Oldham cares
Health and social care for Oldham

Agenda item: 4.1

Commissioning Committee

Title of report:	**Responsible manager/Clinical Director:**
Business Case for Oldham Allocation of GM Crisis Care Funding: Integrated Crisis Safe Haven and Home Treatment Team	Gary Flanagan – Senior Commissioning Business Partner Dr. Keith Jeffery – Clinical Director for Mental Health
Programme Budget Area / Areas to which this relates:	
Mental Health	
Summary of Report:	

This business case has been co-produced with Alison Kendall (Programme Manager for Mental Health Strategy, PCFT) and Stan Boaler (Clinical Lead for Mental Health Strategy, PCFT) and developed as part of wider North East Sector Transformation Group.

This report outlines the proposal for the Oldham allocation of the £10.8m to support 'enhanced adult crisis and urgent care options'. The proposal is for a Crisis Safe Haven service, based at Forrest House on the Royal Oldham site ('Evergreen Lounge'), with integrated Home Treatment Team (HTT) support. The service will be provided overnight from 6pm to 9am, 5 nights a week (initially). The service will support people who may experience a mental health crisis overnight, either known to secondary care services already or referred by RAID following presentation at A&E. The service will be an alternative for people who may otherwise be admitted to a MH acute ward overnight, often on a short-stay, informal (not on a section) basis.

Update from Finance and Contracts Committee 19/07/18

Finance and Contracts Committee agreed to recommend the service outlined in this business case to Commissioning Committee next week, subject to the following being completed prior to service commencement:

- The uncommitted funding from within Oldham's MH Transformation Fund allocation for crisis care should be utilised at the discretion of the Senior Commissioning Business Partner and Clinical Director for Mental Health to understand:
  - How the model can include additional non-medical support through integration with voluntary and third sector partners;
  - Whether there is flexibility to scale the service up to 7 days;
- Agreement between the CCG and the Trust on how and when the funding will be transferred – i.e. funding will be for actual costs incurred up to the agreed financial envelope;
- Adjustment to the costings to recognise overheads should not be included in transformation funded schemes;

NHS Pennine Care NHS Foundation Trust · NHS Oldham Care Organisation Northern Care Alliance NHS Group · NHS Oldham Clinical Commissioning Group · MioCare Group · Oldham Council

- Agreement of a schedule of KPIs and outcomes to ensure that the service is delivering on the objectives set out in this business case around admission avoidance and deflections.

Consideration of Equality and Diversity Implications:

See Section 11: Equality Impact Assessment

Risk Implications:

See Section 9: Risks and Implications

Recommendations to Finance and Contracts Committee:

Finance and Contracts Committee are asked to approve the business case proposal set out in this report for the Oldham allocation of GM funding to support ‘enhanced adult crisis and urgent care options’.

1 Background

The five CCGs have collectively made a recommendation for the locality transformation fund allocation to support ‘Enhanced Adult Crisis and Urgent Care programme options’. The proposals outlined within this paper have collectively been developed through the MH Acute and Crisis Care Task and Finish Group and NES Transformation Group.

The key principles of the investment are set out below.

- Development of an approach that is integrated within the current mental health offer – inter-connecting with/embedded within Access Teams, community MH teams, home treatment, CMHT, Healthy Minds.
- The model is built into/aligned with Locality Urgent Care and Neighbourhood developments to support effective pathways and cost effectiveness
- Primarily focus is on mental health crisis support out of hours, however recognising that there are presentations at all times, notably late afternoon and early evening.
- Focus is on people at risk of hospital admission who require specialist input
- Help-line function needs to be integral
- Expand and broaden remit of home treatment model to work with people in crisis, particularly out of hours.
- Establish a ‘safe haven’ for people as an alternative to ED, recognising that for some people ED is a place to get away from the home environment
- Learning from Stockport STEM pilot will be used, as well as models elsewhere in the country
- Challenges around the estate and the need to be co-located near other 24/7 services may mean that in the first instance the ‘safe haven’ is developed on a hospital site
- Service users and carers need to be engaged to shape the model to meet challenges faced, particularly out of hours, and what support they would like to see
- The approach should include peer support and ideally be a multi-agency approach (VCS in the first instance, housing, employment in the longer term).
- The approach will be iterative and one that responds to evaluation.

The approach will be an aligned approach across all boroughs where possible.

2 Case for Change

2.1. The National Picture

In terms of achieving transformation across the mental health service, the biggest challenge currently facing the service is the need to develop alternatives to admission for people in crisis or mental distress during the evening, overnight and at weekends.

The Five Year Forward View for Mental Health establishes “A 7 day NHS – right care, right time, right quality” as its first priority for action. The report finds that in respect a mental health crisis:

> *“If you feel unwell in the evening, during the night or at weekends and bank holidays there is no choice but to go to A&E. There’s no support out there during these times. It’s crucial that this is changed for the benefit of service users, their families and carers”*

Finding alternatives to acute admission to mental health wards is crucial, not least because of the high cost of inpatient care. From a service user and carer perspective, feedback always confirms that, for the most part, people prefer to receive care and support outside of a hospital setting, remaining closer to their homes and support networks.

As a response FYFV directs that the NHS should expand proven community-based services for people with severe mental health problems (such as schizophrenia or personality disorder) who need support to live safely as close to home as possible.

The FYFV asserts that a 24/7 service is required to save lives by reducing suicide and acknowledges that the majority of Crisis Resolution Home Treatment Teams (CRHTTs) are not currently resourced to operate 24/7. It also recognises that CRHTTs are further compromised in their effectiveness by high caseloads, too narrow a range of skills and professional disciplines held within the team and a distraction from core function by absorption of other wider responsibilities. All localities are instructed to reach an understanding of their gap by assessment of their teams against the CORE fidelity criteria.

The CORE study has found widespread evidence across the country of CRHT teams compromising their effectiveness in reducing hospital admissions through "mission creep". Teams have frequently evolved to over-extend beyond their prime and intended exclusive function focussed on only those in severe crisis and into other sub-acute work in compensation for deficiency elsewhere in services. The study has also found that many teams are further compromised by being too small to provide the necessary intensity of care and too restricted in the diversity of skill mix to provide the work with families that is required to be effective.

The NHSE document 'Making the financial case for community crisis resolution and home treatment services' includes the following statements:

- Only 14% of people had a good experience of crisis care (CQC)
- Only 36% of people with MH needs report a positive experience of A&E (CQC)
- Clear imperative for a minimum offer of high-quality, 24/7, timely, expert response for people experiencing a mental health crisis both in and out of hospital (CQC)
- Mental health attendances appear to be rising rapidly. Official data suggests that from 2011-12 and 2015-16 the number of patients attending A&E with a recorded primary diagnosis of mental health, rose by nearly 20%
- Behind this is likely to be underlying, often unidentified mental health need in hospitals for people presenting with physical health reasons. 65-75% of the most frequent attenders to A&E are likely to have mental health needs
- People with mental health needs are 3 times more likely to attend A&E than the general population, and 5 times more likely to have an emergency admission to acute hospitals (Quality Watch)
- Evidence suggests high demand 'out of hours': most MH attendances between 5pm and midnight (Royal College of Emergency Medicine); most mental health admissions via EDs are between 10pm and 7am (CQC)

2.2. Evidence Base

Enhanced HTT/Safe Haven services in other areas of the country have been evidenced to reduce acute mental health admissions and reduction in A&E attendance. A service delivered as part of a Vanguard project in Aldershot, targeted at individuals already known to community mental health services, achieved a number of positive outcomes for patients. This included:

- 25% reduction in admissions to acute mental health beds
- 16% reduction in A&E attendances for mental health assessments
- Consistently positive feedback from service users including patient reported outcomes of averted suicide attempts, reduced social isolation and loneliness and improved service satisfaction
- Providing an opportunity for peer support and volunteering
- Linking those met in crisis with the health and wellbeing service
- HTT focused on a manageable caseload (including 25% reduction in cohort of patients that would previously have attended hospital but now attend Safe Haven)

Enhanced home treatment teams and safe haven services in other CCGs with similar mental health epidemiology and demographic profiles have realised significant benefits through delivering enhanced HTT and Safe Haven services. In 2016, Bradford eliminated all non-specialist out of area placements[1] (saving £1.8m) and Sheffield has had no out of area placements for over two years, reinvesting a previous out of area placement spend of nearly £2.0m in an improved community offer that provides care closer to home.[2]

Safe haven services that have had a positive impact on patient outcomes have all had statutory service involvement. Whilst services with no clinical input may be beneficial for some people attending the service, the safe haven must have clinical involvement in order for it to operate at a higher threshold and ensure that it is able to meet the needs of those currently but inappropriately admitted and the cohort with short term additional need outside the operational hours of the secondary care team they are already involved with absorb some of the work that the HTT currently delivers outside of its own remit or its core hours.

If the effectiveness of the HTT is optimised, and the service is appropriately resourced, the care provided to those in acute crisis will be in a position to achieve demonstrably better outcomes than treatment offered in hospital. Care delivered at home (or close to home) rather than hospital is better placed to retain or enhance support from social networks, address environmental stressors precipitating the crisis and help develop sustainable coping strategies. The financial evidence is also clear, with alternatives to A&E representing a lower spend and improved ROI for commissioners.

2.3. Pennine Care's Mental Health Strategy

These ambitions and development objectives are also the keystone of The Trust's own Mental Health Strategy, which identifies the development of alternatives to hospital admission as essential to its transformed and sustainable future. Out of hospital services which have been independently evaluated to demonstrably reduced inpatient demand in other areas of the country are currently absent across the Pennine Care footprint.

[1] https://www.rcpsych.ac.uk/pdf/Workshop%20C%20Slides%20-%20UE%20Event.pdf (last accessed 14th June 2018)
[2] https://www.england.nhs.uk/mental-health/case-studies/sheffield/ (last accessed 14th June 2018)

Given the longstanding ambition of almost everyone involved in mental health services not to use inpatient services unless necessary, it is suggested therefore, that there is a good case for Pennine to take forward service developments capable of reducing inpatient demand.

2.4. Current Position

During working hours, the mental health service has a number of options for supporting people experiencing crisis or mental distress, these include Healthy Minds services for people with mild to moderate mental health needs or secondary care services such as the Access Team (which can provide short-term interventions), CHMT for those service users with severe and enduring mental health conditions who require longer term case management and Home Treatment services for people in acute mental health crisis who are at risk of an inpatient admission. However the majority of these services are commissioned to provide support during the hours of 9-5pm, Monday to Friday. The exception being the Home Treatment, which operates over a 7 day period until 9pm in the evening. Each borough has a home treatment team however none of these teams are currently resourced to operate over 24/7. There is a requirement in line with the 5YFV for all home treatment to be compliant with the core fidelity model, which includes 24/7 provision by 20/21.

As a consequence, between 9pm in the evening and 9am the following morning, the only option for people experiencing crisis or mental health distress is to present at the Emergency Department where they can receive a mental health assessment. For the clinician undertaking that assessment, there are only two options – either they discharge the person completely, with follow-up support either through the RAID service or the Access Team the following day, or they admit them to a mental health inpatient bed. For people presenting in crisis, frequently with co-morbid mental health, substance misuse issues and the associated risks, this is often a challenging clinical decision to make.

In this instance, the only option for immediate support and safety for that patient is admission, within that out of hours context. Some of these admissions, not all, will be short in length (5 days or less) whilst the immediate crisis is addressed and community support can be put in place.

This places increasing pressure on the inpatient units across the boroughs, all of which are experiencing an increase in demand from patients with severe and enduring mental health illness, including psychosis, who require detention on an inpatient unit under the Mental Health Act. The pressure on the Trust's inpatient resource, particularly in light of the recent CQC inspection which has prohibited the use of lounges and raised concerns over mixed sex accommodation arrangements, is adding increased pressure on beds as the flexibility within the bed resource is compromised.

For the Trust, the need to develop alternatives to admission and design alternative pathways for people in crisis and distress, particularly out of hours, is paramount.

<u>Home Treatment resource</u>

The model for mental health crisis response across the Trust is under-developed and there is a need to develop a consistent response across the Trust to people presenting in acute distress and crisis. The current HTT are not sufficiently resourced to operate 24/7, and have assumed responsibility for providing brief crisis interventions and provision of 7 day follow up for individuals not receiving long term support from mental health services, in the absence of alternative service provision. This significantly restricts the capacity within the existing HTT's to fulfil their core functions of provision of a community-based intensive home treatment offer as an alternative to

admission. Evaluating the models against best practice and CORE fidelity has established significant gaps across all boroughs, particularly with regard to capacity and skill mix.

If the effectiveness of CRHT is optimised then the care provided by it to those in acute crisis is known to have better outcomes than that restricted to treatment away from home in hospital. Care delivered at home rather than hospital is better placed to; retain or enhance support from social networks, address environmental stressors precipitating the crisis, develop sustainable coping strategies. The current under size and heavily compromised CRHTT teams across the footprint determines that patients in mental health crisis, who would get the best outcome from treatment out of hospital, are instead driven into hospital in the absence of the robust 24/7 alternatives which the evidence base shows are both better and cheaper.

In consideration of the CORE study guidance three priorities for improving the effectiveness of our CRHTTs emerge. They are:

- Protect and focus the function by re-allocation of sub-acute work
- Enhance the capacity to reach the necessary intensity and continuity of care
- Develop the skills assets held within team to deliver better working with families

Protect and focus the function of CRHTT by re-allocation of sub-acute work

Restricting development of the crisis care pathway to only within the CRHT will not in itself address the issue of the existing team being pulled away from acutely ill patients requiring intensive home treatment (up to five visits a day to be effective) from distraction toward the different need, higher volume/lower intensity “all inclusive” work of dealing with everyone presenting in distress.

The seminal CORE study by University College London specifically directs that effectiveness for CRHTTs necessarily requires assuring the capacity to deliver high intensity care through manageable caseloads establishing that “high thresholds for accepting referrals are crucial” and “clear alternative sources of sub-acute support” must be available.

It will therefore be crucial to develop new ways of delivering sub-acute work to unburden existing CRHTTs that currently carry the load in the absence of any other 24/7 service operating outside hospital. This requirement is successfully met in other areas of the country by staffed facilities often referred to as crisis cafés such as the Safe Haven in Aldershot.

If home treatment is to operate at optimum levels then the following issues within current services need to be addressed:

- There is a need to develop stronger community support for people who are living with suicidal thoughts/experiencing mental health crisis but would not meet the threshold for secondary care services;
- Pressure is placed on overloaded A&E departments and psychiatric wards with service users often falling through the gaps with no guarantee of effective follow up;
- Attending busy A&E departments can result in exacerbating a mental health crisis and can end up in unnecessary admissions and service users ending up in a “revolving door” of services. Sometimes admissions seem to be the only option to keep people safe; this project aims to provide a multi-agency approach to ensure people get to the most appropriate support to better meet their needs.

2.5. The ‘Do Nothing’ Option

‘Doing nothing’ is only likely to increase costs to CCG through increasing A&E attendances and inpatient admissions (both to general and psychiatric hospitals). These are funds that could be better spent on mental health services that not only bring better outcomes and experience to people, but also reduce costs to CCGs, acute hospitals Trusts and mental health Trusts.

The GM funding has been allocated to CCGs to develop crisis care options for out of hospital provision. Therefore if this proposal is not accepted then alternative proposal for how this funding can support the crisis and urgent care system will be required.

3 Service Description

3.1. Outline of Service

A Safe Haven provides out of hours help and support to people and their carers who are experiencing a mental health crisis or emotional distress. They are staffed by a partnership of mental health professionals, voluntary and community sector providers and peer support workers and are able to address symptoms in a timely way. Safe Havens offer information and advice about other relevant services in the area and they support people in crisis to stay well at home and provide advice, support and guidance to carers and family members.

The Safe Haven is for patients:

- Who are experiencing mental distress or feel that they are in crisis but who are not acutely unwell
- Who may have underlying mental health issues and may already be accessing mental health services
- Who require immediate short-term support outside of typical service opening hours

A Safe Haven environment provides:

- A safe and calm environment to support patients in crisis overnight as an alternative to A&E attendance and/or admission
- Advice and support to help patients manage their emotional wellbeing and mental health
- Integration with local HTTs for assessment, signposting and ongoing support

A Safe Haven is not:

- An open access service for patients who haven’t received a mental health assessment
- An accident and emergency service for patients with mental health issues
- A ‘holding’ service for people requiring an inpatient bed while an appropriate facility is found

The recommendation is to incrementally work towards the development of a hub and spoke approach, with the safe haven providing a place away from the person’s home, as well as away from A&E, for all people to access mental health crisis support, together with a 24/7 home treatment offer to work at home with those specifically at risk of admission.

It is proposed that a service would be developed that could provide out of hours mental health support and aim to:

- Prevent escalation of mental health problems to avoid a mental health crisis;
- Prevent unnecessary referrals to secondary mental health services, A&E departments and other emergency out of hours services;
- Improve mental health and wellbeing;
- Increase independence and self-management;
- Help to identify groups, organisations and opportunities in the community that can support people in building social networks and develop coping skills to prevent mental health crises in the future;
- Reduce isolation.

The service will be developed based on the existing home treatment team resource. The safe haven will be operational for service users from 6pm onwards with the practitioners being available from 4pm to review any referral information and take a handover from core mental health services (such as CMHT or the Access Team).

This will also provide the team with the opportunity to make onward referrals and contact other services in relation to signposting and advice. This will also provide the team with some administration time to document contacts and interventions, complete care plans etc.

The service will be available to known secondary care service users from CMHT, EIT and Outpatients, service users recently discharged from these services, service users recently discharged from inpatient services, service users signposted from RAID and Access for brief follow up intervention or extended assessment and service users open to Home Treatment.

The integrated home treatment/safe haven will provide a safe and therapeutic environment, which allows a person to deescalate, discuss their thoughts and feelings supported by a mental health professional. Safe haven provides crisis support and planning, psycho-education around managing emotional wellbeing and mental health, examples of this include: exploring distraction methods and techniques, relapse prevention planning and keeping safe plans in order to offer an alternative to admission into hospital. Safe haven provides low level input for people expressing social crisis and emotional distress, rather than acute mental illness. It provides a safe place for them to work through crisis points and prevents them from being admitted to the acute wards in the absence of an alternative mental health offer. Patients report they find this useful, as during the evening and at night this is when they often struggle the most. Safe haven will signpost to third sector service in the community, to offer support and social inclusion.

The fact that the service operates throughout the night will enable it to form part of the 24/7 Home Treatment Offer and support the CCGs in working towards achieving this 5FYV target.

The service will be configured as below:

Borough	Crisis Safe Haven Location	Hours of operation	Home Treatment Team Staffing
Oldham	Evergreen Lounge, Forrest House, ROH	5 days TBC, 6pm-9am*	2 qualified and 1 unqualified member of staff on shift 6pm-9am

*This is to be confirmed as the heat map of admissions shows Mon-Fri as higher numbers of admissions, see Section 4.3.

3.2. Service Description/Care Pathway

Unknown service user

The service user will present to A&E out of hours and will be assessed by the RAID team if a mental health assessment is deemed appropriate. Depending on the outcome of that assessment, the practitioner will have three options to consider – discharge with RAID follow-up if required, admission to a mental health inpatient bed or transfer to the safe haven. If the safe haven is assessed as a safe and appropriate pathway for the patient then the RAID team will make contact with the safe haven team and arrange for a supported transfer from A&E to the safe haven base.

The safe haven cannot be accessed directly by someone not previously known to mental health services or someone without a current risk assessment or care plan. In this instance, the initial mental health assessment and risk evaluation will need to be completed by the RAID practitioner in A&E.

Known service user

For service users already known to mental health services (i.e. with a care co-ordinator within the CMHT or within EIT), safe haven can be identified as part of their care plan / risk management plan. Particularly for those service users known to services who regularly access mental health support out of hours (traditionally through the A&E department), making contact and accessing support through the safe haven can be agreed as part of their care plan in conjunction with their mental health worker. A copy of their care plan and risk assessment will then be shared with the safe haven to ensure safe and appropriate support is provided out of hours. In this instance the service user can then access the safe haven directly out of hours without needing to come via the A&E department.

This will be particularly encouraged with those service users identified as frequent flyers and high users of urgent care services.

The team will look to develop links with third sector provider(s) in terms of developing holistic offers and in developing a volunteer/peer support/mentorship approach.

The safe haven team will support onward referral to other services if deemed appropriate.

The safe haven team can also admit to inpatient wards if this deemed appropriate following further assessment.

3.3. Referral process

Referrals will be made via the RAID team working in A&E for people requiring out of hours mental health support. Service users known to secondary care with safe haven identified as part of their crisis relapse plan will be able to access directly. The process will be fully determined as part of the service specification.

The Crisis Safe Haven will take telephone referrals at any time during their hours of operation and agree arrangements for accepted patients to arrive at the Safe Haven within an hour of referral.

3.4. Hours of operation

The service will operate between 6pm in the evening until 9am the following morning over 5 days. This will incorporate the weekend. Home treatment will therefore be able to deliver over the full 24 hour period, with safe haven being integral to this delivery model between the hours of 6pm and 9am.

3.5. Assessment

The Crisis Safe Haven team has a core responsibility to provide an in-depth assessment for each patient that is seen within safe haven to ensure a mandatory full risk assessment, a mental state examination and pro-forma information is completed within every assessment that the practitioner completes. This enables the practitioners to formulate a treatment plan tailored to the specific needs of the individual as a formulation and are key components of the role. If somebody presents who is known to services, the practitioner would only complete the presenting complaint, and MSE and update the existing risk assessment.

Following on from the in-depth assessment a clinical formulation is carried out which is a theoretically based explanation and conceptualisation of the information obtained from the clinical assessment. This offers a hypothesis about the cause and nature of the presenting problems. In the Crisis Safe Haven, formulations are used to communicate the hypothesis and provide a framework for developing the most suitable treatment approach.

Crisis Safe Haven would implement a plan following assessment which may consist of the following:

- When to discuss a case with a Consultant Psychiatrist
- When to make a referral to other services
- Always include carers and family members
- Always complete an adult or child safeguarding where appropriate
- To complete a keeping safe plan with each patient

The keeping safe plan would then be provided to the patient upon discharge, this would include:-

- Distraction techniques which were discussed as a part of the assessment
- A plan of care and treatment to be provided following discharge from Crisis Safe Haven, and this is signed by both the patient and practitioner.
- Contact telephone numbers for additional support outside of the Crisis Safe Haven team, e.g. Samaritans.

3.6. Care Planning

Dependant on presentation, clinical staff will work collaboratively with patients during their time together in the Safe Haven so that the patient will leave with an agreed 'what next and keeping safe plan'.

3.7. Interventions

The service will offer:

- Comprehensive psychosocial assessments and risk assessments
- Mental state review and monitoring
- Informal peer support
- A range of structured group and 1:1 brief interventions to support with:
    - Coping strategy enhancement,
    - Symptom awareness and management,
    - Recovery and staying well planning,
    - Reducing self-harm,
    - Anxiety management
    - Relaxation
    - Signposting
    - Onward referral

3.8. Involving service users and carers

The team will actively involve the service user, family and carers in all stages of their intervention including assessment and development of care plans. The service will aim to help the service user to learn from the crisis, thus reducing their vulnerability and maximise their resilience. They will at all times empower service users by respecting their independence.

3.10. Acceptance/exclusion criteria

The team will accept referrals for all service users meeting the threshold for secondary care mental health services and with an identified mental health condition.

3.11. Interdependency

The service allows for direct referrals to Healthy Minds, which allows for access to psychological interventions must quicker. Where a patient is open to one of existing services, practitioners will liaise with the corresponding service to update on their recent contact with services and provide them with details of the discharge plan and next steps.

There will be interdependencies with the following services in Oldham and options for how the services will work together are being explored:

- RAID
- Tameside, Oldham and Glossop Mind
- Turning Point Drug and Alcohol service (ROAR)

- Early Help

The service will be included in the care plans for people on a CMHT/HTT caseload but there may be interdependencies with other MH teams with the Trust such as EIP and Inpatient services.

4 Benefits and Outcomes

4.1. Benefits

The below table provides a summary of how this service will help alleviate the significant pressures CCGs and providers and facing across community, crisis and acute pathways.

System Pressure	Impact
Reducing no. of admissions to MH ward	Yes – directly support reduction for short-stay to everyone irrespective of known to services or not, who requires support overnight
Reducing no. of admissions OOA	Yes – indirectly as should lead to increased bed availability with the Trust
Reducing MH A&E attendances	Yes – directly where clinically appropriate
DTOCs from MH wards	Yes – directly as CRHTT provides early supported discharge and crisis safe haven as part of supported discharge
Readmission rates to MH wards	Yes – directly, as would be known to CRHTT and could form part of a supported discharge package
4 hour A&E breaches	Yes – as alternative to A&E for patients who do not need full RAID assessment or are waiting for admission
12 hour A&E breaches	Yes – indirectly with reduction in overall MH admissions creating capacity
Use of lounge on MH ward	Yes – indirectly with reduction in overall MH admissions creating capacity
Lack of out of hours provision – known to services	Yes – directly as no current provision outside ED setting for MH crisis support. The model would support wider spectrum of MH need
Lack of out of hours – not known to services	Yes – the model would support wider spectrum of MH need

There will be locally defined outcomes developed for the service that will be developed from the following expectations of the service to:

- Divert activity from A&E between the hours of 9pm and 9am;
- Provide an alternative to admission between the hours of 9pm and 9am;
- Support reduction in short term admissions of 0-5 days.

4.2. Evidence Base

The Safe Haven stands apart from some other café type facilities in that it has evaluated well in both reduction of acute mental health admissions and reduction in A&E attendance which evaluation associates with a collaborative staffing model involving statutory and voluntary sectors. The local NHS mental health provider is commissioned to contribute nursing staff to work with staff and peer support workers commissioned from two local third sector providers. Emergent local experience around the effectiveness of Sanctuary facilities indicates that the absence of any statutory service involvement through contribution of clinical staffing leads to sub-optimal performance below the required threshold of need. This has meant that although worthwhile work has been done these services have not transpired to come up to meet the level of need the CRHTT needs to pass down to become effective in its raised place in the crisis care pathway i.e. a robust alternative to hospital admission. The partnership approach has bridged this gap and succeeded in:

- 25% reduction in admissions to acute mental health beds
- 16% reduction in A&E attendances for mental health assessments
- Receiving positive feedback from service users
- Providing an opportunity for peer support and volunteering
- Linking those met in crisis with the health and wellbeing service

A recent visit to and meeting with representatives at the Safe Haven in Aldershot confirmed that there is a close, beneficial, and essential interdependent relationship between the Safe Haven and the local CRHTT. The CRHTT is now focussed on a manageable caseload that includes the 25% reduction cohort of patients that used to be in hospital when the CRHTT existed but the Safe Haven did not. It is now able to deliver the necessary intensity of care to this cohort because other people in distress have their different needs met by the Safe Haven better alternative.

4.3. Activity levels

The Crisis Safe Haven/HTT service is being designed as an alternative to admission, and therefore the expected cohort of people who will access this service is based on 2 cohorts of people:

- People referred to RAID out of hours who are known to secondary care teams (i.e. EIT, CMHT, OP) and in many cases may be 'repeat attenders'; and
- People who are admitted on a 'short-stay' basis, often informally (i.e. non-MHA admission).

There is local data that identifies the need for a local Crisis Safe Haven:
Day and times when most admissions occur

A heat map of admission to Pennine Care beds by day and time indicate that weekday evenings generate most admissions:

Admissions By Day and Time

	AdmissionDay							
Hour of Adm..	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Grand Total
3 AM	6	10	8	10	13	11	6	64
4 AM	9	16	11	12	17	7	4	76
5 AM	10	13	15	9	22	9	3	81
6 AM	3	8	9	14	8	10	6	58
7 AM	4	6	6	4	8	4	3	35
8 AM	3	6	2	1	5	6	3	26
9 AM	7	6	2	5	10	6	3	39
10 AM	6	13	6	6	7	6	7	51
11 AM	3	3	6	14	9	14	4	53
12 PM	3	8	9	7	14	15	14	70
1 PM	17	14	13	21	22	9	10	106
2 PM	16	20	28	19	24	10	9	126
3 PM	23	33	33	33	35	14	13	184
4 PM	32	43	30	41	50	16	11	223
5 PM	39	44	48	44	49	11	12	247
6 PM	39	25	56	45	55	22	10	252
7 PM	49	44	33	32	47	23	18	246
8 PM	43	48	43	64	44	20	23	285
9 PM	28	33	34	30	28	17	10	180
10 PM	19	29	15	25	20	10	15	133
11 PM	24	38	31	28	38	28	10	197
Grand Total	404	500	479	510	567	317	217	2,994

It should be recognised that the above heat map indicates that actually there are a higher number of admissions mid-week and therefore the proposed days for the Crisis Safe Haven to be open may need to be reviewed during the first year.

The above table does show that more than half of all admissions occur in less than a third of the day (5pm to midnight) and the below figure shows this for PCFT footprint. The

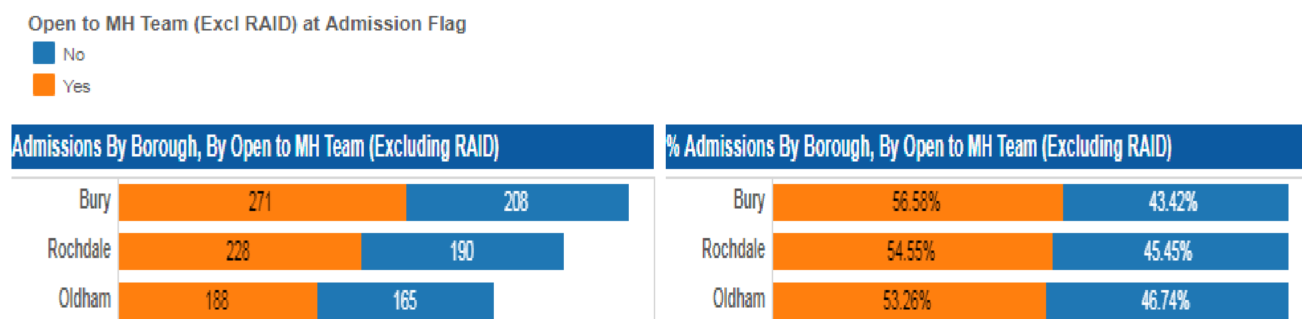
Admissions by CCG Apr17-Apr18	Total number	Day 9am to 5pm	Evening 5pm to 12am	Night 12am to 9am
Bury	358	28%	54%	18%
Oldham	402	21%	55%	24%
HMR	425	25%	55%	20%
Stockport	358	27%	55%	18%
Tameside and Glossop	389	30%	49%	21%
Trust		**26%**	**53%**	**21%**

Pressures to admit from RAID referrals in A&E

60% of patients referred to RAID in A&E are not currently on a CMHT or EIT caseload, and neither are they being seen as an outpatient by a psychiatrist. The below table shows the count of referrals to Oldham adult RAID team, with a referral source of 'Accident and Emergency' that are received between 5pm and 9am in 2017/18, split by open and not open to secondary care mental health.

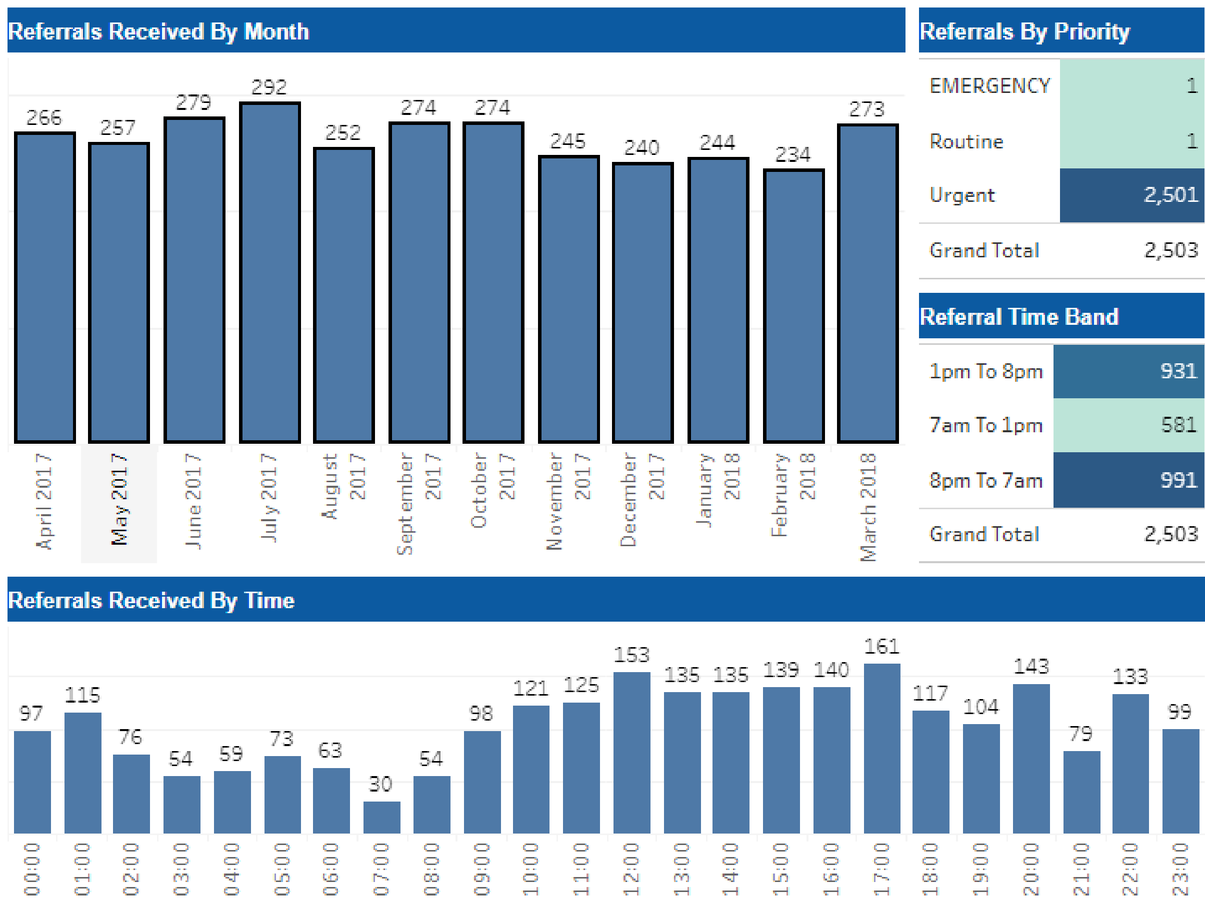
Month	Open to CMHT, EIT or OP team	Not open to relevant team	Total
Apr-17	41	84	125
May-17	38	98	136
Jun-17	44	93	137
Jul-17	49	92	141
Aug-17	43	87	130
Sep-17	35	86	121
Oct-17	25	93	118
Nov-17	36	71	107
Dec-17	37	73	110
Jan-18	34	82	116
Feb-18	34	73	107
Mar-18 (to 20th)	7	36	43
Total	**554**	**837**	**1391**

The high number of people seen by RAID practitioners in A&E who are not known to services are carried through to the high number of patients (45%) not open to services who are admitted to wards.



The data identifies an opportunity to impact on the number of admissions to PCFT mental health wards by introducing a Safe Haven alternative at the time when we admit the most – i.e. between 5pm and midnight. This alternative will provide assessing clinicians, often concerned about risk and safety, a new option of supervised care in the evening and at night that doesn't require admission to hospital. This will be effective in cases where the clinician has assessed a patient not known to services already and is required to make a decision on what is best for the patient based only on the presentation before them (with no history). Often in these circumstances there is the risk of breach and the individual is admitted due to reluctance on the clinician's part to discharge the patient in the middle of the night.

Referrals by time of day to Oldham RAID in A&E



From the above information it can be determined that:

- Referrals to RAID through the evening (5pm to midnight) remains high at 37% of all referrals;
- Referrals during the night from midnight to 8am continue to result in pressure to admit.

Conclusions based on activity information

CORE compliance for Home Treatment Teams demands 24/7 availability, whereas the clinical demand for planned home visits for late evening and night time is exceptionally low. Conversely the current pattern of admission is heavily weighted (consistently more than 70%) towards the evening and night. The Safe Haven will be effective in rebalancing and regularising the threshold to admission over 24 hours with the net effect of reducing total admissions. It is proposed therefore that Safe Haven becomes a new facet of and the principle activity of a new Home Treatment Team 'out of hours' enhancement to staffing that has to be made to be CORE compliant in respect of 24/7 cover.

There is an expected impact on A&E attendances also, and through some of the locality transformation work it was determined that approximately 130 A&E attendances in 18/19 could be avoided with this service, which is based on 10% of the number of people referred to RAID out of hours who are known to secondary care teams (EIT, CMHT, OP) and 10% of repeat attendances

after initial RAID assessment in 17/18. An approximate figure of 75 MH admissions in 18/19 based on avoidance of informal (not on a section) admissions are expected to be avoided due to this alternative to admission option.

5 Timescales

The table below provides a high-level summary of the next steps in the approval process. Further clarity will be required from GMHSCP on exact dates for submission of the TFOG implementation plan. The Implementation plan will need to fully outline mobilisation of the proposed model.

Action	Date
Options paper to PCFT Improvement Board MH Work Streams sub group	Complete
Options paper to PCFT Improvement Board	Complete
GMHSP Locality Visit	Complete
Agreed option across NES commissioners and providers	Complete
Benchmarking exercise for CRHTT against core fidelity	Complete
Establish resource requirement and cost	Complete
Establish commissioner/provider project governance	June
Development of business case (including enablers, recruitment and pathway development)	June
Confirmation of funding allocation	June
Approval by Oldham Cares governance	July
Implementation plan/Operational delivery group established	July
Recruitment process commenced	July
Service commencement	Sept/Oct

6 Costs and Resources

6.1. Staffing profile

The staffing mix for the Oldham Safe Haven will be 2 qualified and 1 unqualified members of staff on shift between 6pm and 9am.

The practitioners would be employed by the HTT and rotate into the Safe Haven as part of the weekly rota.

This approach would provide the necessary level of skill, responsibility and flexibility to deliver a robust alternative to admission as it would be operational throughout the night therefore providing support to known service users as well as providing an alternative to A&E and admission for those people experiencing crisis but not necessarily known the services.

The support for unqualified practitioners/peer workers is yet to be established, however colleagues across third and voluntary sector providers will be engaged to understand how support can be provided to this model. At the time of writing this business case, this has not yet been completed however will be built into the project plan and agreed prior to commencement of the service. It is recognised that non-medical input to the service model is important.

6.2. Accommodation

As outlined above, ideally this new approach should be co-located near to other 24/7 services which may mean that in the first instance the 'safe haven' is developed on a hospital site. Some initial thinking has been given to where this could be on each site. Given this is essentially an 'out of hours' service, accommodation utilised by core mental health service during standard working hours could be considered, such as day hospitals or outpatients departments. The start time of the service would need to be considered however, given that the majority of core services operate until 5pm. All of this existing estate would require some investment to provide for the type of environment required for a safe haven approach.

Available transformation investment:

GM TF Contribution to Locality MH Plans	GM MH Strategy REVISED transfer from GMTF to Localities (000)					
	17/18	18/19	19/20	20/21	Total	Recurrent - TBC
Bury	£-	£423	£423	£211	£1,057	£333
HMR	£-	£422	£422	£211	£1,054	£410
Oldham	£-	£467	£467	£234	£1,168	£415
Total	£-	£1,312	£1,312	£656	£3,279	£1,158

The split for each CCG was agreed with finance leads as 40/40/20 however the GM team have confirmed there is flexibility in agreeing this split. The agreed recommendation by NES and PCFT representatives in discussing the model is 20/40/40, which would be more sensible considering part-year effect of the service in 18/19 as it is mobilised. The tentative plan is for service commencement in September 2018.

The mental health transformation investment will be insufficient to support delivery of a 24/7 within each of the boroughs but will be reviewed at a later date if proven successful and further investment will be considered. The summary for the full-year costings for Oldham is outlined below:

Oldham Safe Haven and Hub 5 Day Crisis Offer Business Case	Recurrent	Non-Recurrent	FYE Gross Cost 18/19	PYE Gross Cost 18/19 (6 mths)	FYE Recurrent Cost
Total Cost	£422,763	£12,104	£434,868	£223,486	£422,763

7 Data Collection

The process for data collection will include considerations such as how the data will be extracted, regularity of the data, and reporting format. This process is not yet developed but will be confirmed during the mobilisation stage and will be supported through the existing contractual processes in place between the CCG and Trust.

8 Evaluation

There will need to be an evaluation following the first 6 months of the service to ensure that the anticipated activity levels are reached and that the people accessing the service are appropriate. There will need to be a review to ensure that the one of the key outcomes of the service – to alleviate pressures in the acute care system – has been met.

The Trust has completed a similar evaluation for the Stockport model (STEM) and the framework that has been developed already will be tailored to support Oldham model.

9 Risks and Issues

Risks will be managed through the implementation process prior to commencement – there will be a project group to monitor the implementation of the schemes in this business case as well as the GM schemes. This will move into existing contract quality and performance monitoring processes from commencement of the service. The risks will also be logged through the ICO reporting process such as the highlight report. Some of the risks that have identified to date are outlined below and will be expanded on fully and managed as part of the mobilisation process:

- Recruitment to the Home Treatment Team posts;
- Transport between sites and also between A&E and the Evergreen Lounge;
- Capacity and demand – i.e. will demand outstrip capacity?
- Third sector partners and procurement requirements need to be determined
- Interface with Acute Trust – perception of service as a ‘MH A&E’ and place for people to be sent to if waiting for a bed.

10 Exit Strategy

Should the funding not be agreed in the longer term for this service, then an exit strategy will be enacted. As the practitioners are all qualified mental health nurses, the redeployment process will be of minimal risk due to the Trust consistently carrying a large number of qualified nurse vacancies.

11 Equality Impact Assessment

Equality Impact Assessment has been undertaken and no concerns identified.

12 Associated Documents

No additional documents