Nottinghamshire County Council

Nottinghamshire County Council Advanced Mental Health Professional (AMHP) Strategy

2017-2021

Forward

This strategy has been developed in response to a rise in demand for Mental Health Act Assessments (MHAA) in Nottinghamshire during 2016/17. This has put significant pressure on the Countywide AMHP (CAMHP) Team, district AMHPs and other Council services and partner agencies. The Council is required to respond to by this by ensuring a coherent strategy and sufficient resources are in place, to manage this high risk work and ensure vulnerable people in Nottinghamshire who need to be detained under the Mental Health Act (1983) receive the required protection.

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1. **Strategic Aims**

1.1 The purpose of this strategy is to ensure the achievement of the following key aims:

- Train and support a sufficient number AMHPs to meet demand and to ensure that the model deployed is the most efficient within the resources that are available
- Ensure that training to become an AMHP continues to be a viable and attractive offer for Nottinghamshire County Council social workers to progress in their career.
- Ensure that all operational and business support processes used followed by AMHPS are as efficient as they can be and utilise all available technology to enable the service deal with increased demand for assessments with finite resources
- Ensure Nottinghamshire County Council maintains an effective relationship with key partner agencies to minimise delays and disruption to AMHP work.

2. **Operational Priorities**

2.1 The successful implementation of this strategy will result in the following day to day operational priorities being achieved

- Incoming referrals are risk managed immediately by a trained and qualified AMHP.
- Assessments need to be undertaken on the day of referral or on time if planned in advance. Assessments cannot be put on a waiting list
- AMHP reports are completed in a timely way, are of a high quality and legally compliant
- Statutory training is undertaken
- Effective partnership work is undertaken to manage barriers and challenges during assessments
- AMHPs can have the capacity needed to support trainee AMHPs.

3. **Current Context**

Please note that the data included in this strategy includes work completed by the Emergency Duty Team (EDT). However, additional detail on operational

challenges and duties of AMHPs reflects work undertaken in the Countywide Team only, unless otherwise specified.

Mental Health Act Assessments

3.1 An assessment under the mental health act is undertaken when a person is deemed to be a risk to themselves or others. It is only undertaken when it felt that all other ways of supporting the person have been exhausted and consideration of a hospital admission is being made.

3.2 Before a person can be lawfully sectioned under the Mental Health Act, they must be assessed by a team of health professionals. This process consist of;

- An interview by an AMHP
- An assessment by two doctors who are qualified to undertake this role.

3.3 The role of the AMHP is to consider the least restrictive alternative and to ensure that there is no other way of supporting the person apart from admission to hospital.

3.4 The AMHP has to decide within 14 days of assessing the person whether to go ahead with the application to detain under the Mental Health Act and give reasons for that decision. The AMHP must communicate their decision to:

- the person’s nearest relative
- the doctors who did the assessment
- the person’s care co-coordinator (if they have one)
- the person’s GP, if they were not involved in the assessment

3.5 The AMHP is responsible for:

- liaising with the bed managers of the hospital and making sure the hospital can admit the person and has a bed available
- making sure the person arrives at the hospital safely. This may involve working with Emergency Services (Police and Ambulance).
- Ensuring that the person’s property is left secure and that any children are going to be appropriately cared for and referred to services if they are in need or at risk. Pets also must be appropriately cared for.

Countywide Team Provision

3.6 The Countywide AMHP Team (CAMHP) was set up as part of a wider Organisational redesign in September 2012. It was set up to specifically carry out Mental Health Act Assessments (MHAA) across Nottinghamshire. Prior to the team being set up, all assessments were completed by AMHPs in district Mental Health Teams and AMHPs received an honorarium payment for maintaining AMHP status. When Hay grading was adopted by the Council, the AMHPs were no longer

allowed to retain the honorarium and all were encouraged to apply for Band C roles. At the same time, the Advanced Social Work Practitioner job description was developed with additional responsibilities at this banding. This organisational change resulted in the Council losing AMHPs and additionally each district Mental Health Team had 6 FTE Band C roles. Further re-organisations have seen a reduction in Band Cs in mental health teams.

3.7 The CAMHP Team consists of a Team Manager, 10 FTE AMHPs and 1 Business Support Officer**.** AMHPs in the CAMHP Team are the Council's expert resource for this work. They only undertake MHAA and are Band C. CAMHP Team AMHPs have a wide range of other responsibilities including:

- Managing and allocating all MHA referrals across all teams

- Supporting and training all student AMHPS by fulfilling a Practice Mentor Assessor role. This responsibility covers all of the Council's social workers who progress to Band B and chose to train to become AMHPs. This is a core task expected from the team members, but currently they are having to fulfil this role within their own time due to needing to meet the core business needs of MHAs. Changes in personnel in Workforce Development has meant that there is a greater call on the expertise of the team in regards of supporting placements

- The team has the responsibility for AMHP trainees and providing a Practice Mentor Assessor role. Prior to the CAMHP Team being set up AMHP students were supervised by AMHPs in district teams who were given an additional payment for undertaking this role. When the CAMHP Team was set up a decision was made that the AMHPs in the CAMHP Team would have responsibility for the Practice Mentor Assessor role but would not receive additional payment because this would be covered by their Band C job description. Changes in personnel in Workforce Development has meant that there is a greater call on the expertise of the team in regards of supporting placements.

- Updating all MHA policies, which are extensive **(please see Appendix 2)**. The team took up this responsibility following the loss of dedicated policy officer posts. Due to demands on the team to undertake statutory assessments policies have become out of date, leading to potential risks if policies are requested as part of an IMR or Coroner's inquest.

- Leading on all work with partner agencies, such as East Midlands Ambulance Service (EMAS), Nottinghamshire Healthcare NHS Foundation Trust NHS and Nottinghamshire Police. The pressures in partner agencies have had a knock on effect to the working patterns of AMHPs. Work has been undertaken by the manager of the Countywide AMHP Team to try and manage some of these issues and create clearer processes and better joined up working. This work has been highlighted in the Crisis Concordat and is ongoing.

- All AMHPs are required to undertake mandatory training to retain their AMHP status. This must be at least 18 hours a year and should be a mix of formal training and self-directed learning. It has proved difficult for the CAMHP Team AMHPs to undertake this training because no more than 3 people out of the 10 people employed can have time off at any point to meet the core business needs.

Locality Team Provision

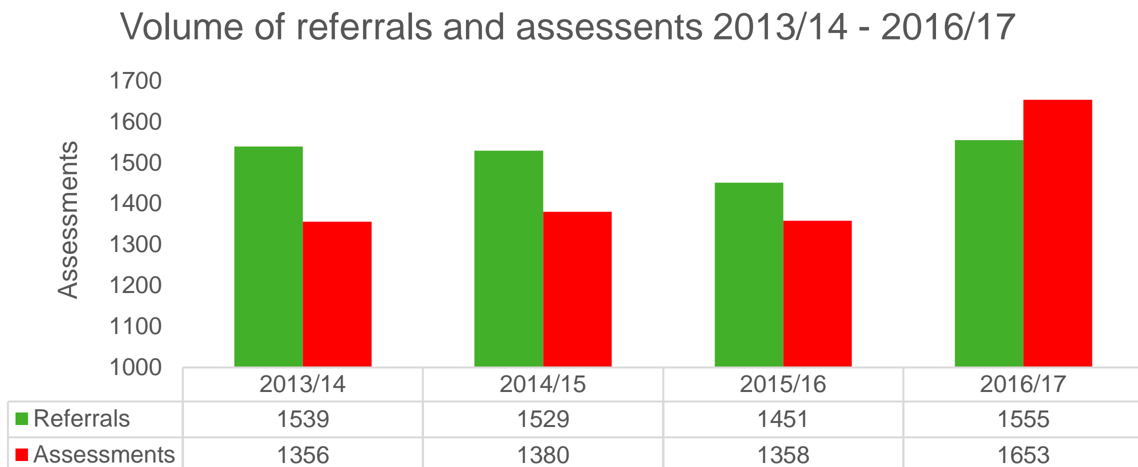
3.8 As of March 2017, there are 18 AMHPs (approx. 13 FTE) in locality teams listed on the district rota, though not all are active at the same time. Each AMHP is required to undertake at least 9 assessments a year. AMHPs in the district teams are either Band C or band B and combine this commitment with other district team responsibilities.

Emergency Duty Team Provision

3.9 As of March 2017, there are 9 (6 FTE) qualified AMHPs who work within EDT, though not all are active at the same time. Like locality team AMHPs, they are required to complete at least 9 assessments per year.

Demand and Pressure on Capacity

3.10 The graph below shows the number of referrals received and the number of assessment carried out each year for the previous 4 years.



	2013/14	2014/15	2015/16	2016/17
Referrals	1539	1529	1451	1555
Assessments	1356	1380	1358	1653

3.11 This graph shows the following key trends:

- The number of referrals received 2015/16 was lower than2013/14 and 2014/15. However, the proportion of referrals that went on to become assessments was higher. The proportion of referrals that went on to assessment increased from 88% in 2013/14, to 90% in 2014/15, to 93% in 2015/16. In 2016/17, the number of assessments exceeded the number of referrals made. This is because is cases where an AMHP has to make multiple assessments because they are

unable to detain the person due a number of factors such as needing a warrant, lack of bed availability or lack of conveyance.

- The total number of referrals received in 2016/17 is 7.5% above 2015/16.
- The total number of assessments required is 21.7% above 2015/16.

Time taken per assessment

3.12 The time taken to complete an assessments varies widely according to the circumstances but on average take around 10 hours to fully complete. This is taking account of; co-ordinating the assessment, information gathering, conveyance, completing the assessment, documentation, referrals to other agencies or other NCC teams such as safeguarding and ensuring the legislation requirements are met (such as securing property etc.).

3.13 As a result of this additional demand, it has been necessary in periods of high demand for AMHPs in the CAMHP Team to undertake two or more assessments in one day. There are management concerns that working to this capacity on an ongoing basis will lead to a reduction in quality of work and/ or the worker experiencing high levels of stress or burn out. This is certain to have an impact on recruitment and retention of AMHPs, which is already challenging.

3.14 In six months leading up to September 2016, the team have had to implement the agreed emergency protocol 9 times, in order to find additional district AMHPs (not on the rota), due to no AMHPs being available to complete the necessary assessments. This is despite the team members sometimes doing 2 or even 3 assessments per day, *(this occurred twice in 2014, once in 2015 and 7 times in 2016).* The pressures in the CAMHP Team therefore can transfer out into the community teams, who are not in a position to support unplanned AMHP work over and above their AMHP duty rota commitments. Requests for MHA cannot be put on a waiting list or passed to other organisations, but must be undertaken as soon as possible following the referral.

3.15 Undertaking a high level of assessments is resulting in workers continuing work, outside day time hours which increases health and safety issues as well as the acquisition of TOIL. The team have been working on how this can be managed by looking at a virtual shift pattern but it is apparent that MHAs are being completed after working hours due to other mitigating factors outside of the control of the NCC employees, which largely come under the remit of partner organisations rather than NCC.

Partnership Challenges

3.16 Undertaking MHAs is a complex, challenging and highly pressured front line role. It requires the need to make an independent decision regarding detention and involves working with people suffering high levels of distress. The time taken to complete an assessment can vary considerably according to the complexity of the case and the availability of resources from key partners, such as doctors, bed capacity, East Midlands Ambulance Service (EMAS) and Police.

3.17 The assessment itself takes up a relatively small proportion of the total time taken to complete an assessment from start to finish. Pressure on AMHP time is largely down to blockages within the process that are caused by pressures experienced by other agencies. These are explored in more detail in the following paragraphs.

Bed availability

3.18 The introduction of the Bed Management Team within the Trust has helped with bed finding problems and made a smoother transition for AMHPs to be able to complete their part in the assessments. AMHPs report a very positive working relationship with the Bed Management Team, who have a 'can-do' approach despite challenges. However, lack of bed availability does have a detrimental impact on the capacity of the team, as practically AMHPs do not detain individuals unless there is a bed available. Even if this is the case, on some occasions beds can suddenly become unavailable meaning the AMHP has to wait with the person and other agencies until another bed is identified. If a bed is not found, or becomes unavailable following an assessment, often the assessment must start again. AMHPs need to have the best possible up to date information to ensure beds are found and remain available wherever possible so that this can inform their activity.

Doctor availability

3.19 The majority of doctors who support AMHP assessments do so in addition to their day to day work. As a result, assessments often have to be timed later in the day to coincide with doctor availability. There is also a general shortage of doctors with the required training and capacity required to meet presenting demand. NCC are working with the trust in regards to this shortage which is local and national. Section 12 doctors are recruited and paid by Nottinghamshire Healthcare NHS Foundation Trust. Issues with capacity will continue to be raised in partnership meetings.

Conveyancing

3.20 Once an individual has been detained under the act, they need to be transported to a place of safety, ideally their hospital placement. Each case is individually risk assessed and in the majority of cases and ambulance is required to convey the individual safely.

3.21 AMHP colleagues routinely log a series of delays due to the lack of ambulance availability and can often wait between 1.5 and 5 hours to ensure safe conveyancing. The need for a separate Mental Health Act vehicle has been raised with the commissioners of EMAS and as part of the East Midland Mental Health Leads group and the Crisis Concordat.

3.22 Private Ambulances are only used when the placement is out of area and it would be unfeasible for EMAS to use its vehicles. Nottinghamshire Healthcare NHS Foundation Trust can also call on its own vehicle to manage high risk incidents, however this in only appropriate for high risk incidents, because it is a high cost resource to deploy. NCC need to clarify this position and build a

business case to better utilise and support Trust resources that factors in AMHP time that is spent waiting for suitable conveyance to become available.

Police response time

3.23 The CAMHP Team has ongoing communication with the Police with regard to s135 (warrants which are obtained by a magistrate) and s136 (taking the person to a place of safety in order to conduct an assessment) work. However, there is a lack of consistent approach in Police action. Officers on duty have different interpretations on their duties and this leads to an inconsistent approach being taken with conveyancing in particular. These issues can also cause delays.

3.24 The Policing and Crime Bill (2017) will also have some impact on increasing pressure on all mental health services across different agencies. The main impact on the Council's AMHP service will be that the time period that someone is going to be held in a place of safety will be reduced from 72 hours to 24 hours. This will not create extra demand but all aspects of a full MHAA, bed management, and transport arrangements will need to happen with even greater urgency than at present. Multi agency planning is already underway to manage changes brought about by the Bill.

Working hours of the CAMHP Team

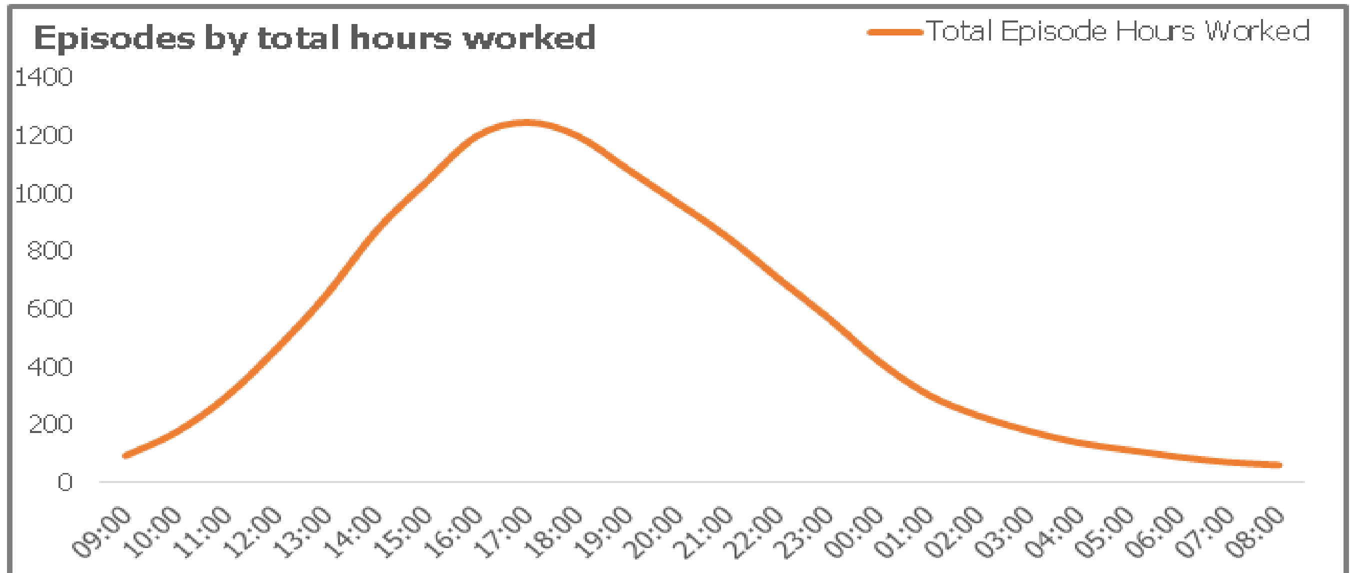
3.25 The core hours of the CAMHP Team are Monday-Friday 8:30-17:00. The Emergency Duty Team manage referrals outside of these hours. The evidence suggests that there is a disconnect between the business hours CAMHP Team, which mirror Adult Social Care Services across the department and the reality of the operational demands of the team, which are unlike any other service in the department.

3.26 Some lower risk work undertaken by AMHPs is by appointment and can be planned 24-48 hours in advance. However, in the majority of cases, where there is increased risk, the work of the CAMHP Team is reactive to events and is demand led. The service is typically under the most pressure in the late afternoon and evening. This is largely because as more doctors become available to attend incidents at this time of day, the AMHP is then able to detain. However, as stated above, this process can be subject to considerable delay due to other mitigating factors outside of the team's control.

3.27 These circumstances lead to AMHPs accumulating large amount of Time Off in Lieu (TOIL), as demand for assessments and the day-to-day operational challenges involved cannot be manged within core hours. This is illustrated by the graph below which shows the number of AMHP related episodes that have been 'worked' (i.e. activity on that particular episode) at what time of day (April 2015 / March 2016)[1]. It shows the number of hours worked outside of contractual

[1] At the time of writing this strategy, it was not possible to secure the resources from the framework team to run an updated analysis for 2016/17. However, all colleagues agree that this graph continues to accurately reflect demand during the working day.

hours and demonstrates that demand for AMHP time does not correspond with these hours. The main management concern is that being an AMHP in the CAMHP Team needs to remain an attractive and supported role within the department, as the council has to fulfil this statutory role and continues to need to be able to recruit into the team as necessary.



3.28 In order to address the pressure this can put on the service at peak times, it is recommended that capacity within the CAMHP is at its peak, during the period of peak demand shown in this graph (typically between 2:00pm and 7:00pm across a whole year). However, changing the working hours of the day time service has a direct effect on the out of hours service provider by EDT under Children's Services. Further work across both teams need to be undertaken to look at the interface between the day time service and EDT.

4. Workforce development

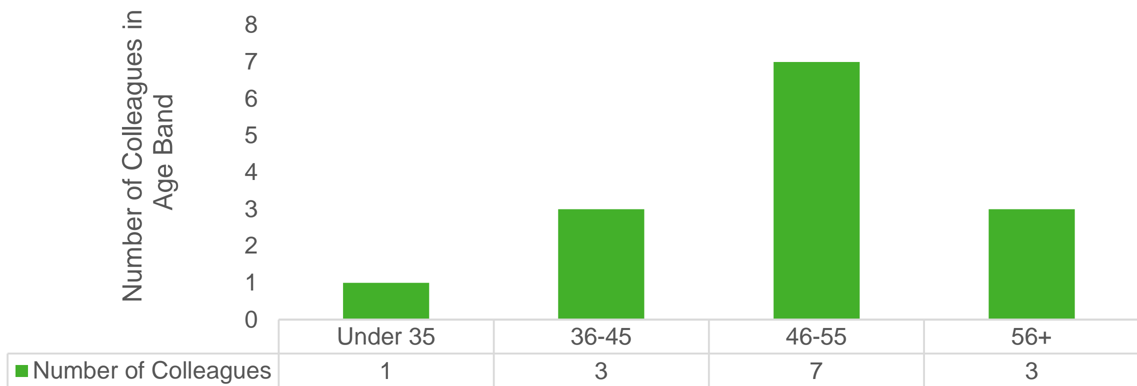
4.1 Workforce Development are continuing to develop the capacity and the skills of the AMHP qualified workforce. In 2016 two staff became AMHP qualified. Plans for 2017 are:

- Four employees to start their stage 1 training for completion in October 2017
- Five employees to start their stage 2 training for completion in October 2017 (meaning these will be AMHP qualified)
- Two employees to start their stage 3 training for completion in December 2017 and thus conferring a post graduate diploma

4.2 The volume of AMHPs that are required is shaped by the chosen service delivery model. In Nottinghamshire, the CAMHP Team is dedicated full time to AMHP work with support from qualified district colleagues. Workforce development of qualified AMHPs is therefore shaped by required output from staff to meet assessment demand rather than by number of qualified AMHPs alone.

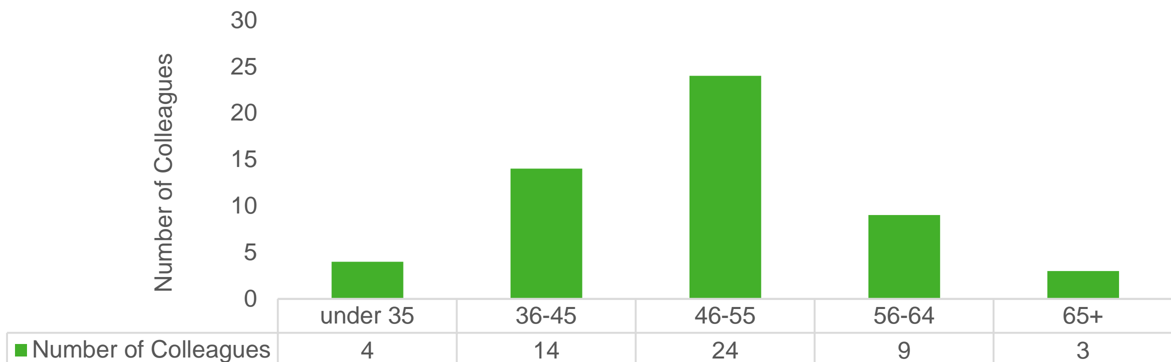
4.3 Centrally held data suggests that currently Nottinghamshire Council employs 54 AMHPs. Not all are practicing for various reasons.

4.4 Another pressing issue with regards to workforce development is succession planning. Although there is little data held centrally about turnover of staff in AMHP roles, the impact of colleagues potentially leaving the service or reducing their hours could be deduced from the age profile of AMHPS in the CAMHP Team. The current age profile (correct as of March 2017) of the CAMHP Team is shown in the graph below.



4.5 Although, it is not possible to predict retirement only based on age, the age profile of the team shows an older workforce (2 of 3 colleagues aged 55+ are 60+) and therefore it is reasonable to assume that the impact of retirement or reduced capacity through reduction of hours will become more acute in the next 5 years.

4.6 Taking into account all 54 trained AMHPS employed by NCC; the age profile of these colleagues are as shown in the graph below



4.7 Focusing on colleagues who are aged 56+

- 3 are in the CAMHP team
- 5 are in the EDT (of 6 qualified)
- 2 are in district teams
- 1 is a current trainee
- 1 is team manager (not on the rota)

4.8 Workforce development are currently securing practice mentor assessors (PMAs) to support stage 1 and stage 2 trainees during their training. Stage 1 trainees will be supported by district AMHPs and those completing their stage 3 training, while stage 2 trainees will be supported by senior practitioners in the CAMHP Team. Ongoing and appropriate support will be provided to all trainees and PMAs by the Workforce Planning and Organisational Development Team and Birmingham University. Money to support the above training including payment for PMAs supporting stage 1 trainees has already been allocated.

4.9 A programme of refresher training will be built in to the 2017/18 training plan with appropriate budgets set aside.

4.10 Once all the relevant elements are put in place for supporting trainees during 2017 there will be a focus on provision for 2018 onwards. This will take into account the following:

- The development of the AMHP provision will link in to the development of the BIA workforce and those needing to access practice educator training. This will not only take into account normal workforce planning considerations but also consider the impact that the new teaching partnership will have in social work development opportunities (e.g. if we need to develop the capacity of Pes how might that affect the numbers being available to train as AMHPs and BIAs?)
- There is the potential development for a new AMHP course by Nottingham Trent University for the autumn of 2018. We are in the very early stages of discussions with the university but the introduction of the teaching partnership will provide a clearer rationale for us to work with the Nottingham universities rather than with Birmingham. Early indications suggest that the current two stage process for AMHP training can be rationalised meaning that employees may become AMHP qualified over one year and will reduce the resource implications associated with securing PMA support for trainees
- Any changes to the structure of a Countywide Team supported by qualified AMHPs in the district will impact on the training provision for 2018 onwards
- Consideration of health staff becoming AMHPs. An AMHP can be a social worker, a psychiatric nurse, an occupational therapist or a clinical psychologist. There is already agreement from the Nottinghamshire Trust to allow AMHP training to be part of workforce development, with the proviso that they will then take part in rotas. This work is being undertaken in the line with the development of a local course at Trent University.

5. Review of options for delivering AMHP service

5.1 There are number service delivery models that can be used to design and deliver an AMHP service. It should be noted that under all models, there are pressures to meet increased demand. The benefits and challenges of the options that have been considered so far are as follows:

Retaining a Countywide Model with core business hours and with support from District AMHPs (Current Model)

Benefits

- Creates a centre of excellence for AMHP work within the Nottinghamshire, whilst supporting the skills of social workers in other teams across the department.
- A dedicated CAMHP Team ensures a more consistent approach to assessments and risk management of cases across the County
- If resourced adequately, it can manage increased demand in a more cost effective way than dispersing a larger group of AMHPs across the County. For example, under current policy a CAMHP Team AMHP completes 10 assessments for every 1 assessment a district AMHP would have the capacity to complete

Challenges

- A significant proportion of demand falls outside core business hours. This is either managed though the accumulation of TOIL within the CAMHP Team or by Emergency Duty Team (EDT)
- Managing sickness and absence and the impact of this on service continuity when managing emergencies can be more challenging, as expertise and pressure is concentrated on a smaller pool of staff.

Reverting to a district / locality model

Benefits

- Expertise would be spread throughout the County, as Band C AMHPs would be retained and dispersed among other teams.
- Less challenging to cover absence

Challenges

- Less consistent best practice
- Does not represent best value for money or return on investment on training and capacity for assessments. Further detail on this can be seen in **Appendix 1**, where the total cost of Nottinghamshire's proposed model is compared to a geographical neighbour who do not have a Countywide Team.

Retaining a Countywide Model with support from District AMHPs and introducing shift patterns for later working (up until 8:00PM)

Benefits

- Retain benefits of current model
- Allows AMHPs to be rota and for more staff to be on shift during peak demand periods, reducing TOIL. Though to an extent, the TOIL generated as a result of this system means that in practice this occurs already, a dedicated shift pattern would make this easier to manage and plan for high demand periods.

Risks

- EDT is a jointly commissioned service with CFCS and introducing shift patterns would overlap with EDT coverage time.
- This approach has had mixed success elsewhere; though some Councils have maintained this approach, other Councils have changed to a shift pattern, only to then revert to one standard shift.
- The wider impact on EDT of such a change has not been fully appraised.
- When raised previously, the idea of shift patterns was not popular with staff. This could negatively impact on future recruitment and retention.
- Introducing a later shift pattern could drive up demand for assessments because day-time AMHPs are likely to apply a lower risk management threshold to EDT. This means extending business as usual hours for AMHPs could increase demand because they are undertaking work that EDT colleagues would have not undertaken.

Other Council's arrangements in the East Midlands in providing an AMHP service and out of hours cover

- Derby City Council now provides a dedicated out of hours AMHP service for Derby City and Derbyshire
- Leicester City Council also provide an out of hours AMHP service for Leicester city, Leicestershire and Rutland. Leicester City previously had staggered shifts but it was not attractive to workers and they reverted to standard hours.
- Leicestershire County Council have staggered day time shifts; 8:30-5:00 and 11:00 -19:00
- Lincolnshire have delegated all AMHP work to Lincolnshire Partnership NHS Foundation Trust
- Nottingham City also previously had a late shift until 20:00 but they abandoned this, as it lead to an increase in demand in later hours and other issues with their EDT.

5.2 On reviewing this evidence and lesson learned from other local authorities within the region, it is recommended that the CAMHP Team Model with core business hours should be retained. The costs of this model have been measured against a regional neighbour and has been found to be cost effective in comparison. Please see **Appendix 1** for further information

5.3 AMHPs in a countywide team provide far greater capacity than their equivalents in other teams. Assessment data suggests that for every 1 assessment completed by a district AMHP, a CAMHP Team AMHP can complete 10

assessments. Therefore, there is a better return on investment on recruiting a smaller number qualified AMHPs or training AMHPs to do AMHP work full time, rather than training a larger cohort of AMHPs who may only do 9 assessments per year each.

5.4 However, further work needs to be done to ensure the capacity of the CAMHP Team is in place when demand is typically at its peak during mid-late afternoon and evenings.

6. Capacity needed to deliver an AMHP service that can meet rising demand in Nottinghamshire

Assessment staffing requirements for an AMHP service

6.1 The assessment of what staffing resources are required to manage demand for Mental Health Act Assessments in Nottinghamshire are based on the following principles

- AMHPs in the CAMHP Team should be spending 75% of their time doing assessments. The remaining 25% of the capacity is needed to properly support trainees, ensure policies and procedures are kept up to date and compliant
- A full-time-equivalent AMHP in the CAMHP Team should have the capacity to complete approx. 125 assessments per year of average length in time (approx. 10 hours)
- All trained AMHPs in district teams must complete a minimum of 9 assessments per year to maintain competency.
- Any assessment must ensure value for money in delivering the required capacity needed to manage anticipated demand.

National AMHP Lead Staffing Model

6.2 These principles have been tested against an external staffing model created by the Chair of the National AMHP Leads' Network. The model uses the following variables to estimate required demand (shown on the following page):

National AMHP Lead Staffing Model

Number of AMHP duty days per year: 253
365 – 104 (weekends) – 8 (bank holidays) = 253 days

Leave and training days per FTE AMHP: Assume each AMHP has 6 weeks (30 days) annual leave per year plus 3 days training

253 – 33 = 220 days (or 44 weeks per year)

Proportion of time spent doing front line work and completing assessments:

Due to the requirements of the Band C role in Nottinghamshire, to manage demand and undertake additional duties, during their working weeks, it is expected that AMHPs should be on front-line duty for 3.5/5 days per week (or 75% of the week).

220 x 0.75 = 165 days

Therefore each full-time AMHP would be on front-line duty for the equivalent of 165 days per year.

Estimated cover required for each AMHP duty day: In Nottinghamshire, it is estimated that the CAMHP Team should be at least 75% staffed on a day to day basis (not withstanding emergencies, or periods when only basic cover is needed). For 12 FTE AMHPs, 9 FTE AMHPs would need to be on front line duty per day)

Therefore, there would be approx. 1485 AMHP front line duty days per year (253 x 9 = 2277) that need to be managed

As the CAMHP Team AMHPs cover all duty days, minus 117 days covered by districts (13 district AMHPs doing 9 assessments per year), this equals a total requirement to cover 2095 days.

Number of AMHPS Required: Therefore, this model suggests in order to cover 2095 days at 75% front line assessment time 12.7 FTE AMHPs would be required to provide sufficient cover at all times and provide sufficient capacity to cover all other duties (2095/165). However, because we expect that on some days more than 9 FTE will on front line duty at any one time, our estimate has been scaled back to 12 FTE. **This does not include demand that is managed by EDT.**

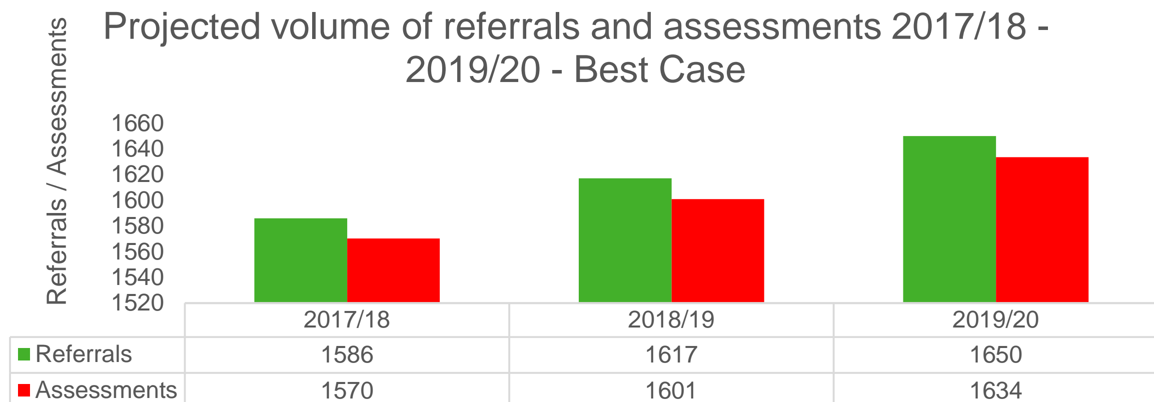
Anticipated demand for the next three years

6.3 There are two key variables which impact on demand on Nottinghamshire County Council AMHPs; number of referrals received and how many of those referrals result in one or more assessments being completed.

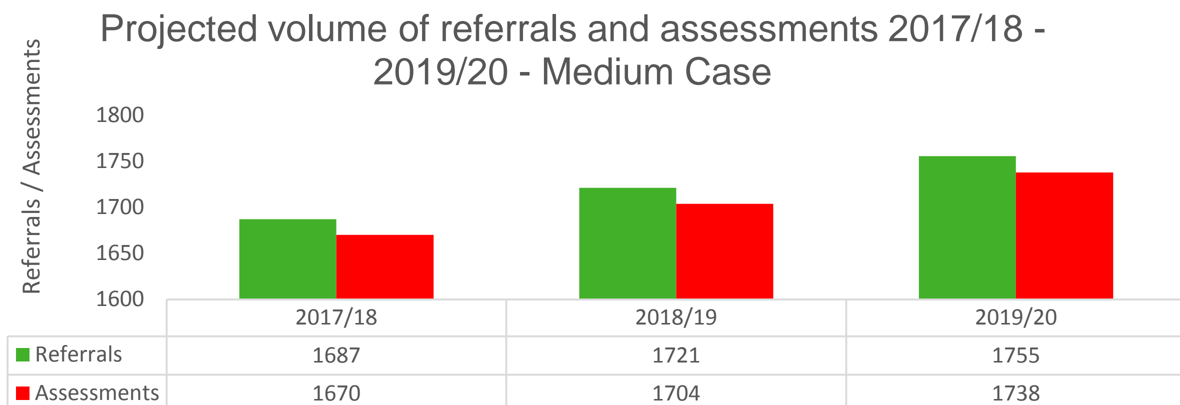
6.4 Based on data available over the previous 4 years, it is reasonable to conclude that a best case scenario is that demand for referrals will increase by more more than 2% each year and that demand will fluctuate within this narrow margin However, this does not reflect changes in policy, environment and infrastructure which could significantly increase demand. For example, colleagues in the Police have estimated that demand could increase by 15% and stay at a higher level based on impact of the Policing and Crime Bill. Furthermore, the building of a new Mental Health Hospital with a psychiatric intensive care unit in within Nottingham City's boundary will also drive up demand in the County.

6.5 Therefore, this strategy projects a growth in referrals of 2% per year under a best case scenario, growth of up to 8.5% in demand in a medium case scenario (with demand being maintained at this level) and at 15% per year in a worst case scenario (again with demand being sustained at this level)

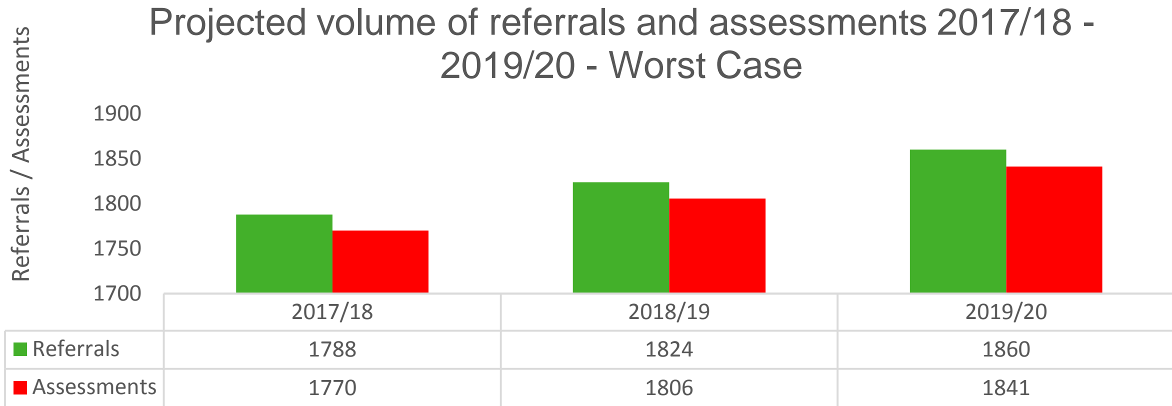
6.6 It is also projected that the proportion of referrals that will result in an assessment will be at 99%. As with the projection for referral demand, this projection is based on the average conversion rate of referrals to assessments over the last 2 years. It is possible that the more recent increase in assessment activity will continue and continue to exceed the number of referrals. The graphs below show how these forces would combine under each of the three scenarios outlined



	2017/18	2018/19	2019/20
Referrals	1586	1617	1650
Assessments	1570	1601	1634



	2017/18	2018/19	2019/20
Referrals	1687	1721	1755
Assessments	1670	1704	1738



6.7 Based on assumption that each AMHP must complete 9 assessments per year to maintain competency, AMHP capacity outside of the CAMHP team should deliver approx. of 10% of all assessments, as a minimum. If demand increases to a medium or worst case scenario in future, this percentage would fall. The actual capacity delivered outside of the AMHP Team during 2016/17 was 28% of all assessments. This should be viewed as the maximum of capacity that can be delivered outside of the CAMHP team. It also shows the extent of the reliance of ‘good-will’ and professional commitment of staff who play a full part on the rota. However, this is not sustainable basis on which to operate this type of front line work.

6.8 It known from operational issues that have arisen that even if AMHPs outside of the Central Team continue to manage 28% of demand even if it rises, is not sustainable for the CAMHP team. Without additional resource in the CAMHP team even if demand only marginally increases and other AMHPS manage to maintain completing 28% of all assessments, the current instability would continue. This is before considering what could happen if demand increases to a medium or worst case scenario and / or capacity delivered by locality and EDT teams falls.

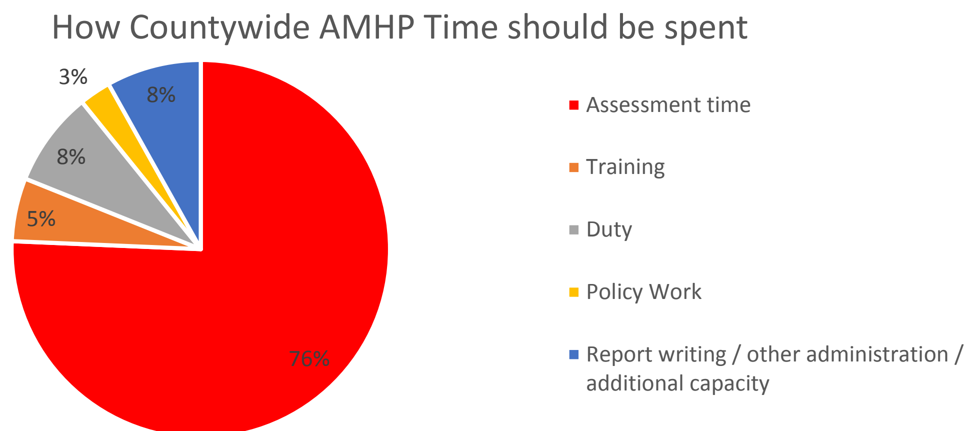
6.9 Demand is not evenly spread and does not follow a particular pattern. Due to other pressures in managing safeguarding across the department, it is not realistic to expect any significant increase in capacity from locality teams which would enable them to pick up a greater number of AMHP referrals than they do already. In addition, assessments recorded as being done be EDT are not always completed in full by EDT and are often handed over to the CAMHP team to complete. Therefore, this does impact on the capacity of the CAMHP team in a way that it is not borne out by looking at the statistics alone.

6.10 Furthermore, the availability of AMHPs in the locality teams does not always correspond with when additional capacity is needed. The operational reality of managing this demand and balancing the resources available is that the situation will vary and change very quickly; from there will be a good balance between

incoming demand and available resource (closely mirroring the best case scenario), to there being no capacity (as in the worst case scenario). Furthermore, due to toil accumulated, even a relatively short period of intense pressure can have a lasting impact on going capacity and responsiveness to demand.

6.11 Overall, increased capacity is needed within the CAMPH team to manage intense periods of demand and that ongoing effect this can have on capacity within the team. Inevitably, in an emergency team there will be periods of slack demand and increase in full time staff would increase the frequency of those periods. However, additional staff would also enable the team to manage intense demand more effectively and cope with excessive waiting times for conveyancing, bed availability etc.

6.12 The chart below shows how it is anticipated that the remainder of AMHP time in the CAMHP Team is spent, as percentage of a standard 37 hour working week. Note that 'training' refers to training of trainee AMHPs. Training requirements for the AMHPS themselves fall under 'Report writing/ other administration / additional capacity'.



Additional Management Capacity.

6.13 From the modelling above and in addition to the recommendation that the CAMHP Team expands to 12 FTE Band C's it is also advised that additional management capacity is needed to manage the team.

6.14 Re-grading the team has been considered, however, it would be highly unusual to not reward social workers for becoming AMHPs. The current model is dependent on gaining an AMHP qualification as a way of progression and is reliant on AMHP work in district teams being planned and not too onerous. Therefore, it is unlikely that Band Bs would be attracted to solely undertaking mental health act work without additional financial incentive. Deploying Band Bs

in the CAMHP Team to only undertake planned work would not be best use of resources as the majority of mental health act work is emergency work. If the model does not retain an attractiveness for the AMHP role, there is a risk that social work colleagues would chose a different training pathway at progression, or chose to continue their career elsewhere.

6.15 The current management capacity is 1FTE Team Manager to 10 Band Cs. It is currently proving difficult for the manager to undertake the core management tasks relating to 12 members of personnel as well as to undertake the management roles that are specific to this team such as:

- Signing off all AMHP reports produced by the CAMHP Team and district AMHPS on framework as part of quality assurance
- Providing specialist knowledge and expertise to all AMHPs undertaking assessments on a daily basis, including afterhours support.
- Attending all necessary multiagency meetings relating to this crisis service- eg with Police, EMAS , CCG's , Trust
- Being an essential member of the AMHP panel, which has responsibility for training , approving and reapproving AMHPs
- Being responsible for updating all Mental Health Act policies in line with changes in legislation. Many of these involve multi agency agreement with Nottingham City, The Trust, Police, CCGs.
- Providing a lead role for all Mental Health Act work in the department. There has been a reduction in senior management roles with a responsibility for mental health. Following re-organisation in 2014, Group Manager roles reverted to generic locality models with each Group Manager retaining a lead in service areas. This model does not retain the capacity to undertake all the work needed, which has been delegated to team managers.

6.16 It is therefore recommended that an additional 0.5 Team Manager is created in the structure to mitigate the pressures outlined above. The rationale for this recommendation is that HR advise that managers should have a span of control of 7-10 staff. This option would enable managers to undertake full management role as well as more strategic work outlined above.

7. Resources and Financial Challenges

7.1 If an additional 2 FTE AMHPs are added into the CAMHP Team establishment this would require additional budget of £85,405. If an additional 0.5 Team Manager post is added, this would require additional budget of £25,987, creating a combined budget pressure of £111,392.

8. Scope for additional work to look at wider efficiencies from process changes.

8.1 The operational processes used by AMHPs have not been scrutinised to see if there are any efficiencies to be gained from process changes, or better utilisation of technology. The main processes of the DoLS service have been extensively engineered to ensure they are efficient as they can be within the confines of the resources and technology available. Taking a similar approach with the AMHP service may yield additional ideas to increase capacity. It is not thought that this would mitigate the need for additional AMHPs to meet demand, it may increase operational resilience to spikes in demand, or if demand exceeds the projections made within this strategy. It is recommended that a Lean+ Review is scoped and that SLT support a request for resources if the scoping exercise concludes that work of this nature would realise efficiency benefits and increase capacity.

9. Monitoring and Governance

9.1 It important this this strategy plays an active role in shaping the day to day activity of colleagues working in the service and delivering the outcomes it sets out to achieve. The success of the strategy (and accompanying materials) will be measured in the following ways:

- A Steering Group is set up chaired by the Group Manager is set up to oversee the implementation of the strategy.
- Quarterly reports to ASCH Senior Leadership Team on progress made and any obstacles to implementing the strategy.
- Complete data sets are made available to ensure fluctuation in demand is monitored closely and is used to project future demand on an ongoing basis.
- Introduction of SMART (specific, measureable, agreed upon, realistic and time based) targets to track agreed outcomes
- Encouraging and listening to feedback from front line colleagues and all stakeholders to ensure there is a shared understand of what is working well and what needs to improvement. This will shaped by a ‘you said; we did’ approach to show how feedback has been listened to and considered.

Appendix 1: Benchmarking with other councils

Comparator authorities in the East Midland all have different AMHP models, some have small centralised teams pulled from a district rota on a daily basis while some have all work being undertaken in district teams. All are struggling to meet demand for MHA and most are moving towards a more centralised approach.

Nottinghamshire

NCC Current Model: 10 FTE AMHPs at Band C in the CAMHP Team (10 FTE * 39,177 = £391,770) + 13 FTE in district commissioning teams (13 FTE*34,538 = 448994) = **£840,764**

NCC Proposed Model (12 FTE * 39,177 = £470124) + (13 FTE*34,538 = 448994) = **£919,118**

Leicestershire

Leicestershire currently have AMHPs working in district teams and paid an enhancement for being AMHPS. They are proposing to move towards a centralised model

LCC Current Model: 22.5 FTE * 37499 = £843,727.50

LCC Proposed Model: 28 FTE * 37499 = £1,049,972

Therefore in comparison:

LCC current model vs NCC current model – NCC is £3,000 less expensive

NCC proposed model vs LCC proposed model – NCC is £130,854 less expensive.

Although the proposed model of 12 FTE AMHPs at Band C in the CAMHP Team is a rise in current costs, the modelling and comparisons illustrates that it cost effective to increase AMHPs in the Countywide Team rather than reward all Band B AMHPs with an enhancement and move the model back to the district teams. Additionally, if the work was moved back to the district teams without increasing the number of full time AMHPs, the Council would have to supply and train an additional 15 AMHPs to be on the district rota (assuming they would complete the minimum of 9 assessments per year) to manage the additional demand that is projected within this strategy. The costs of training additional AMHPs on top of the candidates already identified prohibit this approach from being viable. Furthermore, it could take 2 years before this additional capacity would be in place, by which time demand will have likely increased again.

It is acknowledged that there could be a potential saving in the loss of a TM post if the CAMHP Team were disbanded but there would be a further reduction in capacity to support policy, training and strategic developments. It is very unlikely that the current team manager workforce would be able to undertake this work on a district basis.

Nottinghamshire County Council

Appendix 2: List of Mental Health Policies that the AMHP Team (and others) are responsible for.

Policy	Responsible Party
Domestic Violence and Vulnerable Adults Guidance	Tessa Diment and Lyn farrow
Emergency duty team arrangements (Mental Health) Adults	EDT
Mental Health Act (MHA) Tribunals/Hospital Managers Hearings - guidance for…	AMHP
Mental Health Act 1983 - Guidance on responding to Mental Health Act referrals	AMHP
Mental Health Act 1983 - Local Code of Practice - Access to in-patient beds:...	Debbie.dolan@nottshc.nhs.uk & michael.sergeant@nottshc.nhs.uk with AMHP team
Mental Health Act 1983 - Local Code of Practice - AMHP Health and Safety...	Tessa
Mental Health Act 1983 - Local Code of Practice - Approved Mental Health...	Tina Ramage
Mental Health Act 1983 - Local Code of Practice - Communication with patients...	AMHP
Mental Health Act 1983 - Local Code of Practice - Guardianship - Sections 7, 8...	AMHP
Mental Health Act 1983 - Local Code of Practice - Nearest relative - Mental...	AMHP
Mental Health Act 1983 - Local Code of Practice - Procedure for Police...	AMHP

Mental Health Act 1983 - Local Code of Practice - Section 117 aftercare local...	AMHP
Mental Health Act 1983 - Local Code of Practice - Section 136 of the Mental...	AMHP
Mental Health Act 1983 - Local Code of Practice - Supervised community...	AMHP
Mental Health Act 2003 - Local Code of Practice - Section 135(1) and Section...	AMHP
Mental Health Act: Approved Mental Health Professional - Annual Training...	Tina Ramage
Mental Health Act: Approved Mental Health Professional - guidance on referrals...	AMHP
Mental Health Act: Approved Mental Health Professional - Re-approval of AMHPs	Tina Ramage
Mental Health Act: Procedures for returning to the role of AMHP and new...	Tina Ramage
Transition of patients from adult mental health services to older people's...	Sarah Howarth to co-ordinate (internal policy)
Victims - New arrangements: Unrestricted Chapter 2 patients Guidance	AMHP