Meeting: Strategic Commissioning Board			
Meeting Date	05 October 2020	**Action**	Approve
Item No	13	**Confidential / Freedom of Information Status**	No
Title	Adult Community Crisis Service		
Presented By	Julie Gonda		
Author	Kez Hayat / Jannine Robinson		
Clinical Lead	Dan Cooke		
Council Lead	Julie Gonda		

Executive Summary

This report sets out the requirements for a community support service for people experiencing mental health crisis and are at risk of self-harm or suicide, the funding will allow the service to operate 3 evenings a week and provide daytime aftercare. The service would be for adults (18 years+) and a 12 month pilot is proposed, with thorough evaluations to determine future plans.

The rationale for this approach is to support the Bury Mental Health Recovery & Transformation work, which aims to ensure that support for people with mental health illness is as non-clinical as possible, whenever this is safe. The proposed service will operate a person-centered peer led crisis support model, in a theraputic environment, providing local people with a choice of non-clinical community based crisis care.

Other points to note include:

- National requirement in the NHS Long Term Plan; provide a range of complementary and alternative crisis services to A&E and admission (including in VCSE/local authority-provided services) within all local mental health crisis pathways.
- Localities across GM have Safe Haven crisis provision (Oldham, HMR, Tameside & Glossop and Stockport)
- Engagement with local community providers, clinical providers and service users supports the need for this type of service.
- Clinical Cabinet has previously signed off the approval of a Mental Health Safe Haven crisis service in August 2018 (paper attached for information).
- Bury admission data for adult and older people's mental health wards confirms the highest number of admissions are Monday to Friday, with Friday having the highest number of admissions. Over 45% of people are admitted between 6pm and midnight.
- In depth discussions have been held with the VCFA, BIG, Beacon Service, Earlybreak and PCFT, all agree there is a need for this type of service.

- Detailed evaluation will inform future commissions and the shape of a future service.
- The expenditure is within the original approved budget. This project will be funded from Greater Manchester Mental Health Transformation Fund already allocated to Bury CCG (GM CCGs share of the £10.8 million).
- Support the wider Urgent Care redesign underway at Fairfield Hospital.
- Supports the local and national priorities identified as part of the response to covid-19 and building back better.

7.1 Bury-safe-haven-BC-final.

Recommendations

It is recommended that the Strategic Commissioning Board:

- Approve the commissioning of a Bury Adult Community Crisis Safe Haven evening service pilot for 12 months, operating 3 days a week.

- Approve a 5 days a week daytime follow up aftercare support service, to provide additional support to people who have accessed the Safe Haven, with a view to preventing future crisis situations.

Links to Strategic Objectives/Corporate Plan	Yes
Does this report seek to address any of the risks included on the Governing Body / Council Assurance Framework? If yes, state which risk below:	Choose an item.
Add details here.	

Implications						
Are there any quality, safeguarding or patient experience implications?	Yes	☒	No	☐	N/A	☐
Has any engagement (clinical, stakeholder or public/patient) been undertaken in relation to this report?	Yes	☒	No	☐	N/A	☐
Have any departments/organisations who will be affected been consulted ?	Yes	☒	No	☐	N/A	☐
Are there any conflicts of interest arising from the proposal or decision being requested?	Yes	☐	No	☒	N/A	☐

Implications						
Are there any financial implications?	Yes	☒	No	☐	N/A	☐
Are there any legal implications?	Yes	☒	No	☐	N/A	☐
Are there any health and safety issues?	Yes	☒	No	☐	N/A	☐
How do proposals align with Health & Wellbeing Strategy?	The Mental Health framework is part of the Health & Wellbeing Strategy.					
How do proposals align with Locality Plan?	Mental health is one of the priorities identified in the Bury Locality Plan.					
How do proposals align with the Commissioning Strategy?	Mental health is part of the Commissioning Strategy.					
Are there any Public, Patient and Service User Implications?	Yes	☒	No	☐	N/A	☐
How do the proposals help to reduce health inequalities?	The implementation of the Community Crisis Service will reduce health inequalities and provide non-clinical crisis support for the Bury population.					
Is there any scrutiny interest?	Yes	☒	No	☐	N/A	☐
What are the Information Governance/ Access to Information implications?	As per standard IG requests.					
Has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☒	N/A	☐
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☒	No	☐	N/A	☐
Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☒	N/A	☐
Are the risks on the CCG /Council/ Strategic Commissioning Board's Risk Register?	Yes	☐	No	☒	N/A	☐
Additional details	*NB - Please use this space to provide any further information in relation to any of the above implications.*					

Governance and Reporting		
Meeting	**Date**	**Outcome**
Clinical Cabinet	01/08/2018	Safe Haven paper was approved.

Adult Community Crisis Service

1. Introduction

1.1. This report sets out the requirements for a community support service for people experiencing mental health crisis and are at risk of suicide, the funding will allow the service to operate 3 evenings a week and provide daytime aftercare.

1.2. The original Safe Haven paper was presented to Clinical Cabinet in August 2018, the clinical elements have been implemented with PCFT, and the community element was approved but not, as yet commissioned.

1.3. Strategic Commissioning Board is requested to consider the information in the report and approve the recommendation to commission a 12 month pilot, with thorough monitoring and evaluations to determine future plans.

2. Background

2.1. National, GM and Local Context

2.2. The National requirement in the NHS Long Term Plan stipulates that a range of complementary and alternative crisis services to A&E and admission (including in VCSE/local authority-provided services) should be present within all local mental health crisis pathways.

2.3. Currently in Bury, people experiencing a mental health crisis have the option of presenting at A&E where they would be assessed by the Mental Health Liaison service, or accessing the Home Treatment Team via the Access & Crisis Service. Both of these services have been commissioned as part of the Pennine Care Mental Health contract and form the current mental health acute pathway. There is no formal acute metal health community provision in Bury, however several community groups report that people have presented at their premises in crisis.

2.4. Over a 12 month period, there were 4,333 referrals to the A&E Mental Health Liaison service at Fairfield Hospital, and there were 2,366 admissions to the inpatient mental health ward.

2.5. In response to covid-19, GM has bolstered crisis services with a number of 24/7 phone lines such as the GM expanded Clinical Assessment Service (CAS) and Trust helplines for patients and carers. These services are part of a GM wide plan to facilitate a centralised 24/7 crisis response for urgent mental health needs with the aim of trying to diverts activity away from hospital A&E and into the most appropriate mental health provision for service users.

2.6. Greater Manchester Health & Social Care Partnership is reviewing options to develop 24/7 mental health crisis services further to meet the expedited requirements of the NHS Long Term Plan. There are 4 options being considered, 3 of the options focus on improving the efficiency and effectiveness of the recently established mental health acute trust 24/7 crisis phone lines and option 4 proposes a wider review of existing and new crisis services. Option 4 does include a possible redesign of existing Safe Haven models. Those currently in operation in Oldham, HMR, Tameside & Glossop

and Stockport are clinical models delivered by PCFT and it is proposed these will be reviewed as part of the PCFT footprint and GM review/ redesign.

2.7. A new Bury community mental health Safe Haven would offer an alternative to the clinical approach that is currently being operated in the other PCFT footprint Safe Havens. The Bury model would focus more on delivering a peer led bio-social support to de-escalate crisis in a non-clinical environment with a solution focused approach.

2.8. Locality Work Undertaken

2.9. The Bury Community Safe Haven model and pathway is supported by and has been developed in conjunction with the PCFT lead consultant for Bury and service leads from the A&E Liaison, Home Treatment, Access & Crisis and Community Mental Health teams. It will strengthen existing local crisis pathways, link in with the wider GM crisis pathways and the local social prescribing team to offer person centered support to prevent further episodes of crisis.

2.10. Bury OCO has invested additional resource into the expansion of the PCFT Home Treatment Team. This includes additional Mental Health Therapists and a dedicated Consultant who will also support the Access & Crisis team, Primary Care GP's and initiate Clozoril initiation in the community.

2.11. Bury OCO has contributed to the development of the Core 24 Greater Manchester Mental Health Liaison service standards. Bury OCO is currently working in partnership with HMR CCG and PCFT to commission an all age Mental Health Liaison service that meets Core 24 standards. This will not only expand the resource of the current PCFT Mental Health Liaison Team but will also support the redesign of the urgent care provision at Fairfield General Hospital, by putting mental health assessment and support within the front door function.

2.12. Bury OCO has also commissioned a 10 month pilot for a new voluntary sector mental health support service, The Getting Help Line. It provides access to local mental health services, self-help tools and signposting. It should be noted it is not a crisis service, however it will be linked into the aftercare pathway for visitors accessing the crisis service.

2.13. For information; a London based charity, Maytree Trust, is planning to open a mental health crisis service to replicate their London set up, in Manchester. The house will be in Prestwich, it will provide non-clinical residential care for up to 4 people for a maximum of 4 nights / 5 days. Maytree will accept referrals from anywhere in the UK and the Director from Maytree is keen to establish local pathway links and Bury people could stay there. Capacity is limited and the opening of this service doesn't remove the need for a community crisis service in Bury.

2.14. Bury admission data for adult and older people's mental health wards at Fairfield Hospital confirms the highest number of admissions are Monday to Friday, with Thursday and Friday having the highest number of admissions. 45% of people are admitted between 6pm and midnight. It is anticipated that people experiencing a crisis will start to need help several hours before these times during the escalation period.

2.15. Over 60% of referrals to A&E Mental Health Liaison occur between midday and midnight.

2.16. In Bury, there were 12 deaths from suicide in 2019 and 20 in 2018, with men three times more likely to die by suicide than women.

2.17. A significant number of people experience mental health crisis that are not known to any services. Core mental health services report that social determinants such as housing, relationships, substance misuse and finance difficulties are often factors impacting on a person's crisis. The Bury Crisis Safe Haven and subsequent day time offer will support individuals to manage these issues and prevent people from escalating into crisis situations.

2.18. Commissioning the Voluntary Sector

2.19. The VCF sector is best placed to deliver this type of service, it is proposed that the Bury VCFA oversee the delivery of this new service. The contract will be awarded to the VCFA as a Supplementary Agreement to the main VCFA agreement.

2.20. The main Agreement is due to expire on 31 March 2021, a clause will be inserted into the Supplementary Agreement similar to that used for the Beacon Service to ensure the pilot operates for the full intended period of 12 months.

2.21. The agreement will request the VCFA to sub contract the lead provider role and the responsibility for all operational aspects of the evening crisis service to Bury Involvement Group (BIG). Following engagement work, BIG has been identified as the most suitable provider, other providers may be involved as required.

2.22. The agreement will request the VCFA to identify a suitable organisation to provide the daytime follow up support service, for example via the Social Prescribing team. A dedicated mental health support worker is required to work closely with BIG to provide essential daytime follow up for visitors accessing the evening crisis service.

2.23. The NHS Shared Business Service procurement team has advised that it is possible to make a direct award for this service to the VCFA. The justification for this decision is based on; local knowledge of the market, sub-contracts will be awarded to local providers, the service will be shared across several providers and the value of the contract is below the threshold for a full procurement process.

2.24. A contract exemption form will be prepared.

3. Adult Community Crisis Service

3.1 Service Outcomes

3.2 The locally defined outcomes for the service will include;

- People will have increased choice and access to non-clinical mental health service when experiencing a crisis.
- People will be given the skills to manage future crisis situations, they will be

offered support to recognise and develop their own strategies for crisis prevention.
  - People will receive aftercare following a visit to the service to further support their recovery following a crisis and help to address social determinants.
  - Opportunities for people with lived experience to work as volunteers and/or peer mentors.

3.3 Service Delivery

3.4 The service delivery model will be shaped by the experienced provider, however the service will be required to;

- Operate the evening service 3 days a week; suggested Monday, Thursday and Friday evenings, between the hours of 6pm and 11pm, based on demand on A&E Mental Health Liaison services at Fairfield Hospital and inpatient admissions to mental health wards.
- The service will be based in a central, accessible Bury location.
- Provide 5 days a week daytime follow up aftercare support service for visitors, to provide additional support with their mental wellbeing, with a view to preventing future crisis situations. The aftercare would link into the Bury Voluntary Sector Mental Health Support Service.
- Samaritans Bury branch have offered to provide out-reach support to people accessing the service on a Friday evening, over the weekend.
- Be staffed by experienced workers both qualified and non-qualified, including people with lived experience, with support from an external clinical facilitator.
- Deliver a preventive model of support providing short term practical and emotional interventions to manage a crisis as an alternative to admission to statutory services where appropriate.
- Work within the proposed crisis pathway and keep up to date with changes.
- Establish an information governance protocol, so visitor information can be shared with consent, with health and social care partners.
- Develop effective links with local clinical services, namely Mental Health Liaison, Access & Crisis Service and the Home treatment Team at Fairfield Hospital, to ensure an operational handover each day the evening service operates.
- Operate a resilience plan to maintain service continuity in the event of staffing absences.
- Draft pathway attached.

Community Safe Haven pathway draf

3.5 Staff Training and Competencies

3.6 The nature of this service carries risks, both to the staff and visitors to the service, all providers must ensure staff and volunteers are trained and developed for their roles.

3.7 Providers must have detailed training records available at the commissioner's request.

3.8 All staff and volunteers should be DBS (Disclosure and Baring Service) checked.

3.9 It is the responsibility of all staff to report any issues of concern in respect of the safe operation of the service.

3.10 The lead provider, BIG, will use an external facilitator with a clinical background, and experience in providing individual and group supervision, to develop the crisis team. Group sessions will be used to reflect on work within the setting as well as any team level issues. Individual supervision will focus on the experience of each practitioner and their emotional wellbeing.

3.11 Capacity

3.12 The number of visitors able to access the Community Crisis Service each evening is projected to be between 4 and 7, if staffing is reduced to 2, the service will still operate on a reduced visitor capacity of between 2 and 4.

3.13 The capacity will be agreed with the provider once the final delivery model is agreed.

3.14 Some visitors will require more support than others from the follow up daytime service, and it is expected a small percentage of visitors will be referred into clinical services and equally some visitors will not require any further support.

3.15 The Daytime Mental Health Link Worker will liaise with the evening Service Manager to review capacity.

3.16 Quality Assurance and Monitoring

3.17 The providers will develop robust procedure and policy documents to ensure the safety of staff, volunteers and visitors. The Standard Operating Procedure document has been developed with partners from the wider crisis pathway. Documents will be reviewed and updated periodically as the service develops.

3.18 The service will be closely monitored, meetings will be held fortnightly for the first 2 months of the service going live, then monthly thereafter.

3.19 The monitoring meetings will involve all partners in the Crisis Pathway including representatives from the evening and daytime services, Home Treatment Team, Mental Health Liaison, Access & Crisis and Commissioners. The frequency of these meetings will be adjusted as necessary.

3.20 Before the end of the contract, the provider will work with Commissioners to evaluate:
(i) The impact the service (day and evening) has had supporting people in crisis.
(ii) How effective a role the service (day and evening) plays in the wider crisis pathway.

3.21 In addition, the VCFA will complete a Service Level Agreement Monitoring Report at quarterly intervals and submit it to the Commissioner.

3.22 Evaluation

3.23 To begin with a period of baseline measurement will be required, this will build a picture for future performance and outcome measures, within the first month of the service going live reporting and evaluation criteria will be agreed.

3.24 There is an anticipation that demand will increase for mental health crisis services, as a direct result of covid-19, this combined with the service operating for a limited number of days / hours, will be taken into account when setting performance measures.

3.25 Evaluation will include;

- Number of people visiting the Community Safe Haven.
- Evaluation of visitor experience of the evening service (using a Goal based outcomes tool)
- Number of people supported by the daytime follow up service
- Evaluation of visitor experience of the daytime service (using a Goal based outcomes tool)
- Reduction in the number of repeat or frequent users of the A&E Mental Health Liaison Service.
- Reduction in the number of inappropriate attendances to A&E, with evidence that service users are accessing the community crisis service.
- Evaluation across the wider crisis pathway of processes and the experiences of services interlinking with the Community Safe Haven.

3.26 Costs

3.27 This new service will provide significant learning, the pilot investment budget of £161,627, will provide a 3 day community evening crisis service and 5 day a week daytime follow up support.

3.28 The cost of this service is **£161,627 for 12 months**.

3.29 The expenditure is within the original approved budget. This project is funded from Greater Manchester (GM) Mental Health Transformation Fund already allocated to Bury CCG (GM CCGs share of the £10.8 million).

3.30 Interdependencies with other services

3.31 This service has a strong interdependency with the A&E Mental Health Liaison service, and clear links with the Home Treatment Team and Community Mental Health Team. The demand on these services will impact the number of referrals into the Community Safe Haven service.

3.32 A paper is also being presented to implement a Core 24 compliant model for A&E Liaison Mental Health service across Bury and HMR. The aim of the Core 24 standard is to provide urgent and emergency liaison mental health services for adults and older adults in emergency departments and general hospital wards.

3.33 This service has links with developments to provide ongoing support in both the VCF sector and to universal services.

3.34 This service will be integral to the wider 24/7 mental health crisis pathway that is being developed across the PCFT footprint and GM.

3.35 The services will support the Urgent Care redesign underway at Fairfield Hospital and be part of the wider urgent care pathway for Bury.

4 Associated Risks

4.1 There is a risk the service may not be able to recruit to the fixed term posts. The mental health Commissioning team will work with the Provider to mobilise the recruitment ASAP subject to approval and monitor progress.

4.2 There is a risk that any activity this scheme deflects may be replaced by new activity, therefore not alleviating the pressures in the system. The Mental Health Commissioning team will monitor the impact of the service on the wider system and are working together with NES, footprint and GM colleagues to implement a 24/7 MH Crisis system

4.3 The CCG doesn't currently have evidence to prove the service will provide the required return on investment (2:1) for a transformational scheme. The pilot will be used to test the proof of concept and ascertain the evidence of value for money. A review of the service will be undertaken at 6 months and 12 months.

5 Recommendations

5.1 The Strategic Commissioning Board is recommended to;

- Approve the commissioning of a Bury adult community crisis Safe Haven evening service pilot for 12 months, operating 3 days a week.

- Approve a 5 days a week daytime follow up aftercare support service for visitors, to provide additional support with their mental wellbeing, with a view to preventing future crisis situations.

6 Actions Required

6.1 The Strategic Commissioning Board is required to:

- Approve the commissioning of a Bury adult community crisis Safe Haven service pilot for 12 months.
- Prepare a Supplementary Agreement for this service, to the main VCFA contract.
- Develop the high level mobilisation timeline into a more detailed action plan to support the role out of the service. It is anticipated the service will go live in February 2021.
- Integrate the Bury Community Crisis Safe Haven as part of the wider Local/NES/GM Mental Health crisis pathway in development.

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September 2020

NHS
Bury
Clinical Commissioning Group

Meeting: Clinical Cabinet			
Meeting Date	01 August 2018	**Action**	Approve
Item No.		**Confidential**	No
Title	Integrated Safe Haven and Home Treatment Team – Bury CCG Business Case		
Presented By	Dr Jeff Schryer, Clinical Chair and Mental Health Clinical Lead, Bury CCG		
Author	Catherine Tickle, Programme Manager, Bury CCG		
Clinical Lead	Dr Jeff Schryer, Clinical Chair and Mental Health Clinical Lead, Bury CCG		

Executive Summary

Clinical Cabinet is asked to consider and support the following Business Case to pilot a proof of concept for an Integrated Crisis Safe Haven and Home Treatment Team Model in Bury. The model has been developed across the North East Sector (NES), with Clinical Commissioning Groups (CCG) and Pennine Care Foundation Trust (PCFT) working in partnership, to define the key principles and evidence base of a Safe Haven and Home Treatment service.

NES CCGs have tailored the model to address the demand within their locality and as a result the models vary in terms of delivery location, operational times and days. The Safe Haven will move the Bury locality closer towards the core fidelity model for Home Treatment Teams, as outlined in the 5 Year Forward View for Mental Health.

The main aim of the Safe Haven in the initial pilot stage is to improve outcomes for patients, ease pressures on A&E and inpatient activity, including out of area activity, by ensuring that the right patients are managed in the right place at the right time. If successful, it is envisaged that this model will evolve to adopt an approach that also focuses on early intervention and prevention and during the pilot this element of the model will be further explored.

The Safe Haven will become a new facet of and the principle activity of a new Home Treatment Team 'out of hours' enhancement to staffing. The service will operate from 6pm-9pm, to align with a hand over to the current Home Treatment Team.

Oldham CCG and HMR CCG are also developing Business Cases to support the development of an Integrated Safe Haven and Home Treatment Team locally, which will be considered in parallel to the Bury proposal through their local governance routes. The proposition is for the three CCGs to work together to explore a core specification, evaluation, opportunities for cost sharing and PCFT will coordinate a single recruitment process for the localities.

Clinical Cabinet is asked to consider the options and associated costs for a 3 day, 4 day and a 5 day model and agree the most appropriate option.

Clinical Cabinet is asked to support this business case and agree local investment to pilot the proof of concept from the Greater Manchester (GM) Mental Health Transformation Fund already allocated to Bury CCG (GM CCGs share of the £10.8 million). If supported, it is recommended that the pilot is evaluated after the first 6 months of the service delivery to monitor its progress, delivery against the agreed objectives and value for money.

Recommendations

Clinical Cabinet is asked to:

- Support in principle, subject to Governing Body approval in September, the 5 day model as a 12 month pilot to test the proof of concept at a cost of £228,584 (PYE) in 18/19 (£403,936 FYE), with a further 40k to facilitate 3rd sector involvement in year 1.

- Support a 6 month review to ensure the pilot is meeting the desired objectives and has robust monitoring data to evidence the impact. If at this point the service does not appear to be demonstrating value for money, it is recommended that the CCG re-considers the delivery model.
- Support an evaluation of the 12 pilot coming to Clinical Cabinet to discuss the future of the Safe Haven Model.
- To note further work will now commence to develop a detailed implementation plan, complete the pathway mapping and engage with the 3rd sector.

Links to CCG Strategic Objectives	
To empower patients so that they want to, and do, take responsibility for their own healthcare. This includes prevention, self-care and navigation of the system.	☒
To deliver system wide transformation in priority areas through innovation	☒
To develop Primary Care to become excellent and high performing commissioners	☐
To work with the Local Authority to establish a single commissioning organization	☐
To maintain and further develop robust and effective working relationships with all stakeholders and partners to drive integrated commissioning.	☐
To deliver long term financial sustainability in partnership with all stakeholders through innovative investment which will benefit the whole Bury economy.	☒
To develop the Locality Care Organisation to a level of maturity such that it can consistently deliver high quality services in line with Commissioner's intentions.	☐
Supports NHS Bury CCG Governance arrangements	☐
Does this report seek to address any of the risks included on the Governing Body Assurance Framework? If yes, state which risk below:	No
GBAF *[Insert Risk Number and Detail Here]*	

Implications						
Are there any quality, safeguarding or patient experience implications?	Yes	☐	No	☒	N/A	☐
Are there any conflicts of interest arising from the proposal or decision being requested?	Yes	☐	No	☒	N/A	☐
Are there any financial Implications?	Yes	☒	No	☐	N/A	☐
Has a Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☒	N/A	☐
Is a Equality, Privacy or Quality Impact Assessment required?	Yes	☒	No	☐	N/A	☐
Are there any associated risks?	Yes	☒	No	☐	N/A	☐
Are the risks on the CCG's risk register?	Yes	☐	No	☒	N/A	☐

Governance and Reporting		
Meeting	**Date**	**Outcome**
Clinical Cabinet	02/05/2018	These boxes are for recording where the report has also been considered and what the outcome was. This will include internal meetings like SMT.
		If the report has not been discussed at any other meeting, these boxes can remain empty.

Integrated Safe Haven and Home Treatment Team – Bury CCG Business Case

1. Introduction

1.1 This paper outlines to Clinical Cabinet a proposal to pilot a proof of concept for a Safe Haven Service in Bury. The aim of the service is to improve outcomes for mental health patients, reduce the burden on A&E and inpatients activity for mental health presentations.

1.2 The proposal is in line with the requirements of the 5 Year Forward View (5YFV) to enhance adult crisis and urgent care and will enable Bury to move closer towards the CORE Fidelity model for Home Treatment Team through an enhanced integrated model.

1.3 The 5YFV establishes that all Crisis Resolution Home treatment Teams (CRHTT) should be compliant against specific requirements by 2020 - being operational 24/7 is one of those requirements. The proposal to make Safe Haven integral to Crisis Resolution Home Treatment Teams is intended to achieve the most benefit from this requirement. The demand for home treatment for those on the established caseload of the team is low with most need satisfied with home visits through the day and at night.

1.4 The main benefit intended by the requirement of CRHTT to cover 24/7 is to respond to the needs of people who present in crisis and do so at any time over the 24hr day. The naturally sporadic nature of presentations of people in crisis with high levels of clinical need determines that there has to be an ever present sufficiency of staff to meet the needs of those who are acutely mentally ill and/or very distressed and/or threatening serious self-harm or suicide. Working exclusively to this cohort with a dedicated staff group sufficient to meet their needs would lead to some time when the staff would be under-utilised with no demand present, therefore the Bury Safe Haven will look to cater for 4 distinct cohorts of patients as outlined in section 13.

1.5 The paper seeks to gain Cabinets support to pilot the model with PCFT for 12 months as a proof of concept, with an evaluation at 6 months, to allow the model to be revised where possible during the pilot period.

1.6 Clinical Cabinet is asked to support this business case and agree local investment to pilot the proof of concept from the GM Mental Health Transformation Fund allocated to CCGs (GM CCGs share of the £10.8 million), of which Bury CCGs share is £1,057k in total, with £423k in 2018/19. The expectation from GM is that this resource will support the development of 'enhanced adult crisis and urgent care options'.

2. Background

2.1 The North East Sector (NES) Clinical Commissioning Groups (CCGs) have been working in partnership with Pennine Care Foundation Trust (PCFT) through the Mental Health Acute and Crisis Care Task and Finish Group and NES Transformation Group, to develop a proposal for a Safe Haven Model.

2.2 The prime function of the Safe Haven service is to provide an alternative to hospital admissions for mental health patients, to improve the outcomes and experience for these patients and to address the increasing pressures on A&E and inpatient activity.

2.3 Each GM CCG has been given a proportion of the £10.8m Greater Manchester (GM) Mental Health Transformation monies, to support 'enhanced adult crisis and urgent care options'.

2.4 The following key principles for the investment were collectively agreed through the Task and Finish Group, as set out below:

- Development of an approach that is integrated within the current mental health offer – inter-connecting with/embedded within Access Teams, Community Mental Health 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 the Emergency Department (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 (Voluntary and Community Sector in the first instance, housing, employment in the longer term).
- The approach will be iterative and one that responds to evaluation.

2.5 A single Safe Haven Model across the NES CCG was explored at the Task and Finish Group supported by a joint Business Case. Given the vulnerability of the cohort of patients the service will support, Bury CCG had concerns about the single site model and requirement to transport patients to a proposed site in Oldham.

2.6 Commissioners have worked with PCFT to identify space in the Irwell Unit at Fairfield Hospital to allow a locality based model. Despite the locality delivery, the approach will be aligned across all boroughs where possible, to ease pressures across the wider system. The services, all of which will be delivered by PCFT, will adopt the same key principles and objectives, but will be tailored in terms of location, and operational times to meet local need and investment envelopes.

3. National Picture

3.1 The biggest challenge in transforming mental health services is the need to develop alternatives to admission for people in crisis or mental distress during the evening, overnight and at weekends.

3.2 The 5YFV for Mental Health establishes "A 7 day NHS – right care, right time, right quality" as its first priority for action, recognising that currently there is little choice for patients outside of core hours, but to go to A&E.

3.3 Finding alternatives to acute admission to mental health wards is crucial, not least because of the high cost of inpatient care. Feedback from service user and carers shows 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.

3.4 The 5YFV directs the expansion of 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.

3.5 It asserts that a 24/7 service is required to save lives by reducing suicide. It acknowledges that the majority of Crisis Resolution Home Treatment Teams (CRHTTs) are not currently resourced to operate 24/7 and are 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. Localities are instructed to reach an understanding of their gap by assessment of their teams against the CORE fidelity criteria.

3.6 A CORE study found widespread evidence across the country of CRHT teams compromising their effectiveness in reducing hospital admissions through "mission creep", with teams over-extended beyond their prime and intended function in compensation for deficiency elsewhere in services.

3.7 Many teams were also found to be 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.

4. Evidence Base

4.1 In developing the proposal for a Safe Haven Model, members of the multi stakeholder task and finish group visited a Vanguard Project in Aldershot and reviewed Enhanced HTT/Safe Haven services in other areas of the country, where evidence showed a reduction in acute mental health admissions and reduction in A&E attendance.

4.2 The Aldershot service, 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
- Positive feedback from service users including patient reported outcomes of averted suicide attempts, reduced social isolation, 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)

4.3 Enhanced Home Treatment Teams and Safe Haven services in other CCGs with similar mental health epidemiology and demographic profiles have realised significant benefits.

4.4 In 2016, Bradford eliminated all non-specialists 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]

4.5 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, 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. The cohort with short term additional need outside the operational hours of the secondary care team supporting them to absorb some of the work that the HTT currently delivers, outside of its own remit or its core hours.

4.6 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.

4.7 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.

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[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)

4.8 The financial evidence is also clear, with alternatives to A&E representing a lower spend and improved return on investment for commissioners.

5. Pennine Care's Mental Health Strategy

5.1 The PCFT Mental health Strategy 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. Development of the Safe Haven Model will support delivery of the strategy.

6. Bury CCG – Current Activity

6.1 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. EIP, 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).

6.2 Table 1 shows a heat map of admissions to Pennine Care beds by day and time. It indicates that weekday evenings generate most admissions. The same variation is evident when admissions to North and South wards at Bury's Irwell Unit are considered as shown in table 2.

Table 1: Heat Map –Admissions PCFT Footprint

Admissions By Day and Time

	AdmissionDay							
Hour of Adm..	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Grand Total
3 AM	5	9	5	10	11	9	4	53
4 AM	7	16	10	11	15	6	3	68
5 AM	8	12	12	7	18	8	3	68
6 AM	2	7	9	12	6	9	5	50
7 AM	2	5	4	4	8	3	1	27
8 AM	2	5	2	1	5	5	3	23
9 AM	7	4	2	5	7	5	2	32
10 AM	5	11	5	5	5	4	7	42
11 AM	2	1	2	10	6	6	4	31
12 PM	3	7	8	5	9	10	10	52
1 PM	16	10	9	14	16	7	10	82
2 PM	11	14	19	14	16	7	7	88
3 PM	14	20	24	14	20	7	9	108
4 PM	27	31	22	25	38	13	9	165
5 PM	27	32	39	31	38	10	10	187
6 PM	25	18	40	29	40	18	9	179
7 PM	44	39	27	25	35	15	16	201
8 PM	38	43	35	50	40	15	20	241
9 PM	25	31	32	26	21	15	6	156
10 PM	17	25	12	22	15	8	13	112
11 PM	24	30	28	24	31	21	10	168
Grand Total	328	405	384	384	439	244	182	2,366

Table 2: Heat Map – Admissions Bury (North and South Ward, Irwell Unit)

Admissions By Day and Time

Hour of Admission Date	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Grand Total
12 AM			4	2	1	1	1	9
1 AM	1	4	5	2	2	6		20
2 AM	1	3	2		2	3	1	12
3 AM	1		1	2	1	1		6
4 AM	2	3	2	3	3	1	1	15
5 AM	5		1	1	4	1	2	14
6 AM	1	1		4	1	1	1	9
7 AM		1			1			2
8 AM	1	2		1	2			6
9 AM			1			1	1	3
10 AM		4			2	1	1	8
11 AM				3	1		1	5
12 PM	1	2	2	2	3	3	2	15
1 PM	5	4	2	5	2	2	2	22
2 PM	3	3	5	2	2		2	17
3 PM	2	4	8	3	4	1		22
4 PM	6	13	6	5	3	5	1	39
5 PM	7	7	19	6	4	3	3	49
6 PM	8	4	5	5	12	3		37
7 PM	10	9	3	6	3	5	3	39
8 PM	11	9	4	11	13	4	6	58
9 PM	4	4	6	5	3	3		25
10 PM	3	10	1	3	2	2		21
11 PM	5	4	3	2	4	6	2	26
Grand Total	77	91	80	73	75	53	30	479

6.3 As the heat map in table 2 indicates higher number of admissions mid-week it is proposed that to test the proof of concept the Bury service is operational during Monday – Friday (exact number of days to be agreed as outlined in this business case).

6.4 It is recommended that this is monitored throughout the pilot and reviewed at 6 months to ensure the service is operating on the optimal days to support the system.

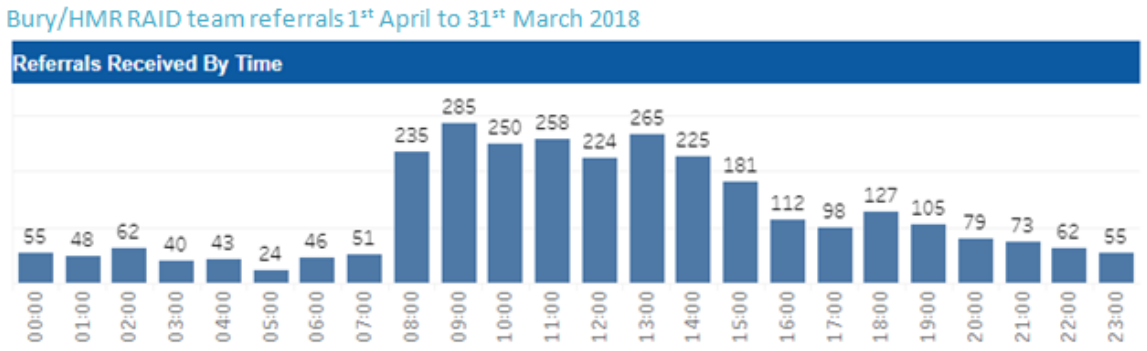
6.5 The Bury data in table 3 shows that more than half of all admissions occur in less than a third of the day (5pm to midnight).

Table 3 – Admission Time Periods by CCG

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%**

6.6 Diagram 1 shows that referrals to RAID after 5pm and before 9am are significant, constituting 46% of all referrals for Bury RAID.

Diagram 1 – RAID Team Referrals 1st April 17 – 31st March 18



6.7 Pressure on assessing clinicians to admit patients following assessment in A&E, out of hours, is increased because of the lack of immediately available service to connect patients to. This is a very significant factor when assessing clinicians are assessing patients who are not known to the service.

6.8 Diagram 2 shows that of all the patients referred to RAID after 5pm and before 9am in A&E more than 75% are not currently on caseload of CMHT, or EIT, and neither are they being seen as an outpatient by a psychiatrist.

6.9 Diagram 3 shows the high numbers of people seen by RAID practitioners in A&E who are not known to services are carried through to the high numbers of patients (43%) not open to services who are admitted to Bury's Adult wards.

Diagram 2: Status of Patients Referred to RAID between 5pm-9am

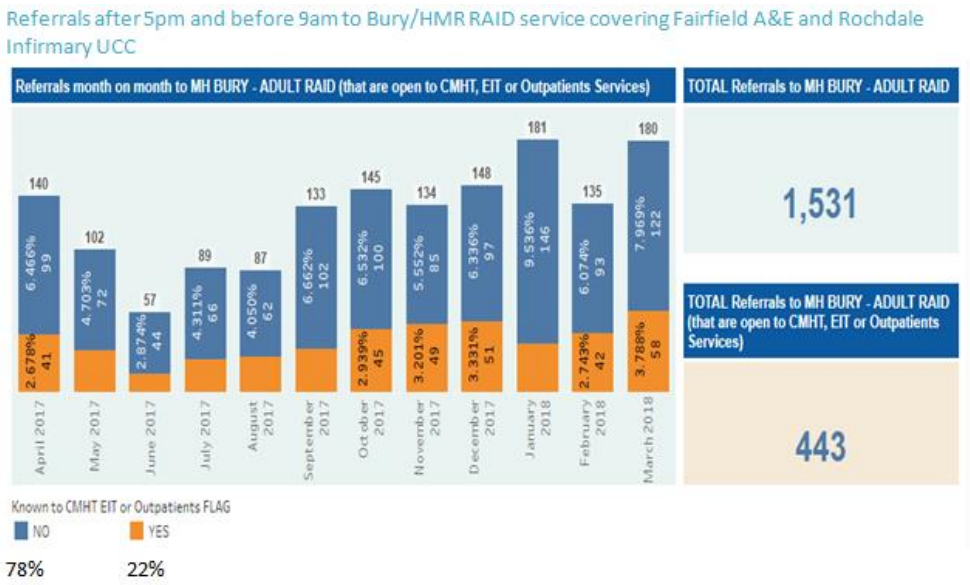
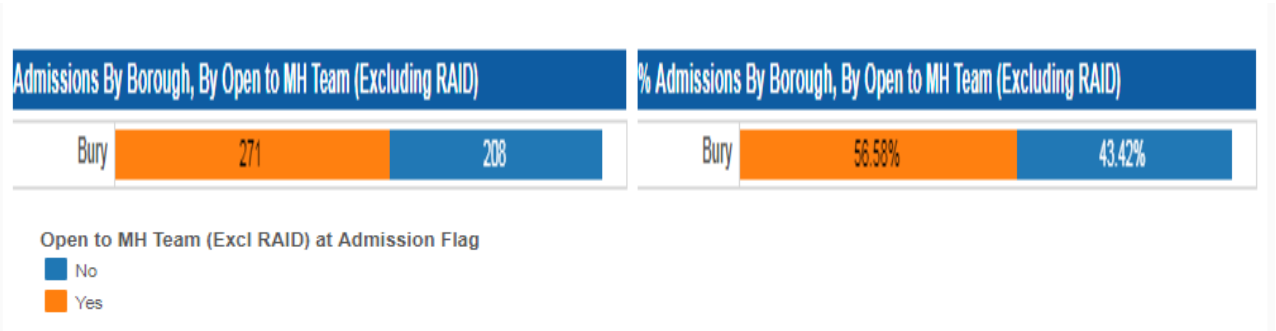


Diagram 3: Percentage of Patients Open to a Mental Health Team on Admission



6.10 This Safe Haven provides assessing clinicians, concerned about risk and safety, a new option of supervised care in the evening and at night that doesn't require admission to hospital.

6.11 This will be especially effective in cases where the clinician has assessed a patient not known to service and on the grounds of safety based only on the presentation before them (there is no history) is reluctant to discharge into the night and therefore defaults to a decision to admit.

7. Bury Safe Haven Proposed Operational Times

7.1 Based on the data in section 6, it is recommended that the Bury Safe Haven service operational times cover the period 5pm -12am, to offer an alternative to admission and that the operational time runs to 8am to align with the handover times of the Bury Home Treatment Team.

7.2 As with the operational days, it is proposed the operational times are monitoring in the pilot and where necessary, and can be facilitated within the financial envelope, these are amended to meet any change in local need.

8. Key Principles of the Bury Service Model

8.1 The Safe Haven will provide out of hours help and support to people and their carers who are experiencing a mental health crisis or emotional distress.

8.2 The service will be staffed by a partnership of mental health professionals and PCFT will be working with the Bury voluntary and community sector providers to support the model, as 3rd sector input into the development and delivery of the model is a key principle for Bury CCG.

8.3 The Safe Haven will offer information and advice about other relevant services in the area and support people in crisis to stay well at home and provide advice, support and guidance to carers and family members.

8.4 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.

8.5 The Safe Haven environment will provide:

- 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

8.6 The CCG will work closely with PCFT and other partners to ensure the Safe Haven does not become:

- 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.

8.7 The recommendation longer terms, subject to the pilot being a success, 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. (check PCFT Bury Team vision also)

8.8 It is proposed that subject to a successful pilot, the service would be developed to 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.

8.9 The pilot service will be developed based on the existing Home Treatment Team resource, 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).

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

8.11 The service will be available to known secondary care service users from CMHT, EIT and Outpatients, those recently discharged from these services, or recently discharged from inpatient services, and those signposted from RAID and Access for brief follow up intervention,

or extended assessment and those open to Home Treatment.

8.12 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.

8.13 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.

8.14 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. Safe Haven will signpost to third sector service in the community, to offer support and social inclusion.

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

9. Service Description/Care Pathway

9.1 Service user not known to other services will present to A&E out of hours and will be assessed by the RAID team if a mental health assessment is deemed appropriate. 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.

9.2 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.

9.3 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.

9.4 For service users already known to mental health services (i.e. with a care coordinator 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.

9.5 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 encouraged with those service users identified as frequent flyers and high users of urgent care services.

9.6 The Bury service referral process will be fully determined as part of the service specification developed to support the pilot and modified as the pilot progresses.

9.7 Going forward, it is envisaged the RAID practitioners will have a role in the Bury Urgent Treatment Centre in identifying people appropriate for Safe Haven before they hit A&E and moving them swiftly to the Safe Haven, whilst also providing in-reach into A&E.

9.8 Having RAID practitioners earlier in the pathway will improve the outcome for patients, reduce

pressure on the system and spend. Discussions are taking place between Mental Health and Urgent Care colleagues to agree this approach.

9.9 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.

9.10 The Crisis Safe Haven team has a core responsibility to provide an in-depth assessment for each patient that is seen to ensure a mandatory full risk assessment, a mental state examination and pro-forma information is completed within every assessment that the practitioner completes.

9.11 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 Mental State Examination (MSE) and update the existing risk assessment.

9.12 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.

9.13 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

9.14 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.

9.15 The service will offer the following interventions:

- 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

9.16 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.

9.17 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.

9.18 The Safe Haven team will admit to inpatient wards if deemed appropriate following further assessment.

9.19 The proximity of the service, located in the Irwell Unit, to A&E will allow for a wraparound model should acute services be required by the patient.

10. Bury Third Sector Involvement

10.1 A key principle of the Bury model is 3rd sector involvement to support patients exiting from the Safe Haven , but also to in-reach into the Safe Haven , where appropriate, to allow a holistic offer to patients addressing the wider determinates impacting on an individual's mental health.

10.2 At the time of writing the Business Case, 3rd sector input has not been appropriately mapped out and a workshop is being arranged by PCFT to bring together third sector colleagues to support development of the model, identify appropriate third sector input and support the evaluation of the pilot. It is also recognised that there is a need to understand the third sector landscape by scoping the services currently available in Bury.

10.3 To ensure 3rd sector input from the outset, opportunities will be explored in the short term to develop pathways to existing 3rd sector services within the locality, to support patients exiting the Safe Haven. The 3rd sector workshop will outline with key partners the requirements for in reach into the Safe Haven and the interventions that can be delivered by the sector and where possible these will be progressed at pace.

10.4 Cabinet is asked to recognise that as this work with 3rd sector is pending, it is not possible to provide an accurate figure of potential costs. It is therefore recommended that the Cabinet approves the inclusion of an indicative sum in the financial envelope to enable 3rd sector involvement, up to £40k which will be retained by the CCG.

11. Interdependencies with the Wider System

11.1 There will be interdependencies with the following services in Bury and subject to Cabinet approval, a workshop is being arranged for early September 18 to work with key partners to agree the pathways for the Safe Haven and outline how the services will work together:

- A&E
- Access Team
- HTT
- Urgent Care Treatment Centre
- RAID/Community RAID
- Bury Healthy Minds
- One Recovery Drug and Alcohol Service
- Inpatient Services
- EIP
- Social Care Services commissioned by LA
- 3rd sector services
- Community Mental Health Team

11.2 The Safe Haven 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.

12. Benefits/Outcomes

12.1 Appendix 2 provides a summary of the anticipated impact the service will have in helping alleviate the significant pressures CCGs and providers are facing across community, crisis and acute pathways.

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

- Divert activity from A&E between the hours of 5pm and 8am, to relieve existing pressures as a significant number of breaches currently relate to limited options for mental health presentations.
- Provide an alternative to admission between the hours of 5pm and 8am;
- Support reduction in short term admissions of 0-5 days.

13. Service Model and Financial Envelope

13.1 The Staffing model and costings have been shared by PCFT Finance with Bury Finance for a 3, 4 and 5 day Safe Haven Model, to allow Clinical Cabinet to consider its options in terms of the level of investment (see appendix 2).

13.2 The indicative cost envelope for the service in year 1, determined by the number of days the service is operational, ranges from:

- £256,533 for a 3 day service
- £332,148 for a 4 day service
- £403,936 for a 5 day service

The above includes non-recurrent costs for estates/security and set up costs. The CCG has not yet validated these costs.

The recurrent costs are:

- £208,259 for a 3 day service
- £281,680 for a 4 day service
- £350,705 for a 5 day service

It should be noted that these figures are FYE and due to the proposed start date of the pilot of November 1st the cost in 18/19 will be lower due to a partial year effect. The costs are included in Appendix 2.

The funding received from the GM Transformation fund is shown below in Table 6. It should be noted that the recurrent funding is only £333k. The costs include overheads at 14%, and in line with the recently agreed letter from Emma Tilston, regarding investments, this uplift needs further breakdown, as it should only include identifiable clinical delivery support costs, not general overheads and surplus contribution.

The staffing costs appear to be reasonable, although they could potentially be explored to see if different shift patterns i.e. long shifts could reduce the total cost given the recurrent level of funding being made available from GM, and that the maximum capacity at any time is 4 patients.

13.3 The costing takes account of shift enhancements, estates costs non recurrent set up costs and transport to enable patients to be transferred between Safe Haven s in the PCFT footprint as an alternative to admission where the local Safe Haven is at capacity. This will be standard process where it is considered in the best interest of the patient to avoid an unnecessary admission.

13.4 The Safe Haven facility can provide care for up to 4 patients at the same time. Given that not all attendees will arrive at the same time and not all will stay until it closes the service has the

rolling the capacity to absorb new demand as it presents through the night so access is not foreseen as a problem.

13.5 To maximise the utility of the Safe Haven its use is extended over four cohorts for whom otherwise there is no access to a service out of hours other than through attending A&E or being a patient on a ward. These cohorts are:

- Those currently admitted to an acute mental health bed because the assessing clinician believes the identified risks are too high to just discharge them into the night from A&.E. This cohort is drawn from the patients currently admitted - 72% of whom are admitted after 5pm and before 9am.
- Those currently sent home following assessment from A&E where the clinician has outstanding serious concerns for safety but recognises that using the very scarce resource of an acute bed would be inappropriate – serious untoward incidents of self-harm and suicide have occurred with this discharged group. This cohort are drawn from the 3000/year patients assessed by Bury RAID – 1531 of whom are seen after 5pm and before 9am - 78% of this 1531 are not known to secondary care mental health services at the time of assessment making safe discharge into no immediate support a risky proposition for some patients.
- Those on caseload of the CRHTT that could be more inclusive to higher threshold of acuity if Home treatment included a required option to support patients at night. The third cohort includes those currently on CRHTT (25-30) but also enables lifting the threshold of acuity of that caseload by extension of their cover over 24 hrs i.e. some admissions could be avoided through the availability of 24hr (rather than 12hr) out of hospital treatment and support.
- Those on CMHT and EIT caseloads that currently in times of crisis attend A&E out of hours because they have nowhere else to turn at that time. This cohort is drawn from the hundreds of patients held on CMHT and EIT caseload that may fall into crisis during 120+ hours per week CMHT is not available.

13.6 Using data for 17/18 there have been approximately 260 inpatient episodes at PAHT (estimated using Month 11 SLAM) which are MH primary diagnosis admitted treated by a non specialist MH provider. The cost of this is was £510k and assuming that the evidence from Aldershot Model is transferable to Bury, it shows that the safe haven model could have the potential to reduce this type of activity by 25%, then this could free up resources within the acute system. The length of stay has not been determined but the cost reduction could potentially be estimated at £128k based on the actual cohort.

13.7 Similarly, of the activity estimated in table 3 (section 6) it indicates that approximately 258 patients could be directed to the Safe Haven instead of being placed in a MH bed. However this could be significantly lower and will be determined through the pilot. Assuming an average cost of £450 to £500 per bed (say £475) this could also save potentially £119k and avoid an out of area placement in the event that PCFT beds were unavailable and conversely freeing up beds for those who require admission to a bed.

13.8 Given that the service model can only look after a maximum of 4 patients at any time, it is important to understand what else the service will be providing, e.g. care plans, signposting etc. and how this impacts on the wider mental health service offer e.g. home treatment teams, community MH teams, RAID etc. There is a risk that if this added value (outlined in 13.4) cannot be demonstrated, then the service shows significant over capacity (table 5) when looking at a potential cohort of 258 patient's pa.

Table 5: Bury CCG Finance Capacity Modelling

Maximum annual capacity		% occupied	% void
3 day model	624	41.3	58.7
5 day model	1,040	24.8	75.2
7 day model	1,456	17.7	82.3

13.9 Table 6 below shows the GM contribution to Locality Mental Health Plans for Bury CCG up to 20/21.

Table 6: Bury Locality GM MH Investment

GM TF Contribution to Locality MH Plans [£000s]	GMTF to Localities: Cash-flow "profile"					
	17/18	18/19	19/20	20/21	Total	Recurrent TBC
Bury	£0	£423	£423	£211	£1,057	£333

13.10 Based on the available investment and the outline costs, Clinical Cabinet is asked to consider supporting a 5 day model for the purpose of the pilot. This will allow what appears to be the optimal model to address the current pressures in the system to be tested, to determine the level of impact on the system and value for money and potential for further investments post the pilot period.

13.11 It is recommended that the CCG considers utlising slippage from the GM Year 1 investment to fund the 3rd sector involvement for the duration of the 12 month pilot. As the pilot commences in November, the year 1 figures are based on a partial year effect.

13.12 The pilot would be utilised as the mechanism to test the third sector involvement and determine the longer term requirements should the pilot be a success and be continued into year 2. The CCG and PCFT will need to monitor the return on investment from the services, deflections and wider impacts on the system and consider if funding can be moved around the system to support future investment into the model.

14. Identified Risks

14.1 The following risks have been identified for the pilot:

- There is a risk the trust may not be able to recruitment to the fixed term posts as the trust is expiring recruitment issues. The CCG will work with PCFT to mobilise the recruitment ASAP subject to approval and monitor progress.
- There is a risk that any activity this scheme deflects may be replaced by new activity, therefore not alleviating the pressures in the system. The CCG and PCFT will monitor the impact of the service on the wider system and are working together to map the acute pathways and solutions to address current pressures. Through transformation the CCG and partners will consider opportunities to work differently and focus on lower tier interventions and preventative work to stop the cycle.
- Currently the CCG and PCFT cannot quantify the impact the service will have on OOA inpatient activity and the anticipated reduction in NEL activity and costs. The CCG will work with NES Commissioners and PCFT to ensure robust monitoring processes are in place.
- The CCG doesn't currently have evidence to prove the service will provide the required return on investment (2:1) for a transformational scheme. The pilot will be used to test the proof of concept and ascertain the evidence of value for money. A review of the service will be undertaken at 6 months and 12 months.
- Third sector involvement required may be more costly than the nominal fee of 40k included in the paper. The CCG and PCFT will consider opportunities for further 3rd sector input through wider Bury Transformation Schemes.

15. Transforming MH Services Across the Bury Locality

15.1 Cabinet is asked to note a meeting being held on 31st July to discuss mental health Transformation in Bury, agree a shared vision and objectives and establish a transformation

group supported by the Transformation PMO to deliver this transformation.

15.2 The Safe Haven model will be discussed at this meeting and opportunities for investment from the Bury Transformation allocation explored.

15.3 The CCG and PCFT are currently planning a multi stakeholder process mapping exercise to map the current acute and crisis pathways, to develop proposals to transform the pathway, including the introduction of the Safe Haven Model. This exercise will help to inform the priorities for the transformation group.

16. Recommendation

16.1 Cabinet is asked to:

- Support in principle, subject to Governing Body approval in September, the 5 day model as a 12 month pilot to test the proof of concept at a cost of £228,584 (PYE) in 18/19 (£403,936 FYE), with a further 40k to facilitate 3rd sector involvement in year 1.
- Support a 6 month review to ensure the pilot is meeting the desired objectives and has robust monitoring data to evidence the impact. If at this point the service does not appear to be demonstrating value for money, it is recommended that the CCG re-considers the delivery model.
- Support an evaluation of the 12 pilot coming to Clinical Cabinet to discuss the future of the Safe Haven Model.
- To note further work will now commence to develop a detailed implementation plan, complete the pathway mapping and engage with the 3rd sector.

17. Next Steps

- Undertaken a process mapping work shop for the acute and crisis pathway with key partners to explore opportunities to improve the pathway for patients and identify efficiencies.
- Work with key partners, including the 3rd sector to development the pathways for the Safe Haven.
- Develop the high level mobilisation timeline in appendix 3 into a more detailed action plan to support the role out of the service from 1st November 2018.

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Sue Hargreaves
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Dil Jauffur
Associate Director, Mental Health & Specialist Services Bury, Pennine Care Foundation Trust

Appendix 1: Expected Impact on the Wider System from the Safe Haven

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

Appendix 2: Safe Haven Financial Modelling

Bury Safe Haven

Please find below the requested costs for 3, 4 and 5 day Safe Haven service in Bury.
Please note that the costs for the voluntary sector have not been included, this is not information that is available to Pennine Care and would need to be provided by the CCG.

BURY

3 day (assumed weekdays)

Bury Safe Haven and Hub 3 Day Crisis Offer Business Case	Recurrent	Non-Recurrent	FYE Gross Cost 18/19	PYE Gross Cost 18/19 (6mths)	FYE Recurrent Cost
Pay	£174,667	£0	£174,667	£87,334	£174,667
Non-pay	£7,632	£42,257	£49,889	£46,073	£7,632
Clinical Delivery Support Costs/Surplus (14%)	£25,959	£6,017	£31,977	£18,997	£25,959
Total Cost	**£208,259**	**£48,275**	**£256,533**	**£152,404**	**£208,259**

Skill Mix	Band	Requirement per shift	WTE Required for Service
Qualified Practitioner 5pm-1am	Band 6	2 per shift	1.50
Qualified Practitioner 12am - 8am	Band 6	2 per shift	1.50
Support worker 5pm - 1am	Band 3	1 per shift	0.75
Support worker 12am - 8am	Band 3	1 per shift	0.75
Total			**4.50**

4 day (assumed weekdays)

Bury Safe Haven and Hub 4 Day Crisis Offer Business Case	Recurrent	Non-Recurrent	FYE Gross Cost 18/19	PYE Gross Cost 18/19 (6mths)	FYE Recurrent Cost
Pay	£236,937	£0	£236,937	£118,468	£236,937
Non-pay	£9,632	£44,177	£53,809	£48,993	£9,632
Clinical Delivery Support Costs/Surplus (14%)	£35,111	£6,291	£41,402	£23,846	£35,111
Total Cost	**£281,680**	**£50,467**	**£332,148**	**£191,307**	**£281,680**

Skill Mix	Band	Requirement per shift	WTE Required for Service
Qualified Practitioner 5pm-1am	Band 6	2 per shift	2.00
Qualified Practitioner 12am - 8am	Band 6	2 per shift	2.00
Support worker 5pm - 1am	Band 3	1 per shift	1.00
Support worker 12am - 8am	Band 3	1 per shift	1.00
Total			**6.00**

5 day (assumed weekdays)

Bury Safe Haven and Hub 5 Day Crisis Offer Business Case	Recurrent	Non-Recurrent	FYE Gross Cost 18/19	PYE Gross Cost 18/19 (6mths)	FYE Recurrent Cost
Pay	£293,950	£0	£293,950	£146,975	£293,950
Non-pay	£13,040	£46,596	£59,636	£53,116	£13,040
Clinical Delivery Support Costs/Surplus (14%)	£43,715	£6,635	£50,351	£28,493	£43,715
Total Cost	**£350,705**	**£53,231**	**£403,936**	**£228,584**	**£350,705**

Skill Mix	Band	Requirement per shift	WTE Required for Service
Qualified Practitioner 5pm-1am	Band 6	2 per shift	2.50
Qualified Practitioner 12am - 8am	Band 6	2 per shift	2.50
Support worker 5pm - 1am	Band 3	1 per shift	1.25
Support worker 12am - 8am	Band 3	1 per shift	1.25
Total			**7.50**

Assumptions:

- *All pay costs are based on the 2018/19 proposed transitional pay rates at mid-point*
- *All posts include enhancements as per the proposed shift pattern and requirements*
- *All pay costs include on costs to PCFT*
- *The costings are based on the 3, 4 and 5 days being worked on weekdays only Mon - Fri*
- *The PYE 2018/19 pay costs assume a mobilisation date of 1st October 2018 and are therefore pro rata*
- *The PYE 2018/19 costs include non-recurrent set up costs of £5,757, £7,677 and £9,596 respectively (3, 4 and 5 days) for mobile working; mobile devices and phones are assumed to be personal issue and are based on the wte*
- *Non-recurrent furniture and fittings costs of £500 (3 and 4 day) and £1,000 (5 day) have been included to set up the Safe Haven within the estate*
- *Non-recurrent estate works, including security CCTV, of £36,000 have been included in the setup costs*
- *Recurrent non-pay costs include travel/printing & stationery/mobile running costs/patient transport*
- *The patient transport figure is unknown, therefore a figure of £5,000, £7,000 and £9,000 respectively (3, 4 and 5 days) has been allocated. This will require further analysis which may result in requiring an adjustment to funding*
- *PCFT clinical delivery support costs and surplus have been applied based on the costing policy*
- *CQUIN has not been calculated on this costing*
- *The FYE recurrent costs are based on 2018/19 and have not been uplifted for inflation*
- *The costings do not include any provision for voluntary sector workforce*

Appendix 3: High level Mobilisation Timelines – Safe Haven

Mobilisation Timescales

Safe Haven Bury	**Action**	**Timescale**
Business case approved	Clinical cabinet approval	1st August 2018
Funding approval	CCG Board	TBC by CCG
Confirmation of intention to invest	Formal letter of approved investment to PCFT to enable recruitment to commence.	TBC by CCG
Recruitment to commence	Posts to be advertised, interviews and recruitment	2/3 months – August to October 2018
Operational	Operational policies and procedures to be developed, clinical pathways and referral processes.	October to November 2018
Estates	To make space within the existing outpatient department at Irwell Unit, Roch House, FGH fit for purpose and installation of anti-ligature furniture.	Design August 2018 Tender September 2018 Construction October 2018
Communication Plan	Communication plan to be developed to ensure all partners briefed on new service offer	October/November
Staff induction	Induction for new staff	By mid-November 2018
Service Launch		1 November 2018

Community Safe Haven (non clinical) DRAFT PATHWAY

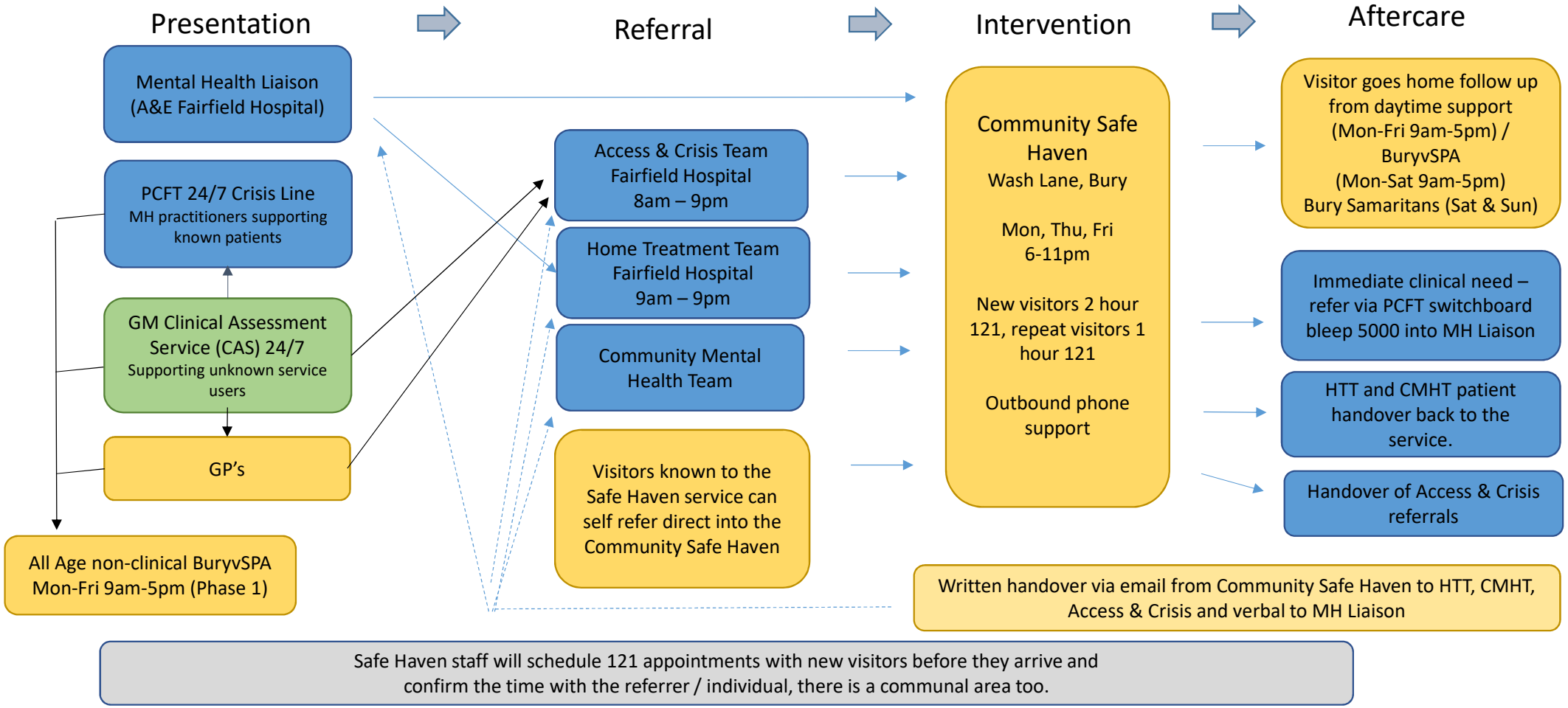
12 month pilot, 3 days a week (Mon, Thu and Fri)

Open 6pm – 11pm, staff hours 5pm until 12.30pm

Green = GM

Blue = PCFT

Yellow = Locality



Safe Haven staff will schedule 121 appointments with new visitors before they arrive and confirm the time with the referrer / individual, there is a communal area too.