South West London and St George's NHS
Mental Health NHS Trust

Crisis & Home Treatment Team investment discussion paper

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Author:	Emma Stinton, Senior Project Manager, Transformation Team		
Owner:	Dawn Chamberlain, Director of Operations		
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Crisis & Home Treatment Team investment and workforce discussion paper

1. Background

1.1. In the Acute Care Pathway Project Group in May 2014, demand pressures and workforce capacity for running sustainable Crisis and Home Treatment Team (CHTT) services were highlighted and the situation was described as critical in one service.

1.2. This was followed by a request from Dawn Chamberlain, Director of Operations, for comparative data for CHTTs in relation to other London Trusts. This was in order to build a case to commissioners for further funding particularly in Wandsworth and Richmond. In order to quantify the problem and bid for additional resources, comparative data is presented here, including comparing teams across the Trust.

2. Key sources and reports

2.1. The National Audit Office report 'Helping people through mental health crisis: The role of Crisis Resolution and Home Treatment services (2007)' looked at value for money and performance of teams against the Department of Health aims for such services. Relevant information from this report includes:

"NHS commissioners should work with mental health provider trusts to assess current Crisis Resolution and Home Treatment capacity in the context of local need, and invest sufficient resources to make fully staffed 24/7 CRHT teams an integral part of the local mental health care pathway. This should include ensuring that Crisis Resolution and Home Treatment teams receive full clinical input and support from consultant psychiatrists, both to provide appropriately skilled and multi-disciplinary Crisis Resolution and Home Treatment teams and to encourage acceptance and knowledge of their role within local mental health services". (p8)

2.2. The Department of Health Policy Implementation Guidance (MHPIG 2001) defines a fully functional Crisis and Home Treatment Team (CHTT) and envisaged that it should consist of around 14 members of clinical staff, serving a population of approximately 150,000 people. It should also fulfil a number of 'fidelity criteria', based on established good practice in CHTT.

2.3. A National Survey of CHTTs in England was commissioned in 2006 (Onyett et al 2006) in which CHTTs widely reported a lack of staffing as the key obstacle to effective operation. This was corroborated by projections based upon the MHPIG.

2.4. The Guidance Statement on Fidelity and Best Practice for CHTTs was produced by the Care Services Improvement Partnership/Department of Health in 2006. In summary:

- A standard team of size 14 is broadly appropriate for a caseload of 25 people requiring home treatment at any one time. Over a full year this should mean that the standard team delivers around 300 home treatment episodes
- Areas of greater need in terms of both deprivation and psychiatric morbidity indices will require a higher staff to population ratio. Typically, these will be inner city teams of large conurbations. While this serves as a rough guide, providers must ensure sufficient staff to cover shifts adequately
- The team should have the ability to provide mobile, 24 hour, seven days per week home treatment to people on its caseload.

2.5. In 2012, as a result of a yearlong independent inquiry and freedom of information requests to CHTTs, Mind produced a report, Mental Health Crisis Care Commissioning Excellence. A briefing for Clinical Commissioning Groups. It stated that it is more important than ever that Clinical Commissioning Groups (CCGs) commission acute and crisis care that has enough skilled staff to provide a timely effective and sensitive response and offers a level and mix of services that meet the crisis needs of all the communities in the local population. It also notes that staff to service user ratios suggested in the guidance may be higher than suggested due to reasons of geography, population density and dispersal. The benchmark only relates to caseload so a team with an appropriate caseload may still be overstretched if they are carrying out a high level of assessments.

3. Funding

3.1. The Trust has a CHTT in each of the five boroughs and the direct cost budgets, funded by the CCGs, are shown below. The Trust receives this funding through the local block contracts with each commissioner.

Table 1 – Direct CHTT Budgets Funded by Health

2014/15 Full Year Effect	Pay Budget WTE	Pay Budget £k	Non Pay Budget £k	Total Direct Budget £k
Wandsworth	24.70	1,348	34	1,382
Sutton	20.00	925	28	953
Merton	15.50	760	27	787
Kingston	13.00	668	10	678
Richmond	13.00	737	5	742
TOTAL	**86.20**	**4,438**	**104**	**4,542**

3.2. The budgets above exclude:

- Crisis Line and the ACP Coordination Centre
- Merton and Richmond team budgets also include posts which are employed by the Trust and funded by the respective Local Authority
- Each local authority may also fund posts within the teams for which the funding and costs do not pass through the Trust e.g. Social Worker posts

3.3. Table 2 below shows CHTT in each of the five boroughs and the direct cost budgets, funded by both the CCG and Local Authority:

Table 2 - Direct Budgets held under Health (inc LA funded posts)

After Investment 2014/15 Full Year Effect	Pay Budget WTE	Pay Budget £k	Non Pay Budget £k	Total Direct Budget £k
Wandsworth	24.70	1,348	34	1,382
Sutton	20.00	925	28	953
Merton **	20.00	917	27	944
Kingston	13.00	668	10	678
Richmond **	13.50	762	5	767
TOTAL	**91.20**	**4,620**	**104**	**4,724**

** Includes posts recharged to the Local Authority

The budgets above exclude the Crisis Line and the ACP Co-Ordination Centre.

4. Benchmarking

4.1. Table 3 below shows the SWLSTG team staffing at the time of benchmarking. It shows how the teams benchmark nationally in 2009 (Wandsworth, Merton and Sutton) and 2011 (Kingston and Richmond). These figures include local authority funded posts:

Service	WTE	Position out of 289 Trusts (1st=lowest funded)	2014/15 WTE
Kingston	10.4	41st	13
Richmond	12.5	65th	13.5
Wandsworth	20.5	183rd	24.7
Merton	21	192nd	20
Sutton	24	215th	21

4.2. Table 4 demonstrates the WTE required based on DH guidance 2006 which recommends 14 WTE per 150,000 population. The benchmarking data also includes other London Boroughs which are comparable to those boroughs in South West London.

Borough	Population (Census 2011)	MINI2k index (psychosis)	Local Index of Need	WTE based on population	2014/15 WTE in current team	Gap against DH staffing guidance and population
Ealing	338,449	0.98	n/a	31.5	n/a	
Harrow	239,056	0.74	n/a	22.3	n/a	
Hounslow	253,957	0.95	n/a	31.5	n/a	
Kingston	160,060	0.62	-29	14.9	13	**2**
Merton	199,693	0.72	12.4	18.6	20	
Richmond	186,990	0.57	-33	17.4	13.5	**4**
Sutton	190,146	0.83	-23	17.7	21	
Wandsworth	306,995	1.44	56.3	28.7	24.7	**4**
Croydon	210,000	0.76	47.7	19.6	n/a	

* MINI2K index is the ratio between the expected admission rates for schizophrenia and psychotic illnesses for the PCT compared to the rate for the whole of England, where England is 1. An index of 1.25 would suggest that the PCT had expected admission rates that are 25 per cent higher than the England average. An index of 0.75 suggests that expected admissions rates are 25 per cent lower than the England average.

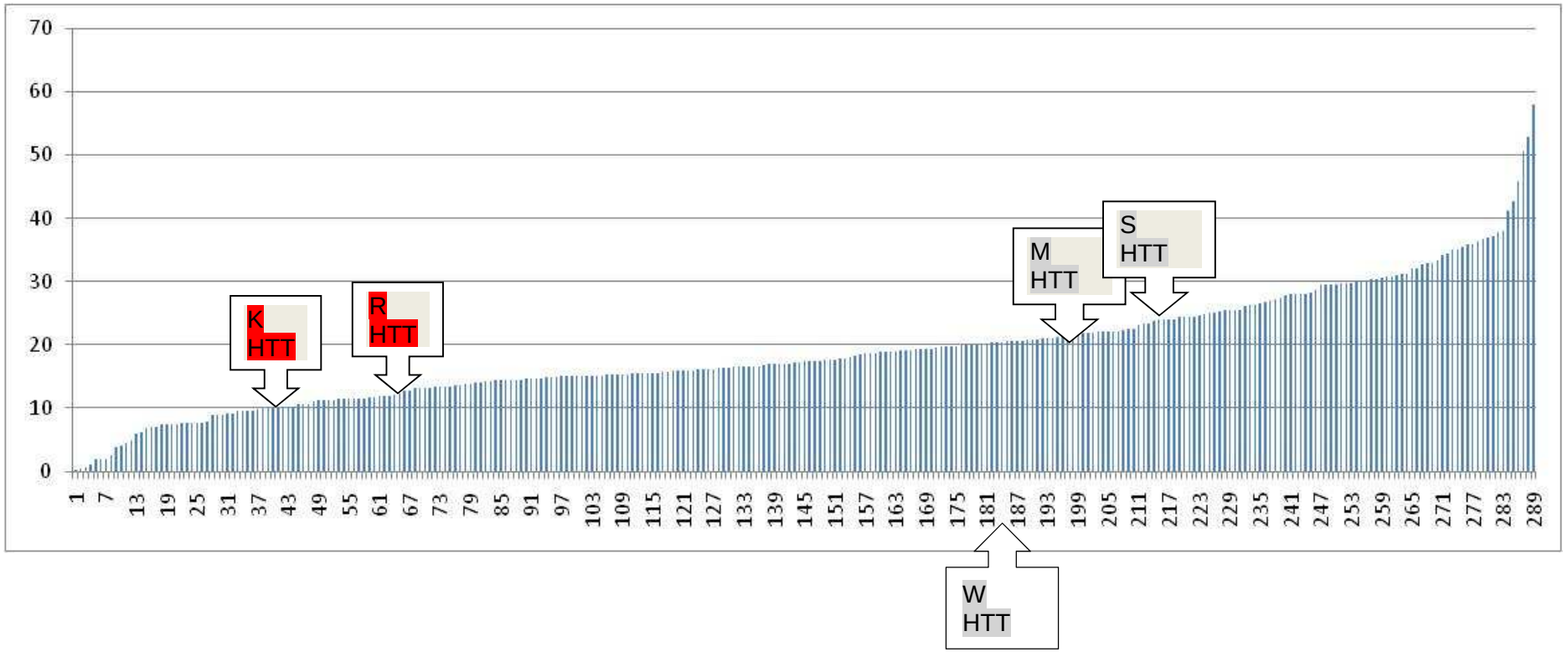
*This is a composite score of many weighted variables that reflect the socio-demographic composition of a defined geographical area (in this case Local Authority areas) such as population density, ethnicity and local crime rates.
The mean LIN scores for boroughs in England is 0, with a borough with a negative score indicating a lower than average mental health need. The LIN differs from the MINI 2K in that it is not based on previous service utilisation.

4.3. The table above indicates that Kingston, Richmond and Wandsworth CMHTs are under resourced.

4.4. Using all data from the mapping the mean team size is 18.4 WTE. This is just below the current size of the Sutton and Merton teams. It should be noted that this will be for a range of National Service Framework episode targets that the teams are required to achieve.

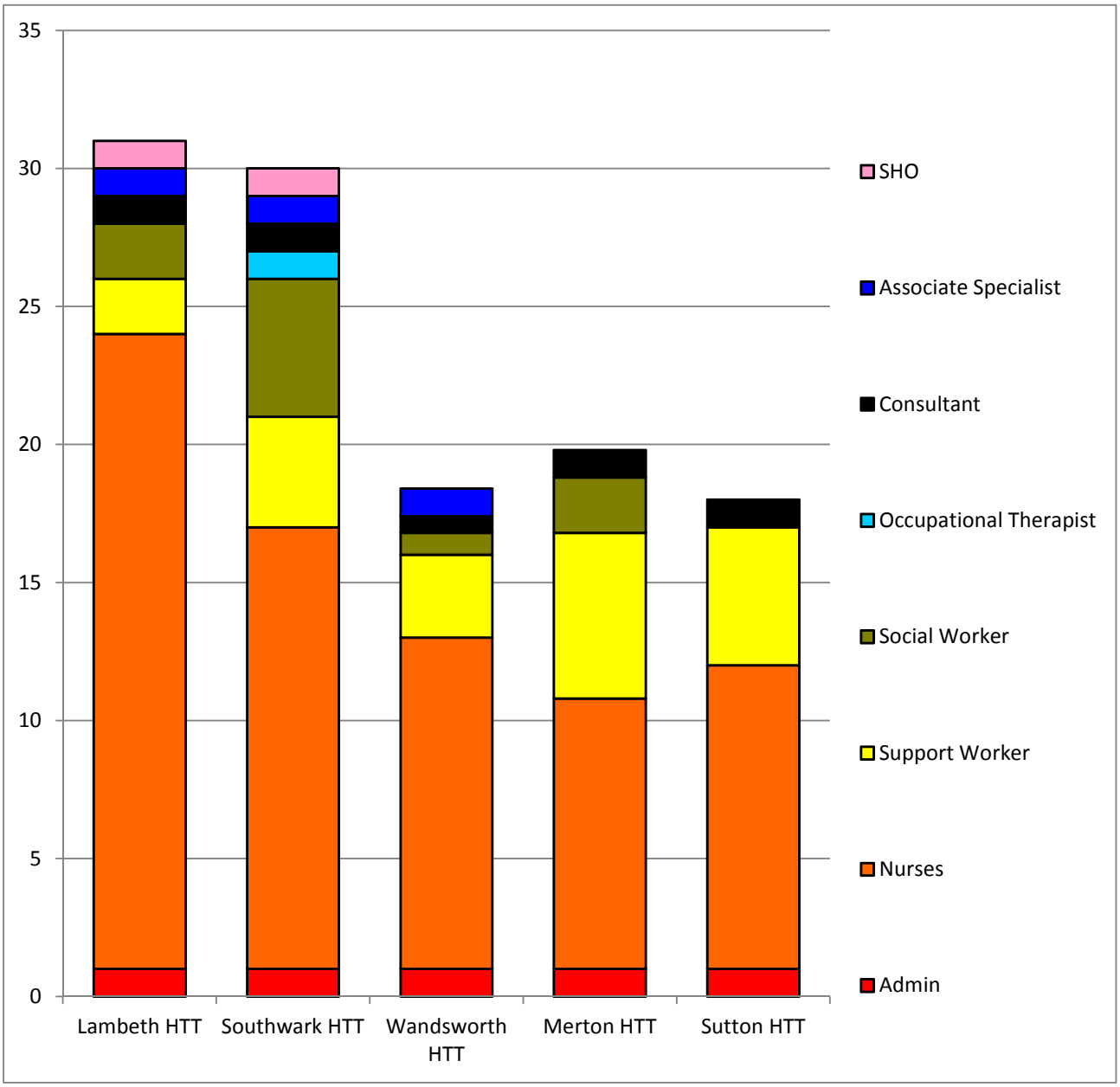
4.5. The benchmarking data can also be seen below represented in a bar chart. The Kingston and Richmond positions highlighted in red show the figures for 2011.

Figure 1: WTE staffing reported for 289 services classified as Crisis Resolution Home Treatment Team



4.6. Some work was carried out internally to look at the staffing levels of Trust CHTTs as compared to Lambeth and Southwark, two well-resourced London teams (including local authority funded posts). This work was done prior to the April 2014 investment in teams which increased Wandsworth staffing by 5 WTE. Figure 2 below shows relatively low comparative staffing levels plus differences in skill mix:

Figure 2: HTT Staffing Levels January 2013 compared to Lambeth & Southwark



5. Current Position

5.1. As part of the Acute Care Pathway workstream of the Transformation Programme the Trust made a decision to invest £600K in CHTTs and a new Acute Care Pathway Coordination Centre (ACPCC) from April 2014.

5.2. The method for apportioning the investment between teams was based on their funded establishment at the time and the episode targets expected of the team as per the National Service Framework. Locally the Merton and Sutton teams are seen as better resourced so the required WTE was calculated by taking Sutton and Merton's current episodes per WTE and applying to the other borough e.g. the NSF episode target for Kingston is 298 and to ensure an 18.5 episode per WTE (average of Sutton and Merton's) they will need 16.2 WTE.

5.3. It is important to note that, due to the limited investment, it did not lead to equity of provision across the boroughs. Sutton & Merton PCT (as was prior to CCGs) invested significantly in their CHTTs a few years ago. In order to bring the other three local boroughs up to a similar level of investment the Trust will need to negotiate with those CCGs. Table 5 shows the required WTE increase, on top of the April 2014 investment, required to provide equality of provision:

Table 5: Actual investment allocation

Borough	Episode Target	Pre April'14 CHTT funded establishment (WTE)	WTE increase required to bring in line with S&M staff: episode target ratio	WTE increase post investment	Required WTE increase to provide equality
Kingston	298	11	5.2	2	**4**
Merton	370	20	0		
Richmond	313	11	6	2	**4**
Sutton	377	21	0		
Wandsworth	715	19.7	19.3	6	**13.3**

5.4. This is represented in WTE rather than funding required as the teams would make the decision locally if this increase would best serve the team as qualified or unqualified members of staff. This would then have to be costed appropriately.

6. Initial Conclusions

6.1. Areas of variation between boroughs exist and do not appear to follow any rationale other than historical investment patterns.

6.2. Kingston, Richmond and Wandsworth CHTTs are below average size in relation to nationally reported service mapping returns. Using the DH guidance of 14 WTE per 150,000 population and local population data as well as episode targets, which are based on the needs and demands of the local population, data it suggests a gap in WTE for Kingston, Richmond and Wandsworth.

6.3. The recent Trust investment in CHTTs went partway to creating equity of service provision across all teams but further investment is required in Kingston, Richmond and Wandsworth.

6.4. The required investment using WTE per population equates to 10 WTE, whereas the required investment using episode target equates to 21.3 WTE across the three boroughs. The main difference is in Wandsworth WTE and this is due to episode targets being a more sensitive measure. These figures have not been costed due to the requirements of staff in each service being different. Further local work is required to map additional staffing requirements to determine if the extra staff would be Band 6 nurses or Band 4 support workers.

Distribution & approvals history

Version	Distributed to	Date	Action required / taken
0.1	Glynn Dodd	07.08.14	
0.1	Frances Smith Angharad A Rudkin	12.08.14 19.08.14	For finance information to be inserted For comments
V0.2	Glynn Dodd	20.08.14	For comments
V0.3	Debbie Hollinghurst	27.08.14	For comments on financial elements
V0.4	Dawn Chamberlain	09.09.14	Further analysis on benchmarking
V0.5	Emma Stinton	15.10.14	For comment
V0.6	Dawn Chamberlain	16.10.14	Sign off