



Evaluation of South London and Maudsley NHS Foundation Trust's Centralised Health Based Place of Safety

November 2017

Contents

Executive Summary	3
Background.....	4
Methodology	5
Overview of section 136 activity	6
Attendances	6
Out of area patients	7
Closures and access.....	8
Police Escalation Logs.....	10
The role of A&E.....	10
Physical health competencies at the health based place of safety	11
HBPOS staff and multiagency working.....	12
New 24/7 staffing model	13
Improving service user experience	13
Impact on patient outcomes.....	14
Multiagency working	14
Facilities and HBPOS environment	15
New facilities	16
Staff perceptions.....	16
Service user perceptions	17
Assessment times.....	18
Assessing AMHP service.....	19
Length of stay.....	20
Outcomes	22

Executive Summary

South London and Maudsley NHS Foundation Trust (SLaM) opened a centralised Health Based Place of Safety (HBPOs) in January 2017. The new model of care, replaced four single occupancy HBPOs sites in Lambeth, Lewisham, Croydon and Southwark with one centralised HBPOs based at the Maudsley hospital. This was developed in response to the need to improve the accessibility and quality of care provided to individuals detained under section 136 (s136) of the Mental Health Act. This report outlines the findings of the evaluation of this new service model.

Findings from the first seven months of operation show that access to a HBPOs has significantly improved, with the new site accepting an average of 13% more s136 referrals each month than across the four sites under the old model. Disruption to the service due to site closures has dramatically reduced, falling from 279 incidents of closure across the four sites in 2016 compared to just one closure in 2017.

Patients are also accepted into the site quicker, with 96% of patients admitted within 30 minutes of arrival, demonstrating the benefit of the dedicated team now on site 24/7. In 75% of cases, police officers are able to leave the place of safety within 30 minutes of arrival (up from 67% in 2016), and the proportion of cases resulting in the police having to stay on site for over an hour has reduced by 50%.

The number of patients taken to A&E prior to admission at the HBPOs has fallen, which in part is due to the improved physical health capabilities of HBPOs staff. Qualitative feedback suggests that having a dedicated HBPOs team has also improved service user experience, impacted on the quality of assessment provided, and improved interagency working across the s136 pathway.

The physical environment has also been transformed through the new purpose built facility. Feedback from service users and staff across the multiagency pathway has been overwhelmingly positive; highlighting the impact on patient experience, and quality of assessment. The environment has been designed to support the delivery of safe and dignified care to patients in a therapeutic setting, and staff have reported being able to use the facilities flexibly to manage risk and respond to the changing needs of the individual in their care.

The rate of admission has fallen by 13% under the new model, which has been attributed to improved practice following the introduction of the dedicated staff team and close working with the Trust's Acute Referral Centre, launched in October 2016. This reduction equates to 8 fewer admissions a month, representing a potential annual saving to the Trust of up to £1.2 million.

There is still work to do to improve patient flow and ensure that patients are not detained at the suite for long periods of time. Currently just 1% of patients breach the 72 hour maximum detention time; however under new legislation coming into force in December 2017, the maximum detention time will be reduced to 24 hours, and 23% of patients seen at the centralised HBPOs between January and July 2017 were detained for over 24 hours.

The availability of inpatient beds for onward admission also remains an issue, highlighted by the fact that the length of stay of those individuals requiring admission is on average ten hours longer than those discharged into the community.

Background

In January 2017, the South London and Maudsley NHS Foundation Trust opened a purpose-built centralised Health Based Place of Safety at the Maudsley Hospital in Southwark. This represented a significant change to the Trust's provision to assess people detained under s136 of the Mental Health Act. Previously there were four single occupancy place of safety sites across the four boroughs of Lambeth, Lewisham, Croydon and Southwark.

The previous HBPoS sites operated independently of one another and did not have dedicated 24/7 staffing. This led to unacceptable delays and compromised care for s136 patients and patients on adjacent wards as staff were pulled from the wards on an ad hoc basis to manage patients. The place of safety sites faced frequent closures due to damaged facilities and staff shortages, and in early 2016, the Care Quality Commission (CQC) found two of the facilities (Lambeth and Lewisham) to be unsafe and not fit for purpose.¹

In response to the constant access issues and to ensure a more effective service to those detained under s136, the Trust decided to establish a dedicated, centralised Health Based Place of Safety site at the Maudsley Hospital with 24/7 staffing. Although the overall capacity remains the same (four assessment rooms) the new facility has two additional spaces which are used flexibly to assist patient flow through the department, particularly during peaks in activity

The new model required investment and significant engagement with local partners, and was dependent upon agreement being reached with local authorities. The new model was scrutinised by the Joint Health Overview and Scrutiny Committee and following a public consultation and extensive joint working with partners it was supported.

It was agreed that the new centralised site would serve as a pilot for the pan-London *Section 136 Pathway and Health Based Place of Safety Specification*, published in December 2016. This outlines key principles for s136 pathway and HBPoS sites such as 24/7 dedicated staffing, improved physical health competencies on site, robust acute and mental health pathways between A&E and HBPoS sites and ensuring the physical environment meets the standards set out in the HBPoS Specification.

To understand the impact of SLaM's new model and therefore the pan-London s136 pathway and Health Based Place of Safety specification, Healthy London Partnership has worked with SLaM staff, service users, the police, the London Ambulance Service and AMHPs to carry out an evaluation of the new service. This report outlines the findings of that evaluation.

¹ Care Quality Commission (2016). *South London and Maudsley NHS Foundation Trust Quality Report*.

Methodology

A range of data (both qualitative and quantitative) was used to conduct the evaluation. The table below provides a summary of the data collected and analysed.

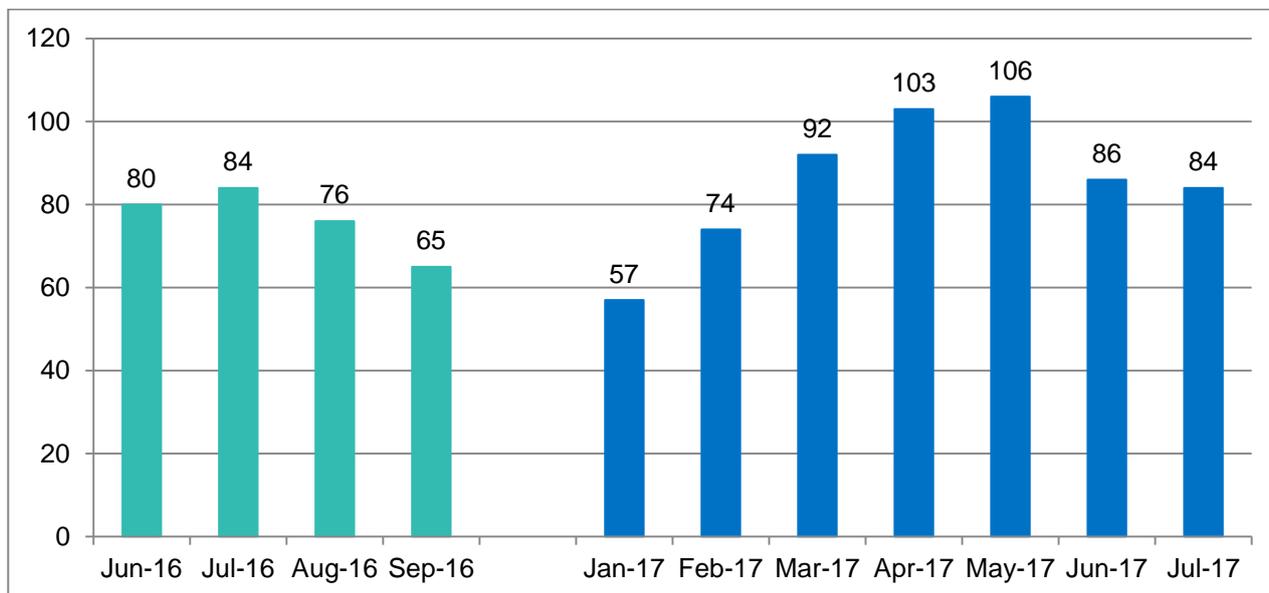
Overview of the data collected	
HBPoS routine service data	<p>Four months of anonymised activity data was provided by the Trust (June-September 2016) from each of the four HBPoS sites that made up the old service model. The dataset included routinely collected information on s136 attendance as well as additional information for the purpose of the evaluation, such as detailed timings of the assessment. Seven months of data was then provided on the new model as a comparison (January-July 2017).</p> <p>Monthly averages have been used where necessary to draw a comparison between the old and new model to account for the differing time periods in the datasets. The data should be interpreted with a little caution due to issues of data quality and completeness; however steps have been taken to highlight any data 'not recorded' in the analysis.</p>
A&E department data	<p>The number of s136 patients seen in neighbouring A&E departments is not routinely recorded; however data from the HBPoS datasets provided information on the number of patients attending A&E either prior to, or during, an admission at the HBPoS site. This has been used to understand the impact of the new model on neighbouring A&E departments.</p> <p>Moving forward more effective data collection is required at A&E departments to understand the number of s136 Mental Health Act assessments that occur in the A&E department.</p>
Service user perspectives	<p>Service user perspectives of both the new and old HBPoS model were collected using questionnaires. Analysis has been included from a longitudinal study carried out by the Trust prior to consolidating the HBPoS sites. This study surveyed 93 s136 patients across the four sites.</p> <p>Since the new model was implemented questionnaires have been distributed to all patients seen at the centralised HBPoS site. Forty-five surveys were returned and analysed for the evaluation, however, the Trust intends on continuing data collection to reach a similar sample size to the 'before' study.</p>
Multiagency staff perspectives	<p>Qualitative data has been gathered from each staff group across the s136 pathway, this includes mental health and acute trust staff, the police, London Ambulance Service and local AMHPs from the four SLaM boroughs. This has been collected through the use of questionnaires, focus groups and one to one interviews with staff.</p>
Police incident escalation logs	<p>The Metropolitan Police have provided a full record of escalated incidents in 2016 and 2017 which have been used to assess whether the number of escalated incidents has reduced under the new model.</p>

Overview of section 136 activity

Attendances

In January 2017, the centralised HBPOs at the Maudsley Hospital site became operational as the only site to accept s136 patients in the Trust. Since its opening, the number of s136 patients accepted into a HBPOs has increased; the monthly average is 13% higher than the 2016 figures.

Chart 1: HBPOs attendances, Jun – Sept 2016 and Jan-Jul 2017



TOTAL (Jun-Sept 2016)	305
Monthly average	76

TOTAL (Jan-Jul 2017)	602
Monthly average	86

When comparing the two time periods, the pattern of activity over the course of the week and time of admission were similar. Activity peaked on a Wednesday, and time of admission steadily rose from the early morning where admissions are at their lowest, through to a peak around midnight (see Chart 2 and 3 below).

Chart 2: Day of admission, Jun – Sept 2016 and Jan-Jul 2017

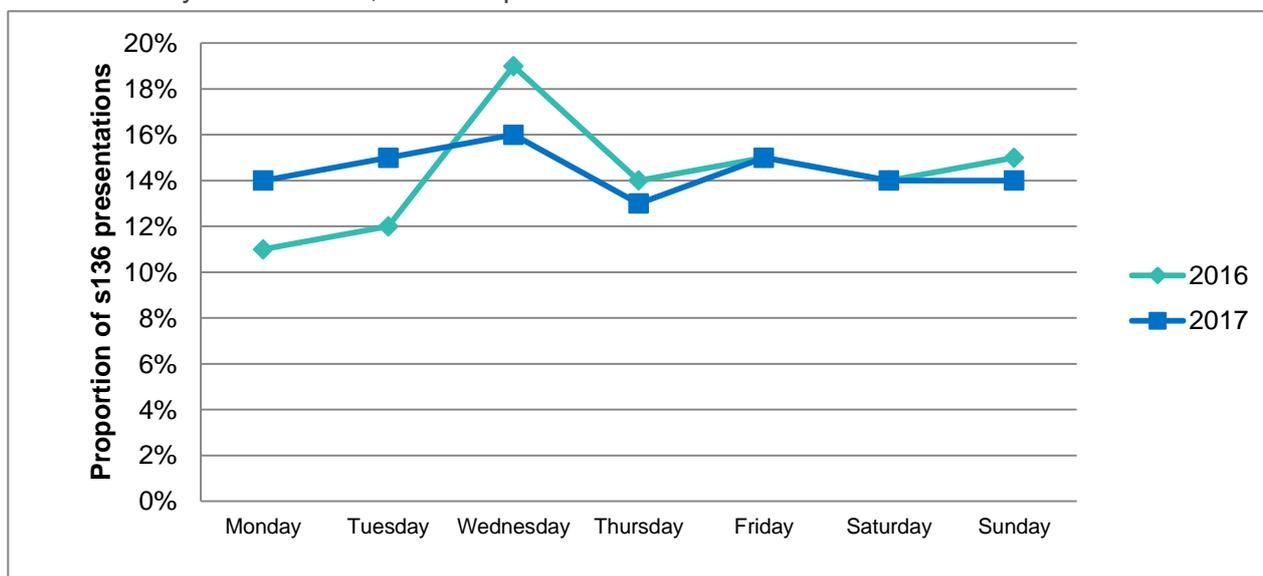
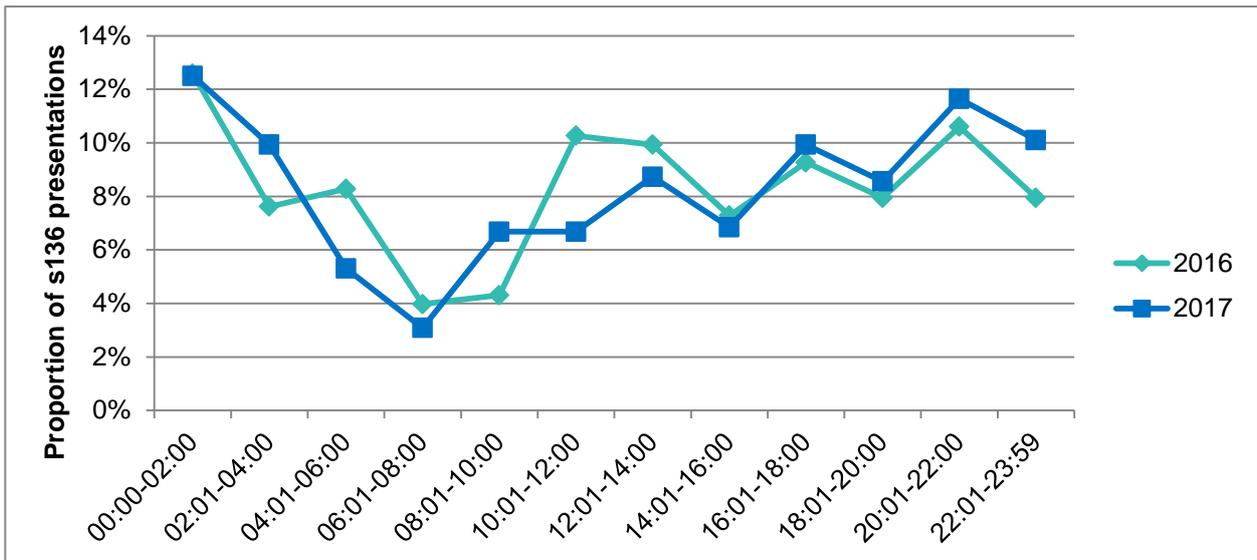
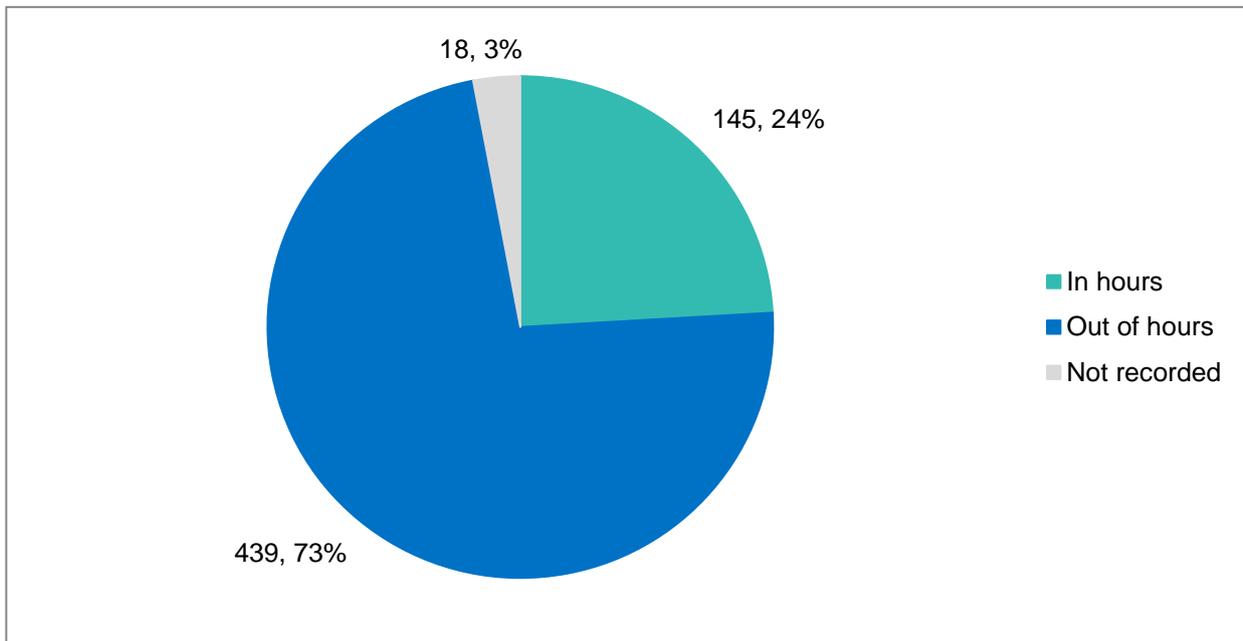


Chart 3: Time of admission, Jun – Sept 2016 and Jan-Jul 2017



Seventy-three per cent of patients accepted to the centralised HBPOs presented out-of-hours (weekdays between 5pm-9am and weekends), demonstrating the importance of a 24/7 staffing model. This trend is consistent across London's HBPOs sites and was also evident under the old model at SLaM, with 79% of patients presenting out-of-hours between June and September 2016.

Chart 4: S136 presentations by in and out of hours, January – July 2017.



N.B. Data labels show the number of patients and percentage.

Out of area patients

There were concerns before the site opened that the centralised site would become the de-facto HBPOs for London with increased activity from out of area patients. However the proportion of out of area patients has remained stable with a 2% reduction under the new model, although there was a higher proportion of missing data in the 2017 data set (see Charts 5 and 6 below). The proportion of patients recorded as having 'no fixed abode' has increased; 1% of patients in the old model compared to 7% of patients from January to July 2017.

Chart 5: s136 presentations by place of residence in/out of area, June – September 2016

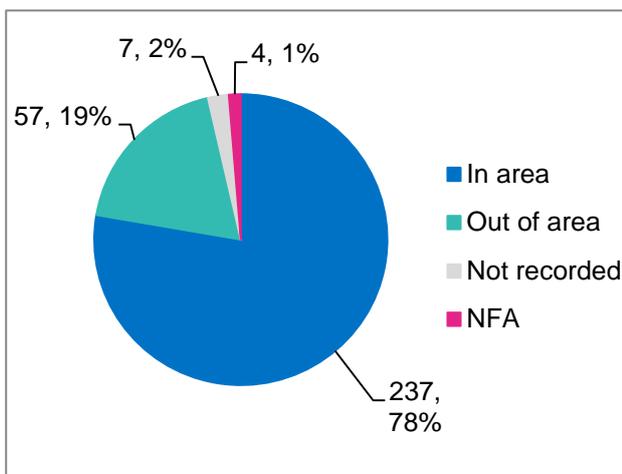
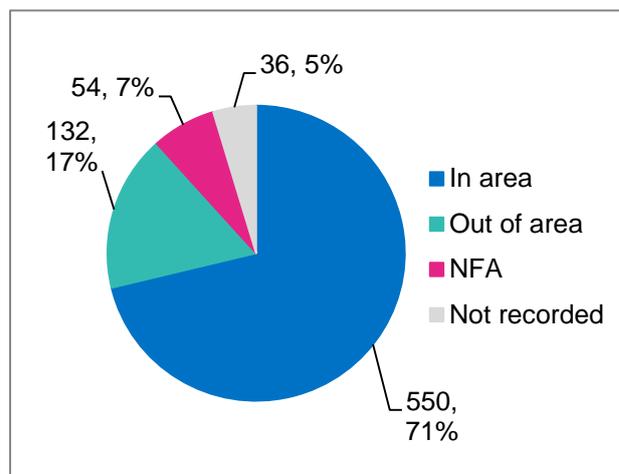


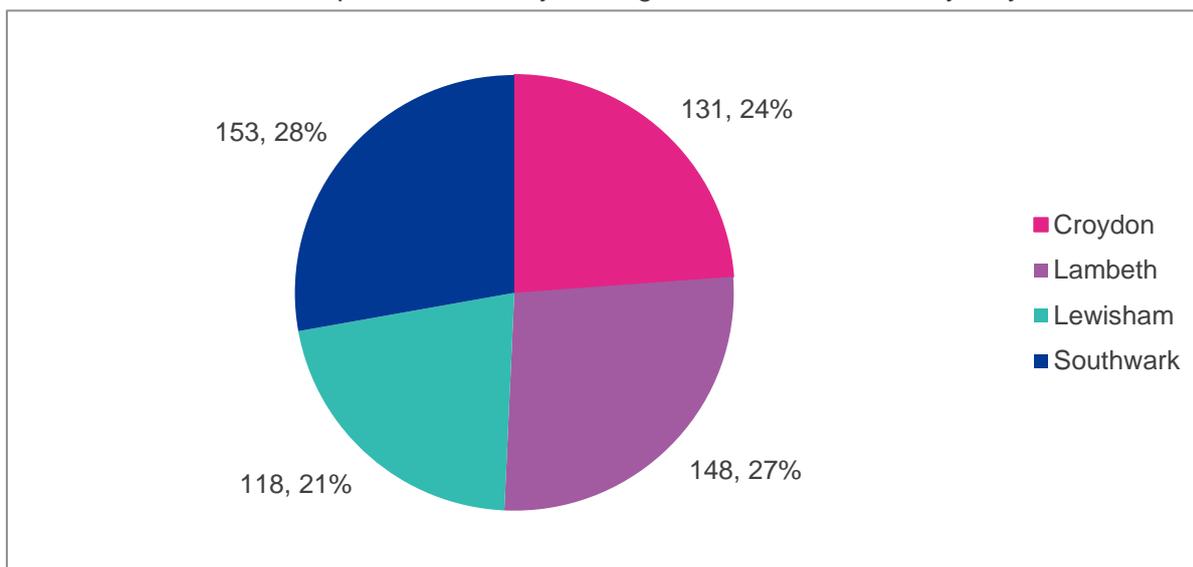
Chart 6: s136 presentations by place of residence in/out of area, January – July 2017



N.B. Data labels show the number of patients and percentage.

Further analysis of in-area patients by borough of residence shows that there is a relatively even spread of s136 activity from each of SLaM's four boroughs (see chart 7). The highest prevalence is seen in Southwark and Lambeth followed by Croydon and Lewisham.

Chart 7: "In-area" s136 presentations by borough of residence, January-July 2017



N.B. Data labels show the number of patients and percentage.

Closures and access

Prior to the centralised HBPOs opening, SLaM's place of safety sites were frequently forced to close due to consistently high levels of demand, the fragile physical infrastructure of two of the suites (Lambeth and Lewisham) and significant difficulties in staffing the sites. It was difficult for staff to ring-fence the rooms for s136 patients therefore they were often used by neighbouring inpatient wards to manage overflow or seclusion. Between January to November 2016, SLaM's HBPOs sites were closed a total of 279 times (see Table 1).

Table 1: Total number of site closures and reasons, January – November 2016

	Staff Shortage	Room in use by neighbouring wards	Maintenance	TOTAL
Southwark	17	94	8	119
Lambeth	33	4	18	55
Lewisham	20	22	7	49
Croydon	37	19	0	56
TOTAL	107	139	33	279

Since the opening of the new site, the unit has only been closed once (due to a short notice staff illness); dramatically reducing the disruption to the service.

There have been 20 occasions between January and July 2017 where occupancy at the place of safety has been at four, and 22 occasions where occupancy has reached five, requiring HBPOs staff to work on patient flow and potentially reroute additional presentations to other HBPOs sites.

Diversion data was not routinely captured in 2016 so it is not possible to know the number of s136 referrals turned away from the four SLaM sites prior to the new site opening. However considering there were 279 incidents of closure between January and November 2016 (an average of 25 a month), it is likely that the number of patients diverted would have been higher before the centralised HBPOs site was operational.

The total number of referrals to the centralised HBPOs between January and July 2017 was 772; an average of 110 patients per month. Overall, 37 patients (5%) were redirected to A&E as medical attention was required, 20 patients (3%) were diverted to their local HBPOs. A further 54 patients (7%) were diverted because the site was at capacity (both adults and CAMHS). The full breakdown of reasons for diverting referrals from the centralised place of safety site between January and July 2017 are summarised below (Chart 8), along with details of the alternative arrangements made (Chart 9).

The onward destination was only recorded in around 50% of cases; but where this information was provided, 16 patients (24%) were diverted to an alternative health based place of safety, and 50 patients (75%) were taken to A&E.

Chart 8: Reasons given for diversion from the HBPOs, January-July 2017

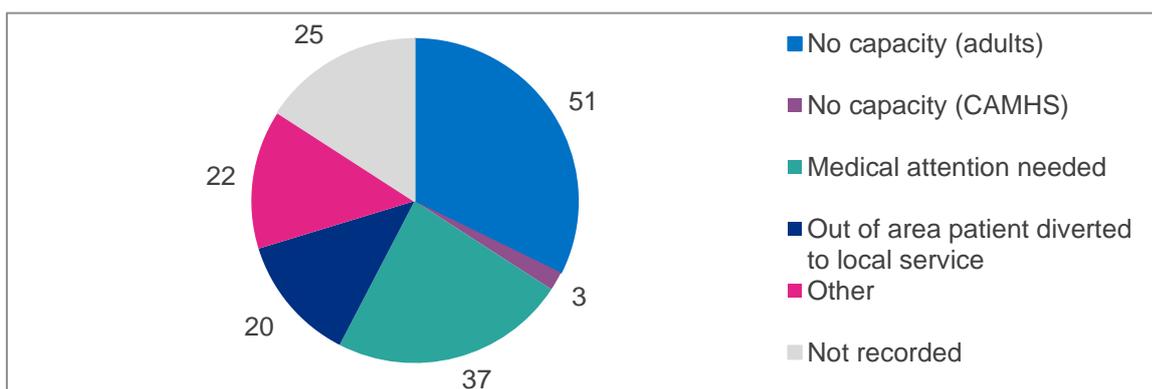
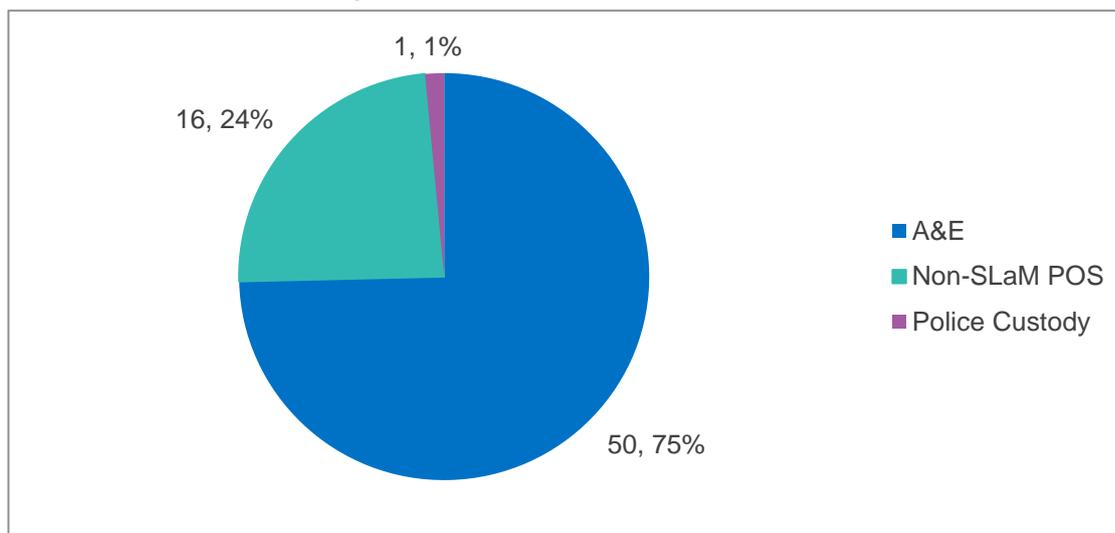


Chart 9: Alternative arrangements for those diverted from the central HBPoS, January – July 2017

N.B. Data labels show the number of patients and percentage.

Police Escalation Logs

The Metropolitan Police Escalation Log also supports the view that access to a HBPoS has improved in the SLAM catchment area since the centralised place of safety has opened. In 2016, the number of incidents reported by officers that related to access to any of the SLAM HBPoS sites was 15, equating to an average of 1.3 incidents a month. From January to July 2017, the monthly average has more than halved with just four reported incidents related to access; an average 0.6 incidents a month.

Improvement is also seen when looking at all escalated incidents relating to s136 (not just those relating to HBPoS access). The total number of SLaM s136 incidents escalated by Metropolitan Police officers has fallen from 2.2 per month under the old HBPoS model, to an average of one per month in the first seven months of 2017.

The role of A&E

Current policy agreed between the Trust, local police and London Ambulance Service outlines that if an individual needs medical attention at A&E prior to the HBPoS, the patient should be taken to the A&E department closest to where they were detained, not closest to the place of safety site (i.e. King's A&E).

Since the new model was introduced, there has been anecdotal reporting of increased pressures on King's A&E, which is adjacent to the centralised health based place of safety:

"It feels like a disproportionate number come to KCH when the place of safety is full" [KCH Police Liaison Officer](#)

"This new model has impacted KCH significantly as patients are being transferred there if there is any medical need as opposed to their locality's A+E department. This has further impacted an already busy A+E service." [ST7 Registrar](#)

The number of s136 patients that are provided with a Mental Health Act assessment in A&E – and therefore not transferred on to the centralised HBPoS – is not routinely recorded, so it has

been difficult to quantify the impact of these patients on A&E since the centralised HBPOs opened.

However, data on the number of patients going to A&E prior to attending the HBPOs suggests that the new place of safety model may have reduced pressures on A&E. The proportion of patients recorded as attending A&E prior to the HBPOs in 2017 was 28%; compared to 33% of patients under the old model. Even when taking into account the increase in overall number of s136 patients in 2017, an average of 25 patients a month were recorded as attending an A&E before transferring to the place of safety under the old model; compared to 15 a month following the opening of the centralised place of safety site. The inconsistency between the staff feedback and the quantitative data may reflect other system pressures in A&E.

On occasions where patients do attend A&E prior to being assessed at the HBPOs, King's A&E is most commonly used, followed by Lewisham and St Thomas'. The full list of A&E's receiving s136 patients before their assessment at the centralised place of safety is outlined in Table 2. Note that in 21% of cases the name of the receiving A&E was not recorded.

Table 2: Receiving A&E for patients attending A&E prior to HBPOs admission, January – July 2017

Receiving A&E department	Number of patients
King's College Hospital	32
University Hospital Lewisham	19
St Thomas' Hospital	14
Croydon University Hospital	10
Queen Elizabeth Hospital	5
University College Hospital	1
St George's Hospital	1
Princess Royal University Hospital	1
St. Mary's Hospital	1
A&E not recorded	23

Further analysis of those taken to King's A&E showed that the majority of these patients were detained in Lambeth and Southwark (both 12 patients). Four patients were detained in Lewisham and two in Westminster. Two patients did not have a place of detention recorded.

Physical health competencies at the health based place of safety

One suggested contributing factor to the reduction in A&E attendances prior to admission at the HBPOs is improved physical health competencies amongst place of safety staff.

Having a dedicated staff team at the place of safety provided the Trust with an opportunity to enhance physical health training to meet the competencies outlined in the pan-London Health Based Place of Safety Specification. Early recruitment to the team allowed some training to occur prior to the opening of the HBPOs which concentrated on common issues seen across the four previous HBPOs sites. Below summarises the training undertaken to date:

- Management of physical health, diabetes and nutrition

- Drug/alcohol assessment and management of withdrawal
- ECG competencies
- Wound care (practical training with King's A&E staff included training for gluing).
- 'In-situ' simulation training
- Paediatric life support (lecture and practical)
- Children's Act/Safeguarding to level 3 CAMHS skills: care of CAMHS patient from 9-18yrs
- CAMHS Promoting Safe and Therapeutic Services (PSTS) training, to manage violence and aggression
- Smoking cessation up to level 2
- Medication management, rapid tranquilisation (continuing to receive refresher training from pharmacy colleagues)
- Immediate life support including appropriate use of a defibrillator
- Simulation Workshop At the Mental-Physical Interface (SWAMPI)
- Basic life support and PSTS instructor training (one staff member trained to instructor level in each)

There are plans for further skills development including linking with the sexual health centre as there is a recognised need to offer greater opportunistic health promotion. There are also plans for senior staff to receive train the trainer Modified Early Warning Score (MEWS) training and a band 5 nurse has taken on the role of physical health lead in the unit.

Staff reported feeling that there is a culture around physical healthcare being a part of the role of the unit and as such physical health is specifically addressed in the morning handover for every patient. Place of safety staff have suggested that there may have been an increase in acceptance of intoxicated patients; in part due to clearer criteria for acceptance to the unit. This was also reported by police colleagues who stated that the practice of going to A&E for 'medical clearance' in cases where individuals are drunk but capable of being assessed has decreased.

Positive feedback has been received from the smoking cessation nurses regarding the HBPOs staff referrals to the service. In addition, doctors who have worked on the unit report a higher level of physical health competencies amongst the nursing team than they have experienced previously. One senior staff member reported that the team were also able to identify features of a presentation that may indicate an organic cause, for example a new onset of psychotic symptoms in middle age.

It has been noted by staff that there's potential for more physical health care being undertaken at the place of safety. The nursing staff highlighted that most staff have had wound care training, but this is not utilised as it is not widely publicised. This highlights the opportunity to create greater awareness of the physical health competencies at the HBPOs amongst police and London Ambulance Service colleagues to reduce unnecessary transfers to A&E.

HBPOs staff and multiagency working

Prior to the opening of the centralised HBPOs, SLaM identified the availability of staff as one of the leading factors resulting in place of safety closures. Other than the nominated place of safety co-ordinator, there were no other staff dedicated to the place of safety in the old model, and when it was occupied, staff were drawn from other wards in the hospital to assist.

Often staffing availability or levels of activity on these wards meant it was not possible to reallocate staff, which resulted in closures of the place of safety (see p. 9 above). When closures did occur, the place of safety would often remain closed for a whole shift, lasting 7.5 – 10 hours.

London Ambulance Service and Police colleagues either had to wait until staff became available, take the individual to A&E, or in some cases, take the individual to police custody; resulting in unacceptable delays and patients being held in an unsuitable environment, often waiting for capacity to become available.

New 24/7 staffing model

In line with guidelines set out in the pan-London HBPOs Specification, the centralised HBPOs is staffed 24/7 by a team that includes dedicated nursing staff, a Unit Manager, an Associate Specialist SpR and a Consultant Psychiatrist. The unit operates daily on a team of five nurses (1x band 6 Clinical Charge Nurse; 2x band 5 Staff Nurses; 2x band 3 Clinical Support Workers) and leadership support is provided by the Unit Manager Monday to Friday 09:00 – 17:00, and from the Acute Referral Centre Clinical Service Lead out of hours.

At all times, the unit is coordinated by a nurse performing the specific role of the Section 136 Co-ordinator. This role is the central point of contact for the unit, optimising patient flow through the unit, and troubleshooting where necessary.

Feedback on the new model from the centralised place of safety staff has been positive:

“Thinking back to how the service used to be run, before even any of the dedicated team came on board, it was run in such an ad hoc way, it was seen as a burden so that probably translated to a poor quality of care for patients. People weren’t specialised and didn’t necessarily have the necessary level of skill required to look after patients, it really was just seen as a bolt on. So, for me I think the improvement in terms of patient care is massive – that’s probably the biggest contribution...I think it’s the skill and the knowledge and the experience of the staffing group that’s really made a difference.” [Former Unit Manager, 2017](#)

“Having dedicated staff which aren’t taken from other teams allows a more cohesive environment which is more able to address patient needs in a more proactive way.” [ST7 Registrar, 2017](#)

“[Before] you’d go there on a rota, and you’d literally just sit there. Sometimes you’d have two external staff plus the coordinator doing the admin stuff, and rarely you’d see them actually interacting with the patients, they were more like bodyguards. But now you’ve got more consistency – staff used to be changing every hour, a new face every hour – but now, they’ve got a whole ward and we’re there for the whole shift and they have an allocated nurse who’s always available to speak to them.” [HBPOs Nurse, 2017](#)

Improving service user experience

In the service user survey carried out before the centralised HBPOs opened, an equal number of respondents spoke either positively or negatively of their experience within the HBPOs. Descriptors were variable, ranging from being treated “well” and with “respect” to “very badly”, being “bullied” or “laughed at”, whilst a number of comments referred to not feeling listened to by staff.

Feedback from service users who have been admitted to the new HBPOs has been largely positive with 76% of patients providing positive feedback on the support they received.

"I was given a named nurse which I think was helpful and I could have a person that could spend time listening to me." [Service User, 2017](#)

"Staff tried to make me feel welcome and that if I had any more worries to approach them" [Service User, 2017](#)

"The staff are very caring and non-judgemental", [Service User, 2017](#)

"Very caring and supportive, would recommend if you need the help." [Service User, 2017](#)

"I think the staff were amazing and caring. They should get a medal." [Service User, 2017](#)

Seventy-nine per cent of service users reported being treated with respect and dignity by staff. Sixty-three per cent of service users reported that they felt listened to by staff and 94% felt that they understood the next steps prior to leaving the unit.

"I felt that the Dr put a good plan in place. He was able to get me an appointment with my GP for the next day and my CRHTT for the following day" [Service User, 2017](#)

Impact on patient outcomes

Place of safety staff have also reported that the dedicated 24/7 staffing model has had a positive impact on the quality of assessments and resulting patient outcomes. In contrast to the previous model when staff were pulled off neighbouring wards, the dedicated team are now able to work more closely with patients to understand their needs and identify the best course of action; and when plans are developed, these are handed over to the next team member on shift.

"[Before] you had essentially random people who were coming to coordinate patients, you might establish a plan on one shift, someone might come on the next shift and no one has even heard that that plan existed. Whereas with the dedicated team, there is an expectation that plans will be handed over and that knowledge and learning from working with patients will be handed over from shift to shift. And I think that contributes to better assessments and care and probably impacts on better outcomes for the patient... You can advocate for the patient because you have a more solid assessment, you have more evidence to go on." [Former Unit Manager, 2017](#)

"A team of individuals who are geared towards a similar goal and see it part of their job, as opposed to an imposition of extra duties from another authority has allowed people to take a more active role in advocating and ensuring that appropriate follow-up is arranged." [ST7 Registrar](#)

"If we've spent a lot of time with somebody and then the formal mental health act assessment happens, then you can advocate for something less restrictive and we can be a bit more involved in that discussion because we've got to know them." [HBPOs Nurse, 2017](#)

Multiagency working

All partners across the pathway have also reported an improvement in relationships and partnership working:

“Relationships have improved massively with police and LAS, and I think that’s something that we all wanted to happen, because we were aware that that relationship was historically quite bad. Now officers and LAS know what to expect. They expect a more consistent approach and know how we work. Even some of us they will recognise by our names and faces and vice versa, so a relationship is really starting to build.” HBPOs Nurse, 2017

“Some of the staff have really embraced joint working with us and I’m aware that one of the charge nurses has secured funding from BRC to undertake a research project with us with view to developing a ‘s136 pocket card’ for paramedics” LAS Mental Health Nurse, 2017

It is really helpful to get to know the staff at the POS, it makes information sharing, planning, handover etc. a more positive experience. Croydon AMHP, 2017

Staff have recognised that there is still room for improvement, and particular difficulties were highlighted when the place of safety site reaches capacity and patients are diverted to A&E. Staff reported that there can be a lack of understanding about roles and responsibilities when managing s136 patients which can lead to conflict, particularly when everyone is under pressure.

I think ultimately the difficulty we have with other agencies is the lack of understanding about each other’s roles and what our capabilities are. Using A&E as an example, you’ve got one extremely high pressured environment arguing with another extremely high pressured environment ... Ultimately the problems we have, and it’s with social services as well, is about lack of knowledge, lack of understanding about the part that each of us play in this pathway. HBPOs Nurse, 2017

There is an opportunity to facilitate additional learning between staff teams and encourage greater understanding and flexibility when teams come under pressure. London Ambulance staff have carried out one day placements at the HBPOs site to learn more about the s136 pathway and there is potential to use additional rotational programmes between place of safety and A&E nursing staff to increase partnership working.

Facilities and HBPOs environment

Improving the quality and safety of the HBPOs environment was a key driver for the development of the new centralised place of safety site. The Care Quality Commission (CQC) visited SLaM to assess mental health crisis services in September 2015. The report, published in January 2016, gave an overall rating of the mental health crisis services as ‘Good’; however the report concluded that two of SLaM’s HBPOs sites (Lewisham and Lambeth) ‘Required Improvement’.²

Particular concerns were raised regarding safety, the privacy and dignity afforded to patients, and the individual’s experience of care which may adversely impact their recovery. SLaM’s proposals to build the centralised HBPOs, acknowledged that the older places of safety (in particular those at Lambeth Hospital and at the Ladywell Unit in Lewisham) were no longer fit for purpose and did not meet the required standards as set out by NHS Estates, CQC or the Royal College of Psychiatrists. It was also recognised that the places of safety were unsuitable for

² Care Quality Commission (2016). *South London and Maudsley NHS Foundation Trust Quality Report.*

children and young people and could appear to be threatening and frightening to those who are in acute distress.³

In multiagency staff interviews before the four local sites were decommissioned there was wide spread agreement that the facilities were in need of improvement. Fourteen out of fifteen staff interviewed reported that the facilities were unfit for purpose or did not support the safety of dignity of the patient.

"The facilities at SLaM are limited and a little outdated. The suite is like a police cell." [Southwark Out of Hours AMHP, 2016](#)

"Patients feel as though they are being held hostage with staff watching them 24/7. Privacy is lacking on all four sites." [Southwark HBPOs Manager, 2016](#)

Despite staff acknowledging that the facilities were "necessarily sparse" to ensure that patients are safe, many believed that the facilities did not provide a dignified and therapeutic environment for acutely unwell patients. Those sites that lacked en-suite toilet facilities, not only limited patient freedom, but demanded more from staff who had to escort patients that could be behaviourally challenging.

New facilities

The new centralised HBPOs has six assessment spaces which provide a range of accommodation options for service users. The unit typically runs at a capacity of four, however, two additional spaces are used flexibly to assist patient flow through the department, particularly during peaks in activity. In most cases these additional assessment spaces are used to temporarily increase capacity or as waiting areas where the police can bring a person while capacity to formally accept the patient is arranged.

The unit has been designed on the principles of openness, least restrictive practices and safety. It has a central nursing office and reception area which is surrounded by a communal space. Five of the assessment rooms are located directly off the communal space. Three of these rooms have en-suite bathrooms. A further assessment room is larger than the others and has a separate wheelchair accessible bathroom.

The unit includes two high dependency rooms which are designed to seclusion specifications. One is located in a separate area of the department which has its own dedicated access. This enables individuals who need immediate containment to be transferred directly from a vehicle to this assessment room without having to walk through the main communal areas of this unit.

The second-high dependency unit is located off the main communal area and has an attached private lounge area. This assessment space was designed to accommodate service users under the age of 18, making SLaM's centralised HBPOs one of the few sites across London that has a designated assessment room for CAMHS patients.

Staff perceptions

Feedback gathered from all staff groups following the opening of the centralised HBPOs site recognised a dramatic improvement in the physical environment and highlighted the positive impact on the patient experience and quality of assessment.

³ South London and Maudsley NHS Trust (2016). *Proposal to improve SLaM's Place of Safety Provision*.

"I think privacy and dignity is much better. You think before you were in a room where you have a massive observation window and there's someone staring at you 24/7, or you're in one of the rooms where someone has to literally sit in the door way and stare at you to be able to see you. We're able to use different ways of observing and engaging with patients now so that, actually, not everyone needs that level of observation." [HBPOs Nurse, 2017](#)

"The roominess and organised bed spaces contribute to a less stressful environment." [Lambeth AMHP, 2017](#)

"Patients are seen within an appropriate environment and this ensures that their safety is maintained." [ST7 Registrar](#)

"Often you see patients that have visited the old 136 and they feel that they are being brought into a cell, and they see that's not the case now. You can come in and go out of your room, there's a toilet. And we encourage patients to come out and you know, there's a lounge, there's music." [HBPOs Nurse, 2017](#)

Staff have provided positive feedback on how the unit's design has enabled them to use the assessment rooms flexibly to reduce risk and provide a better patient experience:

"We're starting to learn how to use the environment in a really positive way in terms of managing risk. We use the rooms to step people down and step people up according to their need. That works really well for us in terms of managing risk, and it ties in with other initiatives we use in the Trust, like the four steps to safety which is a violence and aggression tool." [HBPOs Nurse, 2017](#)

"Aggression has definitely reduced, and I think that has almost solely been because of the environment, just having a bit more space, being able to work around, being able to see that there are other patients there and it's not just you." [HBPOs Nurse, 2017](#)

Service user perceptions

Positive feedback has also been received from service users assessed at the new site:

"I think the new place is more calm and settling than the last 136 suites." [Service user, 2017](#)

"Spacious, nicely laid out. Minimal furniture which was good. Bed ready, food and coffee quite pleasant. Two rooms to oneself. Liked the stencil." [Service user, 2017](#)

The infographic on page 18 has been created using the responses from the service user survey distributed to all patients seen at the centralised place of safety site. The survey provided a list of descriptive words and asked respondents to select the words they felt best described the place of safety. The image gives greater prominence to words that were selected more frequently.

Figure 1: Service user perceptions of the centralised HBPOs, 2017

Sixty-four per cent of service users who provided feedback reported feeling safe in the centralised place of safety. This compares favourably to a pan-London service user survey carried out by Healthy London Partnership in early 2016 that indicated just 36% of patients felt safe in their surroundings in London's HBPOs sites.⁴

Suggestions to improve the environment included having more resources such as books and newspapers to help to alleviate boredom. Service users also commented on the lack of food choices and felt that the place of safety should receive the same meals provided on the wards.

Assessment times

One of the key considerations in the development of the new place of safety model was the need to address delays along the section 136 pathway. Under the old model, police and ambulance staff would at times face long delays accessing place of safety sites whilst staff were pulled from other wards, often with the service user having to wait in the back of the ambulance or police van. Time taken to convene the assessing team and arrange onward care following assessment would also contribute to delays; with lengthy place of safety admissions impacting patient experience, and limiting patient flow, contributing to HBPOs capacity issues.

Under the new model, the average time from arrival at the HBPOs site to patient admission is just 9 minutes, with 96% of patients admitted within 30 minutes; demonstrating the benefit of the 24/7 dedicated staff on site.

In 75% of cases, police officers are now able to leave the place of safety within 30 minutes of arrival (up from 67% in 2016), and the proportion of cases resulting in the police having to stay on site for over an hour has halved – from 16% in 2016 to 8% in 2017.

⁴ Results from online survey developed by Healthy London Partnership with the support of the charity Mind, surveying 154 service users from across London, Jan/Feb 2016.

Due to the resident doctor at the place of safety (associate specialist between 9-5 and Core Trainee/ SHO out of hours), patients now receive an initial medical assessment immediately, rather than having to wait for clinical staff to attend.

The response times for AMHPs have not changed significantly under the new model (see Table 3 below). Before the sites were consolidated, there were some concerns that the additional travel times to the place of safety site would adversely affect the response times for AMHP services, however this seems not to be the case, with response times improving slightly, both in and out of hours.

The out-of-hours response times are considerably longer than in-hours, and place of safety staff have reported significant challenges securing AMHPs through the night as there may only be one AMHP on duty to respond to all requests. Analysis of the time AMHPs are requested shows that 67% of requests are made out-of hours, highlighting the need for adequate AMHP coverage during this time.

AMHPs and HBPOs staff indicated that AMHPs will sometimes make arrangements to attend the HBPOs when the second section 12 Doctor is available, so delays in AMHP response times may reflect other pressures in the system.

The response times of the two s12 doctors involved in a MHA assessment was also collected, however following discussions with HBPOs staff it became apparent that this measure was not recorded consistently and therefore it has not been included in the analysis.

Table 3: Average AMHP response times (from requested to attended)

	2016 (Jun-Sept)	2017 (Jan-Jul)	Change under new model
AMHP (In hours)	3hrs 30 mins	3 hrs 10 mins	▼ Reduced by 19 mins
AMHP (Out of hours)	6hrs	5 hrs 10 mins	▼ Reduced by 49 mins

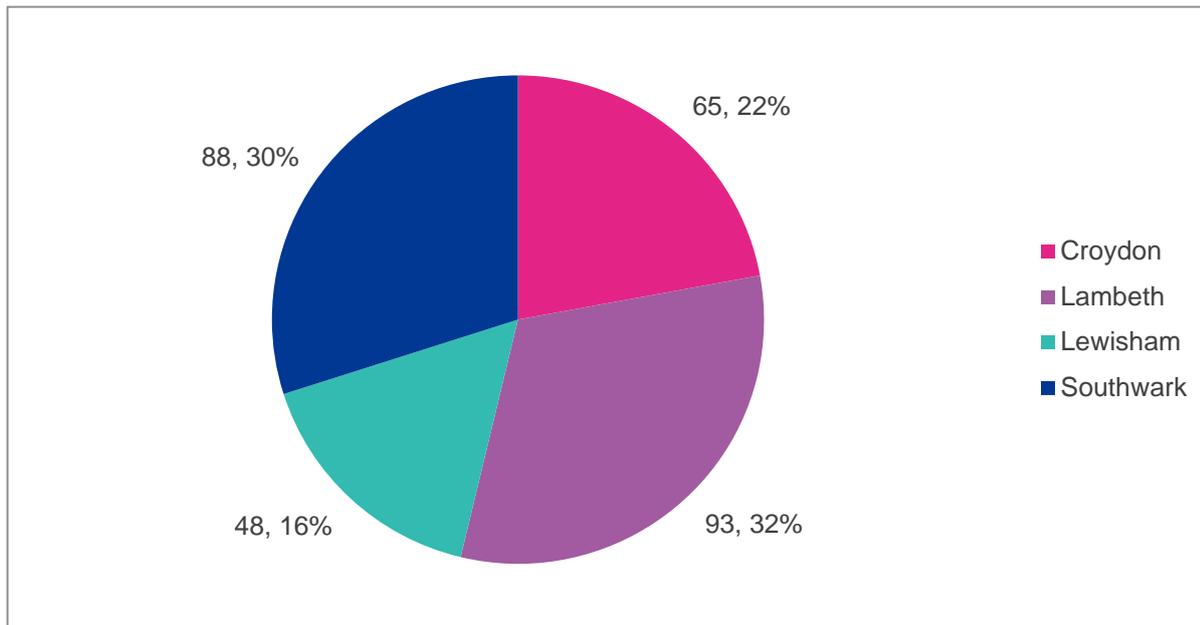
Assessing AMHP service

Current operational policy between the Trust and four local AMHP services outlines that each AMHP service should respond to requests for assessments for residents of their borough or for people detained under s136 in their borough. For “out-of-area” patients where it has not been possible to transfer them to their home borough, the patient will be assessed by one of SLaM's four borough AMHP services on a rotational basis.

It is worth noting that the data collected on the assessing AMHP service was incomplete, with the AMHP service only identified in around 50% of patients accepted to the place of safety. From the data available, analysis showed that Southwark and Lambeth AMHP services assessed the largest proportion of patients at the centralised place of safety, 30% and 32% respectively, followed by Croydon (22%) and Lewisham (16%) – see Chart 10 below. This correlates with the spread of presentations amongst the ‘in-area’ residents as shown in Chart 7 (p.8).

Analysis showed that 75% of patients were assessed either by the AMHP service local to where they live, or where they were detained, in-line with the agreed policy.

Chart 10: Proportion of patients assessed by each AMHP service, January to July 2017



N.B. Data labels show the number of patients and percentage.

Length of stay

Currently, the maximum length of time for which an individual can be detained under s136 of the Mental Health Act is 72 hours. In December 2017, this will be reduced to 24 hours, representing a significant challenge to place of safety sites to optimise patient flow and reduce assessment timelines.

Analysis was carried out to compare the total length of stay at the HBPOs (from arrival to discharge/onward transfer) under the new and old model. Chart 11 below shows the average length of stay for different patient groups from June to September 2016 and January to July 2017. The average length of stay under the new model has remained very similar to length of stay across the four sites operating in 2016 (approximately 18 hours).

Staff at the place of safety have suggested that this may be in part due to a positive change in practice whereby clinical staff do their best to carry out assessments at the most clinically appropriate time to ensure the best outcome for the patient. For example, it may in some cases be better for the patient if staff wait to assess, as the patient is likely to feel a bit better and could be appropriately discharged to the community teams, rather than assessing at the patient's most agitated state and increasing the chances of admission.

In this way, staff are able to use the centralised HBPOs similarly to a Clinical Decision Unit, resulting in less restrictive onward care arrangements for the individual. This is reflected in the admission rates at the centralised place of safety, which are 13% lower than admissions under the old model.

CAMHS patients have seen the greatest improvement in the length of stay at the HBPOs, with the average length of stay reducing by over 10 hours to around 18 hours. However, it is worth noting that due to the small sample size –19 children in the 2016 data set and 28 children in the

2017 data set – this would need to be monitored over a longer period of time to see whether this improvement is sustained. When looking at CAMHS patients that go on to be admitted, the average length of stay rises to 38 hours; 15 hours longer than adults who require admission.

Across all ages, those who go on to be admitted stay at the place of safety for an average of 10 hours longer than those who are discharged, highlighting the remaining issues identifying an inpatient bed.

The average length of stay for patients referred onwards to community mental health services has increased by almost four hours which may indicate greater time taken by the dedicated team to ensure a safe onward referral.

Chart 11: Average length of stay by patient group (dd:hh:mm), Jun-Sep 2016 and Jan-Jul 2017

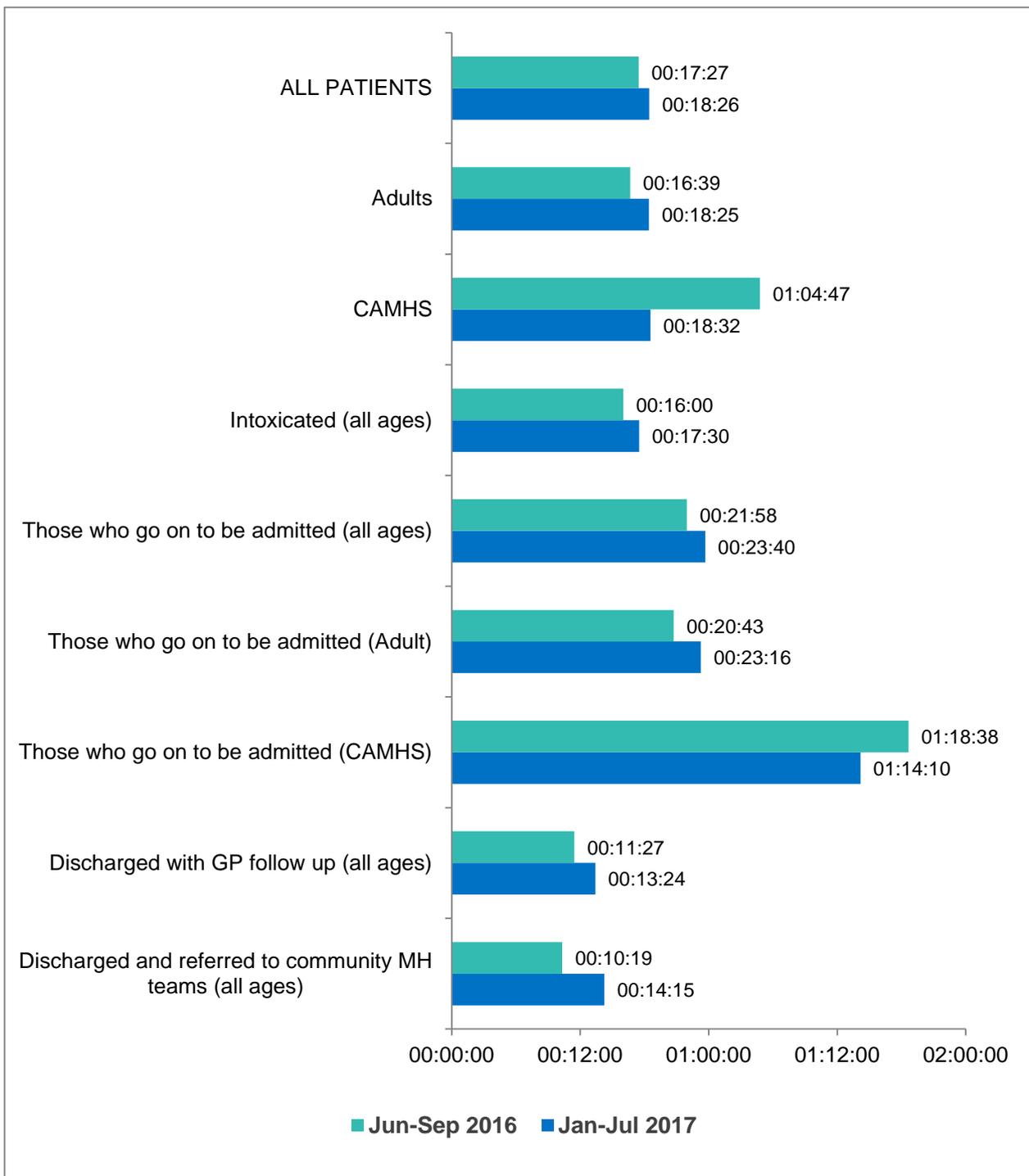


Table 4 summarises the actual length of stay for all patients at the centralised HBPOs between January and July 2017, and identifies breaches under the current and future legislation.

Table 4: All patients' length of stay, Jan-Jul 2017

Length of stay	Number of patients
<u>Within 12 hours</u>	202 patients (34%)
<u>Over 24 hours</u> (Breach under new legislation)	139 patients (23%)
<u>Over 48 hours</u>	23 patients (4%)
<u>Over 72 hours</u> (Breach under current legislation)	4 patients (1%)
N.B. Length of stay data was missing in 89 cases. Proportions calculated above include these cases in the denominator.	

The data shows that under the current legislation, there are very few breaches – four patients over seven months. However, currently 139 of patients' length of stay (23%) would run over the 24 hour time period.

With the longest length of stay amongst those requiring an inpatient bed, the Trust has already taken steps to address the challenges identifying an inpatient bed following an assessment at the place of safety. In October 2016 the Trust launched an Acute Referral Centre (ARC) to act as the single administration point for acute admissions. The service operates 24 hours a day, 7 days a week and is staffed by Home Treatment Practitioners. The team use the ARC dashboard to monitor bed occupancy, planned movements, overspill, and delayed discharges.

As of November 2017, the ARC has begun monitoring the detention time within the centralised place of safety against the 24 hour target, highlighting any breaches. The ARC is now notified when a patient is first admitted to the place of safety so that they are aware that an inpatient bed may be required within the next 24 hours. This allows them to plan ahead and begin the process of identifying an inpatient bed earlier.

Outcomes

Patient outcome was recorded in 97% of cases in the 2016 dataset and 90% of cases from January to July 2017. From the data available, the proportion of patients recorded as admitted to inpatient beds (both formal and informal) under the new model has decreased by 13%.

Even when taking into account the increase in overall numbers of 136 patients, there was a reduction in the number of recorded admissions each month under the new model – from an average of 43 admissions each month (Jun-Sep 2016) to 35 admissions each month (Jan-Jul

2017). If this is looked at in terms of the number of bed days saved, the average length of stay for an acute inpatient admission at the Trust is 28 days.⁵ The reduction in admissions under the new model has potential to result in an estimated annual saving to the Trust of up to £1.2million.⁶

The reduction in admissions has in part been attributed to a positive change in practice whereby staff use their clinical judgement to decide if patients would benefit from time to recover before they are assessed; so as not to rush the assessment and admit an individual who could be safely supported in the community. HBPOs nursing staff also believe that because patients are now seen by a dedicated team who get to know the patient and their needs better, they are able to carry out a more informed assessment and where appropriate, advocate for less restrictive onward care.

The Trust also attributes the reduction in admissions to the launch of the ARC, which began providing a triage service in October 2016. The service is managed by the Home Treatment Team practitioners who provide advice on whether an individual could be safely managed in the community and support staff to set up the appropriate onward care arrangements to allow safe discharge.

Accordingly, the number of patients discharged with arrangements for a mental health follow up in the community has risen by 15% under the new model – from 15% to 30%.

⁵ NHS Benchmarking (2017), *NHS Benchmarking Network Mental Health Project, 2016-17*

⁶ This calculation uses a unit cost for each inpatient bed day of £459; taken from The Manchester New Economy Model - <http://www.neweconomymanchester.com/our-work/research-evaluation-cost-benefit-analysis/cost-benefit-analysis/unit-cost-database>