trends and activity to allow the system to proactively mitigate risks; and
- Driving best practice – using the framework to identify best practice and drive such performance across London.

### 7.3.4 Post programme evaluation

It is recommended that post implementation, an evaluation is undertaken to determine how effectively the programme has achieved its objectives. This should consider the original objectives of the HBPoS consolidation and the primary issues that the programme was intended to address. Evaluation requires measurable outcomes that can be compared against benchmarks that are distilled from the original objectives. It is therefore proposed that an evaluation framework is developed around the objectives below and is utilised to evaluate programme performance.

*Objective 1: Enable the improvement in patient outcomes and experience*

Has the programme improved patient outcomes and experience for those detained under s136? Consideration should be applied to the degree to which the consolidation has impacted patient outcomes and experience and whether these have been in anyway negatively impacted during implementation.

*Objective 2: Facilitate access to 24/7 services*

Has the programme facilitated access to 24/7 services consistently across London and in manner which has long term viability from a financial and workforce perspective?

*Objective 3: Concentrate staff expertise to enable a service suitable to patient needs*

Has the programme established a concentration of staff expertise and can it be demonstrated that these capabilities are delivering the services that patients require?

*Objective 4: Deliver value for money*

Has the implementation and consolidation of sites utilised public funds in an efficient and effective manner? This should take account of both transitional costs, capital costs and business as usual direct and indirect operational costs.

*Objective 5: Ensure synergy with the wider crisis care system*

Can it be demonstrated that the programme and associated consolidation of sites has benefitted the wider crisis care system and moreover can it be demonstrated that the s136 pathway has derived benefit through greater synergies with the wider crisis care system?

In order to evaluate the impact of the programme at a pan-London level, appropriate key performance indicators (KPIs) would need to be established and agreed upon by stakeholders across all five London STPs, LAS and the Police.

Possible KPIs could include:

- Proportion of MHA assessments resulting in involuntary admission, voluntary admission and discharge with or without community follow-up;
- Occasions per month when capacity constraints resulted in ED admission;
- Number of closures of HBPoS sites per month;
- Number of sites with 24/7 staffing;
- Number of occasions per month when time from detention to admission to HBPoS exceeded x minutes; and
- Percentage of s136 patients attending ED for a physical health reason;
- Percentage of place of safety detention periods exceeding 24 hours, without valid clinical reason for extension.

## 8 Commercial case

This section sets out the commercial strategy for the consolidation of HBPoS sites. It considers how procurement and contract management will be managed for any capital investment requirements associated with the preferred option.

This chapter is structured as follows:

- Commercial strategy
- Synergy with wider crisis care system

**The new model of care and reconfiguring HBPoS sites across London is the most effective option to address current issues across the s136 pathway.**

The new model will bring sustainable improvements and lasting benefits for patients, whilst in the medium to long term resulting in a local health economy that is both clinically and financially sustainable, delivering improved access, with 24/7 services and patient improved outcomes and provision of care.

**The reconfiguration will present an opportunity for broader transformation of the crisis care system, including a range of services; a robust commercial process is therefore required.**

- ▶ **With the complex network of stakeholders** involved in the reconfiguration, oversight of the commercial process is critical to the success of the new model of care
- ▶ Whilst it is early in the process to establish the exact service requirements, the **expectation is that services will be required for construction, programme support/implementation, recruitment and training**
- ▶ A commercial strategy supporting the reconfiguration will be developed in conjunction with proposed transformation plans on a STP basis

## 8.1 Commercial strategy

### 8.1.1 Overview

This section sets out the initial plans for procuring and contracting services related to the implementation of the new model of care and HBPoS site reconfiguration. Specifically, it sets out how the transition programme and capital requirements can be delivered in a manner which is timely, cost effective and in accordance with NHS standards.

The requirement to develop a robust commercial strategy is particularly important for this project due to the breadth of stakeholders involved in the transformation to the new model of care. As noted in the management case, the implementation of the project will require coordination and leadership across London's STPs. Due to the complex network of stakeholders, oversight of the commercial and management processes will be critical to the success of the consolidation.

### 8.1.2 Required services

At this early stage in the transformation process, it is difficult to predict the level of services required to deliver a pan-London model of care. Nevertheless, we can expect that the NHS and local partners will need to go to market in order to deliver the capital requirements at the reduced number of sites. In addition, the regional NHS organisations and HLP will need to provide additional ad-hoc support and expertise to support local partners in the implementation phase of the programme. The expected services required at this stage are as follows:

- **Construction:** Where required, additional facilities at HBPoS sites will need to be constructed in order to manage increased capacity;
- **Commissioning:** The NHS and local partners will require support with tasks undertaken to prepare the new environment, including the buildings and equipment and all training, testing and orientation activities for staff;
- **Programme support:** This will be required to ensure that the consolidation is suitably funded, resourced and established in order to deliver the strategic objectives; and
- **Recruitment and training:** Development of recruitment and training plans that enables the workforce to deliver the new model of care.

In addition to these services, there will be a need to consider existing contracting arrangements and to recognise any implications for tariffs as a result of the proposal. With regard to the existing format of contractual arrangements, transformation of this nature provides an opportunity to review and refine commissioning frameworks, potentially exploring alternatives to arrangements such as block contracts.

### 8.1.3 Procurement strategy

The approach for procuring services for the consolidation of HBPoS sites need to ensure that the following objectives are met:

- **Deliver upon the end-user needs:** It is essential the end-user requirement is initially mapped with procurement aligned to users' need and thereby, ensuring the procurement delivers to the end-user specification;
- **Provide optimum value for money:** Qualified suppliers will be assessed on overall value for money. This will enable public money to be optimally spent to improve the quality and services purchased and help deliver more responsive, flexible and affordable services across London;
- **Be managed and governed in an open and transparent manner:** To be managed and governed in an open and transparent manner is a prerequisite for an effective procurement. As the foundation, it determines the ability to provide public services and foster competitiveness and fairness;
- **Consider the planning and timing of procurement:** Procurement planning is important, it helps to decide what to buy, when and from what sources. It also ensures that planners can estimate the time required to complete the procurement process and flush out the requirement to develop the technical specification or scope of requirement. Furthermore, it also helps assess the feasibility of combining or dividing procurement requirements into different contract packages;
- **Properly allocate and manage risk:** Project risks should be dealt with openly from the outset of the project and all stakeholders involved should be encouraged to take an active role in identifying, mitigating and apportioning risk to the party best suited to deal with it;
- **Ensure equality of access to qualified suppliers:** To implement the preferred option, contracts worth many millions of pounds will be required for buying goods and services. Therefore, the services provided should be geared to ensure equality of access to qualified suppliers. This will improve the overall value for money for the goods and services purchased, improve the quality and responsiveness of the services and help ensure the public money is not spent on practices which lead to unfair discrimination. This can be achieved by establishing mechanisms for monitoring contractor's adherence to equality standards approved by the board; and
- **Comply with applicable Government Guidelines and EU Procurement legislation:** Procurement for wider public sector bodies such as health and local government is subject to the public contract regulations. These rules include requirements such as advertising all public contracts below the EU thresholds. It is important that procurement complies with relevant government guidelines and EU procurement legislation where applicable.

## 8.2 Synergy with the wider crisis care system

### 8.2.1 Overview

The new model of care, consolidating HBPoS sites across London, presents an opportunity for broader transformation of the crisis care system. The s136 pathway does not operate in isolation and its effectiveness, patient outcomes and the demand placed upon it are dependent, and in turn impact on, on many other elements of the health and social care system.

A commercial strategy which supports site consolidation should be developed in conjunction with proposed transformation plans on a per STP basis. In particular, this should consider:

- **Joint investment** – the business case proposes the establishment of a ‘combined’ 9 site model, highlighting the potential for the development of broader plans that consider investment in crisis care centres. Such an approach is of great importance given the pressure to Emergency Departments and mental health inpatient provision. To resolve the issue of service demand pressures, it is critical to establish alternatives to Emergency Departments and inpatient admission through wider recovery-based models. An enhanced mental health pathway means Trusts have to review their existing services and care pathways, but it also requires additional investment in new and innovative services that will better support people in the community as alternatives to purchasing more acute beds. There are various innovative services that will better support the crisis care:
  - **Psychiatric Decision Unit:** These units provide interim mental health care and assessment for patients referred from within acute hospital liaison psychiatry services, crisis resolution home treatment teams (CRHTT) and from mental health street triage. They aim to prevent long waits in EDs and provide an alternative, calm and safe environment for patients who require a mental health assessment. The units provide a dedicated 24 hour service with the ability to assess patients for up to 72 hours (24 hours for those detained under s136) with the ultimate aim of supporting the patient back home with an enhanced community package of care and avoiding admission where possible.
  - **Integrated out-of-hours hub/ Street triage:** The principle of these services is to undertake informed needs-led assessments that enable more people in crisis to be supported in community settings. Traditionally, this is particularly challenging outside of normal working hours, when Crisis and Home Treatment Teams often do not have the capacity to assess in people in their home environment. When assessments take place in Emergency Departments often clinicians are left with limited choices, typically to either to send the person home or to admit them. This is not offering the best quality experience to the service user and furthermore admissions add additional cost pressures to the system. Investment in integrated out-of-hour/ street triage services is therefore important for the combined model to be effective and for consistent service provision across London.
- **Shared infrastructure** – Whilst analysis has been undertaken which aims to minimise, where possible, the capital investment needed to support the consolidation, consideration should still be given to where the requirements can be served by existing

infrastructure. Similarly, to achieve greater value for money, where infrastructure investment can be undertaken that can be utilised across a greater array of services, this should be prioritised. An example of this could be a shared model of transportation for mental health patients, where a service for only those who have been detained under s136 would not be feasible. The aim would be to provide eligible patients with safe, timely and comfortable NHS funded transport, for example through transport to, from and between healthcare services and transport to place of residence after inpatient or HBPoS admission.

- **System wide data analysis** – the standardisation of the s136 pathway will provide a foundation for more effective data analysis. The approach needed would be to establish across the crisis care system consistent data capture mechanisms, system requirements, data flow information governance and shared KPIs. A patient level, outcome based data set which delivers robust, comprehensive, regionally consistent and comparable information for children, young people and adults who are in contact with Mental Health Services would also be required. It may also be possible to use clinical and operational data for purposes other than direct patient care. Although there is data available in MHSDS which brings together key information from adult and children's mental health, learning disabilities, autism spectrum disorder, CYP-IAPT and the early intervention care pathway, there are gaps still gaps in the dataset, such as the absence of detailed breakdown of s136 care pathway.
- **Working with non-NHS partners** - Police, local authorities and the voluntary sector all have important roles across the crisis care pathway and opportunities should be sought to work in partnership with non-NHS partners to improve the experience and outcomes of crisis care patients. One particular partnership that demonstrates the potential impact of developing relationships and joint services is the Serenity Integrated Mentoring High Intensity Network Model. This model sees mental health nurses work with Police officers to provide mentoring model based support those who are at high risk of frequent s136 detentions. Implementation of this programme on the Isle of Wight has led to a significant reduction in s136 detentions and there are currently plans for implementation across London.

## 9 Workforce case

This section highlights the existing workforce issues in the crisis care system and describes how these will be addressed by the reconfiguration of HBPoS sites. It discusses the workforce model that will be implemented as part of the preferred option and outlines the potential impact on key stakeholders.

This chapter is structured as follows:

- Current staffing arrangements
- Future staffing arrangements

Very few London HBPoS sites have dedicated trained staff and staffing levels are minimal out of hours; this is despite over 75% of s136 detentions occurring outside of regular working hours. Key components of the workforce model are:

- ▶ **Providing adequate, dedicated staffing 24/7 teams that are suitably skilled in both mental and physical health** at all HBPoS sites is expected to significantly improve patient experience and outcomes, staff experience and reduce cost pressures currently experienced from having to pull staff of inpatient wards.
- ▶ **Two dedicated specialty workforce models have been proposed: a combined staffing model** where the HBPoS is co-located with a crisis assessment unit or Psychiatric Decision Unit (as seen at South West London St. Georges Mental Health Trust), and a **stand-alone workforce model** (as seen at SLAM)
- ▶ **Three possible options have been identified to deliver AMHP services** following the reconfiguration of sites learning from different models across London; however, a more rigorous assessment is required to ensure challenges encountered by AMHPs are addressed and an efficient model is created.
- ▶ Greater transparency is needed to ensure **appropriate training standards have been met in relation to independent s12 doctors** and improved payment and administration protocols.
- ▶ The future operating model is expected to **minimise the number of ED presentations** due to capacity issues and improved physical healthcare provision in the HBPoS sites, both of which will reduce the strain currently experienced by London's Emergency Departments.
- ▶ **Development of a clear strategic direction and purpose** will facilitate transformation of the workforce model as well as a robust workforce strategy that includes staff engagement throughout implementation, robust workforce planning including network approaches across STPs, values based management and leadership and consistent London standards.

## 9.1 Current staffing arrangements

### 9.1.1 Overview

The s136 pathway is complex in nature, engaging multiple stakeholders across the health and social care system and beyond. As a result, a variety of public service staff will be impacted by the new model of care and HBPoS reconfiguration.

For many of those detained under s136, an HBPoS site will be their first experience of a mental health facility. Even for individuals who have used mental health services for some time, by the very nature of being detained under s136, the person is likely to be in acute distress. It is important, therefore, that the person's experience at the HBPoS is welcoming and caring.

While the infrastructure and operations along the s136 pathway are important factors in ensuring high quality of care, the mental health services provided are ultimately an interaction between people. For that reason, the proposed workforce at an HBPoS site is a critical consideration.

This section outlines the existing staffing arrangements along the s136 pathway. It discusses the issues with the workforce model and its implications for patients, staff and the wider system.

### 9.1.2 Conveyance staff

At present, there are a number of issues faced by the staff responsible for conveying those detained under s136 to an HBPoS site. These can be categorised into two broad areas:

- Delays in accessing HBPoS facilities; and
- The interface between conveyance staff and the NHS secondary care trust staff.

#### Delays in accessing HBPoS facilities

Box 10 provides an example from the MET escalation log which illustrates the type of delays which police face in the s136 pathway.

#### Box 10: HBPoS access issues

“Subject was arrested 0725 hours and taken to ED as she is 9 weeks pregnant and has attempted suicide by tying something round her neck. She has been medically cleared at 1230 hours and arrived at custody 1243 hours. Assessment has taken place 0126 on 7th March and an unacceptable delay on finding a bed has occurred, 1325 hours escalation has been sent to Central Mental Health Team. informed me that a bed had been located. However due to long wait subject has become suicidal and started to pull out her hair and has been taken back to ED.”

Instances where a patient is waiting in the back of a police van or ambulance due to unavailability of beds are not an uncommon in the current model.

## Interface between the conveyances staff and the NHS staff within EDs and Mental Health Trusts

The interface between the conveyance staff (police and LAS) and the NHS staff within EDs and Mental Health Trusts has also proved to be a challenge in the past. There are multiple instances where communication has broken down due to unclear standard operating procedures, lack of understanding of roles and responsibilities for each party and unclear escalation procedures. This leads, in some cases, to the conveyance staff taking patients to the closest ED as a default, even in the absence of any physical health concerns.

### Box 11: Staff communication issues

“There was no s136 suite available across [the HBPoS] or neighbouring Trusts. After 2 hours in the van and no sign of an s136 suite becoming available, the subject was taken to custody suite”

“Police detain the male under S136 MHA and attend ED for physical health clearance. Officers are told by a nurse that there is a bed at [HBPoS] reserved for him. Officers attend the HBPoS with the male but are met by a nurse who states that there are no beds available”

### 9.1.3 HBPoS staffing

At present, staffing arrangements across London's HBPoS sites vary significantly. In particular, two issues have been identified in London's HBPoS workforce model:

- Non-dedicated staffing; and
- Variability in the s136 experience levels and skills of the HBPoS staff across London.

Both of these issues can have harmful impacts on patients and other stakeholders within the mental health care system and are discussed in turn below.

#### Non-dedicated staffing

At present, there are no dedicated staff at the majority of London's HBPoS sites other than a staff coordinator. The clinical staff who are called upon to assess patients, work within a rota system during normal office hours, with the majority of the staff being pulled from wards.

This lack of immediate availability can have significant consequences in terms of access to care, waiting times and the length of stay at the HBPoS. For example, a lack of dedicated staffing may mean that the doctor making the initial assessment is delayed due to responsibilities elsewhere, or patients may be required to wait in ambulances or police cars for staff to be sourced from other wards to staff the site. A reduction of staffing in other areas of the trust could reduce the level of care on those clinical areas affected.

When health based places of safety are unavailable due to staffing shortages, the police need to wait until one becomes available or take the person to an ED. Each of these responses is unacceptable as they result in the patient being detained in an environment which is highly unsuitable for their needs during a time of acute crisis.

For each individual detained under s136, the goal is to have a mental health assessment concluded as quickly as is practicable, in order to minimise delays in the initiation of a care or treatment plan. There are often clinical reasons why this cannot be achieved, such as the complexity of individual's clinical presentation, intoxication or language barriers. However, the availability of staff is a major factor increasing the length of stay in some cases.

### Variability in staffing levels & skill-mix

Depending upon the clinical presentation of s136 patients, support staff may be required from other wards. However, at times when wards are very busy it may not always be possible for the appropriately skilled staff member to be released in a timely manner to provide a service at the place of safety. As a result, patients may receive differing levels of service and quality depending on factors which are outside of the HBPoS site's control, such as the timing of detention and the activity of the inpatient wards. In particular, there may not be staff available who have the physical health competencies to provide holistic care and avoid unnecessary transfers to EDs.

In addition, a number of issues with staff training at HBPoS sites have been identified by the Care Quality Commission. For example, a third of nursing and medical staff interviewed in England received training 'on the job' rather than before they started working at the HBPoS. As a result, patients may be seen by staff who are not suitably trained.

#### Box 12: Benefits of a dedicated team

"[Before the centralised site] you'd go there on a rota, and you'd literally just sit there. Sometimes you'd have two external staff plus the coordinator doing the admin stuff, and rarely you'd see them actually interacting with the patients, they were more like bodyguards. But now you've got more consistency – staff used to be changing every hour, a new face every hour – but now, they've got a whole ward and we're there for the whole shift and they have an allocated nurse who's always available to speak to them."

**HBPoS Nurse, SLAM 2017**

### 9.1.4 AMHP services

AMHPs are responsible for organising and co-ordinating Mental Health Act assessments for individuals detained under s136.

When medical recommendations are made to admit the patient to hospital under a section of the Mental Health Act, the AMHP must decide whether to make an application for the patient to be detained. This involves a consideration of the individual's social circumstances and a liaison with the patient's family and 'nearest relative'.

Crucially, AMHPs apply the 'least restrictive alternative' in deciding whether or not to proceed with an application under the Act. This means that the AMHP should have knowledge of local available resources which could possibly be deployed to avoid a compulsory admission to hospital.

The current AMHP arrangements across London's boroughs are varied, as each borough has its own AMHP duty service in their respective local authority area.

**Out of hours AMHP availability:** The office hours are 9 to 5pm, Monday to Friday. Outside of these hours during weekdays and weekends, requests for Mental Health Act assessments are sometimes dealt with by the Emergency Duty team (EDT)<sup>92</sup>. They are often staffed by one EDT social worker (usually an AMHP) but do not have capacity to travel outside of their own borough area to respond to Mental Health Act assessments out of their borough boundary.

#### Box 13: Lack of out of hour AMHP resource

Arrived in custody at 0600 and placed on constant watch and AMHP services called. AMHP states that it will be passed to day shift. Chased later and no AMHP on route.

**Issue with out-of-borough protocols:** There is a current protocol in place across the AMHP services which states that assessments on patients who present in their local authority area will be assessed by that AMHP duty team on behalf of the local authority. For patients who are assessed under s136 and then further detained on a section 2, the 'host' duty AMHP will do the section 2 assessment on behalf of the other local authority. However, if a section 3 is indicated, the 'host' AMHP will not do the assessment as the home borough will retain aftercare responsibility under section 117. The AMHP from the home borough is then required to travel to do the section 3 assessment, which can cause a significant increase in the patients' length of stay.<sup>93</sup>

### 9.1.5 S12 doctor

The use of an s12 doctor is integral to the s136 pathway. The independent s12 doctor provides an independent judgement alongside the AMHP to evaluate if the person detained requires an admission to an inpatient ward. With such a critical role, there are no standardised processes for recruiting or supervising s12 doctors and there are issues of availability. In addition, there can be significant difficulties associated with the administration requirements related to s12 doctors. Invoices are usually paper-based and directed to the service lines, while claims are made in bulk. Furthermore, as illustrated in Box 14 below, there are observed inconsistencies in payment protocols for the s12 doctor when patients are out-of-borough. Variability in s12 doctor skills and expertise has been expressed; this is despite applications for s12 approval in the London region being overseen by one approval panel<sup>94</sup>.

#### Box 14: Unclear s12 payment protocols

Resident of [X] but in [Y] custody. Delay in doing assessment as X refused to pay and s12 Doctors not prepared to come out until a trust agrees who is paying for the assessment.

Potential delays to s12 doctor services adds to the existing supply side issues in providing staff to care for those detained under s136.

<sup>92</sup> EDTs are not mental health specific services and provide a generic emergency response for the local authority covering children's and adult services which include: older people, learning and physical disability and mental health services.

<sup>93</sup> This is a generalisation and this protocol changes for each STP.

<sup>94</sup> London Region approval panel Section 12(2) Mental Health Act 1983. Royal College of Psychiatrists. Available at: <http://www.rcpsych.ac.uk/workinpsychiatry/divisions/london/resources/section12.aspx>

### 9.1.6 Emergency Department staff

Under current protocols, EDs are used when a patient is in need of physical care. However, in addition to these ED attendances, patients are also being transferred to the ED due to lack of capacity at HBPoS sites.

Each presentation to the Emergency Department for a non-clinically appropriate reason puts unnecessary additional strain on the department. In addition, a number of operational inefficiencies can add to the burden:

- A lack of knowledge of roles and responsibilities within the pathway and understanding of the Mental Health Act and Capacity Act means care is variable and disagreements can occur between all professionals in the pathway;
- Difficulties in managing s136 patients in the department whilst the department is full, leading to stress on staff and other patients;
- The transfer of physical health care documentation from Emergency Departments to mental health trusts is not standardised; and
- The responsibility for deciding on whether there are safeguarding concerns is often unclear.

## 9.2 Future staffing arrangements

### 9.2.1 Overview

The reconfiguration of HBPoS sites from the current model to the consolidated model will coincide with a transformation of the workforce delivering mental health services along the s136 pathway. Under the new model, 24/7 specialist services will be concentrated at the HBPoS sites. To ensure the best possible outcomes at these centres, an appropriate workforce model will be required which organises staff and establishes work practices according to patients' needs.

To facilitate this transformation of the workforce model, it's important to develop:

- Clear strategic direction and purpose so that staff at all levels understand their role in helping those during a mental health crisis;
- Genuine staff engagement and involvement in all aspects of the pathway, ensuring that staff members are listened to and feel involved in transforming and innovating their area of work for the benefit of patients;
- Improved planning of staffing requirements to ensure that the trusts attract, recruit and retain the appropriate number of staff to meet future needs;
- Good values based on management and leadership – this involves recognition and appreciation for a job well done, with everyone feeling valued for their contribution; and
- Improved approaches to communication to ensure that information can be exchanged more easily across the wide range of stakeholders in the system.

There are a number of guiding principles at the heart of ensuring that staff are recognised, involved and engaged in order to deliver the best service to those in need. These principles of patient centred care include:

- Delivering robust services that provide the best possible experiences for patients, their families and carers;
- Supporting staff to raise concerns that they may have regarding poor care, safety concerns and morale;
- Developing workforce to realise their full potential through the provision of learning opportunities for staff at every level and suitable clinical supervision;
- Understanding the work performed by staff so that high quality and safe care are consistently provided to patients; and
- Always seeking to support staff health and wellbeing.

Noting the above principles, according to the s136 specification document, there are key criteria that the future workforce model needs to meet. A number of key points related to the proposed workforce model are:

- Every Health Based Place of Safety should have a designated s136 coordinator available 24/7, who is assigned to the site at all times and is the most senior person in the Health Based Place of Safety team at any one time (recommended no less than a Band 6 nurse);
- Sufficient staff should be trained in this role to ensure reliable availability, with contingency in place for accommodating sickness and annual leave; and
- Dedicated staff must be available 24/7 to ensure staff members do not come off inpatient wards. Similarly, if the Health Based Place of Safety is co-located with an Emergency Department there must be adequate staff available to ensure that the unit does not have to rely on members of the liaison psychiatry team to fulfil this role in addition to other demands. The dedicated staff group should be developed to form a specialist team providing speedy and expert assessment of those detained under section 136.

The remainder of this section outlines the proposed staffing arrangements under the new model along the steps of the s136 pathway.

### 9.2.2 Conveyance Staff

Through improving the capacity at each individual site within the consolidated model, and a decreased need for site closure due to staffing issues, the number of incidents where further conveyance is required due to arrival at a site which is at capacity, will decrease. In addition, standardised procedures, for example clarification regarding responsibility for locating capacity at other HBPoS sites, are aimed at reducing variation along the pathway will help conveyance staff to navigate the mental health crisis care system.

Both of these improvements, together with improved administration and communication protocols, will enable both police and LAS staff to convey the patient to the right setting first time, every time. LAS paramedics are vitally important at the conveyance stage in order to make an initial physical health assessment that allows the correct decision to be made regarding the appropriate place of care (ED vs. HBPoS). Conveyance in an ambulance, as opposed to a police care is also important for patient dignity.

### 9.2.3 HBPoS staff

To support this specification, two staffing models have been considered during the options appraisal process:

- Stand Alone model (as seen at South London and Maudsley Mental Health Trust)
- Combined model model with HBPoS and PDU (e.g. Psychiatric Decision Unit, seen at South West London St. Georges Mental Health Trust)

In both models, the creation of a dedicated team of staff is expected to have significant benefits through addressing some of the challenges related to access and care quality:

- Allows relationships to be built between team members, and with other professionals in the s136 pathway including LAS, police, ED staff and AMHPs; improved collaboration will benefit patient care and staff wellbeing.

- Staff are no longer brought from other clinical areas to staff the unit: this reduces delays in accepting patients and prevents impacts of reduced staff numbers being felt on staff and patients in other clinical areas.
- A dedicated team can undergo specific training to develop specialised skills in the care of s136 patients. This benefits both staff development and patient care.
- The dedicated team can also be trained in physical health competencies that can provide patients with more holistic care, improve identification of non-psychiatry presentations and reduce the need for transfer to ED for minor physical health needs or 'medical clearance'.
- Through the benefits above, working as part of an HBPoS team becomes an attractive career option for clinicians, thereby promoting recruitment and retention.

Overall, the introduction of dedicated 24/7 staffing as part of the reconfiguration of the HBPoS sites will facilitate improved quality of assessments and resulting patient outcomes. The dedicated team will be able to work more closely with patients to understand their needs and identify the best course of action, with any plans developed handed over to the next team member on shift.

At SLAM's centralised place of safety, which has piloted the new s136 model of care for London, the rate of admission has fallen by 13% following implementation of the new model. This has been attributed in large part to improved practice following the introduction of the dedicated staff team, together with a close working with the Trust's Acute Referral Centre. A further important impact of dedicated staffing is that on downstream inpatient wards. When staff are brought in from other areas to staff the s136 suite, a reduction in staff in those clinical areas will impact on quality of care for patients there, which will likely effect patient experience and outcomes.

### Standalone model

Each HBPoS in the new configuration will have sufficient demand to require a dedicated staff team:

- The facilities will have a designated consultant psychiatrist with overall responsibility for the service provision;
- A specialty doctor will be on duty Monday to Friday and will carry out mental health assessments to all patients presenting to the suite. This will include making the first medical recommendation for those considered to require detention under the Mental Health Act;
- New out of hours medical staffing rotas are being developed to ensure that the health based places of safety have speedy access to both junior and senior medical staff; and
- There will be a resident junior doctor on site, out of hours, to ensure all immediate medical needs are addressed.

### South London and Maudsley (SLAM)

This is an example of the standalone model. The South London and Maudsley (SLAM) HBPoS site based at the Maudsley hospital has a total of six assessment rooms, four of which are

consistently staffed. The remaining two rooms are designed to the ‘seclusion’ standard, which enables staff to cope with individuals who are the most unwell and display very challenging behaviour. The police have direct access to the seclusion area to avoid the individual having to go through the main entrance of the site.

One room has an adjacent sitting room area which can be separated from the remainder of the unit. This is suitable for CYP or others who may have family members in attendance. Note that this site is available for all ages detained under s136.

There is an s136 rota which includes a Specialty Doctor or consultant who carries out the first mental health assessment when the individual arrives. Where a second doctor is required for Mental Health Act assessment purposes, this is provided by an independent s12 doctor on the approved list of medical staff.

The s136 rota includes both qualified staff and health care assistants; all staff allocated to the HBPoS are dedicated to s136 patients. The team includes:

- Team leader – Band 7 x 1
- Charge Nurses – Band 6 x 6
- Staff Nurses – Band 5 x 12
- Health Care Assistants – Band 3 x 11
- Specialty Doctor – 1
- Administrator / PA – Band 4 x 1

This staffing establishment will provide for 5 staff to be on duty on each shift on a 24/7 basis for a 4 unit suite. This allows the unit to better manage peaks and troughs in activity. Furthermore, the experience from SLAM’s centralised place of safety illustrates that quieter periods give time for on-site training and for adequate breaks and reflection in what is on other occasions a high intensity environment; this has a positive impact on staff wellbeing and contributes to high retention rates.

#### **Box 15: Feedback on benefits of a dedicated staff team**

“Having dedicated staff which aren’t taken from other teams allows a more cohesive environment which is more able to address patient needs in a more proactive way.”

**ST7 Registrar, 2017 SLAM Centralised Place of Safety**

#### **Combined model (PDU and HBPoS)**

The concept of the combined unit is to have an assessment unit and section 136 suite co-located, this enables, a joint workforce that can flex between the assessment unit and the section 136 suite, and in-depth assessment and treatment for patients who would otherwise have been admitted to acute wards.

The service recognises that informed decisions on whether hospital admission may be required are often affected by the circumstances of the assessment. The combined unit/workforce offers

a safe and stable environment through which an informed assessment can take place, and where appropriate arrangements can be set up following assessment.

### *South West London St. Georges (SWLSTGs)*

An example of the combined model is the Psychiatric Decision Unit (PDU) model based in SWLSTGs. The PDU is an integrated assessment suite that encompasses the HBPoS site and provides interim mental health care and assessment for patients referred from liaison psychiatry services in Emergency Departments, crisis home treatments teams and the mental health street triage teams in partnership with the police and ambulance services. The SWL CCGs supported the proposal to develop this Psychiatric Decision Unit, which is based on a model in Birmingham.

When the individual arrives at the PDU they are immediately seen by the nurse to discuss the nature of the crisis and what the best options may be. The time and space that the assessment suite offers gives patients time to think through the immediate crisis and the sort of help they need to recover, both over the short and longer term. It also gives staff time to carry out an informed assessment, create a collaborative, tailored treatment plan and make appropriate arrangements for on-going support in the community where feasible. The assessment suite is not a ward and does not have beds.

The HBPoS adjoins the PDU and the staffing model covers both services. The PDU has capacity for five service users whilst the HBPoS has capacity for two individuals detained under s136. When there are instances where the HBPoS is at maximum capacity and others are waiting to be seen, the PDU can act as a step down area for low to moderate risk service users.

This service has the core aims of:

- Reducing demand on Emergency Departments by transferring people in mental health crisis to an appropriate mental health assessment unit;
- Reducing protracted waits in ED/Emergency assessment units for beds when not immediately available; and
- Offering an enhanced period of assessment and reducing unnecessary admissions giving a better outcome to the service user and keeping expensive acute beds only for those who are most in need.

### **Safe staffing levels for sites under the preferred option**

Table 56 outlines the workforce requirements in order to provide safe staffing levels given various levels of capacity at HBPoS sites across London. This only includes staffing for the s136 suite and excludes the wrap around services. However, it is assumed that the s136 staff when not utilised in the suites can be deployed flexibly to other crisis care services.

**Table 56: Safe level staffing by capacity level**

Capacity	1	2	3	4	5	6
	WTE					
Speciality Doctor Grade	1.0	1.0	1.0	1.0	1.0	1.0
Consultant's Post	0.5	0.5	0.5	0.6	0.7	0.7
Nursing Band 03	3.0	6.0	9.0	12.0	15.0	18.0
Nursing Band 05	3.0	6.0	9.0	12.0	15.0	18.0
Nursing Band 06	1.5	3.0	4.5	6.0	7.5	9.0
Nursing Band 07	1.0	1.0	1.0	1.0	1.0	1.0
Admin & Clerical Band 04	1.0	1.0	1.0	1.0	1.0	1.0

### HBPoS staff training and competencies

Irrespective of which workforce model, healthcare staff working in a Health Based Place of Safety should be sufficiently trained in mental and physical health to safely and effectively perform their role. The provision of a dedicated team allows for s136 specific training to be delivered to a dedicated workforce and for the on-going assessment of skills and training needs; this will improve the quality of care for individuals detained under s136.

Mental health skills include mental state assessments, rapid tranquilisation procedures, safe restraint and knowledge of relevant legislation (e.g. the Mental Health Act and Mental Capacity Act). In addition to mental health skills, it is expected that the staff will be trained in basic physical health competencies, in order to provide holistic care.

It is furthermore anticipated that adherence to the physical health competencies set out in the s136 pathway (appendix 9 of 'Mental Health Crisis Care for Londoners: London's section 136 pathway and Health Based Place of Safety specification'), will reduce the need for physical health assessments or treatment in an ED prior to HBPoS site attendance and for transfer post admission to the HBPoS site. This will reduce the burden on EDs, improve the timeliness of assessments and reduce the use of further conveyance by LAS or police between HBPoS site and the ED.

Training initiatives for a dedicated staff team will, as well as improving team skills and expertise, have a clear role in staff development and career progression. This will have positive impacts on recruitment and retention, both important issues to address across mental health, as highlighted in the Health Education England (HEE) workforce plan<sup>95</sup>.

The importance of staff training within the s136 pathway, and the opportunity that newly formed dedicated staff teams provide has been recognised by HEE. Four London mental health trusts successfully bid for funding to help set up innovative rotational nursing programmes for staff at EDs and HBPoS sites. The aim of these programmes is for HBPoS nursing staff to gain experience in ED, whilst ED nurses gain experience at the HBPoS sites in order to develop their physical and mental health care skills respectively, reduce the dependency on ED for minor physical health needs and develop relationships across organisational boundaries.

<sup>95</sup> Stepping Forward to 2020/21: Mental Health Workforce Plan for England (2017). Health Education England. Available at: <https://www.hee.nhs.uk/our-work/planning-commissioning/workforce-planning/mental-health-workforce-plan>

A summary of the expected physical and mental health competencies are outlined in table 56 below. Feedback (box 15 and 16) from s136 staff at SLAM highlights the benefit of a dedicated staff team on training and competencies.

#### Box 16: Feedback on benefits of a dedicated team

“Thinking back to how the service used to be run, before even any of the dedicated team came on board, it was run in such an ad hoc way, it was seen as a burden so that probably translated to a poor quality of care for patients. People weren’t specialised and didn’t necessarily have the necessary level of skill required to look after patients, it really was just seen as a bolt on. So, for me I think the improvement in terms of patient care is massive – that’s probably the biggest contribution...I think it’s the skill and the knowledge and the experience of the staffing group that’s really made a difference.”

**Former Unit Manager, 2017**

**Table 57: Competencies of HBPoS staff**

<b>Competencies for HBPoS staff (including nursing and medical)</b>
Mental state assessment
Rapid Tranquilisation Procedure
The use of physical intervention and safe restraint
Risk assessment and management including risk to others, from others, to self and to health (including self-neglect).
The use of the Mental Health Act, Mental Capacity Act and an overview of the Care Act.
Observational skill including the level and manner of detail contained in written observations.
Up to date mandatory training in Trust protocols (i.e. information governance, safeguarding, promoting safer and therapeutic services - PSTS).
Liaison with families and carers.
CPR and age appropriate life support, including the ability to use resuscitation equipment
Physical health assessment
Safely administer and monitor medication used or rapid tranquilisation.
Provide monitoring and basic physical interventions e.g. hydration to support basic physical health status.
Recognise and refer on the acutely deteriorating patient providing initial supportive treatment,

including seizures, chest pain, breathlessness, lowering of consciousness.
Manage simple superficial wounds.
Screen and respond to non-acute illness including management of co-morbid infection and identification and onward referral for chronic stable disease.
Perform basic lifestyle screen assessment.
Assessment and management of substance misuse and intoxication. Screen for, prevent and manage uncomplicated alcohol or substance (including nicotine) withdrawal.
Provide full medical examination and systems review (and if appropriate blood tests) to screen for co-morbid physical health conditions to support onward referral if appropriate

## 9.2.4 Approved Mental Health Professional (AMHP) services

The proposal to move from the current model of 20 HBPoS sites to 9 will have implications for current AMHP duty arrangements and local authority duties under section 13 of the Mental Health Act. There are a number of options for how this could be progressed:

**Option 1:** Directly employ AMHPs as part of the HBPoS staffing establishment on a 24/7 basis.

- **Pros:** Dedicated AMHP cover on site would provide a timely response in all cases.
- **Cons:** Additional funding arrangements would be required to enable 24/7 dedicated AMHP services. This would involve significant engagement with the local Boroughs.
- **Challenges:** Local authorities currently have difficulty in recruiting experienced AMHPs.

**Option 2:** Create a dedicated single, STP-based AMHP duty service to assess all patients, regardless of borough of origin. This would cover both normal working hours and out of hours, for all assessments under the Mental Health Act, not solely Section 136 requests.

- **Pros:** Actual activity and demand would be no higher than at present for individual AMHP duty services.
- **Cons:** Depending on where the AMHPs were based, there may be travel and response time issues.
- **Challenges:** There may be legal issues to address in order for AMHPs to act on behalf of other local authorities. For example, there may be warranting, authorisation and possibly honorary contractual arrangements in order for AMHPs to 'act on behalf of' other local authorities.

**Option 3:** Each borough deploys an AMHP to respond to requests for s136 assessments for their borough residents at the HBPoS, as and when required

- **Pros:** Local AMHPs have the knowledge of local resources, which can act as an alternative to hospital admission.
- **Cons:** Increased travel/response time for AMHPs.
- **Challenge:** Potential diversion of AMHPs from other duty work.

To arrive at the best option for AMHP services, a more rigorous assessment of the various ways in which AMHPs can be commissioned is required to ensure the challenges faced by the AMHPs are addressed and an efficient model is created for the consolidated model. Other AMHP models across London should also be looked at, for example how SLAM and SWLTSTG have managed the AMHP workforce with a centralised site. Furthermore, this is an opportunity, given the overall challenges for AMHP availability across London, to explore novel AMHP development programmes, for example the possibility of training Trust staff as AMHPs.

### 9.2.5 S12 doctor

It is important that in the new model, further consideration is given to improving the transparency and consistency of acquiring s12 doctor services. More transparency is needed to ensure training standards have been met in relation to s12 doctors. Payment and administration protocols are required to ensure that s12 doctors are contracted appropriately and aligned to demand patterns. This will ensure optimal patient experience and reduce delay in patient care.

### 9.2.6 Emergency Department staff

When an individual detained under s136 is conveyed to an Emergency Department, the individual remains in police custody throughout the period in ED until one of the following occur:

- A s12 doctor concludes that the patient has no underlying mental health disorder and the individual is discharged from s136;
- ED staff accept responsibility for individual custody for the purpose of the mental health assessment; or
- The individual is conveyed to the local HBPoS site.

In any of these instances, it is vital that information about the individual's needs and any associated risks are clearly documented and explained to the ED staff. It is also the responsibility of the ED staff to inform the AMHP services if necessary. While in the Emergency Department, ED staff and mental health professions should respond in a timely way to support appropriate assessment including following best practice to ensure liaison psychiatry see the individual within one hour of referral and the AMHP and s12 doctor assess within 4 hours of ED presentation.

When the individual is referred to the liaison psychiatry team, the team have a key role in supporting the mental health assessment process but are not involved in the assessment itself. The team's role includes:

- Contributing to the decision regarding whether there is a need to transfer the individual to the local Health Based Place of Safety for a mental health assessment or whether this will occur in ED and alerting the AMHP and s12 doctor of the arrival of the individual;

- Supporting the gathering and transfer of information relevant to the patient's presentation, including obtaining collateral information from other professionals and family/friend and supporting the transfer of physical health care documentation to the Mental Health Trust;
- Deciding whether there are safeguarding concerns, and raising a safeguard alert if necessary; and
- Providing an initial mental health examination to ensure the individuals' needs are met and completion of an immediate mental health risk assessment, which should include liaison with police, LAS, health based place of safety and ED staff.

In addition to these activities, an assessment of both the physical and mental health needs is required. Some of the key steps involved at this stage are:

- Assessment of physical health needs and handover of physical health information to the mental health liaison team;
- The liaison team should concurrently form and communicate an initial assessment plan, including contact details for allocated liaison worker;
- Liaison and ED staff agree together the next stages of the care plan including the time frame for referral and completion of the mental health assessment (if considered appropriate) and the time frames and nature of further physical health assessments and treatments; and
- Proceed with the mental health assessment alongside medical care when there is no cause to believe that physical health assessment will impact significantly upon the patient's mental state.

The future operating model is expected to minimise the number of ED presentations due to capacity issues. Furthermore, it is expected that the future model will also reduce the demand for physical health care in the Emergency Department due to improved physical healthcare provision in the HBPoS sites, thus minimising transfers to ED for 'medical clearance' or minor physical health needs.

In order to ensure that those patients who will still be attending ED under the new model, which will in particular include those with more complex physical health needs, receive high quality and efficient care, ED staff will need to be aware through training of, and adhere to, clear roles and responsibilities, as outlined in the 'Mental Health Crisis Care for Londoners: London's section 136 pathway and Health Based Place of Safety specification'.

# Appendix A

## Overall pan-London ranking of HBPoS sites

Following the analysis against the individual site criteria, the overall pan-London ranking of all HBPoS sites is outlined below, **for the adult population group**.

Ranking	HBPoS site	STP	Weighted score
1	Southwark Place of Safety Suite, ES1 Ward, Maudsley Hospital (new centralised site)	South East London	13.0
2	Highgate Mental Health Centre	North Central London	11.5
3	Hammersmith and Fulham Mental Health Unit	North West London	10.0
3	Riverside Centre, Hillingdon Hospital	North West London	10.0
4	Wolsey Wing, St Bernard's Hospital, Ealing Hospital	North West London	9.5
4	St Charles Hospital	North West London	9.5
4	Gordon Hospital	North West London	9.5
4	Oxleas House	South East London	9.5
4	Wandsworth Recovery Centre, Section 136 Suite, Springfield University Hospital	South West London	9.5
5	The Whittington Hospital	North Central London	9.0
5	Sunflowers Court, Goodmayes Hospital	North East London	9.0
5	Lakeside Mental Health Unit - West Middlesex University Hospital	North West London	9.0
6	City and Hackney Centre for Mental Health	North East London	8.5
6	Green Parks House	South East London	8.5
7	Chase Building, Chase Farm Hospital (2+ 1 reserved , used in exceptional standard)	North Central London	8.0
7	Crystal Ward - Newham Centre Mental Health	North East London	8.0
8	Northwick Park Mental Health Unit, Northwick Park Hospital	North West London	7.0
9	Park Royal Centre for Mental Health	North West London	6.5
10	University College London Hospital	North Central London	6.0
11	Royal Free Hospital	North Central London	5.5
12	Royal London Hospital	North East London	4.5

## STP ranking of HBPoS sites

The table below shows the output of the individual site assessment, ranking HBPoS sites within their respective STPs, **for the adult population group**.

Rankings	HBPoS	STP	Weighted Score
1	Wandsworth Recovery Centre, Section 136 Suite, Springfield University Hospital	South West London	9.5
1	Southwark Place of Safety Suite, ES1 Ward, Maudsley Hospital (new centralised site)	South East London	13.0
2	Oxleas House	South East London	9.5
3	Green Parks House	South East London	8.5
1	Hammersmith and Fulham Mental Health Unit	North West London	10.0
1	Riverside Centre, Hillingdon Hospital	North West London	10.0
3	Wolsey Wing, St Bernard's Hospital, Ealing Hospital	North West London	9.5
3	St Charles Hospital	North West London	9.5
3	Gordon Hospital	North West London	9.5
4	Lakeside Mental Health Unit - West Middlesex University Hospital	North West London	9.0
5	Northwick Park Mental Health Unit, Northwick Park Hospital	North West London	7.0
6	Park Royal Centre for Mental Health	North West London	6.5
1	Sunflowers Court, Goodmayes Hospital	North East London	9.0
2	City and Hackney Centre for Mental Health	North East London	8.5
3	Crystal Ward - Newham Centre Mental Health	North East London	8.0
4	Royal London Hospital	North East London	4.5
1	Highgate Mental Health Centre	North Central London	11.5
2	The Whittington Hospital	North Central London	9.0
3	Chase Building, Chase Farm Hospital	North Central London	8.0
4	University College London Hospital	North Central London	6.0
5	Royal Free Hospital	North Central London	5.5

## Overall pan-London ranking of HBPoS sites

Following the analysis against the individual site criteria, the overall pan-London ranking of all HBPoS sites outlined below is **for the children (under 18s) population group**.

Rankings	HBPoS site	STP	Weighted Score
1	Southwark Place of Safety Suite, Maudsley Hospital (new centralised site)	South East London	13.0
2	Sunflowers Court, Goodmayes Hospital	North East London	12.0
3	Crystal Ward - Newham Centre Mental Health	North East London	9.5
4	Wolsey Wing, St Bernard's Hospital, Ealing Hospital	North West London	9.0
5	Green Parks House	South East London	8.0
5	Wandsworth Recovery Centre, Section 136 Suite, Springfield University Hospital	South West London	8.0
6	Chase Building, Chase Farm Hospital	North Central London	7.5
7	Hammersmith and Fulham Mental Health Unit	North West London	7.0
7	Lakeside Mental Health Unit - West Middlesex University Hospital	North West London	7.0
7	Riverside Centre, Hillingdon Hospital	North West London	7.0
8	Northwick Park Mental Health Unit, Northwick Park Hospital	North West London	6.5
8	Oxleas House	South East London	6.5
9	Gordon Hospital	North West London	6
10	Highgate Mental Health Centre	North Central London	5.5
10	City and Hackney Centre for Mental Health	North East London	5.5
11	Park Royal Centre for Mental Health	North West London	5.0
12	University College London Hospital	North Central London	4.5
12	Royal London Hospital	North East London	4.5
13	Royal Free Hospital	North Central London	4.0
13	St Charles Hospital	North West London	4.0
14	The Whittington Hospital	North Central London	3.0

## STP ranking of HBPoS sites

The table below shows the output of the individual site assessment, ranking HBPoS sites within their respective STPs, **for the CYP population group**.

Rankings	HBPoS site	STP	Weighted Score
1	Wandsworth Recovery Centre, Section 136 Suite, Springfield University Hospital	South West London	8.0
1	Southwark Place of Safety Suite, Maudsley Hospital (new centralised site)	South East London	13.0
2	Green Parks House	South East London	8.0
3	Oxleas House	South East London	6.5
1	Wolsey Wing, St Bernard's Hospital, Ealing Hospital	North West London	9.0
2	Hammersmith and Fulham Mental Health Unit	North West London	7.0
2	Lakeside Mental Health Unit - West Middlesex University Hospital	North West London	7.0
2	Riverside Centre, Hillingdon Hospital	North West London	7.0
3	Northwick Park Mental Health Unit, Northwick Park Hospital	North West London	6.5
4	Gordon Hospital	North West London	6
5	Park Royal Centre for Mental Health	North West London	5.0
6	St Charles Hospital	North West London	4.0
1	Sunflowers Court, Goodmayes Hospital	North East London	12.0
2	Crystal Ward - Newham Centre Mental Health	North East London	9.5
3	City and Hackney Centre for Mental Health	North East London	5.5
4	Royal London Hospital	North East London	4.5
1	Chase Building, Chase Farm Hospital	North Central London	7.5
2	Highgate Mental Health Centre	North Central London	5.5
3	University College London Hospital	North Central London	4.5
4	Royal Free Hospital	North Central London	4.0
5	The Whittington Hospital	North Central London	3.0

## **OUTER NORTH EAST LONDON JOINT HEALTH OVERVIEW AND SCRUTINY SUB-COMMITTEE, 2 OCTOBER 2018**

**Subject Heading:**

Healthwatch Havering – Services for  
People who have a Visual Impairment

**Report Author and contact details:**

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**Policy context:**

The information presented summarises  
work undertaken by Healthwatch  
Havering to scrutinise in that borough  
for people who have a visual  
impairment.

**Financial summary:**

No impact of presenting information  
itself.

### **SUMMARY**

The attached report by Healthwatch Havering summarises a review of services for people with a visual impairment.

### **RECOMMENDATIONS**

1. That the Joint Committee considers the attached Healthwatch Havering report and takes any action it considers appropriate.

**REPORT DETAIL**

The attached report details work undertaken by Healthwatch Havering into local services for people with a visual impairment. The report makes a number of recommendations for relevant organisations including London Borough of Havering and NHS bodies.

**IMPLICATIONS AND RISKS**

**Financial implications and risks:** None of this covering report.

**Legal implications and risks:** None of this covering report.

**Human Resources implications and risks:** None of this covering report.

**Equalities implications and risks:** None of this covering report.

**BACKGROUND PAPERS**

None.

# Services in Havering for people who have a visual impairment: a review

## June 2018



## What is Healthwatch Havering?

Healthwatch Havering is the local consumer champion for both health and social care in the London Borough of Havering. Our aim is to give local citizens and communities a stronger voice to influence and challenge how health and social care services are provided for all individuals locally.

We are an independent organisation, established by the Health and Social Care Act 2012, and employ our own staff and involve lay people/volunteers so that we can become the influential and effective voice of the public.

Healthwatch Havering is a Company Limited by Guarantee, managed by three part-time directors, including the Chairman and the Company Secretary, supported by two part-time staff, and by volunteers, both from professional health and social care backgrounds and lay people who have an interest in health or social care issues.

### Why is this important to you and your family and friends?

Following the public inquiry into the failings at Mid-Staffordshire Hospital, the Francis report reinforced the importance of the voices of patients and their relatives within the health and social care system.

Healthwatch England is the national organisation which enables the collective views of the people who use NHS and social services to influence national policy, advice and guidance.

Healthwatch Havering is your local organisation, enabling you on behalf of yourself, your family and your friends to ensure views and concerns about the local health and social services are understood.

Your contribution is vital in helping to build a picture of where services are doing well and where they need to be improved. This will help and support the Clinical Commissioning Groups, NHS Services and contractors, and the Local Authority to make sure their services really are designed to meet citizens' needs.

***'You make a living by what you get,  
but you make a life by what you give.'***  
***Winston Churchill***

## INTRODUCTION

A significant role of a Healthwatch is to support and enable the most vulnerable members of the community to have a voice and to influence services which have a substantial impact on their day to day lives.

This report on Eye Services responds to the concerns expressed by residents, professional staff and voluntary organisations about the service model, the facilities, the level of support and, above all, the disjointed processes that service users experience. The number of organisations involved in this chain of care has surprised us. This contributes to the inability to be able to clearly describe the Care Pathways, which may result in residents who are blind or partially sighted being without the physical and health and wellbeing support they require.

In this report we look at the journey patients make from attending their optician for routine eye tests and glasses, to being referred to the hospital services at Barking Havering and Redbridge University Trust (BHRUT) for more complex care, to those residents who find themselves with an eye condition that requires them to register a Certificate of Visual Impairment (CVI) with the London Borough of Havering (LBH), and the support available to help our residents and their families to adjust their lives for the long term.

Managing long-term conditions requires all organisations to work together, maximising the opportunity by sharing clinical information and technology. It is a concern that some of the information we requested was recorded on a manual basis and only estimates of CVIs issued could be provided for 2016/17; given the role the CVI has in supporting national epidemiological analyses of the needs of people who have a visual impairment, this is particularly disappointing.

Our report indicates that a lot more could be done to improve the experience of patients, especially the provision of an Eye Clinic Liaison Officer (ECLO) at BHRUT, which we have been advised, continues to be delayed despite the support and offer of funding from the Pocklington Trust, the Royal National Institute for Blind People and the continued lobbying of the local Sight Action Group.

There is information and guidance available from the Royal College of Ophthalmologists for all hospital medical staff, comprehensive advice available for everyone from the RNIB, supportive and responsive local services from the London Borough of Havering, advice and information from CarePoint and the voluntary sector such as Sight Action and Partially Sighted Havering.

Our view is that, unless there is a more comprehensive understanding of the individual parts of the entire process of care needed in eye services and how they are interconnected, then we may only address the symptoms of an inadequate service model. However, the commitment shown from organisations to address this problem indicates that it is possible to achieve a more holistic model of care for our residents.

In preparing this report local organisations and individuals have been enormously helpful and we are very grateful for their support.

Commissioning services, redesigning clinical pathways and working across the boundaries of different organisations is a challenge. This, together with the financial pressures being faced by all organisations, makes it important that commissioners and service providers carefully determine where best value for money can be achieved while still delivering on statutory requirements and quality of service and care.

A good place to start this report is to set out the view of patients and carers which is contained within the UK Vision Strategy:

‘Seeing it my way’

- ✓ That I have someone to talk to
- ✓ That I understand my eye condition and the registration process
- ✓ That I can access information
- ✓ That I have help to move around the house and to travel outside
- ✓ That I can look after myself, my health, my home and my family
- ✓ That I can make the best use of the sight I have
- ✓ That I am able to communicate and to develop skills for reading and writing
- ✓ That I have equal access to education and lifelong learning
- ✓ That I can work and volunteer
- ✓ That I can access and receive support when I need it

## PROLOGUE - Karen, a Healthwatch Havering member

I'm one of the members of the Working Group which contributed to this report. I'm also severely sight impaired (blind) myself. Although my eye problems were with me from birth, I only got myself registered as blind when I was in my early 20s. I had muddled through school and my first few jobs somehow, with hardly any support. Although I can't remember exactly who it was that recommended getting registered, I do recall feeling unenthusiastic. I couldn't imagine how being "officially disabled" was going to help me, especially being a young, confident and ambitious person. But as it turns out they were right, and I would now recommend registration (which is called a Certificate of Visual Impairment, or CVI) to anyone.

I believe the many positives of getting a CVI are largely unknown and for some reason under-publicised, so I've listed \* a few of them that have made my life easier and often more financially comfortable - you can read them in section 9 of this report. Let me make it clear that even once you have a CVI, you always have the option to use or not use it. No one is going to "out" you as sight impaired without your permission. It's just a tool you have at your disposal but if you choose never to use it that's fine, and you won't be forced to. I carry a credit-card-style registration card in my wallet as proof of my status, which was provided to me by my local authority. It's convenient and discreet.

KAREN

*\* Karen's suggestions are listed on page 39 onward*

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- 7. The importance of good and accessible information**
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## 1 RECOMMENDATIONS

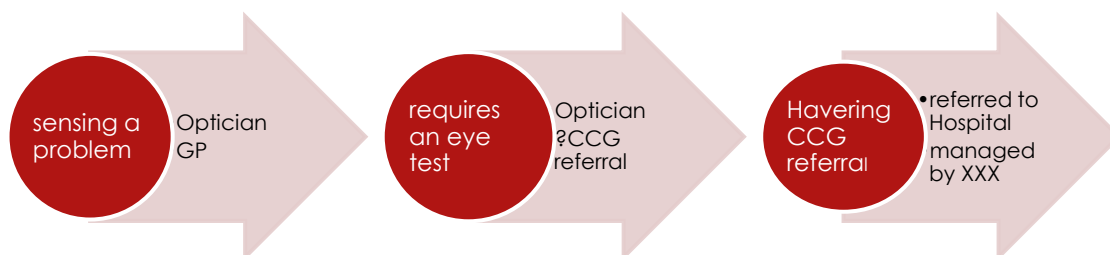
1. That all organisations work together to streamline the referral/assessment process, with the aim of reducing the expenditure and providing a faster service
2. That the CCG review and streamline the assessment, referral and treatment process, with the aim of giving patients a faster diagnosis and possibly saving money by reducing the number of clinical visits
3. That the CCG commission a more holistic model for non-emergency care, based on Care Pathways, drawing on expert opinion, evidenced based practice and mapping clearly what the patient and carer can expect
4. That the CCG review:
  - The care pathway for emergency eye care
  - The guidance and advice provided by the NHS111 service, and
  - The arrangements for patients needing to be transferred to Moorfields
5. That BHRUT and the CCG accept the offer which has been made by the RNIB and the Pocklington Trust to fund/support the appointment of an ECLO to enable the role to be provided as soon as possible, and that BHRUT and the CCG commit to funding and maintaining the role.
6. That all organisations:
  - Recognise that diagnoses of irreversible vision loss can have a traumatic impact on people's lives
  - Develop a Service Level Agreement (SLA) with a voluntary organisation to provide a support service to patients at both Queens and King George Hospital
  - Provide a suitable confidential space with equipment and furniture
7. That everyone be given access to an environment that supports and enables high quality eye care for the prevention and treatment of eye disease to optimise, preserve and restore vision

8. That BHRUT build on current good practice models to develop a Patient and Carer Partnership group facilitated by BHRUT staff
9. That BHRUT create a more dynamic, integrated relationship between the A&E Department and the Outpatients Department to better support both staff and patients
10. That BHRUT and LBH use their best endeavours to ensure that staff and residents are aware of the DVLA Patient and Doctor Guidance and the information provided on the RNIB website regarding visual disorders and driving
11. That care be taken to ensure that all relevant data is shared with Moorfields in order to support a robust needs assessment for those who have visual impairments
12. That BHRUT update their manual recording of CVIs to an electronic database which can provide information in a timely and accurate way to support both BHRUT and the wider health and social care community
13. That BHRUT review its procedures to ensure that all medical staff are complying with the Royal College guidelines and that all Consultant staff and Hospital Eye Clinic staff observe the Guidance note from DH England published 17 August 2017
14. That BHRUT and LBH work together to share the data on CVIs and RVIs to support the appropriate commissioning models for both health and social care and support the epidemiological analysis work which is reported via an NHS England Public Health Indicator
15. That LBH consider incorporating the RNIB database information into its commissioning intentions and requirements to support both current and predicated service models
16. That LBH continue to support voluntary services such as those meeting at Yew Tree Lodge and the opportunities that they provide for residents and, in particular, the highly valued evening club

17. That LBH accept that people who are not digitally literate or able to access digital systems require support to ensure that they can continue to be involved in their community and the opportunities this offers
18. That all organisations aim to achieve the highest possible standards of information, ensuring that they enable people to make informed choices and decision

## 2 WHERE THE JOURNEY BEGINS AND THE ROLE OF THE CLINICAL COMMISSIONING GROUP

### The Journey



- Sensing a Problem

For most of us the recognition that our vision is deteriorating can come from finding it more difficult to read small text, maybe when driving the car or that feeling of eye strain at the end of a busy day. Some people then contact opticians for an eye test, others seek an appointment with their GP.

- Requires an eye test

Residents told us about their experiences and it seemed that there was no standard pathway and, in some cases, a meandering and time-consuming pathway. Examples are

- Patients who attend their local optician were sometimes referred to their GP, others were referred directly to the Westland.
- Patients who attended their GP were sometimes referred to the Westland Clinic for assessment and Westland clinic referred patients back to the GP for further referral,
- Patients were referred to the Westland Clinic for assessment and treatment,
- Patients were referred to BHRUT for assessment and treatment and some to the Treatment Centre.

- In discussion with groups of patients when they began to share their experiences, it became evident that in many cases the current care pathway seemed more like a lottery than clinical efficacy.

### Consider

Does this referral journey provide the simplest, most cost effective and optimal route?

We understand that other parts of the country do not have a referral/assessment centre as part of the referral from GP/Optician to Hospital. In many places, the optician can refer directly to the hospital

### Recommendation 1:

That all organisations work together to streamline the referral/assessment process, with the aim of reducing the expenditure and providing a faster service

### Recommendation 2:

That the CCG review and streamline the assessment, referral and treatment process, with the aim of giving patients a faster diagnosis and possibly saving money by reducing the number of clinical visits

## **The role of the CCG**

Within the NHS service provision, commissioners are required to assess the needs of their individual populations and then purchase services from local providers of care. As part of this role, the CCG assesses how many residents will need care during the year.

The CCG commission services locally from BHRUT, Westland Clinic and the Treatment Centre and more specialist services from hospitals such as Moorfields.

Commissioning services requires detailed specifications and clear performance monitoring techniques, below are areas where concerns have been raised regarding performance.

- Residents' thoughts on what a quality experience should have

Residents told us that, for them, quality is the total experience and although they valued highly the work of the clinical staff, they identified areas where there was a lack of quality in the total experience:

- Lack of an Eye Clinic Liaison Officer - *'An investment of £1 can net a return of £10.57 to health and social care budgets - RNIB'*
- Support in the overall experience for older people with sight problems
- Congested treatment areas making it hard to manoeuvre walking frames
- Need for a range of good practical information being easily available for patients recognising the need for language translation and Easy Read
- Need for more equipment for patients to support them at home and work - Low Visual Aids - particularly important for young people

- Patients' thoughts on what performance standards should deliver

Patients and carers were seeking to be more informed about the standards of service available in outpatients. Patients suggested that a charter or similar should be displayed setting out the service delivery standards, examples given were

- How the clinic operated - many found it a very confusing environment

- What to expect and how to prepare themselves, prior to their first attendance.
  - More adherence to appointment times - many people said that when they had an appointment for 2.00pm they never expected to be able to leave before 4.30pm, others commented you needed to allocate the entire day if you had to attend the clinic.
  - Explanations to patients when the clinic was delayed or running late
- **Involving patients in designing services**

The assessment of residents' needs is an important part of commissioning; however, we could not find evidence to demonstrate involvement with service users. The Low Vision Service was criticised for lack of engagement and accessibility for service users and their families
  - **Improving the emergency eye care facilities in A & E**

Patients have told us that although the care is good in the A & E Emergency Eye Unit, the area is very congested and the facilities poor. Patients said that GPs were very reluctant to care for eye accident conditions. When attending on the advice of GPs or 111 some patients found the experience distressing and have stated that they have been turned away as the visit was not necessary or told to come back the next day. Some were told to go to Moorfields without any conversation about how with an eye injury the patient travelled to Moorfields.

### Consider

How can the CCG by working in partnership with BHRUT enhance and maximise the service commissioned on resident's behalf?

How is the CCG preparing for the increasingly older generation who are very high users of the service?

Our research indicates that the clinical teams are very keen to improve the service model. Patients value the service and voluntary organisations who work closely with the hospital are also very supportive and keen to help with improving the service model.

Recommendation 3:

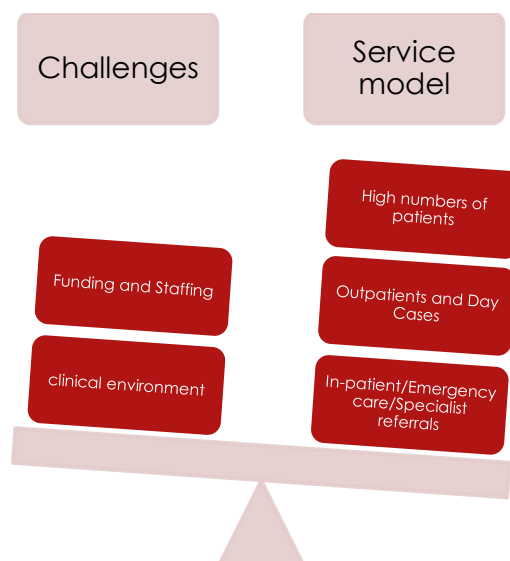
That the CCG commission a more holistic model for non-emergency care, based on Care Pathways, drawing on expert opinion, evidenced based practice and mapping clearly what the patient and carer can expect

Recommendation 4:

That the CCG review:

- The care pathway for emergency eye care
- The guidance and advice provided by the NHS111 service, and
- The arrangements for patients needing to be transferred to Moorfields

### 3 THE ROLE OF BARKING, HAVERING AND REDBRIDGE UNIVESITY HOSPITALS TRUST (BHRUT)



BHRUT are the main provider of Ophthalmology care for the residents of Havering. The hospital currently provides outpatients' appointments, outpatient treatments, day case procedures and in-patient operations. There are also facilities for patient to be treated for emergency eye care.

There has been nothing that would indicate a lack of confidence in the clinical staff, on the contrary it is well regarded by both staff and patients. Everyone to whom we spoke offered their opinions as a way of achieving the approach of 'a valued service that gets better'. Patients said that their care often exceeded their expectation.

For such a large service provider, crucially, there is no ECLO. It is highly possible that partially sighted residents and blind residents have been leaving the eye clinic not knowing, or unsure of, the name or nature of their eye condition. In addition, patients have not been offered formal counselling either at the time or later.

- What does an Eye Clinic Liaison Officer (ECLO) do?

ECLOs provide people recently diagnosed with an eye condition with the practical and emotional support which they need to understand their diagnosis, deal with their sight loss and maintain their independence.

CVI Guidance Notes from the DH England provide the following advice on ECLOs

*“16. It is good working practice to have ECLOs in hospitals as this helps to create a good link between health and social care and enhances joined up support for the patient. Clinic staff should be suitably trained to be able to manage what may be an emotional and upsetting time for the patient. The patient should be asked to sign if they consent to their information being shared. It is important to document the patient's decision in their notes and to advise them of the benefits of sharing their information. The patient does not have to consent to share information, and they can also withdraw their consent at any point by contacting the relevant organisations.”*

### Consider

Being diagnosed with an eye condition that will considerably change someone's lifestyle can be difficult to come to terms with, and everyone reacts differently. People can be worried about unemployment, at a higher risk of falls and social isolation. It can be an extremely confusing and uncertain time and, in many cases, emotionally traumatic.

- ❖ People with learning disabilities are 10 times more likely to have serious sight problems than other people.

**Recommendation 5:**

That BHRUT and the CCG accept the offer which has been made by the RNIB and the Pocklington Trust to fund/support the appointment of an ECLO to enable the role to be provided as soon as possible, and that BHRUT and the CCG commit to funding and maintaining the role.

**Consider**

It is recognised good practice to provide Specialist Advisers on a voluntary basis in services where there is trauma or potentially a negative diagnostic outcome. For fourteen months this service has not been available at BHRUT to patients who receive a diagnosis that their condition is untreatable and will result in them becoming partially sighted or blind. A life-changing diagnosis with no ability to link with an organisation whose networks and advice can provide that vital stepping stone, helping an individual and their family maintain their emotional balance in the months ahead of them.

- ❖ People with sight loss are three times more likely to suffer depression.

**Recommendation 6:**

That all organisations:

- Recognise that diagnoses of irreversible vision loss can have a traumatic impact on people's lives
- Develop a Service Level Agreement (SLA) with a voluntary organisation to provide a support service to patients at both Queens and King George Hospital
- Provide a suitable confidential space with equipment and furniture

- Patients' and Relatives' concerns

Patients and relatives have raised many concerns:

- There is no ECLO or Voluntary Sector support available to patients on diagnosis
- Difficulty contacting the appointments department
- Waiting times for appointments, often confusion with personal and clinical details
- Overcrowding and delays in the outpatient areas
- There has been no information - leaflets/pamphlets, posters or audio material, plus a lack of information in the Accessible format, and equipment from December 2016 to December 2017
- Recently a table with leaflets and useful information has been placed in the main waiting room: it would be helpful if there was signage indicating who patients and carers should speak to, to get advice
- Patients reported a cupboard has been put up with Sight Aids on display. It is placed in a dark corner of the main waiting room and people with sight problems find it difficult to identify Aids in the cupboard.
- Cramped treatment areas
- Lack of the full range of clinical expertise expected in an ophthalmology department
- Clinical staff looking stressed and demoralised, both in Outpatients and A&E
- Lack of appropriate facilities for counselling and support
- No obvious support for patients with Learning Disabilities or patients with other physical needs such as poor mobility
- Royal College of Ophthalmologists together with RNIB have developed a Certificate of Visual Impairment Information poster template for hospital clinics this is not on display.
- Emergency Eye Care in the A & E has very poor facilities and patients complained that they are shuttled between A&E to Team 2 Outpatients.

### Consider

The issues raised in this report are very similar to those contained in a CQC report for Moorfields resulting in a rating of Requires Improvement. Is it worth considering the possibility of BHRUT linking with Moorfields to learn about the development and progress they are undertaking as they strive to achieve a Good rating?

#### Recommendation 7:

That everyone be given access to an environment that supports and enables high quality eye care for the prevention and treatment of eye disease to optimise, preserve and restore vision

#### Recommendation 8:

That BHRUT build on current good practice models to develop a Patient and Carer Partnership group facilitated by BHRUT staff

#### Recommendation 9:

That BHRUT create a more dynamic, integrated relationship between the A&E Department and the Outpatients Department to better support both staff and patients

## 4 THE CERTIFICATE OF VISUAL IMPAIRMENT (CVI)

How this process works and which organisations are responsible for which part seems to have caused a lot of confusion. To assist with a better understanding of the roles and responsibilities of local organisations this section contains extracts from a range of nationally recognised bodies. In the Background Reading section at the end of this report we have identified the sources that we have considered. This process is recognised as complex and to quote the RNIB:

*‘At the moment, however, as RNIB and others have identified, the process of certification isn’t always working completely smoothly: certainly, when it is combined with registration: and in fact, it is often incorrect to assume that an area with comparatively low certification rates has relatively few blind and partially sighted residents. A vast range of professionals are involved, all of whom can slow down or block the process’*

The CVI formalises the status of someone as visually impaired and acts as a referral for a social care assessment if the individual is not yet known to social services.

### Guidance from the Department of Health (DH)

The DH document published on 17 August 2017 “Certificate of Vision Impairment: Explanatory Notes for Consultant Ophthalmologists and Hospital Eye Clinic Staff in England”, advises:

#### *“Purpose of the CVI form*

*“4. Hospital clinic staff should explain the importance of certification and the sharing of information with their local authority, their GP and the Royal College of Ophthalmologists Certifications Office at Moorfields Eye Hospital. If the patient still does not consent to sharing information they should be*

*made aware they may miss out on valuable support and information.*

*“5. Completing and sending off the CVI in a timely manner is not only beneficial for the patient but will enable community health and social care agencies to plan appropriate services as part of local strategies such as falls prevention or loneliness and isolation.*

*“6. If the patient has also provided consent to share the CVI form with the Certifications Office at Moorfields Eye Hospital, the CVI will be used to record diagnostic and other data that is used for epidemiological analysis and reported via an NHS England Public Health Indicator.”*

For this process, three statutory organisations are involved:

- BHRUT
- LBH
- The DVLA

### BHRUT

It is the role of the senior medical staff at BHRUT to make the assessment and decision to issue a CVI. This process is part of a nationally-designed pathway with clear guidelines available to support medical staff and hospitals in performing this responsibility efficiently and with care.

The Royal College of Ophthalmologists guidelines state:

*“The College believes that an important component of good clinical care by ophthalmologists is the offer of a Certificate of Vision Impairment (CVI) to eligible patients and encourages its members to promote the uptake of the CVI amongst patients who are likely to benefit from it and to facilitate the process of registration as far as it is in their power to do so.”*

The Guidance adds:

### *Certificate of Vision Impairment Form*

*'Part 1 of the CVI form clearly indicates the section that must be completed by the consultant ophthalmologist and they should also complete the visual acuity and diagnosis section as set out in Part 2 of the CVI as well. The CVI should be completed fully and accurately. The patient should be actively involved in completing the form which may be completed in part by members of the eye clinic staff where indicated on the form, such as by an Eye Clinic Liaison Officer (ECLO).*

*16. It is good working practice to have ECLOs in hospitals as this helps to create a good link between health and social care and enhances joined up support for the patient. Clinic staff should be suitably trained to be able to manage what may be an emotional and upsetting time for the patient. The patient should be asked to sign if they consent to their information being shared. It is important to document the patient's decision in their notes and to advise them of the benefits of sharing their information. The patient does not have to consent to share information, and they can also withdraw their consent at any point by contacting the relevant organisations.'*

The next stage involves the patient and the decision that they make as to whether to register with the local council (in Havering, LBH):

*'Being registered as partially sighted or blind enables a person to access a range of benefits to help them manage their condition and the impact it may have on their lives. Registration is voluntary, and access to benefits and social services is not dependent on registration.'*

Registration is voluntary, and whilst it is essential to obtaining some benefits and concessions, it is not a prerequisite for accessing support from social services.

However, we would strongly encourage all patients to seek access to the assessment process provided by the borough. By completing the form, the borough is required to undertake a full assessment of an individual's needs and to provide the necessary help and support needed.

The College also states that:

*'The Referral of Vision Impairment (RVI) letter is used where registration is not appropriate or where the patient has declined registration but wants advice and information about the difficulties caused by loss of vision.'*

### LBH

LBH is responsible for assessing the needs of the Borough's population and delivering a range of support and social care provision for people with sight disabilities, and this includes working with voluntary organisations. Under the Care Act 2014, local authorities continue to have specific duties to assess and provide information, rehabilitation and support to visually impaired people. This includes making contact with people within 2 weeks of receiving their CVI. LBH is also responsible for the formal registration process of CVI. For more detail, see section 6 of this report.

### The DVLA

Albeit that registration as blind with the local authority is voluntary, an individual who is a driver and is diagnosed with a visual impairment is obliged by law to comply with Driver and Vehicle Licensing Authority (DVLA) requirements (which in many cases will result in disqualification from driving). The DVLA provide a patient and doctor guidance document regarding visual disorders, as do the RNIB.

### Consider

Some of the information we requested using FOI was only recorded on a manual basis and only estimates of CVI issued could be provided for 2016/17. This is disappointing given the role the CVI has in supporting epidemiological analysis which is reported via an NHS England Public Health Indicator.

Where a patient consents to registration, the CVI form is also shared with the Certifications Office at Moorfields Eye Hospital, producing data that is ultimately used to shape and commission the local services through the Joint Strategic Needs Assessment (JSNA). If the data is inadequate or inaccurate, it will lead to levels of need not being properly identified.

#### Recommendation 10:

That BHRUT and LBH use their best endeavours to ensure that staff and residents are aware of the DVLA Patient and Doctor Guidance and the information provided on the RNIB website regarding visual disorders and driving

#### Recommendation 11:

That care be taken to ensure that all relevant data is shared with Moorfields in order to support a robust needs assessment for those who have visual impairments

## 5 DOES THE CURRENT INFORMATION AND TECHNOLOGY PROVIDE AND MEET EXPECTATIONS?

Concerns have been expressed to Healthwatch that there is no adequate way of measuring those patients issued with CVI by the consultants at BHRUT and people registering a CVI for assessment and support being received by LBH. Without the right information, LBH cannot allocate sufficient resources to people with Visual Impairments.

Healthwatch have tried to consider how best to address this on-going concern. Our approach, admittedly basic, was to issue FOI requests to BHRUT and LBH.

According to the FOI responses received from both organisations, the position for 2016/17 is:

- BHRUT Ophthalmology Department only keeps information in a manual record by patient name and not date; about 300 CVIs were issued in that year
- LBH received in total from all ophthalmology units (i.e. mainly from BHRUT but also from elsewhere) - 93 CVIs

Below are the formal responses from both organisations:

- BHRUT

Healthwatch's FOI request was sent on 20 February 2018, but the response was not received until 21 May 2018.

**Question:** In 2016/17, how many Certificates of Visual Impairment (CVI) were issued by the Ophthalmology Department for people resident in Havering?

**Response:**

'Further to your request dated 20 February 2018, please find our response to your enquiry below. Please also accept our apologies for the delay in getting back to you.'

“Our Ophthalmology department keeps a manual record of this information; however, it is not split by CCG/area. Details are recorded by patient name and not date. We can only estimate that there were circa 300 CVI’s in 2016/17.”

- LBH

Question: For the year 2016/17 - How many Certificates of Visual Impairment were received by the Council (distinguishing between those issued by BHRUT and those issued by other ophthalmic units, if any)

Response:

93 Certificates of Visual Impairment. This information is not held in the way requested and cannot distinguish between BHRUT and other Ophthalmic units

Question: How many assessments of need were made following the receipt of a CVI. How many assessments, if any, were made of individuals needs for support as a result of visual impairment were made without the issue of a CVI

Response:

With CVI - 87

Without CVI - 149

Question: How many people, if any, refused registration as blind despite the issue of a CVI

Response: Information not held

### Consider

To make good commissioning decisions and plan appropriately for health and social care, managing all long-term conditions requires all organisations to work together, maximising the use of, and sharing, clinical information and technology.

#### Recommendation 12:

That BHRUT update their manual recording of CVIs to an electronic database which can provide information in a timely and accurate way to support both BHRUT and the wider health and social care community

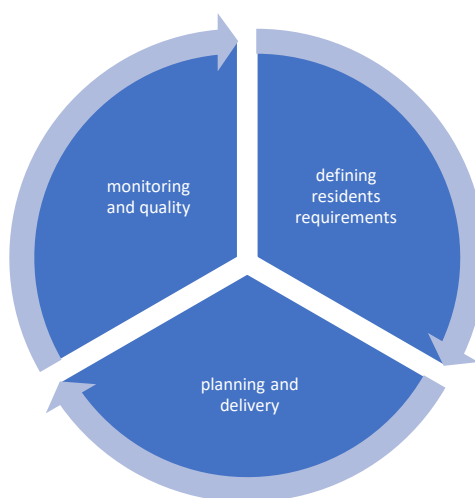
#### Recommendation 13:

That BHRUT review its procedures to ensure that all medical staff are complying with the Royal College guidelines. All Consultant staff and Hospital Eye Clinic staff observe the Guidance note from DH England published 17 August 2017

#### Recommendation 14:

That BHRUT and LBH work together to share the data on CVIs and RVIs to support the appropriate commissioning models for both health and social care and support the epidemiological analysis work which is reported via an NHS England Public Health Indicator

## 6 WHAT IS THE ROLE OF THE LONDON BOROUGH OF HAVERING (LBH)?



LBH is responsible for assessing the needs of the Borough's population and delivering a range of support and social care provision for people with sight disabilities, and this includes working with voluntary organisations. Under the Care Act 2014, local authorities continue to have specific duties to assess and provide information, rehabilitation and support to visually impaired people. This includes making contact with people within 2 weeks of receiving their CVI. LBH is also responsible for the formal registration process of CVI.

- **Numbers of patients registering**

Concerns have been expressed to Healthwatch that there has been a decline in the number of patients registering for assessment with the borough, the rationale for this concern being that a deterioration in people's eyesight predominantly affects the older generation and Havering has the oldest population in London which is also steadily growing, so a decline in registering seemed counter-intuitive.

This was tested by another FOI request.

**Question:** Please provide the number of people registered with the Council as blind as of 31 March (or the nearest available date) in each of the years 2010, 2011, 2012, 2013, 2014, 2015, 2016 and 2017.

**Response:**

- 2010-11 = 1258
- 2013-14 = 1284
- 2016-17 = 1134

LBH explained that the number of registrations is measured only once every three years, hence it was not possible to provide data for each of the years specified.

Healthwatch followed this up with a meeting with the Service Manager for Disabilities in December 2017, at which he offered the view that Havering's numbers registered appeared lower than other boroughs because, as part of the preparation for the registration review in 2016/17, they carried out a comprehensive review of the existing register and removed from it people who were no longer in the borough, including those that had died or moved away - in some cases, a while earlier, because the service is not notified of every death or move outside the borough.

This explanation goes some way to explaining the apparent statistical anomaly but may not be a complete answer.

### Social Care Information Centre

The Health and Social Care Information Centre data for 2014 does demonstrate a similar trend however, the report raises its concern about the accuracy of the 152 councils reporting.

*“The statistics relating to blind people who have an additional disability may understate the true numbers.*

*“Due to additional guidance on deaf blind registration where there was information on additional disabilities for people having multiple disabilities including deaf or hard of hearing,*

*councils were advised to count this under the category of deaf or hard of hearing. This could lead to a bias towards deaf or hard of hearing disabilities” (emphasis added)*

### Consider

It has not been possible for Healthwatch to assess whether there is a genuine decline in the number of patients seeking assessment as part of the CVI and RVI process. As LBH has recently undertaken a comprehensive review of the list, going forward, LBH is in an advantageous position to be able to monitor accurately the number of residents with a CVI or an RVI.

The FOI response from BHRUT has demonstrated, however, that record keeping for CVIs is by use of a manual system and is only able to offer very approximate confirmation of numbers of CVI's undertaken by the Ophthalmology Department, seemingly and crucially without being able to identify the borough of residence so that neither the local authority can be confident of the number of residents eligible to be registered nor the CCG can be confident that it is paying through its commissioning arrangements for the right number of patients .

The RNIB's Sight Loss Data Tool is the UK's biggest collection of eye health datasets. It collates a wide range of publicly available datasets enabling a tailored story about the local area; and the benchmarking report shows users how local areas compare to their region and nation, across a set of key indicators.

**Recommendation 15:**

That LBH consider incorporating the RNIB database information into its commissioning intentions and requirements to support both current and predicated service models

**Voluntary Sector services**

During the process of completing this report we have had the pleasure of working with three voluntary groups, Havering Over Fifties Forum (HOFF), Sight Action Havering and the Partially Sighted Group. It has been invaluable spending time with their members to seek their views on eye services. The Partially Sighted Group and the Havering Over Fifties Forum both benefit from LBH support, particularly with the use of premises as they average between 50 - 120 members each.

LBH is undertaking a 'Review' to ascertain if they can continue to provide the Yew Tree Resource Centre on a Monday evening. This is a much-valued focus point for Havering residents who are partially sighted or blind.

While it is necessary to ensure that public funds and resources are used to best effect, it is easy to create an impression that out-of-hours provision are subordinated more to the convenience of staff and cost control than to addressing the inequality of disadvantaged people being unable to access facilities others take for granted.

**Consider**

There is good access to information and personal support in the borough. In addition, there is on-going development to support further use of electronic systems.

The challenge for LBH is to consider ways in which individuals who are not able to access electronic services such as email or use or afford a smart phone are kept informed and aware of services and

opportunities as these people may be some of the most vulnerable in the community.

People who have a visual impairment are not always able to access clubs or other social gatherings and facilities that others are able to use.

**Recommendation 16:**

That LBH continue to support voluntary services such as those meeting at Yew Tree Lodge and the opportunities that they provide for residents and, in particular, the highly valued evening club

**Recommendation 17:**

That LBH accept that people who are not digitally literate or able to access digital systems require support to ensure that they can continue to be involved in their community and the opportunities this offers

## 7 THE IMPORTANCE OF GOOD AND ACCESSIBLE INFORMATION

Healthwatch England gives the following advice on ‘What should you expect from the NHS when it comes to accessible information?’

The aim of the standard is to make sure that people who have a disability, impairment or sensory loss get information that they can access and understand, and any communication support that they need.

This includes making sure that people get information in different formats if they need it, for example in large print, braille, easy read or via email.

It also includes appropriate support to help individuals communicate, for example, support from a British Sign Language (BSL) interpreter, deafblind manual interpreter or an advocate.

All organisations that provide NHS or adult social care are required to follow the new standard, including NHS Trusts and Foundation Trusts, and GP practices.

Five things that you should expect from organisations that provide NHS or adult social care:

- You should be asked if you have any communication needs, and asked how these needs can be met
- Your needs should be recorded in a clear and set way
- Your file or notes should highlight these communication needs so people are aware and know how to meet them
- Information about your communication needs should be shared with other providers of NHS and adult social care, when they have consent or permission to do so
- Information should be delivered to you in a way you can access and understand, with the option for communication support if needed

### Consider

The evidence we have seen suggests that some people leave the Eye Clinic not fully realising the implications of the diagnosis that they have a visual impairment.

The support of an ECLO, highlighted earlier in this report, would go some way to alleviating this; but the ready availability of detailed information would also assist in understanding at a time in the affected people's lives when they are particularly vulnerable.

### Recommendation 18:

That all organisations aim to achieve the highest possible standards of information, ensuring that they enable people to make informed choices and decision

## 8 WHAT IS AVAILABLE WITHIN THE COMMUNITY TO SUPPORT HAVERING RESIDENTS?

The following is a brief summary of information available to local residents; it is not an exhaustive guide.

### ✓ London Borough of Havering

‘Information and service guide for people who are vision impaired’

This useful guide is available on line and in printed format. It is **available by contacting the Customer Services, Adult Social Care** on 01708 432000

[www.haveringcarepoint.org/care-advice/living-with-a-sensory-impairment/](http://www.haveringcarepoint.org/care-advice/living-with-a-sensory-impairment/)

‘browsealoud’ software is available to improve accessibility of webpages. It enables users to change the colour scheme, alter text size and have information read aloud:

[www.texthelp.com/en-gb/products/browsealoud/](http://www.texthelp.com/en-gb/products/browsealoud/)

### ✓ CarePoint

CarePoint are the Council’s Information Service point. They can provide advice on a wide range of issues related to Sight Impairment, such as which concessions people are entitled to and they actively promote residents registering as it helps the council improve the support available for those living with sight impairment in Havering.

CarePoint offer Drop-In clinics across the borough, and to contact them for more information you can

Telephone 01708 776770 selecting option 2

Email [carepoint@peabody.org.uk](mailto:carepoint@peabody.org.uk)

### ✓ Sight Action (Havering)

Sight Action (Havering) is a local voluntary sector society for vision impaired people in Havering. Sight Action is also a registered charity (1078815).

It is supported by East London Vision (ELVis). ELVis is designed to provide an effective and efficient way of ensuring that vision impaired people living in East London get the support and services they need.

Sight Action also works closely with the Thomas Pocklington Trust. Sight Action has a wealth of experience and knowledge and works closely with the RNIB to achieve the best possible standards of care for residents in the borough.

Email [enquiries@sightactionhavering.org.uk](mailto:enquiries@sightactionhavering.org.uk)

✓ **Partially Sighted (Havering) - voluntary organisation based at Yew Tree Lodge**

Partially Sighted Society Havering is a voluntary organisation, also based at Yew Tree Resource Centre. The Society pays London Borough of Havering for the use of Yew Tree Resource Centre to run a Monday evening social group, and also runs a Drop-In group every Tuesday afternoon.

The Society's meetings give opportunity for residents to meet in the evening, once a month, and provide a much-valued social outing and emotional support. It also provides weekend events such as barbeques where other family members can join in. The Society is well networked into the borough and provides members with information, contacts, advice and transport help to attend the meetings and events. Users were extremely positive about the "club". The service meets on 3rd Monday of each month between 8pm and 10pm. Transport can be provided.

The Drop-In Group service aims to offer advice and information; and to provide opportunities for visually impaired people to socialise with other visually impaired people, and to share hints and advice on how to get around everyday problems they encounter. In addition, the Society's volunteers demonstrate specialist equipment and how they can be used, thus encouraging independent living.

The Drop-In group meets every Tuesday between 12:30pm and 3pm at Yew Tree Resource Centre.

Contacts: Peter Slattery = [Peter.Slattery@blueyonder.co.uk](mailto:Peter.Slattery@blueyonder.co.uk) and  
John Slattery = [dapjbs@gmail.com](mailto:dapjbs@gmail.com)

✓ Royal National Institute for the Blind (RNIB)

This nationally respected organisation has a wealth of information and guidance on their website, as well as interactive and video information and the ability to speak to one of their advisers. It is worth a visit and can be particularly helpful for family and friends in helping to guide people through the myriad of complex issues which arise, from clinical advice, to employment opportunities, training and fitness and wellbeing.

Contact: [www.rnib.org.uk](http://www.rnib.org.uk) or telephone 0303 129 9999

✓ Havering over Fifties Forum (HOFF)

The HOFF is a non-political organisation which offers a platform where the over 50's can find information and raise issues which are of a concern to them.

The forum is open to Havering residents aged over 50. It meets monthly, usually on the second Tuesday of the month, in the Council Chamber at Havering Town Hall

Contact 07541 511973 for general enquiries; 01708 733711 for membership

Website: [www.havo50forum.org](http://www.havo50forum.org)

Email: [contact@havo50forum.org](mailto:contact@havo50forum.org)

## 9 BACKGROUND READING

To support our work, we have sourced the following documents which we hope will provide additional information to the reader.

- 1) The Importance of an Eye Clinic Liaison Officer - the link below takes you to the RNIB site where a detailed paper sets out the economic benefits to having an ECLO as a key member of the service.

<http://www.rnib.org.uk/economic-impact-eclo>

- 2) The Royal College of Ophthalmologists provide as part of its professional resources advice on the CVI

[www.rcophth.ac.uk/professional-resources/certificate-of-vision-impairment/](http://www.rcophth.ac.uk/professional-resources/certificate-of-vision-impairment/)

It has also produced two videos of interest:

<http://youtu.be/yk0sFBtKNf8> for professionals

[http://youtu.be/4iX\\_0\\_SlLOE](http://youtu.be/4iX_0_SlLOE) for patients

- 3) Certificate of Visual Impairment

[www.gov.uk/government/publications/guidance-published-on-registering-a-vision-impairment-as-a-disability](http://www.gov.uk/government/publications/guidance-published-on-registering-a-vision-impairment-as-a-disability)

- 4) Information available from RNIB

[www.rnib.org.uk/eye-health/registering-your-sight-loss](http://www.rnib.org.uk/eye-health/registering-your-sight-loss)

- 5) DVLA guidance and RNIB guidance for drivers

[patient.info/doctor/visual-disorders-dvla-guide](http://patient.info/doctor/visual-disorders-dvla-guide)

[www.rnib.org.uk/information-everyday-living-getting-around/driving](http://www.rnib.org.uk/information-everyday-living-getting-around/driving)

- 6) LBH advice services  
[www.havering.gov.uk/accessibility](http://www.havering.gov.uk/accessibility)  
[www.haveringcarepoint.org/.../2015/06/Visual-Impairment-booklet1.pdf](http://www.haveringcarepoint.org/.../2015/06/Visual-Impairment-booklet1.pdf)
- 7) The Partially Sighted Group  
[familyserviceshub.havering.gov.uk/kb5/havering/directory](http://familyserviceshub.havering.gov.uk/kb5/havering/directory)
- 8) The changes to the electoral system  
[www.gov.uk/government/organisations/department-of-health](http://www.gov.uk/government/organisations/department-of-health)
- 9) UK Vision Strategy - Seeing It My Way  
[www.visionuk.org.uk/seeing-it-my-way-the-peoples-voice](http://www.visionuk.org.uk/seeing-it-my-way-the-peoples-voice)
- 10) RNIB statistical information  
[www.rnib.org.uk/.../key-information-and-statistics](http://www.rnib.org.uk/.../key-information-and-statistics)
- 11) RNIB Accessible Information Standards AIS  
[www.rnib.org.uk/sites/default/files/RNIB-FAQLeaflet-GP-Practice-Manager-for-1605-implementation-Oct2016\\_0.pdf](http://www.rnib.org.uk/sites/default/files/RNIB-FAQLeaflet-GP-Practice-Manager-for-1605-implementation-Oct2016_0.pdf)

## KAREN'S SUGGESTIONS - *Following from her Prologue on page 4*

### EMPLOYMENT

Getting, and keeping, a job is particularly difficult when you have impaired vision. In fact the shocking fact is that only 27% of those of us of working age are in employment. Luckily though there is some support available.

#### Blind In Business -

<http://www.blindinbusiness.org.uk/>

This organisation, set up by three blind graduates, provides training & advice for sight impaired people hoping to find work or education opportunities. They sent me on helpful workshops & gave me loads of personal guidance when I was looking for my first full-time job.

#### RNIB -

<https://www.rnib.org.uk/information-everyday-living/work-and-employment>

The RNIB provides an absolute wealth of information and advice about how to choose, find and keep a job. For a young person unsure of how to embark on their career, the Trainee Grade Scheme (<https://www.rnib.org.uk/information-everyday-living-work-and-employment-practical-support/trainee-grade-scheme>) is probably of most interest. This provides a year of paid work in one of many areas of employment - a fantastic way to learn key skills & decide what's right for you.

#### Access to Work -

<https://www.gov.uk/access-to-work>

This government scheme provides support if you already have or are about to start paid employment. In my case, I was able to get a voice recorder and a hand-held video magnifier, both of which have been a huge help at work.

#### Blind Person's Tax Allowance -

<https://www.gov.uk/blind-persons-allowance>

This allowance means that you can earn an extra couple of thousand pounds before you start having to pay income tax. It's free money, and is automatically added each year, without you having to reapply.

## EDUCATION

There is a range of help available for sight impaired people who want to learn & develop their skills.

### Disabled Student's Allowance -

<https://www.gov.uk/disabled-students-allowances-dsas>

While studying, this fund provided me with various pieces of IT equipment plus an assistant for note-taking & other tasks.

## Special Examination Arrangements

Wherever you're studying - further or higher education, or gaining a professional qualification - you should request help with materials & exams. I have been able to get electronic versions of printed course materials emailed to me in advance, and had extra time given to me during exams. The format of exams could also be changed to suit your needs. Contact your institution of provider for details.

## BENEFITS

You may not think that your sight impairment costs you money, but I can almost guarantee that it does. From paying for taxis that other people wouldn't need, to buying magnifiers & other visual aids, to replacing the bottle of wine that you knocked onto the floor. You're entitled to benefits, so don't shy away from claiming them.

### Personal Independence Payments (PIP) -

<https://www.gov.uk/pip>

Previously known as Disability Living Allowance, this benefit can be paid to you regardless of your income or employment status. The amount depends on how your disability affects your daily life. Contact the RNIB before applying - they can give you essential guidance on how to fill in the forms.

### Working Tax Credits -

<https://www.gov.uk/working-tax-credit>

If you're working more than 16 hours a week, you can claim this benefit and there is extra money available for those with a CVI.

### General benefits advice -

<https://www.rnib.org.uk/benefits-and-support>

The RNIB, as you'd expect, has a wealth of information available on this subject. Note especially that they provide a 'benefits calculator' that will check what and how much you should be entitled to.

## TRAVEL

I believe travel is the area of my life which is most affected by my sight loss. Accessing the services below has made an enormous difference to my ability to travel and consequently to my sense of independence.

### Freedom Pass -

<https://www.londoncouncils.gov.uk/services/freedom-pass>

This is the single most beneficial thing that my CVI has given me. It is a card which gives me free travel across London and free bus journeys nationally. I use it on trains, tubes and buses every day. It is only available to residents of London boroughs.

### Blue Badge -

<https://www.gov.uk/government/collections/blue-badge-scheme>

Most people think of the blue badge as being associated with a particular car, but people with a CVI can get a 'mobile' blue badge which they can use in any vehicle in which they're a passenger. Blue badge holders sometimes get free parking or discounts/exemptions on things like the Congestion Charge, so it is well worth having.

### Disabled Persons' Railcard -

<https://www.disabledpersons-railcard.co.uk/>

With this card you can get 1/3 off rail fares on all networks, for yourself and for your companion if you're not travelling alone.

### Other rail concessions -

[http://www.nationalrail.co.uk/stations\\_destinations/44965.aspx](http://www.nationalrail.co.uk/stations_destinations/44965.aspx)

Even if you don't buy a railcard, you can use your CVI registration card to get discounts of up to 50% for both of you as long as you are travelling with a companion.

## ENTERTAINMENT

It is always worth mentioning your sight impairment when booking tickets for the theatre, comedy clubs etc, and when arriving at an attraction such as a museum or theme park. Frequently you will get a complimentary ticket for your companion, but there are other benefits on offer such as the ability to 'queue jump' at certain theme parks.

### CEA Cinema Card -

<https://www.ceacard.co.uk/>

This card is accepted in many cinemas across the country, and allows your companion to get a free ticket.

### TV licence -

<http://www.tvlicensing.co.uk/check-if-you-need-one/for-your-home/blindseverely-sight-impaired-aud5>

The discount given to blind (severely sight impaired) TV licence holders is a whopping 50%.

The things I've mentioned here are just the tip of the iceberg, but I hope they'll prove useful to anyone considering getting a CVI, or who's not sure what they can do with the one they already have. I recommend doing some Google research, perhaps about your own eye condition, or about how sight impaired people pursue the pastimes you're interested in. It can be a huge relief just to discover that you are not alone, that there are people experiencing similar things to you, and that there are solutions out there which can make your life easier & richer.

**Karen**

## 10 TABLE OF ABBREVIATIONS

A&E (Department)	Accident and Emergency Department
BHRUT	Barking Havering and Redbridge University Trust
CCG	Clinical Commissioning Group
CVI	Certificate of Visual Impairment
DVLA	Driver and Vehicle Licensing Authority
ECLO	Eye Clinic Liaison Officer
FOI	Freedom of Information
GP	General Practitioner
HOFF	Havering Over Fifties Forum
LBH	London Borough of Havering
Moorfields	Moorfields Eye Hospital
NHS	National Health Service
RNIB	Royal National Institute of Blind People
Royal College	Royal College of Ophthalmologists
RVI	Referral of Vision Impairment
SLA	Service Level Agreement

Healthwatch Havering thanks all service users, staff and other participants who have contributed to this review for their help and co-operation, which is much appreciated.

### Disclaimer

This review is representative only of those service users, staff and other contributors who participated. It does not seek to be representative of all service users and/or staff.

## Participation in Healthwatch Havering

Local people who have time to spare are welcome to join us as volunteers. We need both people who work in health or social care services, and those who are simply interested in getting the best possible health and social care services for the people of Havering.

Our aim is to develop wide, comprehensive and inclusive involvement in Healthwatch Havering, to allow every individual and organisation of the Havering Community to have a role and a voice at a level they feel appropriate to their personal circumstances.

**We are looking for:**

### Members

This is the key working role. For some, this role will provide an opportunity to help improve an area of health and social care where they, their families or friends have experienced problems or difficulties. Very often a life experience has encouraged people to think about giving something back to the local community or simply personal circumstances now allow individuals to have time to develop themselves. This role will enable people to extend their networks, and can help prepare for college, university or a change in the working life. There is no need for any prior experience in health or social care for this role.

The role provides the face to face contact with the community, listening, helping, signposting, providing advice. It also is part of ensuring the most isolated people within our community have a voice.

Some Members may wish to become **Specialists**, developing and using expertise in a particular area of social care or health services.

### Supporters

Participation as a Supporter is open to every citizen and organisation that lives or operates within the London Borough of Havering. Supporters ensure that Healthwatch is rooted in the community and acts with a view to ensure that Healthwatch Havering represents and promotes community involvement in the commissioning, provision and scrutiny of health and social services.

## Interested? Want to know more?



Call us on **01708 303 300**

email

**[enquiries@healthwatchhavering.co.uk](mailto:enquiries@healthwatchhavering.co.uk)**

Find us on Twitter at **@HWHavering**



*Healthwatch Havering is the operating name of  
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Find us on Twitter at **@HWHavering**



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## HEALTH OVERVIEW AND SCRUTINY SUB-COMMITTEE, REPORTS AND WORKPLAN MONITOR

<b>MEETING DATE</b>	<b>DEADLINE FOR SUBMISSION OF PAPERS (CLEARED REPORT, PRESENTATION ETC TO HAVERING DEMOCRATIC SERVICES)</b>
<b>02/10/2018</b>	<b>20/09/2018</b>
<b>Barking &amp; Dagenham</b>	
Health Based Places of Safety	
BHRUT – Improving Cancer Care	
Healthwatch Havering – Services for the Visually Impaired	
Work Programme Update	
<b>15/01/2019</b>	<b>03/01/2019</b>
<b>Waltham Forest</b>	King George Hospital Urgent Care Centre CQC Rating
	NELFT
<b>09/04/2019</b>	<b>28/03/2019</b>
<b>Redbridge</b>	CCGs

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