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**Lancashire Care**  
NHS Foundation Trust

## UNDERSTANDING OF THE KEY DRIVERS OF S136 ACTIVITY

7 January 2019



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2018

# OUR APPROACH

This document sets out the findings and conclusions from a brief review of s136 presentations within Lancashire Care Trust

The short review undertaken over three days included:

- Review of the Trusts Quality and Performance Report
- Interviews with representatives of the BI and Performance Team, Lancashire Police, Trust Operations Team and also the Trust Director of Strategy and Deputy CEO
- Review of the Trust Improvement Action Plan
- Review of Ad Hoc data with the BI/Performance Team
- Review of National Mental Health Benchmarking Data
- Review of the Oak Group Report

Given the short timescale of the review this report sets out some headline areas for consideration by the Trust. It should not be treated as a comprehensive action plan for improvement.

We would like to thank all representatives of the Trust for their support in undertaking this short piece of work within a rapid timeframe.

# THE TOTAL NUMBER OF S136 DETENTIONS WITHIN LANCASHIRE IS PLACING THE HEALTH, CARE AND JUSTICE SYSTEM UNDER CONSIDERABLE PRESSURE

## CURRENT POSITION

Lancashire Care NHS Foundation Trust is experiencing increasing levels of s136 detentions. This is putting considerable strain on Lancashire Police, the availability of Trust s136 suites and acute provider Emergency Departments. Such pressure is impacting on the ability of the system to deliver statutory performance targets and delivers a poor service user experience and outcome.

s136 of the MHA allows a “warranted” police officer to take a person to a place of safety when they consider that the individual is a risk to themselves, others or indeed others to them. The detention lasts for 24 hours, with a potential to extend by a further 12 hours if needed.

The police officer must ensure that the person is taken to a place of safety. This is usually an approved s136 suite in a hospital, or an acute hospital Emergency Department. Police cells should not be used for the detention. Where it is practicable to so do a police officer should consult a mental health professional prior to detaining an individual on s136.

The individual should be seen if possible within 3 hours of detention, condition permitting. The individual can then be discharged, or detained voluntarily or under s2 or 3 of the MHA. The time period for the detention is driven by s12 Doctor, AMHP and bed availability and can be considerable at times.

S136 detentions take up a considerable amount of time of police and health and care professionals and often result from a number of care system failures where an individual's condition becomes a crisis due to a lack of early intervention and prevention.

## Potential Impact

Poor service user experience

Increased number of service users presenting in a crisis

Increased pressure on Police to resource detention

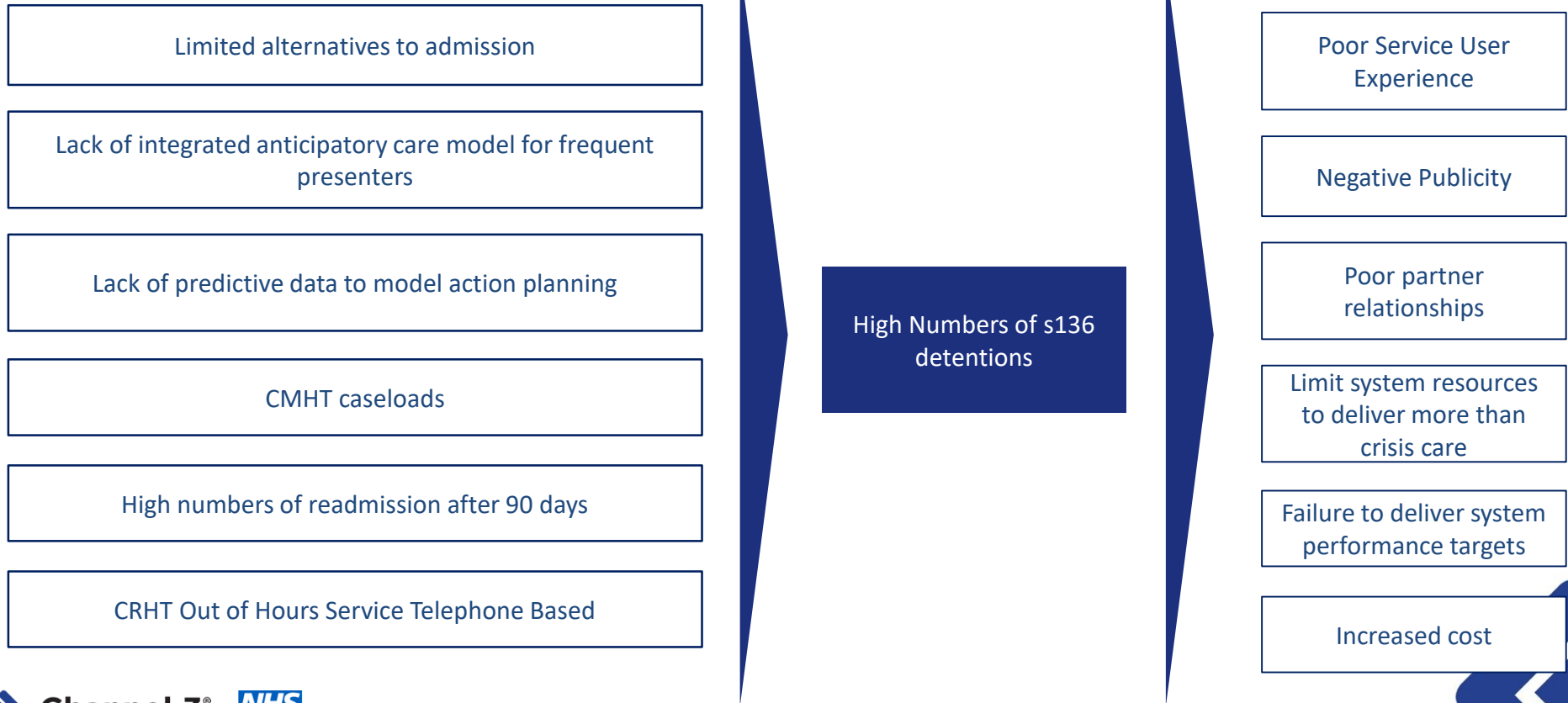
Increased demand for acute hospital EDs and pressure on 1,4 and 24 hour targets

Increased demand for out of hours AMHPs and s12 approved Doctors

# THE NUMBER OF S136 DETENTIONS ARE DRIVEN BY A VARIETY OF FACTORS WITHIN THE HEALTH AND CARE SYSTEM

“Examining the whole pathway is a crucial means of understanding where productivity and efficiency improvements can be made. This includes where patients could be better cared for in terms of quality of care, patient experience and value for money”

NHS Improvement: Unwarranted Variation May 2018



# THE PRESSURE CAUSED BY S136 DETENTIONS MAY BE A SYMPTOM OF WIDER SYSTEM PRESSURE AND INEFFICIENCY

LCFT estimate that CMHT Caseloads are in excess of 35 - this impacts on the ability of teams to effectively home treat and support service user recovery journey

A significant number of service users have a length of stay in excess of 120/180 days – this impacts on patient flow and causes delays in admissions and increased occupancy and OAP use

Lack of anticipatory care plans for Frequent Presenters can result in increased presentation and places demand on the system

CRHT only provide telephone advice overnight – potentially increasing demand for services

Police training in mental health is limited – all officers had an update following implementation of new legislation

MH Liaison Psychiatry Teams have limited resource to cover a Core 24 model of care and have significant use of Medical Locums: impacting on ability to deliver waiting time targets

Increased s136 detentions

Between Jan – Sept 2018 LCFT had 954 s136 detentions

LCFT had an average of 106 s136 detentions pcm between Jan – Sept 2018 This is an average of 3.5 detentions per day (The Trust has 8 s136 suites)

Between Jan – Sept 2018 LCFT had 318 breaches of 24 hour target (33%) Averaging 35 breaches pcm

LCFT has a significant number of service users who have a length of stay in excess of 180 days – 18 – 33 over the past 12 months impacting on patient flow

LCFT readmission rates after 90 days (AMH) ranges from 11.8% - 20.9% over past 12 months – Average 16.9%

Lancashire Police estimate over the past 6 months 32 individuals have had 3 or more detentions (From Jan – June 2018 60 individuals had 2 or more detentions)

LCFT estimate that the conversion rate for s136 detentions is approximately 41% to an inpatient admission

## THE DETENTION RATE SHOULD NOT BE CREATING THE IMPACT THAT IS BEING EXPERIENCED. PATIENT FLOW IS ALSO CONTRIBUTING TO THE POSITION

LCFT has 8 s136 suites spread across the county. From January – September 2018 the Trust had 954 detentions. An average of 106 per calendar month. This equates to an average of 3.5 detentions per day.

The Trust estimates that of those 954 detentions- approximately 41% convert to admission. This equates to 391 admissions over a 9 month period.

Whilst the conversion rate raises a wider question on training and the application of s136. the actual detention rate should not be placing the wider system under the pressure it is currently experiencing.

Interviews with health and police staff indicated that the pressure is caused by a lack of patient flow . This can be evidenced from a number of factors including:

- LCFT bed occupancy
- LCFT length of stay
- High utilisation of out of area placements
- A lack of Learning Disability and Detoxification beds placing strain on bed use
- A model of care where crisis teams only provide telephone support overnight potentially causing increased requests for Police support
- Length of time Police Officers spend in Acute hospital Emergency Departments with detained service users (Police estimate an average duration of 14 hours)
- Significant strain being placed on Mental Health Liaison teams covering EDs, Acute Wards and MHDUs – sometimes over multiple sites. Delivering a Core 24 model whilst resourced for a sub 9 – 5 Core model of care.

**Oct 2017 – Sept 2018 LCFT used 10674 out of area bed days – an average of 889 pcm at an estimated cost of £5.4m.**

**LCFT plus OAP bed occupancy between Oct 2017 – Sept 2018 ranged from 103.9% - 118.1%**

**LCFT average length of stay between Oct 2017 – Sept 2018 ranges from 38.4 - 50.8 days (Averaging 43.9 days)**

**The number of service users exceeding a 180 day length of stay ranged from 18 – 33 between Oct 2017 – Sept 2018 with a 12 month average of 25 PCM**

**Liaison breaches average – 1hr 50.4%, 4 hr – 15.2% and 12 hr 3.1% over the period from Oct 2017 – Sept 2018**

# LCFT HAS PUT AN ACTION PLAN IN PLACE TO ADDRESS ITS OPERATIONAL PRESSURES

Action Plan
Develop and implement new crisis house acceptance e criteria
Implement MH Liaison Team in line with funding
Embed enhanced Liaison Team offer
MHSC/s136 short term acceptance criteria
Additional private capacity: Priory
Implement actions 10 steps to effective discharge
Commissioners to review ICS 3 <sup>rd</sup> sector options for additional capacity
Development of new admission tool for clinicians
Data analysis around drivers of demand
Frequent attenders MDT programme
Blackpool Synergy Project: Street Triage
MH Access line evaluation
Pilot 24/7 Home treatment team
MH DU Interim Solutions
Thematic Review
PD Pathway Diagnostic Substance Misuse
Embed Bed Hub
IDT/New Clinical Model
Primary Care Recovery Model
Secondary MH Pathway review

Whilst these actions may in themselves solve isolated issues there is a risk that some of the more underlying operational issues which may be driving demand are not tackled.

From an analysis of LCFT data these could include:

- Ensuring that community mental health teams have the capacity to treat service users safely in the community and support their recovery journey – avoiding where possible a deterioration of their condition and subsequent crisis presentation. This is evidenced from high CMHT caseloads, and high readmission rates after 90 days
- Using both retrospective and predictive data to model capacity/demand and drive system wide action planning. Data collection and analysis appears more ad hoc than strategic and performance reports are retrospective and lack trajectories linked to action plans
- LCFT has a project to review Frequent Presenters and a Project to review Drivers of Demand and Personality Disorder – it will be important that these are reviewed at a system level and that agreed anticipatory care plans are put in place for individuals to reduce system wide pressure and demand
- LCFT is experiencing high levels of demand but must ensure that its capacity/demand modelling is linked to an understanding of the drivers of demand and that capacity is modelled based upon the predicted impact of improvement action not current demand
- LCFT is implementing a number of improvement actions to improve flow including use of locality senior matrons to review bed status, flow and also out of area repatriation. LCFT must ensure that they track the impact of this exciting project and ensure that data can be tracked dynamically.

# LCFT HAS A RICH DATA SET AND COULD USE THIS MORE EFFECTIVELY TO OPTIMISE PERFORMANCE AND DRIVE SERVICE IMPROVEMENT/TRANSFORMATION

The Trust BI and Performance Teams have a rich data set but this is not optimised to provide predictive reports to drive service improvement

The Trust BI and Performance Teams provide a "Performance Reporting" function and need to shift to a Model of Performance Management and Service Improvement

The Trust QPR provides a wealth of data but it does not correlate data sets. Actions are not set out with clear timescales and trajectories for improvement

The Trust BI team receives over 200 ad hoc requests a month for reports. Whilst some of these may be necessary they dilute the resource available to develop the Trust BI systems

The Trust Head of Performance has developed a number of dashboards to support service managers – these provide useful snap shots of performance and should be developed further

The Trust relies on multiple paper based and excel based systems to collect data- this is particularly the case for the Bed Bureau and also the Liaison Team – this creates not only a DQ issue but also a delay in actioning performance issues

## Improvement Action

Develop a comprehensive Information Management Strategy

Identify small number of core reports and KPIS which provide a health check of the business and support improvement planning/action

Embed Performance Management within Service Design and Transformation – using predictive analytics to drive improvement action

Reduce the reliance on multiple paper based systems – capturing data once and using shared data sets with partners where appropriate

Provide an action orientated QPR with clear improvement trajectories and share with commissioners and partners to drive service transformation

Link data sets to provide operations teams with a comprehensive view of cause/effect measures to drive continuous improvement initiatives



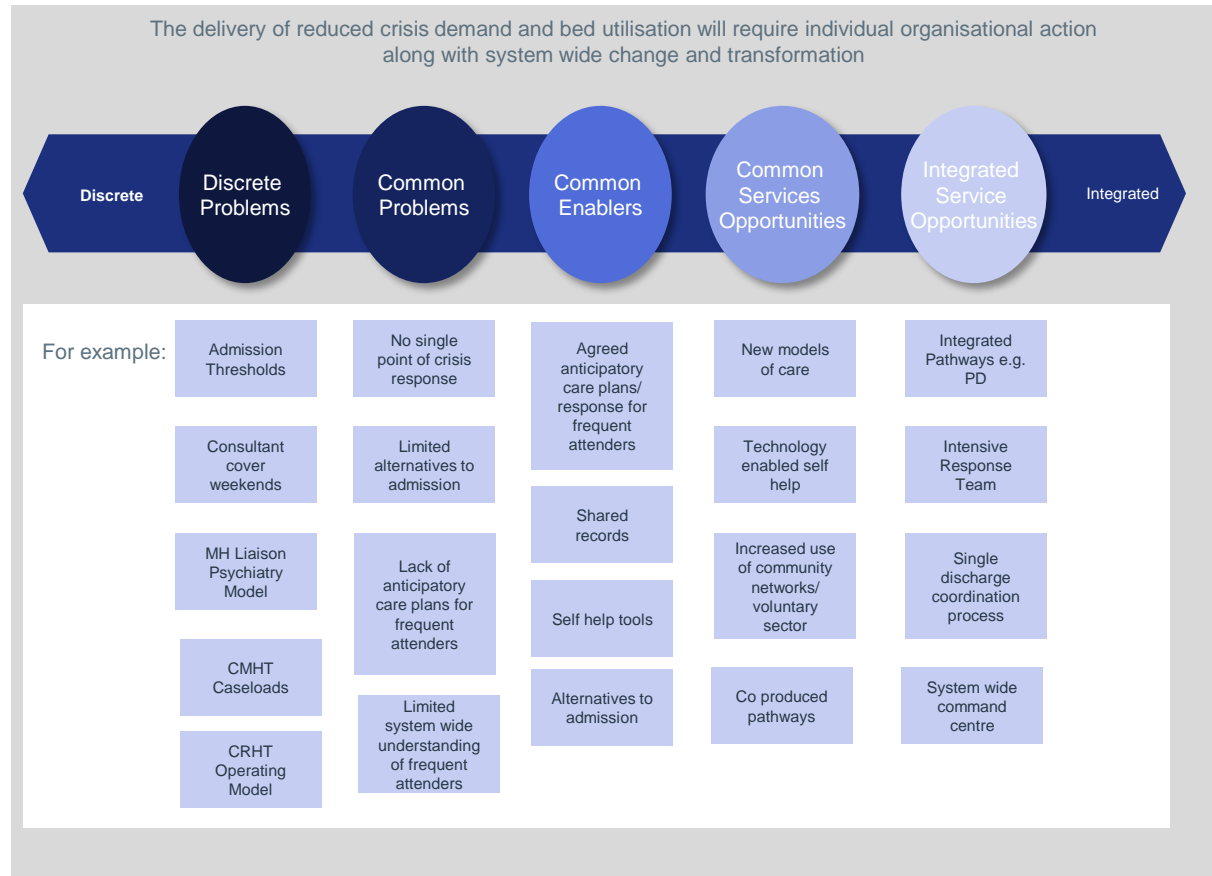
# THE TRUST SHOULD ALSO CONSIDER HOW IT WORKS BOTH ORGANISATIONALLY AND AT A SYSTEM LEVEL TO CONTINUE TO DRIVE IMPROVEMENT ACTION

Our review of LCFT data highlighted that the Trust experiences significant issues with occupancy, use of out of area placements, long average lengths of stay, limited access to intensive rehabilitation, learning disability and intensive specialist detoxification beds.

It also highlighted that there are a reasonable number of service users who have over a 180 day length of stay.

High levels of bed utilisation are both a cause and effect of wider system issues. They can reflect high levels of detentions where crises occur, cause delays in transfers of s136 detentions and cause a poor service user experience when placed in a remote out of area placement.

The Trust Action Plan sets out discrete improvement actions. It may however be worth considering how those actions relate to not only LCFT but also to the wider system as set out opposite. Such actions can then be prioritised and resourced to ensure effective delivery. The actions should also be data driven.



# S136 DEMAND AND PERFORMANCE IS DRIVEN BY MULTIPLE FACTORS

The total number of s136 detentions within LCFT should not be causing performance issues

LCFT has 8 s136 suites which should be more than sufficient to cope with demand:

- Jan – Sept 2108 – 954 s136 detentions
- Average of 3.5 s 136 detentions per day

LCFT performance team estimate that 41% of s136 detentions convert to an admission

33% of s136 detentions breach the 24 hour target

LCFT Bed Occupancy and Operating Model is potentially impacting on patient flow

A lack of LD and detoxification beds are placing pressure on general acute mental health bed demand

A high number of Frequent Presenters are placing significant pressure on s136 demand

A high number of service users who have a >180 day length of stay is impacting on Trust occupancy levels

LCFT estimate that CMHT caseloads are in excess of 35 – placing significant pressure on teams to effectively care coordinate

LCFT only provide a telephone CRHT service overnight – limiting capacity to home treat

Whilst a Core 24 Liaison Model is in place LCFT estimate that this is only resourced on a Core 9 – 5 basis

Liaison Psychiatry teams cover multiple roles including provision of MHDU cover and multiple sites in some instances

Liaison Psychiatry teams have significant issues with recruitment and retention and a significant use of locum Drs

Acute mental health ward staff provide cover for some s136 suites placing increased demand on staff impacting on ward resourcing

Wider system issues may be impacting on levels of demand

Police Officers receive limited mental health training

Police Control Room staff have found it difficult to contact LCFT Crisis Support

Police have no alternatives other than s136 suite or ED

Additional CMHT pressure may result from changes to s75 agreement

There is limited use of joint data to drive continuous improvement in service delivery



# THERE ARE A NUMBER OF POTENTIAL AREAS FOR IMPROVEMENT ACTION

During our short review we have identified a number of areas where the Trust may wish to consider placing effort to reduce the pressure from crisis demand. These include:

- Ensuring that the data used to drive capacity demand modelling takes a long term focus and is based upon a preventative model of care. Whilst this needs to include gaps based on current demand and benchmarking data it also needs to reflect the national drive to shift demand from restrictive bed based services to a community based preventative and self help model of care
- Building the capacity of community teams. Ensuring that service users have allocated care coordinators, alternative models of support are built into the delivery model including peer support workers and networks
- Developing multi agency integrated pathways for frequent presenters ensuring that NICE compliant pathways of care and anticipatory care plans are in place
- Developing an improvement model to reduce Out of Area Placements to Zero by 2020 in line with national guidance. Including reviews of inpatient operating models and active management of OAPs when they occur
- Looking to maximise the use of data to drive decision making
- Looking to maximise the use of technology to support service delivery particularly where services are split cross site and in the more remote parts of the county

## Potential Impact

Reduce numbers of crisis presentations

Reduce the number of admissions

Ensure that clinical teams are focussed on what they do best

Reduce frequent presenter demand and improve service user experience

Reduce cost

Improve staff morale



# SUPPORTING INFORMATION

# OUR ANALYSIS OF TRUST AND POLICE DATA HIGHLIGHTS A NUMBER OF AREAS FOR FURTHER INVESTIGATION

This section of our report sets out our findings from a review of:

- The data presented in the Trust QPR for September 2018
- S136 data provided by Lancashire Police
- Lancashire Care FT Action Plan for Improvement
- Oak Group Capacity Review
- LCFT Benchmarking Data

**High numbers of detentions – 41% conversion to admission**

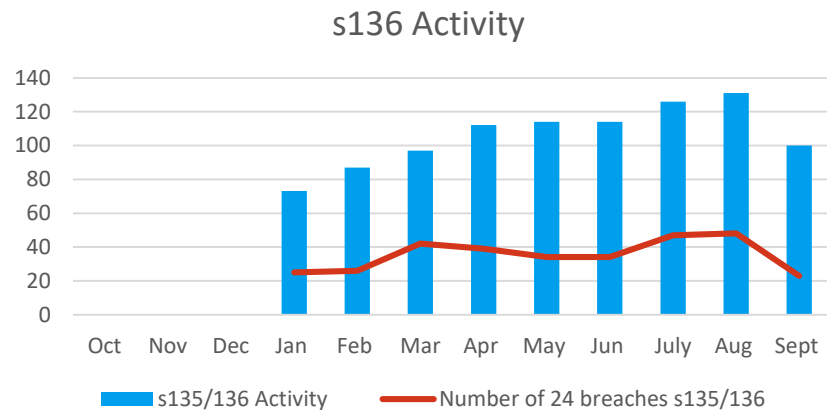
**Increased use of ED for s136 clearance resulting from delays in finding patient beds**

**Significant issues with patient flow – impacting on time taken to admit**

**Liaison psychiatry model of care placing demand on teams**

**Capacity of CMHT/CRHT to deliver effective care in community to reduce the risk of crisis**

## The number of s136 detentions has increased over the past 12 months



Between January 2018 and September 2018 the Trust dealt with 954 s136 detentions. 41% (391 converted to an admission)

318 of those detentions resulted in a breach of the 24 hour target set within the Police and Crime Act.

The Trust has put an Action Plan in place to deliver improved performance this may have resulted in reduced detentions in September

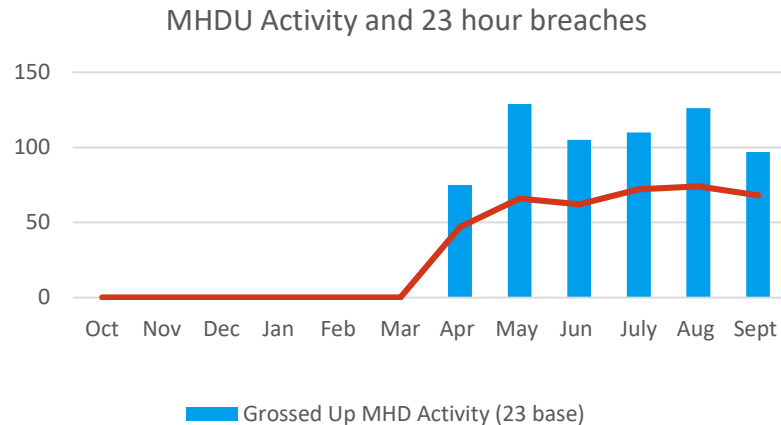
s136 detentions place pressure on both ED liaison and acute MH ward teams

Liaison Teams provide cover for MHDUs which may impact of their ability to deliver target performance

LCFT estimate that the conversion rate for s136 detentions is approximately 41% - the remainder are discharged with no follow up or 38% discharged with follow up

A high number of detentions resulting from crisis presentation is causing delays in ED due to a lack of available beds

# Since April 2018 the Trust has seen significant breaches of the 23 hour target within its MHDUs



Between April 2018 and September 2018 the Trust accepted 642 service users onto its MHDU.

61% of those service users accepted resulted in a breach of the 23 hour target

The Trust highlights delays are caused by a significant pressure from an increased number of service users who require an admission

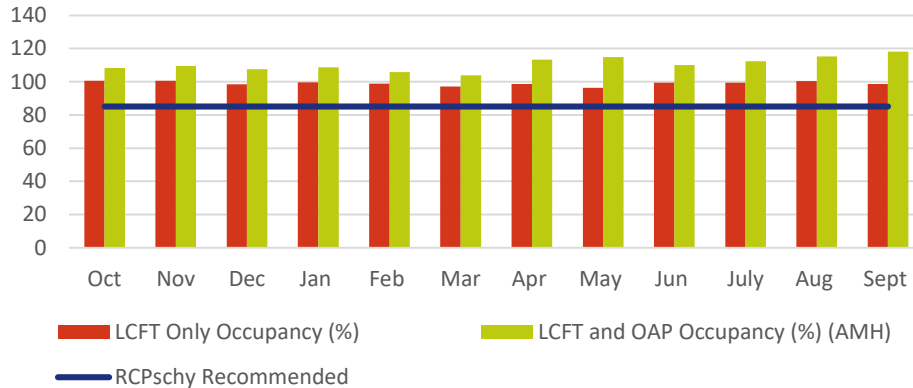
The Trust has put an Action Plan in place to respond the increased pressure

Liaison Teams provide cover for MHDUs which may impact of their ability to deliver target performance

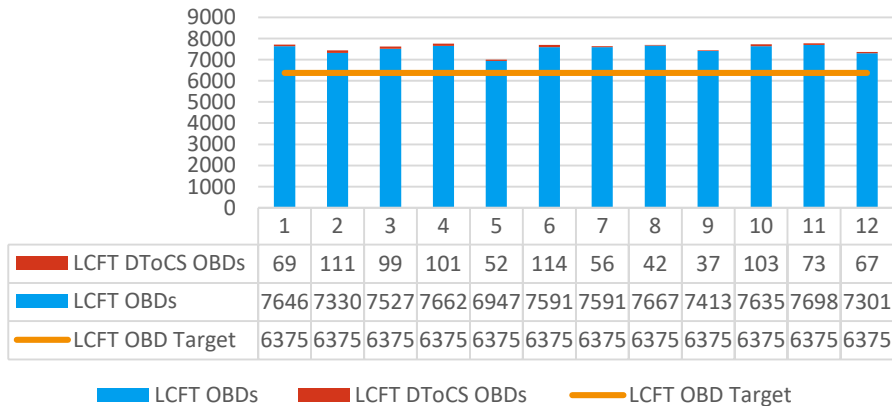
Liaison Teams whilst providing a Core 24 model of care are resourced to a level of 9-5 Core and often operate across sites

# The Trust is experiencing a significant issue with patient flow in AMH beds

LCFT Percentage Bed Occupancy Compared to RCPsych Guidance



LCFT OBDs including DToCs



LCFT occupancy including OAPs runs at between 103 – 118% between Oct 2017 – Sept 2018

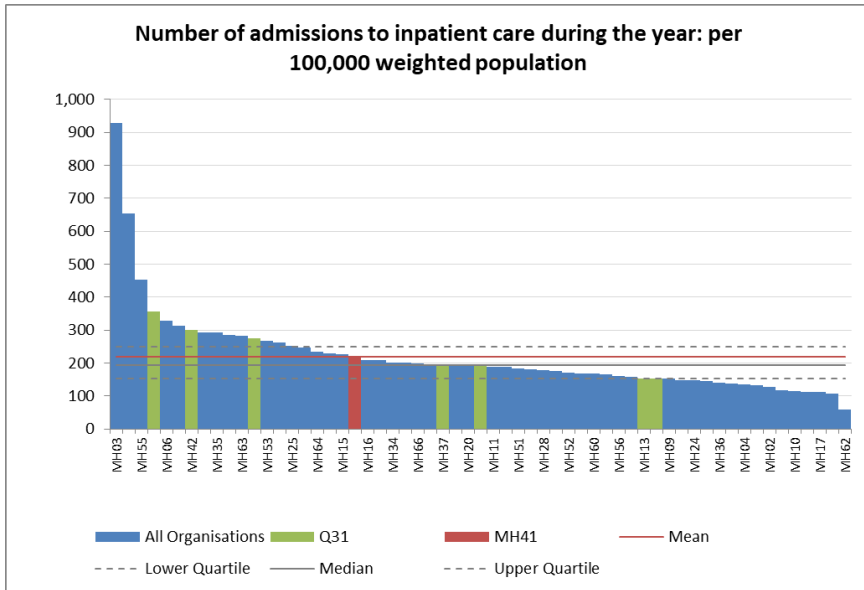
LCFT occupancy runs at between 96.4 – 100.6% occupancy compared to a RCPsych target of 85%

The Trust has a DToC rate of between 0.57% and 1.13% when compared to a target level of 7.5%

The Trust reports an average of 25 service users who have in excess of a 180 day LoS – this places acute patient flow at significant risk

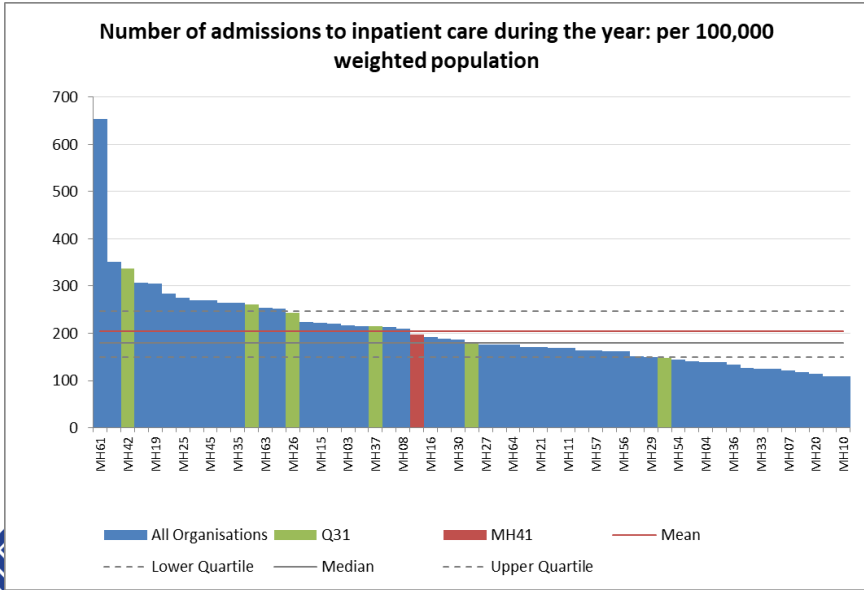


# Demand for admission has reduced within LCFT year on year yet occupancy remains high



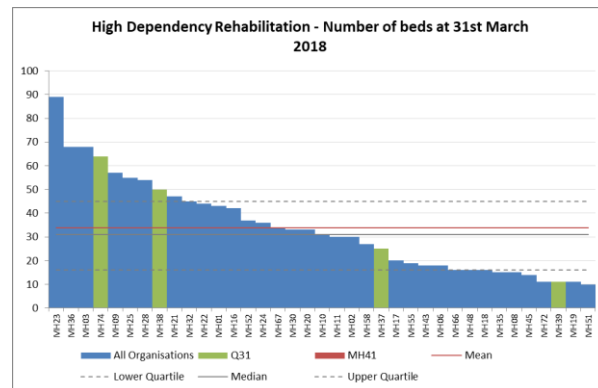
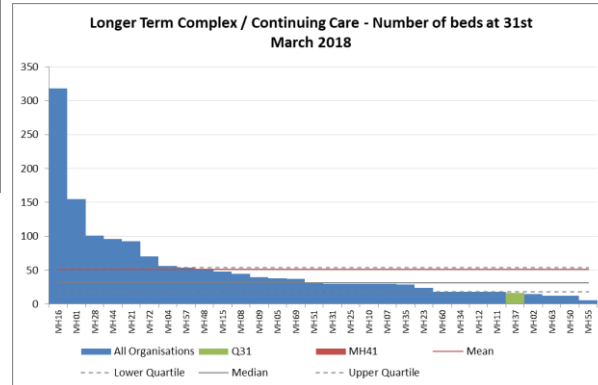
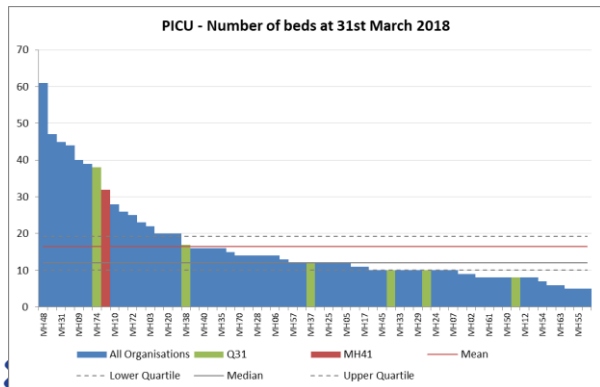
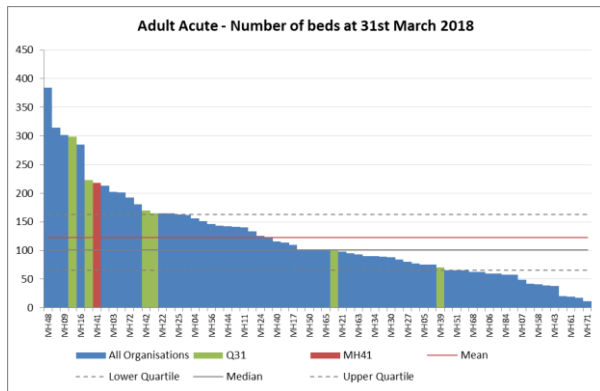
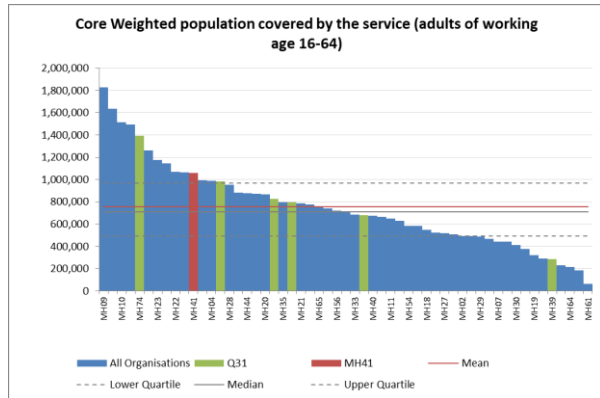
- 2016/17**
- 2304 LCFT Acute MH admissions
  - 217 admissions per 100k weighted population
  - Mean 220 admissions per 100k weighted population

- 2017/18**
- 2086 LCFT Acute MH admissions
  - 197 admissions per 100k weighted population
  - Mean 204 admissions per 100k weighted population
  - North West trend is increasing rate of admissions



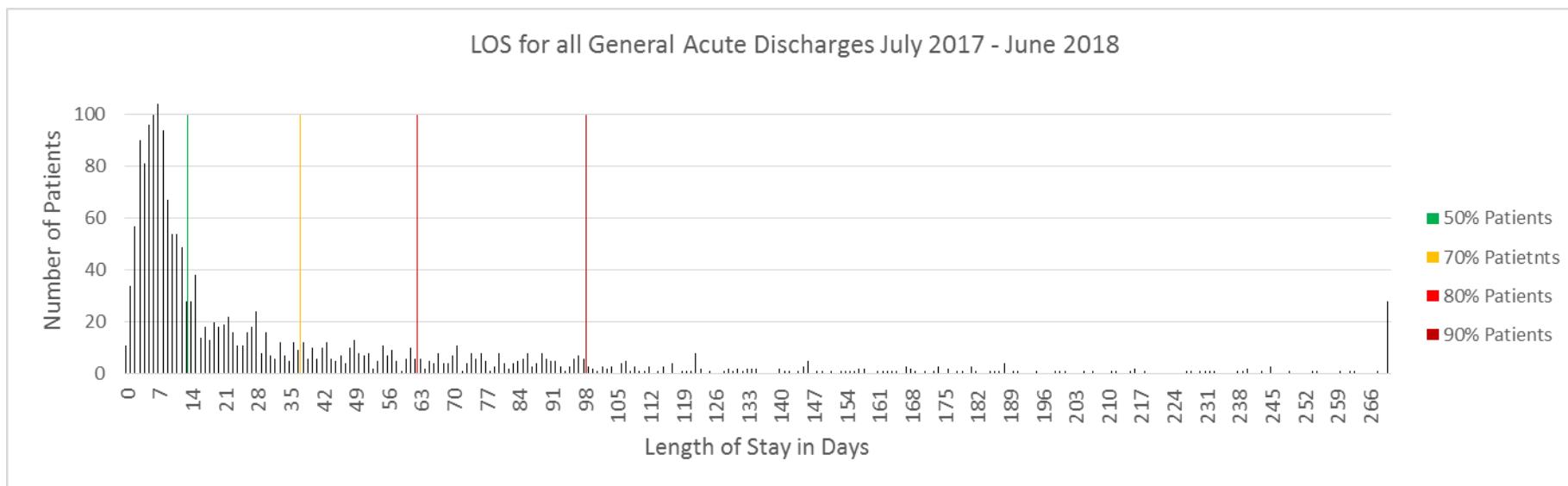
- LCFT have reduced admission demand at a greater rate than the national mean
- LCFT admissions demand moved from 1.4% lower than mean to 3.4% lower than mean
- LCFT moved from 5<sup>th</sup> lowest NW rate of admission to 3<sup>rd</sup> lowest

# The lack of long term rehab and HDU beds places significant demand on acute beds impacting on length of stay, occupancy and patient flow



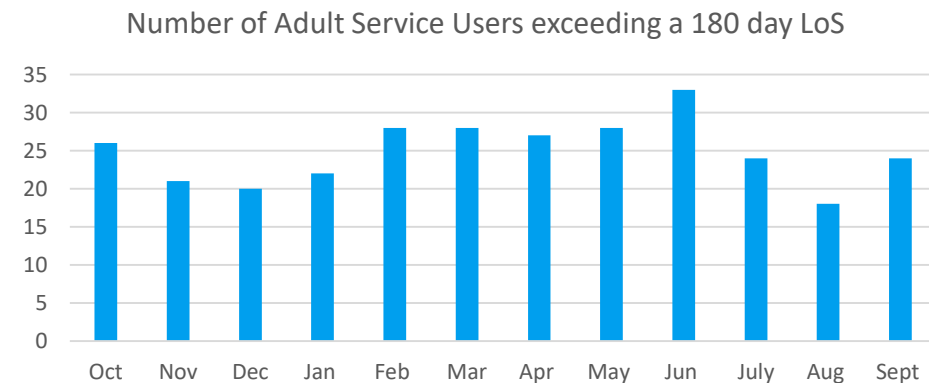
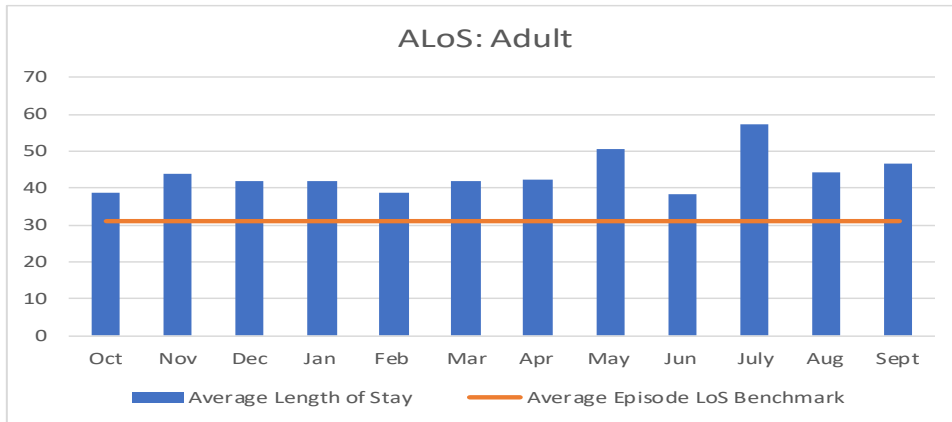
- LCFT Acute Bed numbers are 7.9% higher than the national mean (20.5 per 100k weighted population vs mean of 19)
- LCFT have no Long-Term Complex Care ('Rehab') beds, compared to a mean of 7.9 per 100k weighted population
- Lack of any Long-Term Complex beds means that this patient cohort is 'housed' in LCFT Acute Beds
- LCFT PICU numbers are 13.9% higher than the national mean (3.0 per 100k weighted population vs mean of 2.6)
- LCFT have no High Dependency rehabilitation beds, compared to a mean of 5.3 per 100k weighted population
- Lack of any High Dependency Rehabilitation beds means that this patient cohort is 'housed' in LCFT PICU Beds

## There is a significant impact on acute bed capacity from the lack of long term rehab beds which impacts on patient flow



- 1839 discharges from General Adult Wards in 12 months
- Average LOS 38.3 days on Adult Acute Ward compared to national mean of 35 days
- 90% discharged with LOS of 98 days or under
- 144 (8%) cases discharged with LOS of 120 days or more
- 10584+ OBDs in excess of 120 day stays - Equivalent of 29 beds
- Average LOS on Acute Ward if 120+ LOS transferred to Rehab Ward: 32.6 days

# Patient flow is a significant factor in reducing availability of AMH beds



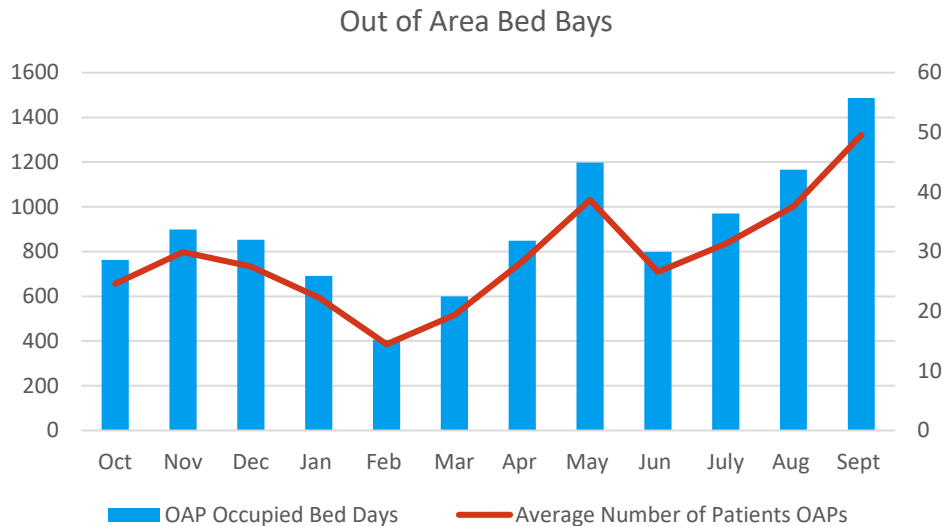
The Average Length of Stay for Adults is between 38.4 and 50.8 days compared to a Target of 31 and a national average of 36. The Trust Ops team indicate that the ALoS is significantly influenced by service users with a LoS in excess of 120 days

Length of stay is having a significant impact on bed availability and performance against s136 and MHDU performance targets where an admission is required

The number of Adult Service Users with a length of stay in excess of 180 days is between 18 – 33 during the past 12 months



## Out of Area Bed utilisation causes significant pressure and cost within the LCFT area



During 2017/2018 the Trust utilised 8665 OAP bed days at a cost of £4.3m. This equates to an average daily cost of £506/bed day. This is £81/bed day more than the national average cost for an OAP (Source: NHS Digital Returns 2017/2018)

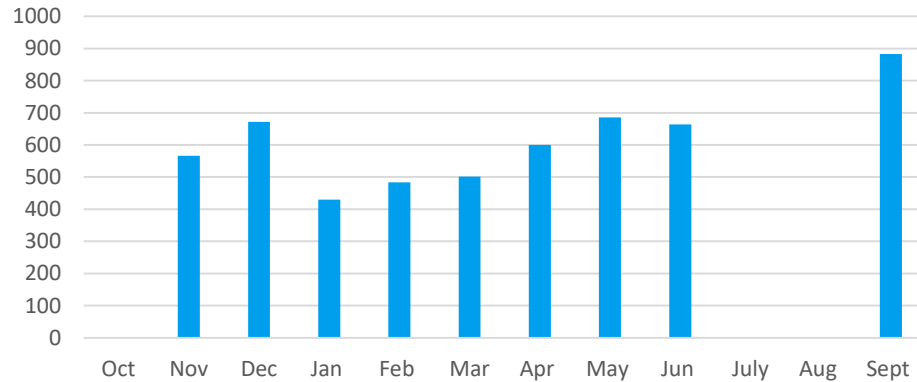
During the past 12 months the Trust utilised 10674 OAP bed days at an estimated cost of £5.4m (based on Trust average cost of £506/bed day for 2017/2018)

During Q1 and Q2 of 2018/2019 the Trust utilised 6467 OAP bed days at an estimated cost of £3.27m

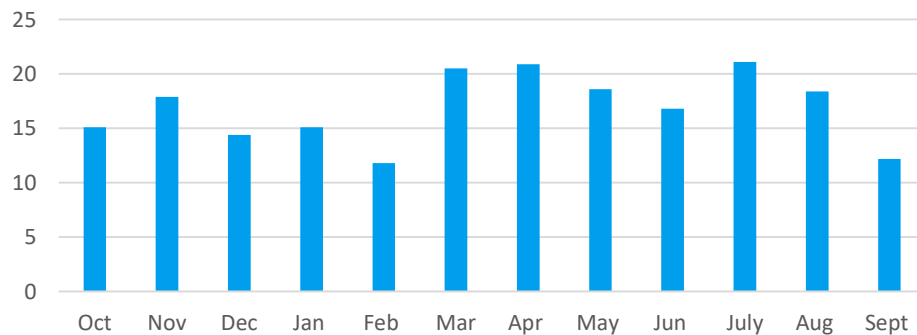
The ALoS for an OAP episode during the past 12 months range from 27 – 31 days - repatriation has been impacted by lack of patient flow. LCFT have appointed senior locality matrons to oversee flow recently.

# Patient flow is impacted by the CMHT operating model and performance

Service users without a care coordinator > 2 weeks



Readmission rates 90 days (AMH) %

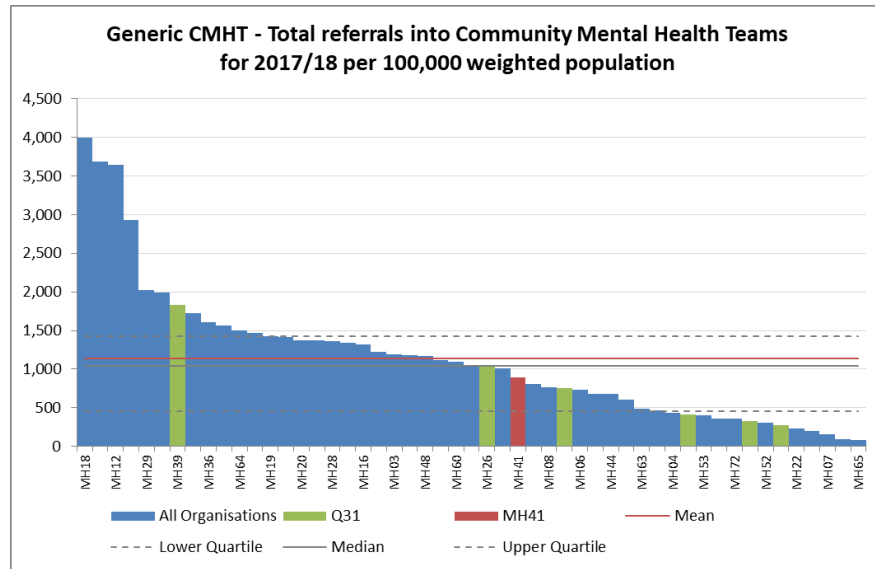


LCFT has a significant number of service users who do not have a care co-ordinator after 2 weeks. This ranged from 430 to 883 individuals in the past twelve months. The Operations team highlight an issue with DQ on this number. It will be important to resolve this admin issue urgently.

During the past 12 months between 11 and 21 service users have been readmitted after 90 days for adult services each month. With 9/12 months breaching the target. This may be an indicator of community capacity to support service users.

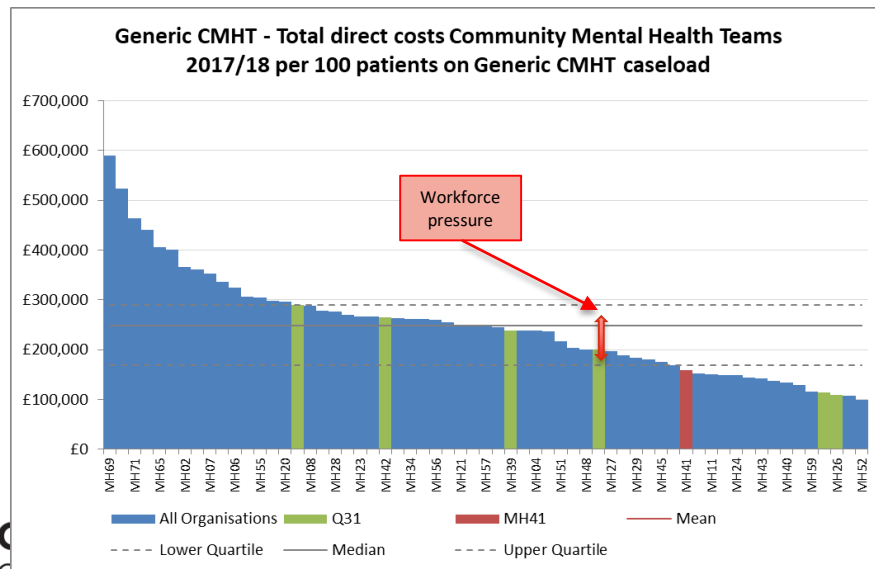


# Referral rates to LCFT CMHTs are below the national mean but teams are absorbing activity within a limited resource



## Community Mental Health Team Referrals

- LCFT CMHT referrals are below national mean – 889 per 100k
- National Mean rate of 1,141 per 100k
- Pattern within LCFT illustrates impact of START in ensuring that CMHTs can focus on enduring Severe Mental Illness



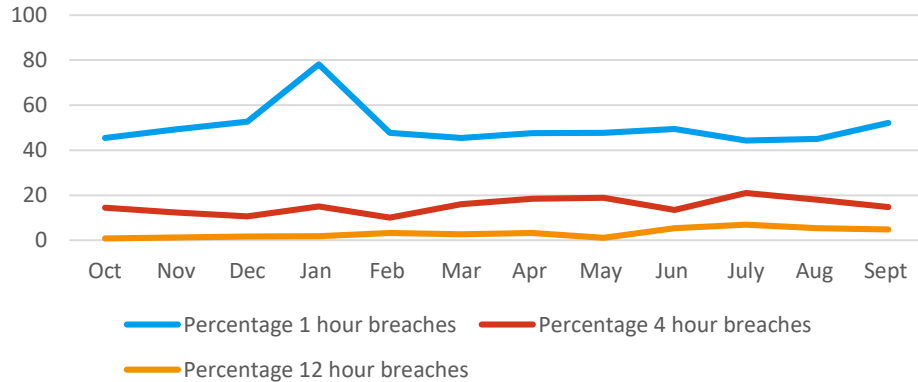
## Community Mental Health Team Referrals

- LCFT CMHTs cost £158,895 per 100 patients on caseload
- National Mean cost £247,867 per 100 patients
- Gap between mean cost and LCFT cost per patient (finance/demand) is indicative of level of pressure (often described as “acuity”) absorbed by staff, impacting on wellbeing

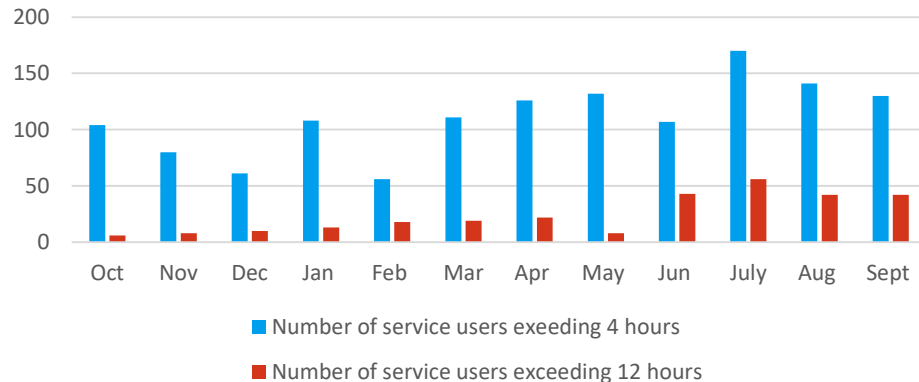


# The liaison psychiatry model of care impacts on team performance

Percentage of Liaison Breaches



Number of Service Users Breaching Liaison Targets



The percentage of service users breaching the 1 hour target ranges from 44.3 – 78.1% over the past 12 months, with between 10.6 – 21% breaching the 4 hour standard.

The number of service users breaching the 4 hour target is between 56 – 170 in the last 12 months with between 6 and 56 breaching 12 hours

The number of service users breaching 4 and 12 hour targets places acute hospital EDs under considerable pressure whilst also providing a poor service user experience. Such delays can result from Liaison team operating models, bed availability and AMHP and s12 Doctor availability



# The liaison psychiatry model of care impacts on team performance

North Lancs	Jul	Aug	Sept
%age 1 hour compliance	39.2	34.4	52.8
%age 4 hour breaches	28.8	31.7	16,6
%age 12 hour breaches	6.4	7.6	5.6

Pennine Lancs	Jul	Aug	Sept
%age 1 hour compliance	46.5	45.3	52.5
%age 4 hour breaches	19.1	9.4	14.1
%age 12 hour breaches	10.6	6.4	5.9

Central and West Lancs	Jul	Aug	Sept
%age 1 hour compliance	50.9	64.1	50.5
%age 4 hour breaches	8.0	6.0	12.0
%age 12 hour breaches	1.2	0	1,1

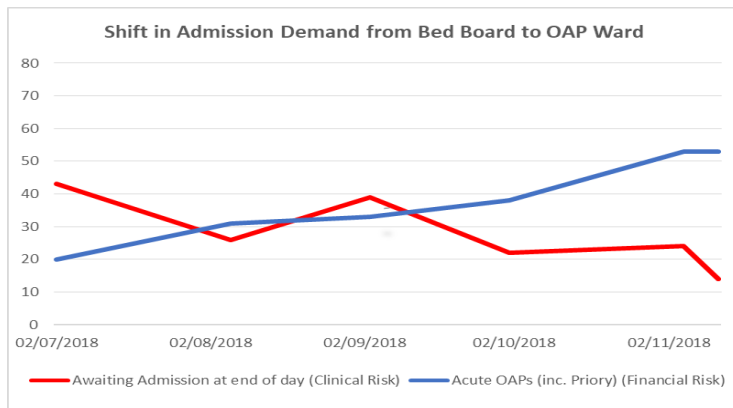
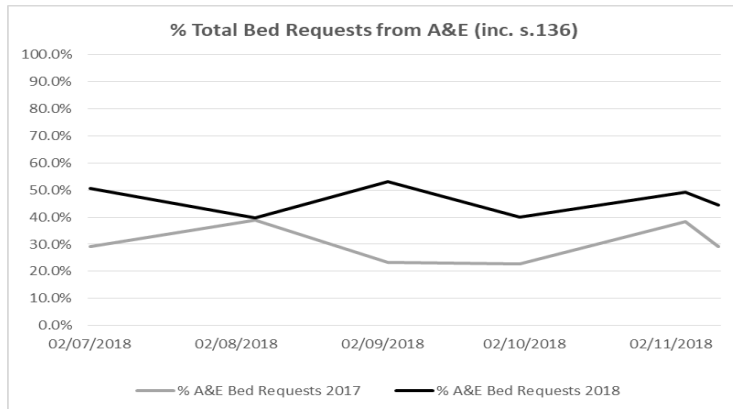
Liaison teams provide cover across ED and MHDU - this will impact significantly on ability to respond to the 1 and 4 hour targets

The Liaison Team in Preston covers two sites along with the MHDU. This will place significant strain on ability to deliver performance standards

Delays in accessing beds and staffing vacancies/sickness impact on overall performance

The Operations team indicate that the number of service users presenting intoxicated who are referred onto the liaison team are significant – this creates an increased demand for specialist support

## LCFT Census analysis highlights increased demand from EDs



- The percentage of total referrals from A&E has been notably higher at all census points except 2 August, when actual numbers and % were the same as 2017
- This demonstrated a shift in the location of bed referrals from elsewhere in the system to A&E
- Previous analysis has demonstrated the impact of increased use of s136 and use of A&E by the police as a Health-Based Place of Safety

