Reference: FOI.ICB-2526/213

Subject: MH Control Room Triage Service 2017

I can confirm that the ICB does hold some of the information requested; please see responses below:

QUESTION	RESPONSE
Please provide me with any documents held by the ICB Clinical Effectiveness and Research Team in relation to evaluation of the MH Control room triage service 2017. Please provide any commissioning documents/ contracts/ Service delivery plans and/ or service evaluation of MH Control Room Triage and or Street Triage service commissioned by the CCG/ ICB since 2017.	The ICB undertook a search in folders relevant to the MH Control Room Triage and/or Street Triage Service for the terms, **evaluation, contract, delivery plans, and business case**. The ICB identified over 5000 documents when searching for the term contract. The ICB has applied section 12 (Cost of compliance exceeds the appropriate limit) to the documents found through the search of the word contract. The ICB has determined that to identify whether those documents were in scope of the request would require review of each individual document. The ICB has estimated at 5 minutes per document, this would take over 400 hours to process. The ICB has provided all documents for the search terms evaluation, delivery plans and business cases. Please note: unless otherwise stated these documents are draft and do not represent final versions. If the ICB has not provided a final version of a document, then it is not held by BNSSG ICB. FOI responses are publicly available and therefore personal information has been redacted. The ICB considers the names of staff

	and case studies in the evaluation report personal identifiable information and has applied a Section 40 (Personal information) exemption to this information.

The information provided in this response is accurate as of 26 November 2025 and has been approved for release by David Jarrett, Chief Delivery Officer for NHS Bristol, North Somerset and South Gloucestershire ICB.

Avon and Somerset Control Room Triage

Interim Evaluation Report

June 2017

Written by:
[redacted]
Graduate Evaluation Assistant
Avon Primary Care Research Collaborative | North Somerset Clinical Commissioning Group

Contents

Executive summary

Background: this report presents a mixed-method, interim evaluation of the first six months of the Control Room Triage service based at Avon and Somerset Police Head Quarters. The Control Room Triage refers to a team of mental health professionals who are working in the police control room to triage service-users experiencing mental health crisis. The aim of the service is to decrease the number of detentions under Section 136 (S136) applied by the police, and in doing so reduce demand on health-based places of safety. The service is currently funded as a two year pilot from September 2016 - August 2018 and the evaluation refers to data from October 2016 – March 2017.

Objectives: The objectives of the evaluation are to address:

1. Demand on services: to explore whether the Control Room Triage is associated with reduced demand on health-based Places of Safety and police deployments linked to S136.
2. Uptake: to explore the demand for the Control Room Triage by analysing monthly activity reports and producing case studies of individual service-user journeys through the system.
3. Experience: to understand stakeholders' satisfaction and experience of the service and how this compares to their prior expectations.

Methods: To address the above objectives, the following data was sourced: health-based Place of Safety admissions, cost-saving estimate, lifespan of mental health 'logs' on the police system, number of police deployments to mental health incidents, monthly activity reports collated by the Control Room Triage team, case studies, and interviews with stakeholders.

Findings:

- Demand on health-based places of safety in the Avon and Somerset area has decreased in 5 out of the first 6 months of the service, compared to the same time period in the previous year (Oct-Mar 15/16).
- The recorded number of detentions under S136 that have been avoided due to the Control Room Triage is 25, suggesting a cost-saving of £44,500 in the first six months.
- There is evidence to show that police time spent on mental health logs has decreased by 3 hours 45 minutes per incident during the implementation of the service compared to the same time period in the previous year (Oct-Mar 15/16).
- Monthly activity reports from the Control Room Triage show that the service is largely being used appropriately and consistently. The three most frequent types of incident referred to the service are: 'suicidal', 'concern for safety', and 'missing person'.
- Six case studies show how the Control Room Triage has intervened in the first six months of operation. The case studies provide specific details of occasions when police time has been saved and when S136 has been used appropriately.
- Seven qualitative interviews were conducted with stakeholders to understand their thoughts and opinions of the service. Views were generally positive, with some areas for improvement identified such as more training for police officers around mental health and increased awareness of the Control Room Triage amongst police and mental health staff.

Background to the service

The Control Room Triage (CRT) is a new service that is being funded on a pilot 'test and learn' basis for two years from September 2016 – August 2018. The service is running in partnership between Bristol, North Somerset, South Gloucestershire, Bath and North East Somerset, and Somerset Clinical Commissioning Groups (CCGs), Avon and Somerset Police, the Police and Crime Commissioner, Avon and Wiltshire Mental Health Partnership NHS Trust (AWP), Somerset Partnership NHS Foundation Trust, and Avon Fire and Rescue Service. The Control Room Triage involves the secondment of a team of AWP mental health nurses into the Avon and Somerset police control room. The team work alongside call handlers and police officers to provide advice and support to mental health-related 999 and 101 calls. Control room supervisors will alert the CRT of relevant incidents by adding a mental health triage 'tag' to particular call cards that may benefit from mental health expertise.

The broad aim of the service is to reduce the number of inappropriate detentions under Section 136 (S136) and thereby reduce demand on health-based places of safety. Section 136 of the Mental Health Act refers to police powers to remove an individual from a public place if they are displaying mental health problems that may be a threat to themselves or others. The individual is usually taken to a health-based 'Place of Safety' for a Mental Health Act (MHA) assessment.[1] The estimated cost of a detention under S136 is £1780[2].

Aims and objectives of the evaluation

Aim of the evaluation: To evaluate the first six months of the Control Room Triage service (October 2016 – March 2017) in regards to the views of stakeholders, admissions to health based Places of Safety and the overall uptake of the service. NB. Data from September 2016 was excluded from this evaluation due to incompleteness.

Objectives of the evaluation:

1. Demand on services: to explore whether the Control Room Triage is associated with reduced demand on health-based Places of Safety and police deployments for detaining individuals under S136.
2. Uptake: to explore the demand for the Control Room Triage by analysing monthly activity reports and producing case studies of individual service-user journeys through the system.
3. Experience: to understand stakeholders' satisfaction and experience of the service and how this compares to their prior expectations.

The evaluation will be used to demonstrate whether the pilot is meeting its aims. The evaluation will form the basis for the case for continued funding and development of the service. It is also anticipated that there will be interest from other CCGs and Police Forces in the findings from this pilot.

The intended audience for this report is Avon and Somerset Police, the Police and Crime Commissioner, the five participating CCGs, AWP, and Somerset Partnership.

Please see Table 1 below for a summary of the evaluation objectives, service objectives and the evaluation questions that aim to address each one:

Evaluation objective	Service objective	Evaluation questions
Demand on services	Objective 1: To reduce the volume of individuals detained under the Mental Health Act.	How does the number of individuals detained under S136 during the first 6 months of the pilot compare to the same 6 months of the previous year?
Demand on services	Objective 2: To reduce the number of police deployments made on Mental Health logs and increase intelligent dispatch decisions.	How much police time has been saved on responding to call logs with a mental health triage tag during the first 6 months of the service?
Demand on services	Objective 3: To reduce the demand on health-based places of safety and the use of police cells for S136 assessments.	What has the demand been on health-based places of safety for S136 assessments during the first 6 months of the service? (excluding A&E) How does this data compare to the same 6 months of the previous year? What has the demand been on police cells for S136 assessments during the first 6 months of the service? How does this data compare to the same 6 months of the previous year?
Uptake	Objective 4: To monitor the number and type of calls being taken by the Control Room Triage	How many mental health calls are processed by the CRT team? What is the pattern of use? How many individuals not known to mental health services have been identified by the CRT team? What are the outcomes for service-users in terms of onward referral?
Experience	Objective 5: To provide a service that results in positive experiences for stakeholders and high levels of satisfaction.	How satisfied are stakeholders with the service? What are the attitudes of stakeholders towards the service? What are the lessons learned? Have there been any unforeseen or unintended consequences – either positive or negative? To what extent has the quality, quantity and timeliness of information flow impacted upon decision making for Avon and Somerset Police? How has partnership working impacted upon management of threat, harm and risk?

Methods

Objective 1: demand on services. To reduce the volume of individuals detained under the Mental Health Act.

This objective has been addressed by comparing the number of individuals taken to a health-based Place of Safety (POS) for an MHA assessment in October 15 – March 16 and October 16 - March 17. The data has been sorted into admissions to Mason ward (POS located at Southmead Hospital) from the Avon area and admissions to Rydon and Rowan wards (POS located in Somerset). Data regarding Mason ward was sourced from AWP reports and data regarding Rydon and Rowan wards were sourced from the ward managers. This was decided due to the availability and completeness of the data. In addition, the cost of an average detention under S136 (£1780) has been multiplied by the number of detentions under S136 that were avoided due to the CRT to give an estimate of potential savings. These figures have been recorded on the monthly activity report produced by the CRT.

Objective 2: demand on services. To reduce the number of police deployments made on Mental Health logs and increase intelligent dispatch decisions.

'Police time saved' is captured on the CRT activity report under 'did the triage prevent further police involvement?' However, in order to quantify the amount of time saved a 'log lifespan' analysis was conducted. This compared the total time that each log labelled with a mental health qualifier remained open in October - March 15/16 and October - March 16/17.

In addition, the number of logs with mental health qualifiers that were graded as 'resolution without deployment' in 15/16 were compared to the number of logs that tagged 'mental health triage' and were graded as 'resolution without deployment' in 16/17. It is acknowledged that this comparison is not using the same measures - a mental health 'qualifier' is added at the end of the lifespan of a log, whereas a mental health triage 'tag' is added at the beginning of the lifespan of a log. However this was deemed to be the best way to estimate the effectiveness of the CRT at increasing intelligent dispatch decisions. Due to there being no data for mental health triage tags in 15/16, the most appropriate way to identify cases linked to mental health was to use the mental health qualifier for comparison.

Objective 3: demand on services. To reduce the demand on health-based places of safety and the use of police cells for S136 assessments

To address this objective, the number of times that a health-based places of safety was used for an MHA assessment in October to March 15/16 was compared to October to March 16/17. In addition, the number of times that police custody was used for S136 assessment in October to March 15/16 was compared to October to March 16/17.

Objective 4: uptake. To monitor the number and type of calls being taken by the Control Room Triage team

The success of this objective has been measured by two methods. Firstly, monthly activity reports from the CRT from October 16 – March 17 have been analysed. These reports capture the following information for each log: date, time of call, length of contact, age group, gender, ethnicity, catchment area, what triggered phone call to the police, known to mental health services, learning

disability, known to Children and Adolescent Mental Health Services (CAMHS), intoxicated, type of triage, outcome of triage, did the triage prevent further police involvement, was S136 considered, was S136 used, time S136 applied, and referred on.

Secondly, case studies were produced by the evaluator and the Control Room Triage manager to provide an in-depth look at six specific service-users and their journeys through the system, including scenarios in which: a) no police officer was dispatched, b) police officer dispatched and S136 diverted, and c) police officer dispatched and service-user detained under S136 and taken to a Place of Safety. The case studies were produced by selecting examples of call logs from STORM (police database) that matched the three pre-agreed scenarios above. Any names or personally identifiable data were removed. These examples show some of the ways in which the service has been used.

Objective 5: experience. To provide a service that results in positive experiences for stakeholders and high levels of satisfaction.

The evaluation steering group agreed that qualitative interviews would be the most appropriate method to address this objective. The evaluator set up and conducted seven semi-structured interviews with staff from the Control Room Triage (*n*= 3) and staff representatives from Avon and Somerset Police (*n* = 4). Participants were selected with the help of the Mental Health Liaison Officer and the Control Room Triage manager, who identified people to take part based on their knowledge of staff that have used the service. All of the interviews took place at Avon and Somerset Police Head Quarters in Portishead from 13th – 16th March 2017, at a time that was convenient for the interviewee within their normal working hours. Each interview was held in a small, private room where the evaluator met with the participant face to face. Verbal consent was obtained and a dictaphone was used to record each interview. The interview schedule, devised by the evaluator and approved by the evaluation steering group, was loosely followed, allowing the opportunity for open and uncontrolled conversation. A copy of the interview schedule can be found in the appendix A. The interview duration ranged from 11 minutes to 46 minutes in length.

Table 2 below shows the job titles of the interviewees:

Mental health staff	Police staff
Mental health practitioner Mental health practitioner Control Room Triage team manager	Sergeant Force Incident Manager Control room supervisor Control room supervisor

The interview recordings were listened to by the evaluator and summarised, with key quotes transcribed verbatim. The evaluator used thematic analysis[3] to organise the data. This method involved transcribing the data, reading the transcripts several times, and noting down recurring patterns of meaning (codes). The codes were then grouped by similarity and each group was given an overall title or theme name. Within each theme the remaining codes were then grouped by similarity into sub-themes and relevant coded data extracts or quotes were matched to each one. Through this iterative process the final 5 themes and 15 sub-themes were identified. This method was inductive, meaning that the codes were not pre-empted and instead were driven by the data. However this process is inherently subjective and cannot be fully free from evaluator bias.

Results (quantitative)

Objective 1: detentions under the Mental Health Act

For data relating to S136 and health-based Place of Safety admissions, see objective 3.

Between October 2016 and March 2017 there were 25 recorded occasions when S136 was 'considered but not used', according to the monthly activity reports produced by the Control Room Triage staff. If the average cost of each detention under S136 is £1780, then there is likely to have been a £44,500 saving during the first 6 months of the service. If this trend continues, there will be a saving of £89,000 after 12 months and £178,000 after 24 months. However this prediction is purely speculative and those 25 occasions cannot be directly linked to the CRT.

Objective 2: police time saved

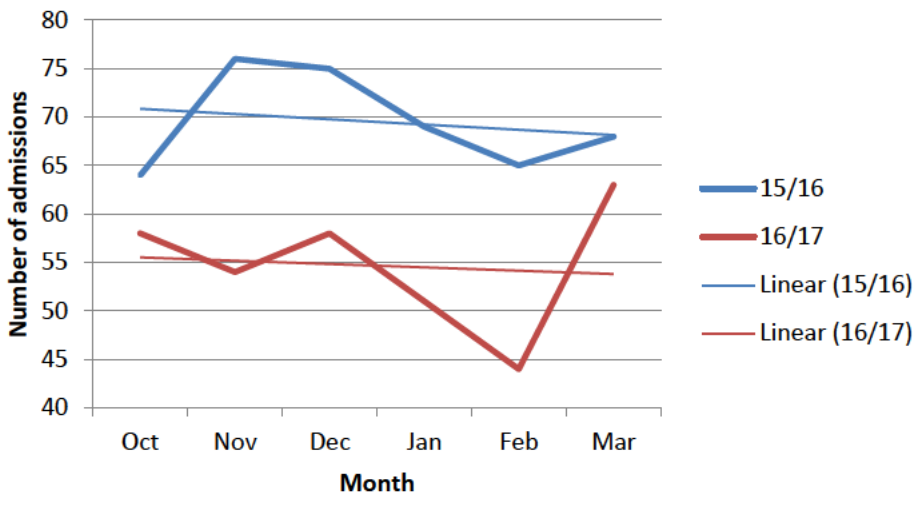
A log lifespan analysis identified that between October 2015 and March 2016 there were 9,483 incidents for Avon and Somerset police with a mental health qualifier (a label added at the end of the lifespan of a log). These incidents had an average lifespan of 9 hours 5 minutes. From October 2016 to March 2017 there were 9,921 incidents for Avon and Somerset Police with a mental health qualifier. These incidents had an average lifespan of 5 hours 20 minutes. This shows a reduction in lifespan of 3 hours 45 minutes per incident.

Police deployments were also analysed. In the 15/16 period, 28% of logs with a mental health qualifier were graded as 'resolution without deployment'. In the 16/17 period, 16% of logs tagged for mental health triage were graded as 'resolution without deployment'. Despite the increase in deployments, the average lifespan of the logs has reduced by 3 hours 45 minutes.

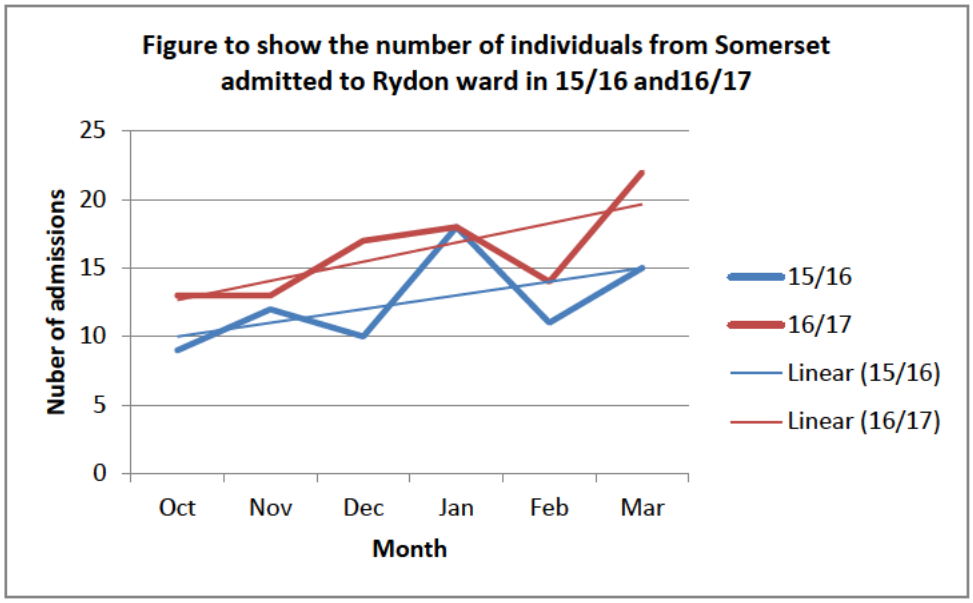
Objective 3: demand on health-based places of safety and use of police cells for S136

The number of admissions to Mason ward for individuals detained under S136 in the Avon Police area (Bristol, North Somerset, South Gloucestershire, Bath and North East Somerset) is shown in the figure below. The number of admissions to Mason ward in the 16/17 period is consistently lower than the 15/16 period. There was a large dip in February 2017 but the reason for this fluctuation is not known.

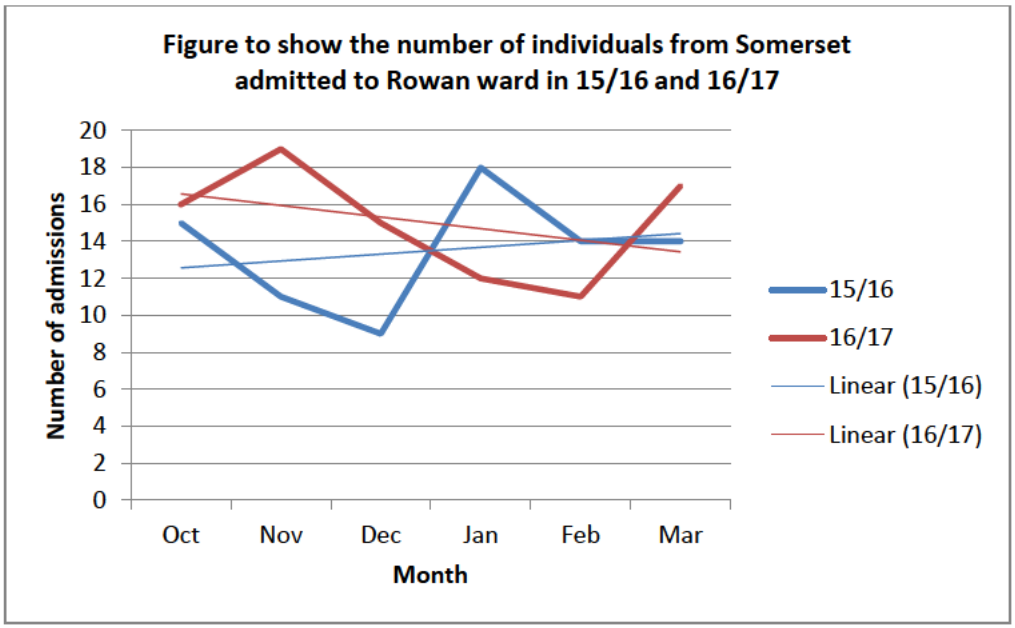
Figure to show the number of individuals from the Avon area admitted to Mason ward in 15/16 and 16/17



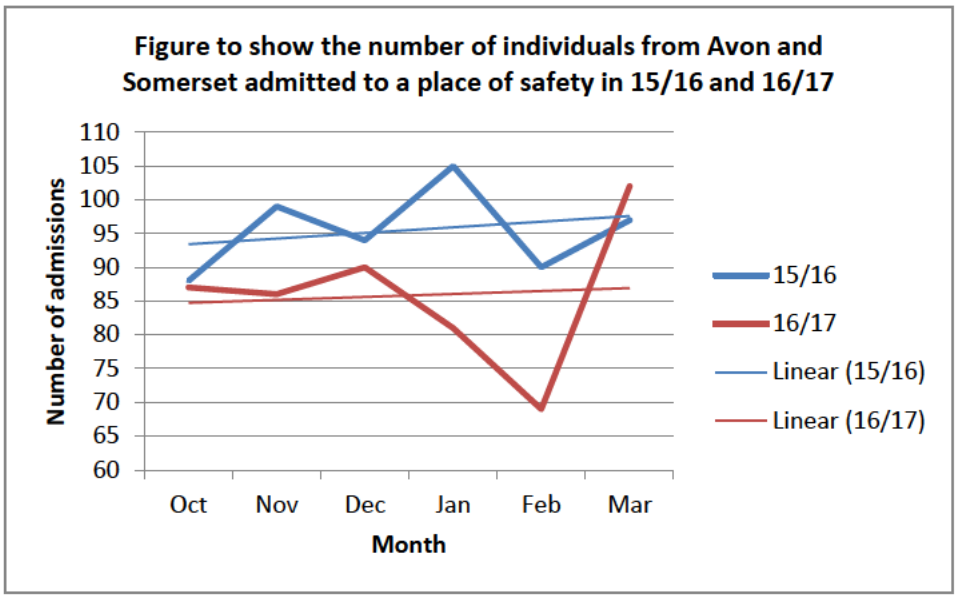
The number of admissions to Rydon ward for individuals detained under S136 in Somerset is shown in the figure below. There is an overall increase in admissions at Rydon ward from Oct – Mar in both years, although the rate of attendances in 16/17 is generally lower. Reasons for the fluctuation in admissions each month is not known.



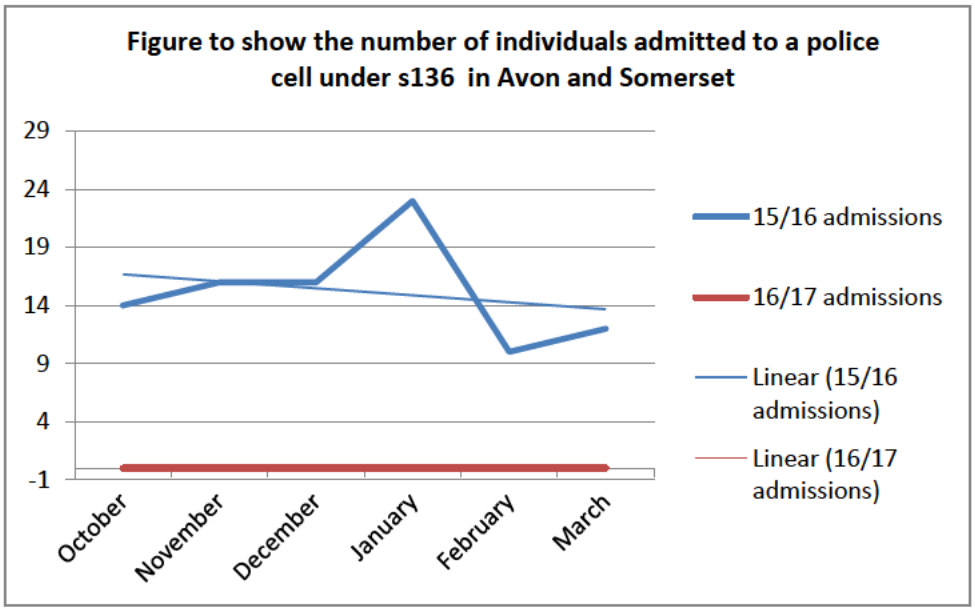
The number of admissions to Rowan ward for individuals detained under S136 in Somerset is shown below. The trend in 15/16 was upwards, whereas the trend in 16/17 was downwards. This data shows very large fluctuations from one month to the next but the reasons for the fluctuations are not known and do not appear to be consistent across the years.



The combined number of admissions to Mason, Rowan, and Rydon wards for individuals detained under S136 in Avon and Somerset is shown in the figure below. This figure shows an overall increase in both years from Oct to Mar. Admissions for 16/17 were lower in 5 out of 6 months compared to 15/16. The largest change was seen from Feb 2017 to Mar 2017 where there was an increase from 69 to 102 admissions. The reasons for these fluctuations are not known.

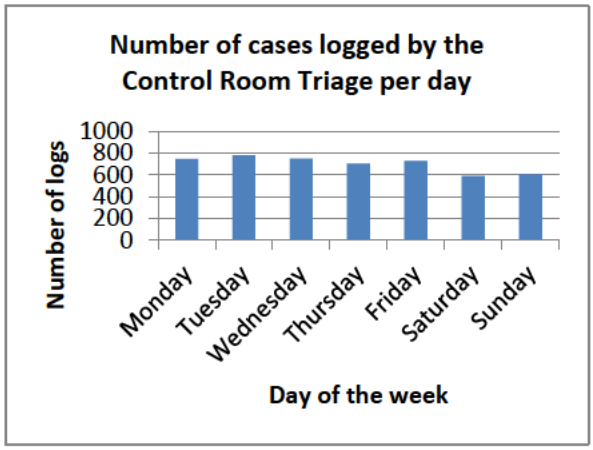


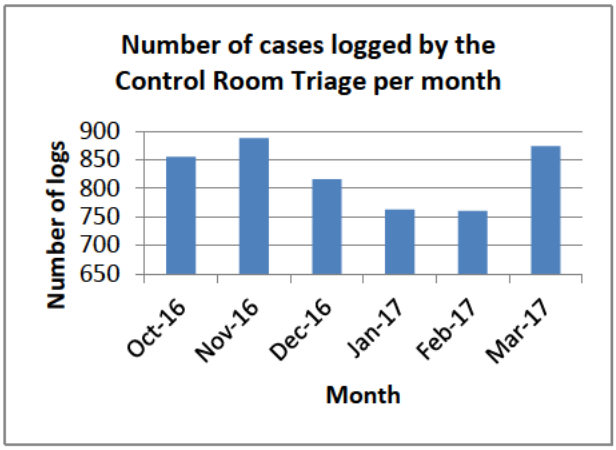
The number of individuals detained in a police cell under S136 in the Avon and Somerset Police area is shown in the figure below. The figure shows a downward trend in 15/16 whilst figures for 16/17 are zero for every month. This is to be expected due to the new guidelines not to take adults under S136 to a police cell for assessment in the Policing and Crime Act 2017[4].

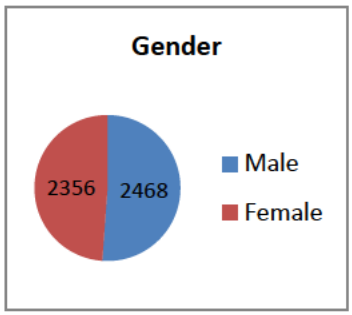


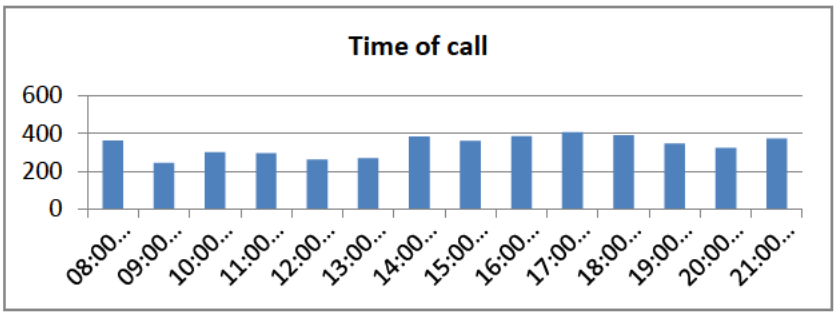
Objective 4: the number and type of calls being taken by the Control Room Triage team

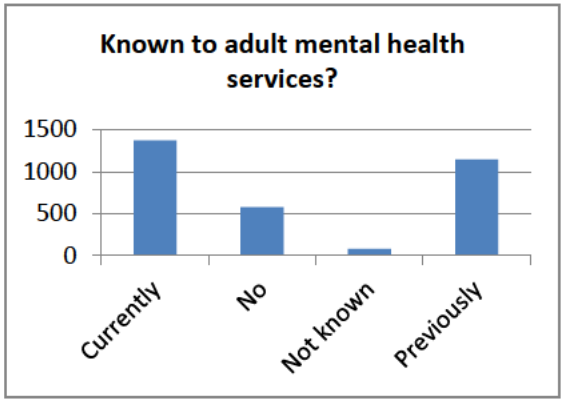
The following tables display the combined data that was collected from October 2016 to March 2017 on the Control Room Triage monthly activity reports. This data incorporates every call / incident that was processed by the team during this time period.

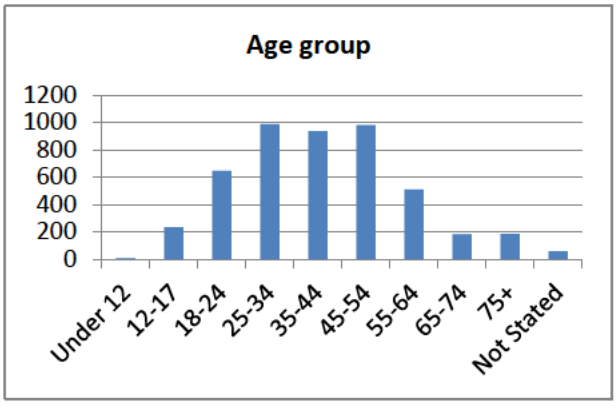


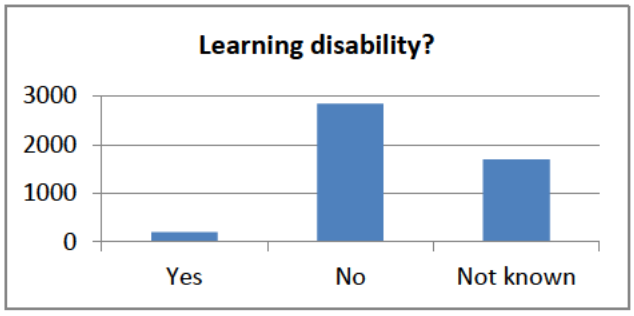


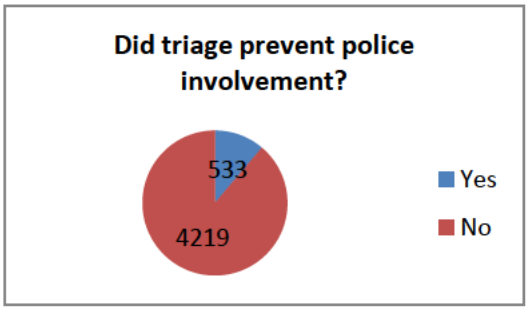


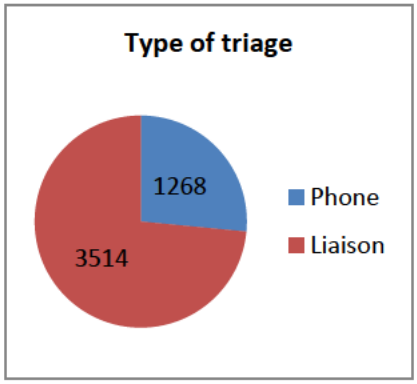


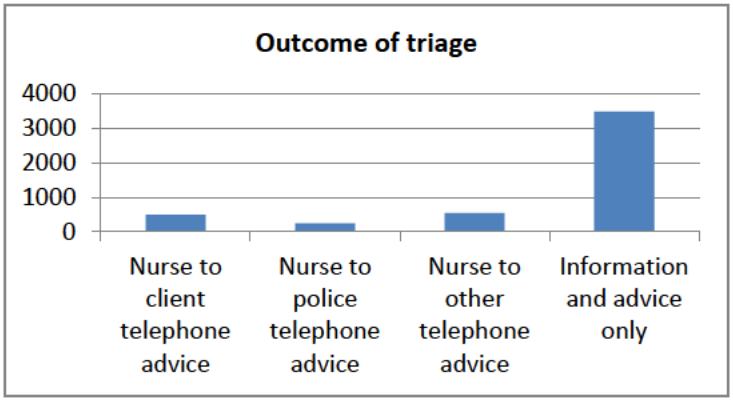


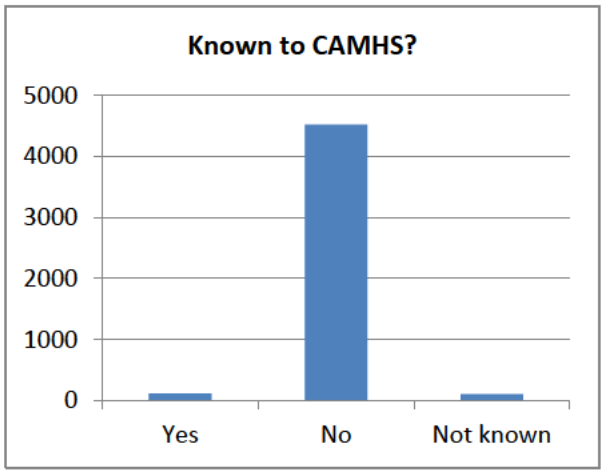


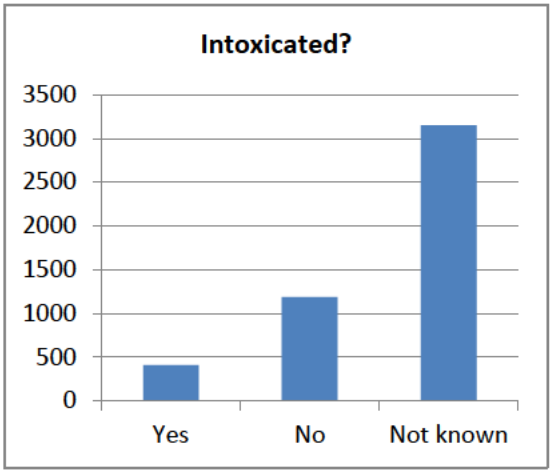


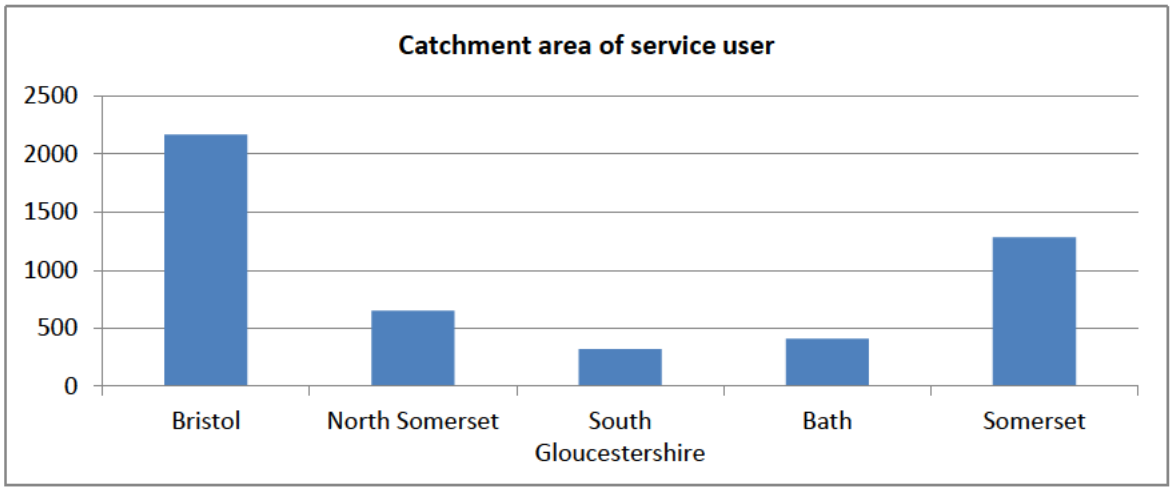


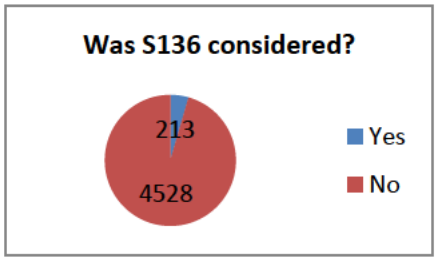

Type of triage
1268
3514
Phone
Liaison

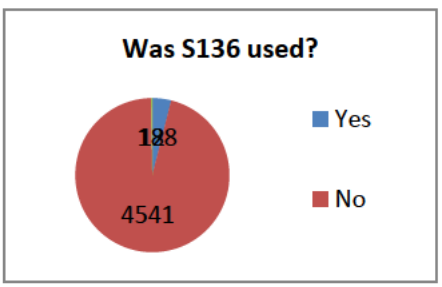

Outcome of triage
4000
3000
2000
1000
0
Nurse to client telephone advice
Nurse to police telephone advice
Nurse to other telephone advice
Information and advice only

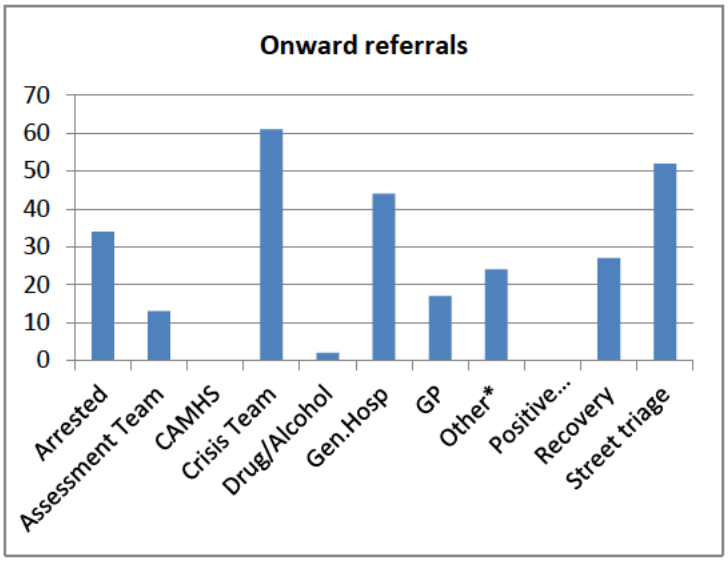

Known to CAMHS?
5000
4000
3000
2000
1000
0
Yes
No
Not known


Intoxicated?
3500
3000
2500
2000
1500
1000
500
0
Yes
No
Not known


Catchment area of service user
2500
2000
1500
1000
500
0
Bristol
North Somerset
South Gloucestershire
Bath
Somerset


Was S136 considered?
213
4528
Yes
No


Was S136 used?
188
4541
Yes
No


Onward referrals
70
60
50
40
30
20
10
0
Arrested
Assessment Team
CAMHS
Crisis Team
Drug/Alcohol
Gen.Hosp
GP
Other*
Positive...
Recovery
Street triage

There are some discrepancies in the above graphs. The total number of 'cases logged by the control room triage' is 4956. However none of the other graphs total 4956, suggesting that there is missing data. Therefore these graphs should be used to give an indication of service use only.

The monthly activity reports also collect data on ethnicity. 70% of service-users were recorded as White – British. 20% of service-users' ethnicity was unknown. 4% of service-users were recorded as White – Other. With regards to the reason for the phone call to the police, 27% of calls were logged as 'suicidal', 24% were 'concern for safety, and 10% were for a 'missing person'. A further 8% were logged as 'distressed' and 6% of calls were for an 'information request'. The remaining 25% of calls were made for a range of reasons including 'threats to harm others' (3.6%), 'domestic' (3.6%) and 'unusual behaviour' (3.0%). Finally, the CRT reports also document the time of every S136 that was alerted to the triage team and this data shows that 92% of detentions under S136 notified to the CRT from October 16 – March 17 occurred between 8 am and 10 pm.

Please see appendix B for case studies that demonstrate individual pathways through the system.

Findings (qualitative)

Objective 5: Stakeholder experiences

The following section outlines the five main themes that were derived from the qualitative data and includes verbatim quotes from participants. To anonymise the findings, the participants have been coded from P1 – P7, based on the order in which they were interviewed, followed by either 'P' to denote police staff or 'MH' to denote mental health staff. Please note that the CRT is also referred to as 'mental health triage' in these interviews.

The five themes are:

1. Model of the Control Room Triage
2. Implementation of the Control Room Triage
3. Value of the Control Room Triage
4. Wider police and mental health systems
5. Culture change

Theme 1: Model of the Control Room Triage

The service operating hours of 8:00 – 22:00 were commented on by most of the participants. However, there were differing opinions about the appropriateness of these hours in meeting the demand for the service.

> *"It would be nice to have them there 24/7, but I think that 8am-10pm is a fairly good time"* P2P

> *"There's no question that we could do with a 24 hour service. You could turn your monitor off at 10pm and have like 5 or 6 logs sat there, so that's without question".* P3MH

This suggests that future work addressing the demand for the service from 22:00 – 8:00 might be beneficial, in order to either justify the current operating hours or to consider extending the hours.

The findings from the interviews showed that whilst the mental health triage comprises a new, small team of 3.5 staff plus the manager, the team are functioning very well, suggesting a positive working environment.

> *"I think as a team we* [mental health triage] *work really well, we've got two new staff coming in so hopefully that will still be the case and we'll be quite a close-knit team."* P7MH

However, the size of the team has been challenging, particularly for managing staff absence and holidays.

> "*They* [mental health triage] *are doing a good job to manage with the resource that they have."* P4P

It is likely that as knowledge of the service continues to increase amongst the police and amongst the public, demand for the service will also increase:

> *"Calls from officers that are out with people have increased, it's still maybe not as high as we'd like but there have definitely been more calls since people have got to know we're there."* P7MH

> *"Unfortunately police lines are still tied up because they* [members of the public] *are calling police and saying 'can I speak to someone from the mental health team'".* P7MH

This additional demand is an unintended consequence of the service. The Control Room Triage model is not set up to take calls from members of the public in this way and this risk should be monitored going forward.

Finally in this theme, there were suggestions about how the scope of the service could be widened to further benefit the police:

> *"Increasing the number of care plans for regular callers,* [for example] *the top 10 for each district might be useful. It would also be useful to state, where relevant, that the crisis team will call the individual back for follow-up."* P6P

However, this is only the view of one individual and may not represent the needs and wishes of other staff at Avon and Somerset Police.

Theme 2: Implementation of the Control Room Triage

Police knowledge of the service and of mental health in general was a recurring theme during the interviews. Measures were put in place when the service launched to try and manage the anticipated workload for the Control Room Triage. For example, staff were told that only control room supervisors could 'tag' mental health and the process of advertising the service was deliberately minimal:

> *"We didn't advertise it* [mental health triage] *too much to district officers because the fear was, let's try and get this up and running gradually. The majority of the work will come through the control room anyway* [and] *if all of a sudden we blitzed it from the control room*

and we get officers with every person they're with who has mental health issues phoning up it would just cripple them" [mental health triage]. P4P

Most of the participants felt that speaking directly to the team once they were in post was a good way to learn about the service:

"I've spoken to all of the staff and found out what they do … but I didn't have any formal training…that for me was sufficient…it's a lot easier to actually see them doing it." P1P

However it is likely that not all police staff would have been as proactive as P1P above, meaning that for some people a more formal introduction may have been helpful. It was also interesting to find out that the police do not currently receive any training about mental health from a clinical perspective, and this may be a gap that some would like to see filled:

"We've had recent input on some mental health training but I didn't find that particularly helpful to be honest. It was all on legislation which didn't really deal with what we needed … it would kind of be nice for officers to get some advice on mental health training, as in different mental health conditions and what they mean and how they [individuals with a mental health condition] *may act and react.*" P6P

There was general consensus among all of the mental health staff interviewed (*n =3)* that the control room staff have been very welcoming and accommodating during the implementation of the service:

"From the off, I would say 99% of them have been very welcoming. They couldn't do enough to sort of help us settle in and if you get stuck with anything there is always somebody about that will help you." P7MH

"It's nice to be in a role where you're constantly thanked for what you do, like people cannot thank you enough…the police they're just so pleased to have us here." P3MH

Many of the staff attitudes towards the service reflect this positive outlook:

"*I expected there to be a lot of barriers because we're health and they're police, and historically health and police have not had a great relationship*...[but] *it's been nothing but positive."* P5MH

"I expected that the mental health triage would make my life easier, particularly around risk assessments, and it has. It has exceeded [my expectations] *by some distance."* P1P

"*Sometimes, it shouldn't necessarily be this way, but someone will almost be forced to come and talk to us about something because an officer has come up and said 'I need to know some information from the mental health team' or 'can they contact us' and then you sort of almost get the impression that that person is a bit reluctant, but then actually they're the people that have then come back again because you've given them information that has helped them."* P7MH

It is evident that the majority of participants only had positive things to say about the Control Room Triage. However, some negative views were expressed. For example, there appeared to be some resistance towards health and police services working more closely together:

"*It certainly feels like the police are sometimes picking up where other agencies are closing their doors, particularly out of hours."* P4P

"*Some people would criticise and say what business is it of the police to have mental health experts disclosing information from Rio, but actually I think we're proportionate in what we're doing there."* P4P

There was also concern from one participant that the Control Room Triage added an extra barrier in the process of receiving support:

"Sometimes it [mental health triage] *can be a block to speaking to people directly…other times it's helpful not having to make that call* [to crisis team] *and you've just got someone on tap, so it kind of depends on the incident I guess."* P6P

These mixed views are to be expected when implementing a new service across such a large geographical area; not everyone will have the same experiences and opinions. The same can be said for the satisfaction of the individuals in these new roles. One participant commented that the current reality of the Mental Health Practitioner role is somewhat different to the role that was advertised:

"I think we've all been disappointed about the street triage not happening, because the idea was it was supposed to happen I think a month into the service being started and unfortunately because of a lot of staffing issues it hasn't happened…I think we're all missing the face to face contact that we've all had in previous roles".* P7MH

However this is likely to be resolved soon with the implementation of North Somerset street triage. *street triage in this example refers to the Bristol street triage team who are broadly working to the same aims as the CRT. Street triage is not covered in this evaluation.

Finally in this theme, several challenges were described by participants during the implementation of the service. Despite recording the details of every job actioned by the Control Room Triage, there has been no consistent pattern of demand. As a result, the team have had to be flexible with their time management:

"*I guess by sometimes trying to do the right thing for one person you could deny the service to others, if that makes sense, and that's a really difficult balancing act, especially when you don't know what's coming because it isn't always a steady feed."* P4P

There were also comments about the data recording methods, suggesting that is has been difficult to quantify success:

"*I think what the data doesn't show is that we're managing and de-escalating situations, such as suicide, before they get to the point of needing police input."* P5MH

"*The data sheets are quite limited on what we can deliver*". P5MH

Some difficulty was reported with the allocation of work amongst street triage and Control Room Triage, particularly referring to occasions where there has been a duplication of work:

"There have been a few logs where there has been more than one person involved, which is dangerous because you've got two people looking up records and then you're sort of sitting in the control room and thinking 'oh I'll try ringing the person' and then you don't realise that street triage are also trying to phone them … we're a bit concerned that at some point something might be missed." P7MH

The main challenge that was described by all of the mental health staff interviewed was around the difficulty they face when trying to arrange an onward referral for a service-user. This appears to be a huge barrier that occurs in their everyday work:

"I think if anything our biggest problem has been with our own staff, with NHS staff, trying to refer people into crisis teams." P3MH

"I think we've just come to learn now that the NHS is very disjointed, there are teams and pockets of people who all do things completely differently, and we've all decided that to drop the 'r-word' for referrals is a bit like dropping a 'c-bomb'… don't ever say you want to make a referral because they just won't talk to you! It's all about how you approach it". P3MH

It is likely that as the crisis teams become more aware of the Control Room Triage this issue may reduce, but it probably won't be fully resolved due to the high volume of individuals who use the service.

Theme 3: value of the Control Room Triage

Despite the challenges that have arisen during the first 6 months of the Control Room Triage, the interview findings show that this new service is highly valued and has had a largely positive impact on all invested agencies. Many of the participants described the effect that the service has had on improving the relationship between health and police. This step towards partnership working cannot be empirically measured, but the qualitative findings go some way towards detailing this change:

"The police are starting to understand a bit more about mental health and I think some of the mental health practitioners are kind of understanding a bit more about the police." P3MH

Having mental health nurses in the police control room has also been valuable to the police with regards to decision making:

"They've got access to all the NHS systems and when we're doing the risk assessments which we do a lot, they make a really, really big difference to us to allow us to formulate what are the right decisions." P1P

"As police officers we tend to be quite risk averse and if it's something that could end up coming back to bite you, you could end up spending 4, 5, 6 hours with someone rather than risk something going wrong, so to have that bit of empowerment and feel that you can make those decisions has definitely come back as being very positive." P6P

Another benefit that emerged from the interviews was the effect of the Control Room Triage on saving police time. Again, this variable is difficult to measure empirically, but the anecdotal evidence suggests that this has been very valuable to the police:

"They can be a lot more skilled in some of the conversations that they can have with these people than our staff are, so they're taking a lot of work away from us which is good, and it's all time consuming work as well because these aren't quick jobs to deal with." P1P

"It's probably saved some welfare checks and police officer's time…definitely." P2P

In general, many positive attitudes towards the Control Room Triage were described during the interviews. Just a few of them are evidenced below:

"I've been doing this [job] for 25 years now and this is probably the best thing that we've ever done as a department. They're absolutely invaluable. Our work is changing- in the old days we used to deal with crimes and burglaries, and now it's just mental health issues and having them out there as an integral part of the control room is…invaluable is the right word." P1P

"*I think they* [mental health triage] *have done really well. They seem like really nice people and actually we're all trying to work towards the same goal, which is around giving the service-user the best possible service"* P4P

"*I do use them. I probably over use them to be honest! But they are very useful."* P2P

It is clear from these quotes that the Control Room Triage has been deemed very valuable by the individuals who were interviewed, particularly in terms of decision making, partnership working, and saving police time.

Theme 4: wider police and mental health systems

This theme refers to the wider context of police and mental health services; how they are set up and how they are received by the public. A key sub-theme in these interviews was the complexity of mental health services. Not only is the provision of services very different across the five local authority areas covered by Avon and Somerset police, recording systems and ways of accessing the services also differ. This has caused confusion for both police and mental health staff in the control room:

"What we want in a very clear pattern or pathway because it doesn't [currently] *make it very clear to police who they go to. There are different pathways and probably a lot of jobs we could triage and work on where there isn't a need for street triage to go out "* P5MH

"For example, South Gloucestershire crisis team will only take GP referrals and will not accept referrals from anywhere else so it is a waste of police time to be phoning through." P3MH

"More education is needed for the police around the scope of mental health services and helping them to understand that mental health services comprise of more than one element. For example crisis teams, recovery teams, primary care liaison service, early intervention teams, CIP teams etc." P3MH

Interestingly, callers to Avon and Somerset police have displayed mixed attitudes towards police and mental health services. Some service-users do not want anything to do with Control Room Triage:

"We're trying to contact them and as soon as you introduce yourself as a mental health team it's 'woah, I don't have mental health issues', so it can be from the service-user as well. The minute you say 'mental health' it's like 'why are you calling me? I called the police about this'." P3MH

Whereas other service-users are not comfortable speaking to the police:

"*Sometimes you've got someone who says they are going to kill themselves. They don't want anything to do with the police but they might be happy to talk to someone from mental health triage."* P4P

Theme 5: culture change

Theme 5 gathers together all of the findings related to culture change. In any situation, a change to the tried and tested ways of working or established attitudes and opinions in an organisation takes a long time. Nevertheless, over the course of the first 6 months of the Control Room Triage service there are reports of small changes taking place. The following quotes refer to changing attitudes amongst staff:

"… we got very few calls from police officers at the beginning but slowly as it goes on, and slowly as we engage with police officers, the same police officers will come back because they think, actually this is really helpful, they've saved me a lot time here and there was a positive outcome" P5MH

"I think we've all maybe learnt a little bit of when we need to step back. Our role does have its limits and we'll do as much as we can. Sometimes you'll provide all of the information but if someone is suicidal and they're in a position where they're not safe, actually you kind of have to accept that you've reached the point where you've done as much as you can and actually the police need to take over." P7MH

The findings also showed examples of some important learning taking place, both on a personal level and an organisational level, as times have changed:

"I think an officer said to me once 'I'm not sure who to talk to, do I talk to crisis team or do I talk to you?' and I can see that. Historically they've always gone to crisis teams and I guess it's about that change of culture, changing the ways of working." P5MH

"*I think I've learnt a lot about the law and about policing".* P3MH

"It has become apparent that we deal with a lot of people who have mental health issues, not just suicides but across a whole range of incidents, such as vulnerable victims and persistent callers." P2P

"*Social media has become a way for people to write about their feelings and intentions."* P3MH

Please see appendix C for a thematic map of the analysis.

Discussion

This is evaluation and not research, so the findings are only applicable to the local area covered by Avon and Somerset Police and should not be generalised to other areas. However the learning that has been uncovered in the first six months of the Control Room Triage can and should be shared.

There are a number of limitations of this evaluation to consider when using the findings to inform decision making. Firstly, there are issues with data quality. The data relating to the log lifespan analysis and the cost saving from the number of detentions under S136 avoided are only estimations. These have been included in the results section purely to give an indication of time and money saved but should not be treated as fact. It is likely that the average log lifespan reduction of 3 hours 45 minutes will not relate to a cost saving for Avon and Somerset Police as this time would have been spent working on other jobs. However, the findings do suggest that Avon and Somerset Police are making better deployment decisions sooner, and responding accordingly swifter. It would be reasonable to suggest that this change is associated with the Control Room Triage, particularly as the timing of this change coincides with the introduction of the service.

The POS data comparison shows that in 5 out of 6 months, there were fewer admissions to a POS in 16/17 compared to 15/16. The ward-level data shows that admissions to Mason ward have decreased whilst admissions to Rydon ward have increased and admissions to Rowan ward are variable. This is surprising considering the new guidelines not to take adults under S136 to a police cell for assessment in the Policing and Crime Act 2017. This change was speculated to lead to an increase in POS admissions. Whilst the apparent decrease in admissions to a POS may be positive, this evaluation does not consider the effect of the decrease on referral rates to local crisis teams, which may in fact be over-whelmed with patients. Furthermore, the change cannot be fully attributed to the CRT because Street Triage has also been in operation locally (street triage is outside the scope of the current evaluation).

The overall reduction in POS admissions is likely to represent an overall reduction in the number of times S136 was applied during this time period, which coincides with the introduction of the Control Room Triage. However an analysis of the data over a longer time period would be needed to make any firm conclusions. The fall in the number of individuals detained in police custody under S136 to zero is positive but not unexpected, due to the new guidelines. It is unlikely that the figures presented on health-based POS capture every individual who has been admitted for a mental health act assessment. This is because a minority of individuals are taken to local emergency departments and this data is not included in the current evaluation. In addition some individuals are taken to a POS outside the Avon and Somerset area which is also not captured in the evaluation. However, where patients have been conveyed to other Places of Safety, the standard practice is to return them to Mason ward for assessment when staff and beds become available, so the majority of these cases will still have been counted.

The data captured in the monthly activity reports from the Control Room Triage is useful to show the demographics of service-users. It is clear that the demand for the service is fairly consistent across every day of the week and during the operating hours, with a slightly less busy period between 12:00 – 14:00. The majority of service-users are either ‘currently’ or ‘previously’ known to mental health services. In around 11% of cases the triage prevented further police involvement. ‘Information and

advice only' was the most common outcome of the triage and the largest proportion of service-users were residents of Bristol, with the fewest living in South Gloucestershire. The most frequent onward referral was to a crisis team and the second most frequent onward referral was to street triage. Going forward, it might be useful to add more detail to some of these categories, such as the type of triage provided. Furthermore these activity reports only capture cases that have been tagged for mental health triage and do not represent every single mental health crisis that has occurred in the area. This is partly due to the opening hours of the service and issues occurring out of hours. As well as this, it is likely that police officers are not always contacting the CRT for advice. It is clear that this is happening because the total number of times S136 was recorded on the CRT log for Oct 16 – Mar 17 is 188, but admissions at Mason ward during the same time period were 328. However, the Policing and Crime Act 2017 states that a police officer must speak with an Approved Mental Health Professional (AMHP) prior to detaining someone under S136, so this discrepancy is likely to decrease.

A wealth of information was uncovered from the seven interviewees and it is clear that the majority of opinions and experiences of the CRT are positive. The operating hours were a contentious issue with mixed views presented. The interviews revealed that some repeat callers are phoning the police and requesting to speak to the CRT – this needs to be monitored closely because this is not a function that the service was designed to provide. It appears that the implementation process has been fairly smooth and as more organisations have learned about the CRT, the staff are finding it easier to work with other mental health agencies. Repeated advertising of the service has been useful to spread the word amongst police staff and there may be a need for this to continue. The impact of the CRT on police decision making was noted by many interviewees but more clarity was needed by some people regarding the pathway for accessing the service. The interviewees also reported negative attitudes from members of the public towards police and mental health services but this only reflects the views of some service-users. One of the most profound findings was around the change in culture that is occurring with police and health services working more closely together; something that has not always been achieved in the past. This change cannot be measured empirically but the interview findings demonstrate the wider system benefits of the CRT.

Overall the interview findings enhance the evaluation by adding greater depth and detail about people's views and experiences of the CRT that could not have been uncovered using quantitative methods. However the interviews were conducted and analysed by only one evaluator so the interpretation is somewhat subjective. Similarly, the case studies presented in appendix B are a useful addition because they provide specific examples of situations that the Control Room Triage has been involved with. These examples were selected by the CRT manager and the evaluator, so they are likely to show only a snapshot of scenarios that highlight that positive impact of the CRT.

Recommendations

1. Continue to monitor POS admissions across the Avon and Somerset Police area to identify if the observed decrease is a stable trend.
2. Continue to advertise the CRT amongst police staff to ensure that the service is widely known about so that the team can log and process more mental health related calls.
3. Amend the CRT monthly activity report to include more details of the type of calls received to enhance the information that is currently captured.

4. Consider training on mental health conditions for police officers that goes beyond learning about legislation, as requested in the interviews.
5. Use both the full and the interim evaluation to reach an evidence-informed decision regarding the continuation of the CRT beyond the 24 month pilot.
6. Engage an evaluation partner to conduct a full evaluation at 18 months. This should include:
    - An update on all of the above measures
    - Interviews with service-users and a wider range of police and health staff (e.g. commissioners and police officers) to get a more comprehensive overview of how the service has been received
    - An analysis of the impact of the CRT on referral rates to crisis teams in the Avon and Somerset area
    - An analysis of the impact of Bristol street triage and North Somerset street triage on the rates of S136 in Avon and Somerset
    - Data regarding S136 admissions to A&E to get a wider picture of the number of detentions
    - An analysis of the demand for the CRT outside of the operating hours

References

[1] https://www.rethink.org/living-with-mental-illness/police-courts-prison/section-136-police-taking-you-to-a-place-of-safety-from-a-public-place

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[3] Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative research in psychology*, *3*(2), 77-101.

[4] https://mentalhealthcop.wordpress.com/2017/03/03/the-new-section-136/

Appendices

Appendix A: Interview schedules

Verbal Information and Consent

Avon & Somerset Police and AWP nurses

Thank you for taking the time to meet with me today. I will just tell you a little bit about myself and the purpose of this interview. So my name is [redacted] and I work as a Graduate Evaluation Assistant for North Somerset CCG. As part of the evaluation of the Control Room Triage I have put together a few questions to find out the initial thoughts and opinions of people working in or using the service. As the service has been up and running for 6 months now this is a good opportunity to find out what is working well and what could be improved.

Are you happy for me to record this interview? I will be the only person to listen back and I will use the recording to check that the notes I make during the interview are accurate. I will then delete the recording.

Would you like a copy of my notes after the interview?

Do you have any questions before we begin?

CRT steering group members

Thank you for taking the time to meet with me today. As you know, as part of the 6 month evaluation of the Control Room Triage I have put together a few questions to find out the initial thoughts and opinions of people working in or using the service. The aim is to use this as an opportunity to find out what is working well and what could be improved.

Are you happy for me to record this interview? I will be the only person to listen back and I will use the recording to check that the notes I make during the interview are accurate. I will then delete the recording.

Would you like a copy of my notes after the interview?

Do you have any questions before we begin?

Interview schedule for CRT team members and manager

1. Can you provide your job title and explain your role within the Control Room Triage?
2. What training did you receive prior to beginning your role?
3. How helpful / thorough was the training provided?
4. Do you require any further training?
5. How confident are you in dealing with the workload that comes through to the triage team?
6. What were your expectations of the service before it began?
7. How does your experience compare?
8. What has worked well?
9. What have been the challenges?
10. What do you think could be changed going forward? … And how?
11. Overall, how satisfied are you with the service? Can you explain why?
12. To what extent has the working pattern of the Control Room Triage team met the demand for the service?
13. Have you observed any unintended consequences of the Control Room Triage service?
14. Is there anything else you would like to add?

Can you tell me why…
Could you explain your answer…
Could you expand your answer…

Interview schedule for Avon and Somerset Police Representatives

1. Can you provide your job title and explain your role within the Control Room Triage?
2. What training or information did you receive prior to the start of the service?
3. How helpful / thorough was the training provided?
4. Do you require any further training or information?
5. What were your expectations of the service before it began?
6. How does your experience compare?
7. In general, what has worked well?
8. What have been the challenges?
9. What could be improved/changed going forward? … and how?
10. Overall, how satisfied are you with the service so far?
11. What impact has the CRT had on your previous-normal working day?
12. How has the placement of MH nurses in the control room impacted upon decision making for Avon and Somerset Police?
13. In what ways has the Control Room Triage impacted on the management of threat, harm and risk for Avon and Somerset Police?
14. Have you observed any unintended consequences of the Control Room Triage service?
15. Is there anything else you would like to add?

Can you tell me why…
Could you explain your answer…
Could you expand your answer…

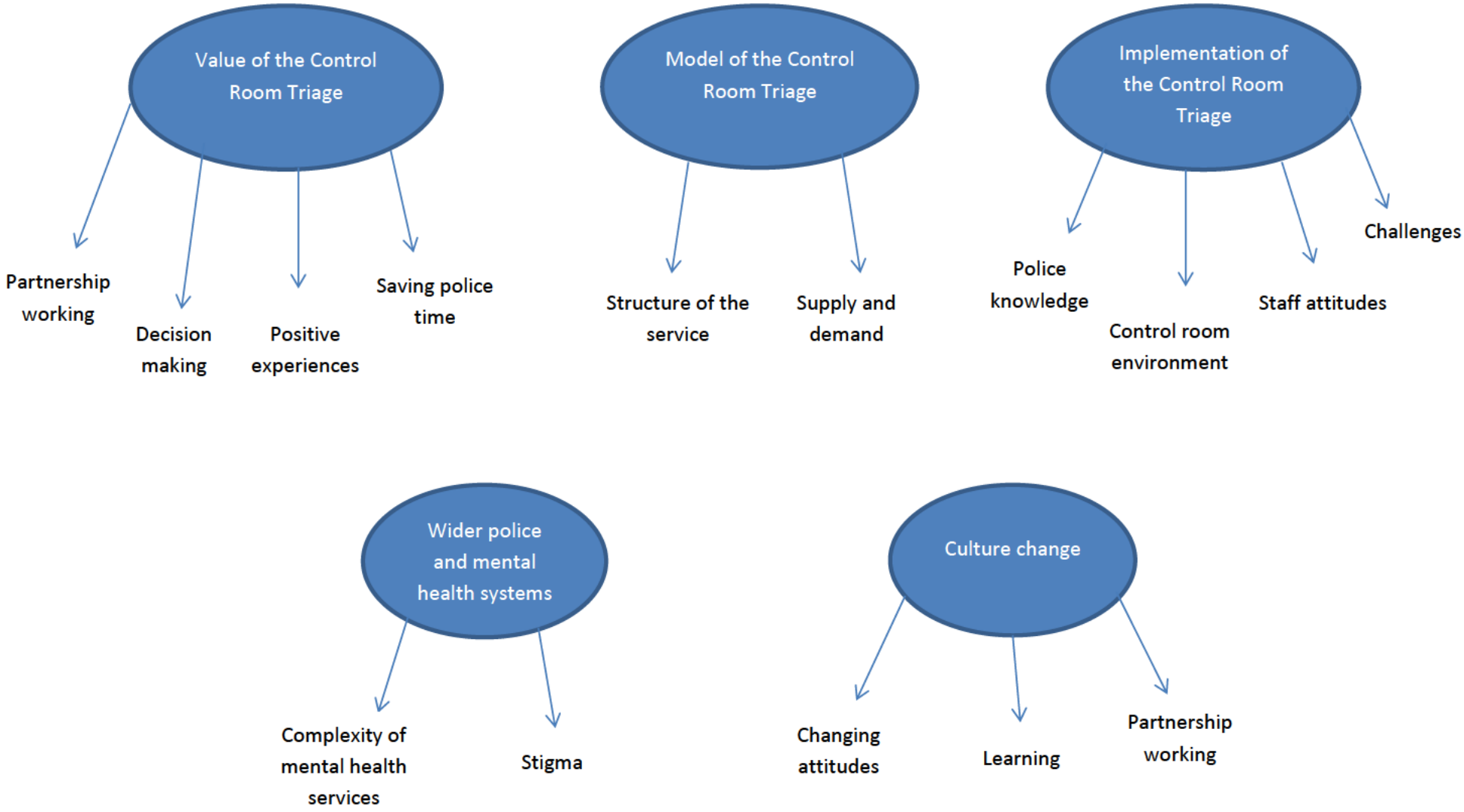
Appendix B: Case Studies

[redacted]

[redacted]

[redacted]

Appendix C: Thematic Map



Avon & Somerset Control Room Triage 6 Month Evaluation - June 2017

October 2016 → November 2016 → December 2016 → January 2017 → February 2017 → March 2017

Admissions to health-based places of safety have **decreased** in 5 out of the first 6 months of the service, compared to the same time period in the previous year, based on figures from Mason ward, Rydon ward, and Rowan ward. The use of police custody for section 136 (S136) has fallen to zero.

Police time spent on mental health logs has decreased by an average of **3 hours 45 minutes** per incident compared to the same 6 months of the previous year.

The control room triage has recorded 25 avoided detentions under S136, meaning a potential saving of **£44,500** so far (average cost of S136 = £1780).

In 2016/17, 16% of logs tagged for mental health triage were graded as 'resolution without deployment' compared to 28% of logs with a mental health qualifier in 2015/16. Police deployments have **increased;** time spent on incidents has **decreased**.

Concern for safety 24%

Suicidal 27%

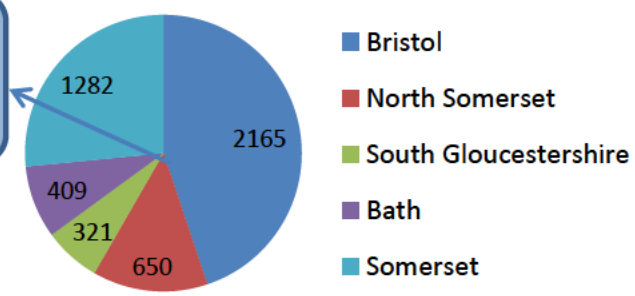
Most frequent service-users

Distressed 8%

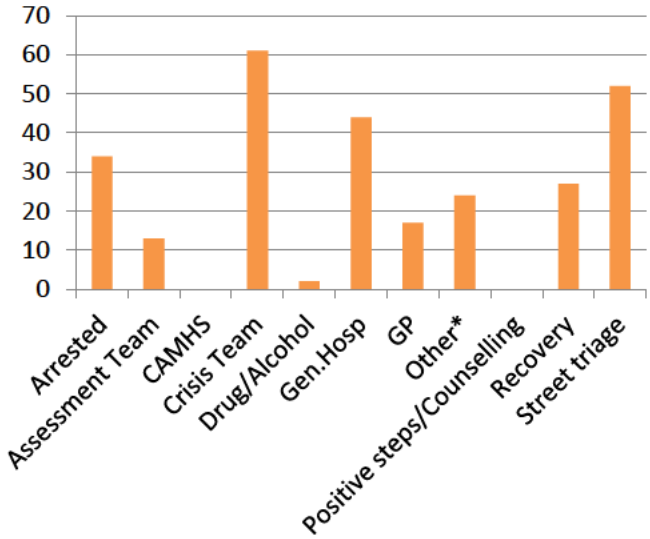
Missing person 10%

= **4827** logs in 6 months

Catchment area of service users



Onward referrals Oct 16 - Mar 17



"I expected that the mental health triage would make my life easier, particularly around risk assessments, and it has. It has exceeded [my expectations] *by some distance."* Control room supervisor

"It would kind of be nice for officers to get some advice on mental health training, as in different mental health conditions and what they mean". Police Sergeant

[redacted] – Graduate Evaluation Assistant, North Somerset CCG

Evaluation of the Control Room Triage service based at Avon and Somerset Police HQ.

Top Line Summary of Proposal:

- Evaluate the Control Room Triage service through:
    - Monthly monitoring of activity and call records at service user level, commencing in September 2016. Data will be recorded by the Control Room Triage (CRT) team and reviewed at on a bi-monthly basis by the Control Room Triage steering group.
    - Interim evaluation to take place in April-June 2017 using data from the first 6 full months of the service (October 2016 -March 2017). The purpose of the evaluation will be to identify learning from the implementation of the service and to inform the possible re-commissioning of the service, in time for the 18/19 planning round.
    - Full evaluation to be completed in March 2018 when the service will have been running for 18 months of the 24 month pilot. The details of this will be planned post the interim evaluation in June 2017, but it is recommended that the full evaluation will include monthly monitoring data on activity; service user feedback; provider feedback; stakeholder feedback; and evidence from in depth case studies showing service user outcomes as a result of the service. This will need to be completed before the end of the pilot phase (the beginning of September 2018) to be able to inform commissioning decisions.

Activity	2016				2017												2018							
	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
Monthly report																								
Steering group review																								
Interim evaluation																								
Full evaluation																								

Evaluation of the Control Room Triage service based at Avon and Somerset Police HQ		
Project team	Team manager: [redacted] CRT steering group members: Representatives from Bristol, North Somerset, South Gloucestershire, Somerset and Bath and North East Somerset CCGs, Avon and Somerset Police, Office of the Police and Crime Commissioner, AWP, and Avon Fire and Rescue Service. Evaluation lead: [redacted] (North Somerset CCG)	
Background to service	This is a new service that is being funded on a pilot 'test and learn' basis for 2 years in partnership between five CCGs, Avon and Somerset Police, the Police and Crime Commissioner, AWP, and Avon Fire and Rescue Service. The service involves the secondment of a team of AWP Mental Health nurses into the police control room. The team will work alongside call handlers and police officers to provide advice and support to Mental Health-related 999 and 101 calls. The aim of the service is to reduce the number of Section 136's that are applied unnecessarily and thereby reduce the demand on health-based places of safety.	
Purpose	What is the purpose of the service?	The primary purpose of the Control Room Triage is to provide a service at the first point of contact that is right for the individual by supporting the identification of the most suitable pathway at the earliest opportunity. This will be achieved by the inclusion of Mental Health nurses in the control room, whose role will be to advise police officers on Mental Health cases by drawing on their expert knowledge and promoting collaborative, cross-partnership working. The objectives of the service are: 1. To reduce the volume of individuals detained under the Mental Health act. 2. To reduce the number of police deployments made on MH logs and increase intelligent dispatch decisions. 3. To reduce the demand on health-based places of safety and use of Police cells for S136
	What outcomes will it achieve?	The outcomes anticipated include: • Identification of individuals not known to Mental Health services • Reduction in volume of individuals detained under the Mental Health Act • Monitoring of persistent callers with MH qualifiers • Reduction in the number of deployments on MH logs • Reduced demand on health-based places of safety and use of Police cells for S136 • Improved information flow between partnership agencies
Stage of development	This model is new to Avon and Somerset Police, and as such it requires a more formative (improvement) approach to evaluation throughout the pilot phase. This will: • assess the implementation and delivery of the service, whether this was carried out as planned and how it can be improved as it goes forward.	

	• demonstrate to stakeholders whether or not the project aims/objectives are being met.	
Level of complexity and context	What are the context/ environment in which it is working?	This is a new and innovative model and there are associated risks to be aware of: • Unintended consequences including risks around the model – supply induced demand; inappropriate requests for advice from police or inappropriate allocation of Mental Health nurses' time to specific cases. • Variation in advice from the four Mental Health nurses. • Inappropriate use of the service, such as inappropriate requests. • Confounders – i.e. are there other services also working in the system with the aim of reducing S136's? Need to be clear how the evidence presented show results from this service and not the impact of other services. Also need to investigate how other services will affect this one. • Local, national and political interest and sensitivities. • Capacity/appropriately trained staff to deliver the service in the control room. • Evidence from Norfolk showed that it was difficult to estimate cost-effectiveness of their similar service. This should be taken into account when managing expectations of the findings. • Inadequate or variation in the advertising and publicity of the service to relevant police staff to engage with Mental Health nurses, creating variation in uptake among the police.
Evidence base	What is the evidence base? How have similar services previously been evaluated?	Norfolk constabulary ran a very similar pilot project commencing in 2014 with Mental Health practitioners in the control room. This was evaluated by a team of researchers from the University of East Anglia. The evaluation used a mixed methods approach including four key components: STORM and Bespoke database, the rate of use of S136, qualitative interviews with a range of stakeholders and a staff survey for control room staff and frontline police staff. The evaluation found that a Control Room Triage is a valuable service intervention that should be continued. Recommendations included increasing the team's skill base in dementia care and ensuring the Control Room Triage team have a greater role in instances of attempted suicide or self-harm. Elements of the Norfolk evaluation will be used to inform the Avon and Somerset evaluation; however the scale of the evaluation will be smaller as it will only have the capacity of one person to carry out the work.
Purpose of interim Evaluation	The rest of this evaluation plan will refer to the interim evaluation that will take place after the service has been running for 6 full months (the report will be collated from April-June 2017). The purpose of the interim evaluation is to show whether the service is meeting its aims and to identify areas for improvement. There are three broad areas on which the evaluation will focus: 1. **Effectiveness** Understanding the effectiveness of the service at reducing demand on Mental Health services and police services.	

	2. **Impact** Exploring the impact of the Control Room Triage on outcomes for callers with Mental Health problems. 3. **Experience** Understanding stakeholder satisfaction and experience of the service and how this compares to their prior expectations. See table below for details of the objectives and evaluation questions. The evaluation will be used to demonstrate whether the pilot met its aims. The evaluation will form the basis for the case for continued funding and development of the service. It is also anticipated that there will be interest from other CCGs and Police Forces in the outcomes of this pilot. The intended audience is Avon and Somerset Police and the five participating CCGs.
Design and methods	This will be a mixed methods, formative, internal, interim evaluation design including the following: • Control Room Triage activity, which will be compiled monthly. • Control Room Triage steering group review of call activity data on a bi-monthly basis. • 6 months of call data captured in control room log. • Discrete, qualitative, face-to-face interviews with a range of stakeholders (n=5-7). • Case studies (n=3-5). These will be short narratives of individual service user journeys through the system. These will be identified by the evaluation lead and the Control Room Triage team manager, who will provide professional, subjective reflections on the benefits/consequences of the service for the service users. These will be written up by the evaluation lead. • Data on the use of health-based places of safety for S136 assessments. • Data on the use of police cells for S136 assessments. • Rates of section S136s. 18 months final evaluation to include call data, service user feedback, provider feedback, financial review of cost efficiencies, police staff survey and hospital/health-based places of safety data.
Ethics and Governance	Case studies. Service users will not be aware that their data is being used in this way. In order to comply with ethical guidelines, no personally identifiable information will be used.
Outputs	June 2017: report detailing the findings of the interim evaluation using data from September 2016-February 2017, including recommendations for improvements to be implemented as the service continues. June 2018: final evaluation report.
Timescales	See table below.
Funding	Within existing resources

Purpose / Aim: To evaluate findings from the first six months of the Control Room Triage service.				
Broad Theme	**Service Objectives**	**Evaluation questions**	**Data Sources / Tools**	**R -Responsibility** **T - Timescale** **Ri - Risks**
Effectiveness: Understanding the effectiveness of the service at reducing demand on Mental Health services and police services.	**Objective 1** To reduce the volume of individuals detained under the Mental Health Act.	How does the number of individuals detained under S136 during the first 6 months of the pilot compare to the same 6 months of the previous year?	Number of S136 recorded on control room log. Compare with baseline numbers of individuals detained under the Mental Health act in same 6 months of the previous year (Oct-Mar 15/16). AMHP team for each local policing area to be contacted for data. Estimation of the cost of an average S136 (£1750) multiplied by the number of S136s that have been avoided due to the CRT to give an estimate of cost-effectiveness. S136 conversion rate to be analysed.	R: control room team to log the number of individuals detained under the MHA. T: to be collected monthly and reviewed by steering group. Ri: confounders in the system may cause changes in the rate of detention., e.g. national rise in S136
Effectiveness: Understanding the effectiveness of the service at reducing demand on Mental Health services and police services.	**Objective 2** To reduce the number of police deployments made on MH logs and increase intelligent	How much police time has been saved on responding to Mental Health logs during the first 6 months of the service? Has any duplication occurred where	'Police time saved' is captured on the control room log under 'did the triage prevent further police involvement?' • There is no baseline comparison for this measure and the data is subjective.	R: control room team to log the number of cases in which police time has been saved and where duplication has occurred.

	dispatch decisions.	Bristol Street Triage have attended incidents that CRT were already working on, or vice versa?	However, 'log lifespan' analysis may provide an indication. Examples from CRT manager of duplication.	T: to be collected monthly and reviewed by steering group. Ri: there is no baseline data.
Effectiveness: Understanding the effectiveness of the service at reducing demand on Mental Health services and police services.	**Objective 3** To reduce the demand on health-based places of safety and the use of police cells for S136 assessments.	How has the demand on health-based places of safety for S136 assessments changed during the first 6 months of the service? (excluding A&E) How does this data compare to the same 6 months of the previous year? How has the demand on police cells for S136 assessments changed during the first 6 months of the service? How does this data compare to the same 6 months of the previous year?	Use of health-based places of safety for S136 assessment in October to March 16/17, compared to October to March 15/16. Use of Police custody for S136 assessment in October to March 15/16 compared to October to March 16/17	R: [redacted] to liaise with Bristol S136 team for health-based places of safety data. [redacted] to address data on police cells. T: to be collected after the first 6 months of the service (April 2017). Ri: confounders in the system may cause changes in demand on health-based places of safety.

Impact: Exploring the impact of the Control Room Triage on outcomes for callers with Mental Health problems.	**Objective 4** To monitor the number and type of calls being taken by the Control Room Triage team and the outcomes for service users.	How many MH calls are dealt with by the CRT team? How many individuals not known to Mental Health services have been identified by the CRT team? What is the percentage of repeat callers who are tagged for mental health triage? What are the outcomes for service users in terms of onward referral?	Monthly reports from control room capturing: • Date • Time of call • Length of contact • Age group • Gender • Ethnicity • Catchment area • What triggered phone call to the police? • Known to MH services? • Learning disability? • CAMHS? • Intoxicated? • Type of triage? • Outcome of triage? • Did the triage prevent further police involvement? • Was S136 considered? • Was S136 used? • Time S136 applied • Referred on? Case studies. An in-depth look at 3-5 specific service-users and their outcomes, including scenarios in which: a) No police officer is dispatched	R: Control Room Triage team manager to update log. [redacted] to produce case studies. T: call data to be collected monthly and reviewed by steering group. Case studies to be collated Feb-March 2017. Ri: inconsistencies in coding among members of the team. Subjectivity of case study method.

			b) Police officer dispatched and S136 diverted c) Police officer dispatched and service user detained under S136 and taken to place of safety	
Experience: Understanding stakeholder satisfaction and experience of the service and how this compares to prior expectations	**Objective 5** To provide a service that results in positive experiences for stakeholders and high levels of satisfaction.	Are stakeholders satisfied with the service? Are stakeholder attitudes positive towards the service? What are the lessons learned? Have there been any unforeseen or unintended consequences – either positive or negative? To what extent has the quality, quantity and timeliness of information flow impacted upon decision making for Avon and Somerset Police? How has partnership working impacted upon management of threat, harm and risk?	Face-to-face interviews with the 1 or 2 Mental Health nurses and the Control Room Triage manager: 1. What has worked well? 2. What have been the challenges? 3. What can /should be improved/changed going forward? … And how? 4. How does your experience of the service compare to your prior expectations? 5. How helpful / thorough was the training provided? 6. How confident are you in dealing with calls that come through to the triage team? 7. How satisfied are you with the service? 8. To what extent has the working pattern of the Control Room Triage team met the demand for the service? 9. Have you observed any unintended consequences of the Control Room Triage service?	R: [redacted] will conduct 5-7 interviews in total. T: these will take place in March-April 2017, after the first 6 months of the pilot to reflect the implementation phase. Ri: misinterpretation of qualitative responses.

			Face to face interviews with 3 or 4 representatives from Avon and Somerset Police (dispatcher, supervisor, response officer, and force incident manager): 1. What has worked well? 2. What have been the challenges? 3. What can /should be improved/changed going forward? … and how? 4. How does your experience of the service compare to your prior expectations? 5. What impact has this had on your previous-normal working day? / Impact on daily practice? 6. How satisfied are you with the service so far? 7. Have you observed any unintended consequences of the Control Room Triage service? 8. How has the placement of MH nurses in the control room impacted upon decision making and affected your consideration of the National Decision Making Model? 9. To what extent has the Control Room Triage impacted on the management of threat, harm and risk?	

Check List Questions

Identify	Questions	
Study type	1. Is this a service evaluation or research?	1. Interim evaluation of a new service.
Project Governance	2. Who will take responsibility for getting the evaluation off the ground and oversee its delivery? 3. Who will write the evaluation plan, identify the required resources and engage stakeholders? 4. Do you need an advisory or steering group?	2. Lead: [redacted]; High level oversight: [redacted]; Support and advice. APCRC; support and advice. CRT steering group; support and advice. 3. [redacted] 4. Yes, already in place. To include PPI if possible.
Project resources	5. What resources are available to support this evaluation? What resources do you think you might need / how much might it cost? Who might fund the evaluation? 6. What level or type of evaluation do you need?	5. There is no budget to support the evaluation, so the work will be done internally and will depend on input from staff /staff time. The evaluation lead will not be in post by the time of the full evaluation, so alternative support will need to be sought. 6. Because of the lack of budget/resources and capacity within the team to conduct a full evaluation, the proposed interim evaluation plan is not fully comprehensive. The APCRC recommended an independent evaluation, but due to the lack of funding available for the evaluation the CCG have chosen to do an internal evaluation
Support for the project: All Stakeholders	7. Who are your key stakeholders? a. Who needs to be informed? b. Who do you need to involve in the evaluation planning, delivery and dissemination? 8. Who in-house has skills, experience and expertise to support you with your project? i.e. Service user and public involvement, equalities, communications and engagement, evaluation leads	7. Key stakeholders include: Avon and Somerset Police, BNSSG, Somerset and BaNES CCGs, the Police and Crime Commissioner, AWP, and Avon Fire and Rescue Service 7a. tbc 7b. Project team, providers, analysts,, APCRC (for support and guidance) 8. The evaluation will be developed by the evaluation lead, key stakeholders, and APCRC. It is also expected that those mentioned above and others will have responsibility for delivering the evaluation. PPI involvement would be beneficial. AWP and Avon and Somerset Police will be responsible for collecting and recording essential monitoring data.
Support for the project: Service User Involvement	9. How will you involve service users, service users, carers and the public in your evaluation? Consider this in terms of the design, delivery (data collection) and dissemination (communicating your findings).	9. TBC
Context: Evidence Base	10. What is the evidence base for the planned service, service change, pilot? 11. How have similar services been evaluated in the past?	10. A similar service was commissioned and evaluated in Norfolk and was deemed to be successful. 11. See notes and review of Norfolk.
Context: Understanding the Service	12. Is it clear who the service is for? (population group, needs and characteristics) 13. Is it clear what the desired intermediate and long term outcomes are and how the activities of the service or intervention will lead to these?	12. Yes. It is for residents of Avon and Somerset with Mental Health crises. 13. The desired intermediate outcomes are for a reduction in police time spent on MH logs and for service users to be signposted to more appropriate pathways. This will be achieved by having the MH nurses in the control room triaging calls and giving advice. Longer-term outcomes are for there to be a reduction in the number of S136s and reduced demand on health-based places of safety.

Scope of the project	14. Have you agreed with your stakeholders the purpose of the evaluation? 15. Are you clear what the evaluation will focus on? 16. Is it clear why you are conducting an evaluation?	14. Yes. 15. There is a general idea but this should be refined through stakeholder engagement/steering group discussions. 16. To assess whether the pilot met its aims and to determine whether the service should be expanded/made permanent.
Aims and Objectives of the evaluation	17. Have you engaged your stakeholders to help you identify your evaluations aims (why you are doing this evaluation) and objectives (what you are trying to achieve)? 18. Are your aims and objectives SMART?	17. Yes. 18. They will be
Evaluation approach	19. What evaluation approach or method are you planning to take? 20. Do you need to commission an external evaluation?	19. Formative, mixed methods. 20. An external evaluation would be ideal; however there is no funding for this.
Data requirements	21. What information and data do you already have available to support your evaluation? 22. What additional data collection do you need to undertake to be able to answer the aims and objectives of your evaluation?	21. Monitoring data collected by the Control Room Triage team. 22. Provider experience/satisfaction; financial data; health-based places of safety data.
Data Collection, Analysis and Reporting	23. What data do you need to collect? Will your data collection tools work? Are there any validated tools that can help? 23a. Who will collect the data? 24. How will you analyse the data? Who will analyse the data? 25. How and who will write up the findings? 26. Have you identified any training needs to support these activities?	23. Monitoring activity from control room; provider (Avon & Somerset police and nurses) feedback (interviews); section 136 data. 23a. It has been decided that the evaluation will be done internally. 24. Tbc 25. [redacted] 26. No
Timescales, responsibilities and resources	27. What are the timescales for the evaluation and the data collection? 28. Who will be responsible for each of these? 29. Do you need any additional resources or funding?	27. Interim evaluation will take place using data from first 6 months- report to be ready for end of June 2017. 28. Tbc 29. Additional resources will be needed to conduct the full evaluation as the Evaluation lead [redacted] will no longer be in post.

Costing Assumption

Band	Mid-Point	On-cost
2	£16,535.72	£20,068.85
3	£18,333.52	£22,373.00
4	£21,263.00	£26,128.00
5	£25,550.98	£31,624.61
6	£30,660.57	£38,174.09
7	£36,612.50	£45,803.27
8a	£45,150.03	£56,746.68
8b	£53,817.85	£67,857.09
8c	£63,020.97	£79,653.65
8d	£75,573.25	£95,743.16

Band	Top of Scale	On-cost
2	£18,157.78	£22,148.01
3	£19,852.00	£24,319.00
4	£22,683.00	£27,948.00
5	£28,747.00	£35,721.00
6	£35,577.00	£44,476.00
7	£41,787.00	£52,436.00
8a	£48,514.00	£61,059.00
8b	£58,216.00	£73,495.00
8c	£69,169.00	£87,534.00
8d	£83,258.00	£105,594.00

Mid-point

		Weekday		Saturday		Sunday			
	Shift	8:00 -16:00	16:00 - 0:00	8:00 -16:00	16:00 - 0:00	8:00 -16:00	16:00 - 0:00		
	Hrs	8	8	8	8	8	8		
	Enhancement	100%	115%	130%	130%	160%	160%	**Total**	1.182143
Bristol Street	Band 7	1	0	0	0	0	0	40	
	WTE	1.00	0.00	0.00	0.00	0.00	0.00	1.00	
	Cost	£45,803	£0	£0	£0	£0	£0	£45,803	
	Band 6	1	2	1	2	1	2	168	
	WTE	1.00	2.00	0.20	0.40	0.20	0.40	4.20	
	Cost	£38,174	£87,800	£9,925	£19,851	£12,216	£24,431	£192,397	

		Weekday		Saturday		Sunday		
	Shift	8:00 -16:00	14:00 - 22:00	8:00 -16:00	14:00 - 22:00	8:00 -16:00	14:00 - 22:00	
	Hrs	8	8	8	8	8	8	
	Enhancement	100%	108%	130%	130%	160%	160%	**Total**
Control Room	Band 7	1	0	0	0	0	0	40
	WTE	1.00	0.00	0.00	0.00	0.00	0.00	1.00
	Cost	£45,803	£0	£0	£0	£0	£0	£45,803
	Band 6	1	1	1	1	1	1	112
	WTE	1.00	1.00	0.20	0.20	0.20	0.20	2.80
	Cost	£38,174	£41,037	£9,925	£9,925	£12,216	£12,216	£123,493

		Weekday	Saturday	Sunday	
	Shift	15:00 - 23:00	15:00 - 23:00	16:00 - 22:00	
	Hrs	8	8	8	
	Enhancement	111%	130%	160%	**Total**
NS Street	Band 6	1	1	1	40
	WTE	0.60	0.20	0.20	1.00
	Cost	£26,340	£9,925	£12,216	£48,481

	WTE	**Pay Cost**	**Cover**	**Final WTE**	**Pay Cost**
Band 7	2.00	£91,607	0	2.00	£91,607
Band 6	8.00	£364,372	20%	9.60	£437,246
	10.00	£455,978		11.60	£528,853

Top of Scale

		Weekday		Saturday		Sunday		
	Shift	8:00 -16:00	16:00 - 0:00	8:00 -16:00	16:00 - 0:00	8:00 -16:00	16:00 - 0:00	
	Hrs	8	8	8	8	8	8	
	Enhancement	100%	115%	130%	130%	160%	160%	**Total**
Bristol Street	Band 7	1	0	0	0	0	0	40
	WTE	1.00	0.00	0.00	0.00	0.00	0.00	1.00
	Cost	£52,436	£0	£0	£0	£0	£0	£52,436
	Band 6	1	2	1	2	1	2	168
	WTE	1.00	2.00	0.20	0.40	0.20	0.40	4.20
	Cost	£44,476	£102,295	£11,564	£23,128	£14,232	£28,465	£224,159

		Weekday		Saturday		Sunday		
	Shift	8:00 -16:00	14:00 - 22:00	8:00 -16:00	14:00 - 22:00	8:00 -16:00	14:00 - 22:00	
	Hrs	8	8	8	8	8	8	
	Enhancement	100%	108%	130%	130%	160%	160%	**Total**
Control Room	Band 7	1	0	0	0	0	0	40
	WTE	1.00	0.00	0.00	0.00	0.00	0.00	1.00
	Cost	£52,436	£0	£0	£0	£0	£0	£52,436
	Band 6	1	1	1	1	1	1	112
	WTE	1.00	1.00	0.20	0.20	0.20	0.20	2.80
	Cost	£44,476	£47,812	£11,564	£11,564	£14,232	£0	£129,648

		Weekday		Saturday		Sunday		
	Shift	8:00 -16:00	15:00 - 23:00	8:00 -16:00	15:00 - 23:00	8:00 -16:00	16:00 - 22:00	
	Hrs	8	8	8	8	8	8	
	Enhancement	100%	111%	130%	130%	160%	160%	**Total**
NS Street	Band 6	0	0.6	0	1	0	1	30.4
	WTE	0.00	0.60	0.00	0.20	0.00	0.20	1.00
	Cost	£0	£30,688	£0	£11,564	£0	£14,232	£56,485

	WTE	**Pay Cost**	**Cover**	**Final WTE**	**Pay Cost**
Band 7	2.00	£104,872	0	2.00	£104,872
Band 6	8.00	£410,291	20%	9.60	£492,349
	10.00	£515,163		11.60	£597,221

Do nothing - WTE Provided

Mid-Point

	WTE	Pay Cost	Assumed Enhancement
Band 7	2.00	£91,607	£91,607
Band 6	9.50	£362,654	£427,932
	11.50	£454,260	£519,538

Top of Scale

	WTE	Pay Cost	Assumed Enhancement
Band 7	2.00	£104,872	£104,872
Band 6	9.50	£422,522	£498,576
	11.50	£527,394	£603,448

Mid-Point

		Weekday		Saturday		Sunday		
	Shift	8:00 -16:00	14:00 - 22:00	8:00 -16:00	14:00 - 22:00	8:00 -16:00	14:00 - 22:00	
	Hrs	8	8	8	8	8	8	
	Enhancement	100%	108%	130%	130%	160%	160%	**Total**
Control Room	Band 6	1	1	1	1	1	1	112
	WTE	1.00	1.00	0.20	0.20	0.20	0.20	2.80
	Cost	£38,174	£41,037	£9,925	£9,925	£12,216	£12,216	£123,493

		Weekday		Saturday		Sunday		
	Shift	9:00 -17:00	15:00 - 23:00	9:00 -17:00	15:00 - 23:00	9:00 -17:00	15:00 - 23:00	
	Hrs	8	8	8	8	8	8	
	Enhancement	100%	111%	130%	130%	160%	160%	**Total**
Street Triage Bristol	Band 6	1	1	1	1	1	1	112
	WTE	1.00	1.00	0.20	0.20	0.20	0.20	2.80
	Cost	£38,174	£42,469	£9,925	£9,925	£12,216	£12,216	£124,925

		Weekday	Saturday	Sunday	
	Shift	15:00 - 23:00	15:00 - 23:00	15:00 - 23:00	
	Hrs	8	8	8	
	Enhancement	111%	130%	160%	**Total**
Street Triage North Som	Band 6	1	1	1	56
	WTE	0.60	0.20	0.20	1.00
	Cost	£25,481	£9,925	£12,216	£47,622

	WTE	Pay Cost	Cover	Final WTE	Pay Cost
Band 7	1.80	£82,446	0	1.80	£82,446
Band 6	6.60	£296,040	20%	7.92	£355,248
Band 3	1.00	£22,373	0%	1.00	£22,373
	9.40	£400,859		10.72	£460,067
Pay Cost		£460,067			
Non-pay Cost		£13,802			
Overheads		£71,080			
		£544,949			

Top of Scale

		Weekday		Saturday		Sunday		
	Shift	8:00 -16:00	14:00 - 22:00	8:00 -16:00	14:00 - 22:00	8:00 -16:00	14:00 - 22:00	
	Hrs	8	8	8	8	8	8	
	Enhancement	100%	108%	130%	130%	160%	160%	**Total**
Control Room	Band 6	1	1	1	1	1	1	112
	WTE	1.00	1.00	0.20	0.20	0.20	0.20	2.80
	Cost	£44,476	£47,812	£11,564	£11,564	£14,232	£14,232	£143,880

		Weekday		Saturday		Sunday		
	Shift	9:00 -17:00	15:00 - 23:00	9:00 -17:00	15:00 - 23:00	9:00 -17:00	15:00 - 23:00	
	Hrs	8	8	8	8	8	8	
	Enhancement	100%	111%	130%	130%	160%	160%	**Total**
Street Triage Bristol	Band 6	1	1	1	1	1	1	112
	WTE	1.00	1.00	0.20	0.20	0.20	0.20	2.80
	Cost	£44,476	£47,812	£11,564	£11,564	£14,232	£14,232	£143,880

		Weekday	Saturday	Sunday	
	Shift	15:00 - 23:00	15:00 - 23:00	15:00 - 23:00	
	Hrs	8	8	8	
	Enhancement	111%	130%	160%	**Total**
Street Triage North Som	Band 6	1	1	1	56
	WTE	0.60	0.20	0.20	1.00
	Cost	£28,687	£11,564	£14,232	£54,483

	WTE	Pay Cost	Cover	Final WTE	Pay Cost
Band 7	1.80	£94,385	0	1.80	£94,385
Band 6	6.60	£342,243	20%	7.92	£410,691
Band 3	1.00	£24,319	0%	1.00	£24,319
	9.40	£460,947		10.72	£529,395
Pay Cost		£529,395			
Non-pay Cost		£15,882			
Overheads		£81,792			
		£627,069			

Option 2

Mid-Point

		Weekday		Saturday		Sunday		
	Shift	8:00 -16:00	14:00 - 22:00	8:00 -16:00	14:00 - 22:00	8:00 -16:00	14:00 - 22:00	
	Hrs	8	8	8	8	8	8	
	Enhancement	100%	108%	130%	130%	160%	160%	**Total**
Control Room	Band 6	1	1	1	1	1	1	112
	WTE	1.00	1.00	0.20	0.20	0.20	0.20	2.80
	Cost	£38,174	£41,037	£9,925	£9,925	£12,216	£12,216	£123,493

		Weekday		Saturday		Sunday		
	Shift	8:00 -16:00	16:00 - 00:00	8:00 -16:00	16:00 - 00:00	8:00 -16:00	16:00 - 00:00	
	Hrs	8	8	8	8	8	8	
	Enhancement	100%	115%	130%	130%	160%	160%	**Total**
BNSSG Street Triage	Band 6	1	3	1	3	1	3	21.6
	WTE	1.00	3.00	0.20	0.60	0.20	0.60	5.60
	Cost	£38,174	£131,701	£9,925	£29,776	£12,216	£36,647	£258,439

	WTE	**Pay Cost**	**Cover**	**Final WTE**	**Pay Cost**
Band 7	1.80	£82,446	0	1.80	£82,446
Band 6	8.40	£381,932	20%	10.08	£458,318
Band 3	1.00	£22,373	0%	1.00	£22,373
	11.20	£486,751		12.88	£563,137
Pay Cost		£563,137			
Non-pay Cost		£16,894			
Overheads		£87,005			
		£667,036			

Top of Scale

Mid-Point

		Weekday		Saturday		Sunday		
	Shift	8:00 -16:00	14:00 - 22:00	8:00 -16:00	14:00 - 22:00	8:00 -16:00	14:00 - 22:00	
	Hrs	8	8	8	8	8	8	
	Enhancement	100%	108%	130%	130%	160%	160%	**Total**
Control Room	Band 6	1	1	1	1	1	1	112
	WTE	1.00	1.00	0.20	0.20	0.20	0.20	2.80
	Cost	£44,476	£47,812	£11,564	£11,564	£14,232	£14,232	£143,880

		Weekday		Saturday		Sunday		
	Shift	8:00 -16:00	16:00 - 00:00	8:00 -16:00	16:00 - 00:00	8:00 -16:00	16:00 - 00:00	
	Hrs	8	8	8	8	8	8	
	Enhancement	100%	115%	130%	130%	160%	160%	**Total**
BNSSG Street Triage	Band 6	1	3	1	3	1	3	21.6
	WTE	1.00	3.00	0.20	0.60	0.20	0.60	5.60
	Cost	£44,476	£153,442	£11,564	£34,691	£14,232	£42,697	£301,103

	WTE	**Pay Cost**	**Cover**	**Final WTE**	**Pay Cost**
Band 7	1.80	£94,385	0	1.80	£94,385
Band 6	8.40	£444,982	20%	10.08	£533,979
Band 3	1.00	£24,319	0%	1.00	£24,319
	11.20	£563,686		12.88	£652,683
Pay Cost		£652,683			
Non-pay Cost		£19,580			
Overheads		£100,839			
		£773,103			

Mid-Point

		Monday-Thursday			Friday			Saturday			Sunday			
	Shift	8:00 -16:00	14:00 - 22:00	21:00 - 9:00	8:00 -16:00	14:00 - 22:00	21:00 - 9:00	8:00 -16:00	14:00 - 22:00	21:00 - 9:00	8:00 -16:00	14:00 - 22:00	21:00-9:00	
	Hrs	8	8	12	8	8	12	8	8	12	8	8	12	
	Enhancement	100%	108%	123%	100%	108%	130%	130%	130%	153%	160%	160%	130%	**Total**
Control Room	Band 6	1	1	1	1	1	1	1	1	1	1	1	1	196
	WTE	0.80	0.80	1.20	0.20	0.20	0.30	0.20	0.20	0.30	0.20	0.20	0.30	4.90
	Cost	£30,539	£32,830	£56,116	£7,635	£8,207	£14,888	£9,925	£9,925	£17,465	£12,216	£12,216	£14,888	£226,850

		Monday-Thursday			Friday			Saturday			Sunday			
	Shift	9:00 -17:00	15:00 - 23:00	21:00-9:00	9:00 -17:00	15:00 - 23:00	21:00-9:00	9:00 -17:00	15:00 - 23:00	21:00-9:00	9:00 -17:00	15:00 - 23:00	21:00-9:00	
	Hrs	8	8	12	8	8	12	8	8	12	8	8	12	
	Enhancement	100%	111%	123%	100%	111%	130%	130%	130%	153%	160%	160%	130%	**Total**
Street Triage Bristol	Band 6	1	1	0	1	1	0	1	1	0	1	1	0	112
	WTE	0.80	0.80	0.00	0.20	0.20	0.00	0.20	0.20	0.00	0.20	0.20	0.00	2.80
	Cost	£30,539	£33,975	£0	£7,635	£8,494	£0	£9,925	£9,925	£0	£12,216	£12,216	£0	£124,925

		Monday-Thursday			Friday			Saturday			Sunday			
	Shift	9:00 -17:00	15:00 - 23:00	21:00-9:00	9:00 -17:00	15:00 - 23:00	21:00-9:00	9:00 -17:00	15:00 - 23:00	21:00-9:00	9:00 -17:00	15:00 - 23:00	21:00-9:00	
	Hrs	8	8	12	8	8	12	8	8	12	8	8	12	
	Enhancement	100%	111%	123%	100%	111%	130%	130%	130%	153%	160%	160%	130%	**Total**
Street Triage North Som	Band 6	0	1	0	0	1	0	0	1	0	0	1	0	40
	WTE	0.00	0.40	0.00	0.00	0.20	0.00	0.00	0.20	0.00	0.00	0.20	0.00	1.00
	Cost	£0	£16,987	£0	£0	£8,494	£0	£0	£9,925	£0	£0	£12,216	£0	£47,622

	WTE	Pay Cost	Cover	Final WTE	Pay Cost
Band 7	1.80	£82,446	0	1.80	£82,446
Band 6	8.70	£399,396	20%	10.44	£479,276
Band 3	1.00	£22,373	0%	1.00	£22,373
	11.50	£504,215		13.24	£584,095
Pay Cost		£584,095			
Non-pay Cost		£17,523			
Overheads		£90,243			
		£691,860			

Top of Scale

		Monday-Thursday			Friday			Saturday			Sunday			
	Shift	8:00 -16:00	14:00 - 22:00	21:00 - 9:00	8:00 -16:00	14:00 - 22:00	21:00 - 9:00	8:00 -16:00	14:00 - 22:00	21:00 - 9:00	8:00 -16:00	14:00 - 22:00	21:00-9:00	
	Hrs	8	8	12	8	8	12	8	8	12	8	8	12	
	Enhancement	100%	108%	123%	100%	108%	130%	130%	130%	153%	160%	160%	130%	**Total**
Control Room	Band 6	1	1	1	1	1	1	1	1	1	1	1	1	184
	WTE	0.80	0.80	1.20	0.20	0.20	0.30	0.20	0.20	0.30	0.20	0.20	0.30	4.90
	Cost	£35,581	£38,249	£65,380	£8,895	£9,562	£17,346	£11,564	£11,564	£20,348	£14,232	£14,232	£17,346	£264,299

		Monday-Thursday			Friday			Saturday			Sunday			
	Shift	9:00 -17:00	15:00 - 23:00	21:00-9:00	9:00 -17:00	15:00 - 23:00	21:00-9:00	9:00 -17:00	15:00 - 23:00	21:00-9:00	9:00 -17:00	15:00 - 23:00	21:00-9:00	
	Hrs	8	8	12	8	8	12	8	8	12	8	8	12	
	Enhancement	100%	111%	123%	100%	111%	130%	130%	130%	153%	160%	160%	130%	**Total**
Street Triage Bristol	Band 6	1	1	0	1	1	0	1	1	0	1	1	0	112
	WTE	0.80	0.80	0.00	0.20	0.20	0.00	0.20	0.20	0.00	0.20	0.20	0.00	2.80
	Cost	£35,581	£38,249	£0	£8,895	£9,562	£0	£11,564	£11,564	£0	£14,232	£14,232	£0	£143,880

		Monday-Thursday			Friday			Saturday			Sunday			
	Shift	9:00 -17:00	15:00 - 23:00	21:00-9:00	9:00 -17:00	15:00 - 23:00	21:00-9:00	9:00 -17:00	15:00 - 23:00	21:00-9:00	9:00 -17:00	15:00 - 23:00	21:00-9:00	
	Hrs	8	8	12	8	8	12	8	8	12	8	8	12	
	Enhancement	100%	111%	123%	100%	111%	130%	130%	130%	153%	160%	160%	130%	**Total**
Street Triage North Som	Band 6	0	0.5	0	0	1	0	0	1	0	0	1	0	40
	WTE	0.00	0.40	0.00	0.00	0.20	0.00	0.00	0.20	0.00	0.00	0.20	0.00	1.00
	Cost	£0	£19,125	£0	£0	£9,562	£0	£0	£11,564	£0	£0	£14,232	£0	£54,483

	WTE	Pay Cost	Cover	Final WTE	Pay Cost
Band 7	1.80	£94,385	0	1.80	£94,385
Band 6	8.70	£462,662	20%	10.44	£555,194
Band 3	1.00	£24,319	0%	1.00	£24,319
	11.50	£581,365		13.24	£673,898
Pay Cost		£673,898			
Non-pay Cost		£20,217			
Overheads		£104,117			
		£798,232			

Mid-Point

			Monday-Thursday			Friday			Saturday			Sunday							
	Shift	8:00 -16:00	14:00 - 22:00	21:00 - 9:00	8:00 -16:00	14:00 - 22:00	21:00 - 9:00	8:00 -16:00	14:00 - 22:00	21:00 - 9:00	8:00 -16:00	14:00 - 22:00	21:00-9:00			**WTE**	**Pay Cost**	**Cover**	**Final WTE**	**Pay Cost**
	Hrs	8	8	12	8	8	12	8	8	12	8	8	12		Band 7	1.80	£82,446	0	1.80	£82,446
	Enhancement	100%	108%	123%	100%	108%	130%	130%	130%	153%	160%	160%	130%	**Total**	Band 6	10.50	£485,288	20%	12.60	£582,346
Control Room	Band 6	1	1	1	1	1	1	1	1	1	1	1	1	196	Band 3	1.00	£22,373	0%	1.00	£22,373
	WTE	0.80	0.80	1.20	0.20	0.20	0.30	0.20	0.20	0.30	0.20	0.20	0.30	4.90		13.30	£590,107		15.40	£687,165
	Cost	£30,539	£32,830	£56,116	£7,635	£8,207	£14,888	£9,925	£9,925	£17,465	£12,216	£12,216	£14,888	£226,850						

															Pay Cost	£687,165	
															Non-pay Cost	£20,615	
			Monday-Thursday			Friday			Saturday			Sunday			Overheads	£106,167	
	Shift	8:00 -16:00	16:00 - 0:00	0:00-8:00	8:00 -16:00	16:00 - 0:00	0:00-8:00	8:00 -16:00	16:00 - 0:00	0:00-8:00	8:00 -16:00	16:00 - 0:00	0:00-8:00			£813,946	
	Hrs	8	8	8	8	8	8	8	8	8	8	8	8				
	Enhancement	100%	115%	123%	100%	115%	130%	130%	130%	160%	160%	160%	123%	**Total**			
BNSSG Street Triage	Band 6	1	3	0	1	3	0	1	3	0	1	3	0	224			
	WTE	0.80	2.40	0.00	0.20	0.60	0.00	0.20	0.60	0.00	0.20	0.60	0.00	5.60			
	Cost	£30,539	£105,360	£0	£7,635	£26,340	£0	£9,925	£29,776	£0	£12,216	£36,647	£0	£258,439			

Top of Scale

			Monday-Thursday			Friday			Saturday			Sunday							
	Shift	8:00 -16:00	14:00 - 22:00	21:00 - 9:00	8:00 -16:00	14:00 - 22:00	21:00 - 9:00	8:00 -16:00	14:00 - 22:00	21:00 - 9:00	8:00 -16:00	14:00 - 22:00	21:00-9:00			**WTE**	**Pay Cost**	**Cover**	**Final WTE**	**Pay Cost**
	Hrs	8	8	12	8	8	12	8	8	12	8	8	12		Band 7	1.80	£94,385	0	1.80	£94,385
	Enhancement	100%	108%	123%	100%	108%	130%	130%	130%	153%	160%	160%	130%	**Total**	Band 6	10.50	£555,394	20%	12.60	£666,473
Control Room	Band 6	1	1	1	1	1	1	1	1	1	1	1	1	184	Band 3	1.00	£24,319	0%	1.00	£24,319
	WTE	0.80	0.80	1.20	0.20	0.20	0.30	0.20	0.20	0.30	0.20	0.20	0.30	4.90		13.30	£674,098		15.40	£785,177
	Cost	£35,581	£38,249	£65,380	£8,895	£9,562	£17,346	£11,564	£11,564	£20,348	£14,232	£14,232	£17,346	£264,299						

															Pay Cost	£785,177	
															Non-pay Cost	£23,555	
			Monday-Thursday			Friday			Saturday			Sunday			Overheads	£121,310	
	Shift	8:00 -16:00	16:00 - 0:00	0:00-8:00	8:00 -16:00	16:00 - 0:00	0:00-8:00	8:00 -16:00	16:00 - 0:00	0:00-8:00	8:00 -16:00	16:00 - 0:00	0:00-8:00			£930,042	
	Hrs	8	8	8	8	8	8	8	8	8	8	8	8				
	Enhancement	100%	115%	123%	100%	115%	130%	130%	130%	160%	160%	160%	123%	**Total**			
BNSSG Street Triage	Band 6	1	3	0	1	3	0	1	3	0	1	3	0	224			
	WTE	0.80	2.40	0.00	0.20	0.60	0.00	0.20	0.60	0.00	0.20	0.60	0.00	5.60			
	Cost	£35,581	£114,748	£0	£8,895	£28,687	£0	£11,564	£34,691	£0	£14,232	£42,697	£0	£291,095			

Comparison

	Separate Street Triage	BSNSSG Street Triage
Control Room 8:00-22:00	Option 1	Option 2
Control Room 24/7	Option 3	Option 4

	Pay Cost		Non-Pay Cost 3%		Overheads 15%		Total Cost	
	Mid-Point	**Top of Scale**	**Mid-Point**	**Top of Scale**	**Mid-Point**	**Top of Scale**	**Mid-Point**	**Top of Scale**
Do nothing - Shift Pattern	£528,853	£597,221	£15,866	£17,917	£81,708	£92,271	**£626,426**	**£707,409**
Do nothing - WTE Provided	£519,538	£603,448	£15,586	£18,103	£80,269	£93,233	**£615,393**	**£714,784**
Option 1	£460,067	£529,395	£13,802	£15,882	£71,080	£81,792	**£544,949**	**£627,069**
Option 2	£563,137	£652,683	£16,894	£19,580	£87,005	£100,839	**£667,036**	**£773,103**
Option 3	£584,095	£673,898	£17,523	£20,217	£90,243	£104,117	**£691,860**	**£798,232**
Option 4	£687,165	£785,177	£20,615	£23,555	£106,167	£121,310	**£813,946**	**£930,042**

Do Nothing - Based on shift pattern provided: Control Room 8:00 - 22:00			
		WTE	**£**
Pay Cost	**Band 7**	1.00	£45,803
	Band 6	3.36	£148,192
Total Pay Cost		4.36	£193,995
Non pay cost at 3%			£5,820
Overheads at 15%			£29,972
Total Cost			£229,787

Option 2 - BNSSG Street Triage Team, Control Room 8:00 - 22:00			
		WTE	**£**
	Band 7	0.60	£27,482
Pay Cost	**Band 6**	3.36	£148,192
	Band 3	0.33	£7,458
Total Pay Cost		4.29	£183,131
Non pay cost at 3%			£5,494
Overheads at 15%			£28,294
Total Cost			£216,919

Option 4 - BNSSG Street Triage Team, Control Room Cover 24/7			
		WTE	**£**
	Band 7	0.84	£38,475
Pay Cost	**Band 6**	5.88	£272,219
	Band 3	0.47	£10,441
Total Pay Cost		7.19	£321,135
Non pay cost at 3%			£9,634
Overheads at 15%			£49,615
Total Cost			£380,384

Do Nothing - based on shift pattern provided			
		WTE	**£**
Pay Cost	**Band 7**	2.00	£91,607
	Band 6	9.60	£437,246
Total Pay Cost		11.60	£528,852.53
Non pay cost at 3%			£15,865.58
Overheads at 15%			£81,708
Total Cost			£626,426

Do Nothing - based on WTE provided			
		WTE	**£**
Pay Cost	**Band 7**	2.00	£91,607
	Band 6	9.50	£427,932
Total Pay Cost		11.50	£519,538
Non pay cost at 3%			£15,586
Overheads at 15%			£80,269
Total Cost			£615,393

Option 1 - Separate Street Triage Teams, Control Room Cover 8:00 - 22:00			
		WTE	**£**
Pay Cost	**Band 7**	1.80	£82,446
	Band 6	7.92	£355,248
	Band 3	1.00	£22,373
Total Pay Cost		10.72	£460,067
Non pay cost at 3%			£13,802
Overheads at 15%			£71,080
Total Cost			£544,949

Option 2 - BNSSG Street Triage Team, Control Room Cover 8:00 - 22:00			
		WTE	**£**
Pay Cost	**Band 7**	1.80	£82,446
	Band 6	10.08	£458,318
	Band 3	1.00	£22,373
Total Pay Cost		12.88	£563,137
Non pay cost at 3%			£16,894
Overheads at 15%			£87,005
Total Cost			£667,036

Option 3 - Seperate Street Triage Teams, Control Room Cover 24/7			
		WTE	**£**
Pay Cost	**Band 7**	1.80	£82,446
	Band 6	10.44	£479,276
	Band 3	1.00	£22,373
Total Pay Cost		13.24	£584,095
Non pay cost at 3%			£17,523
Overheads at 15%			£90,243
Total Cost			£691,860

Option 4 - BNSSG Street Triage Team, Control Room Cover 24/7			
		WTE	**£**
Pay Cost	**Band 7**	1.80	£82,446
	Band 6	12.60	£582,346
	Band 3	1.00	£22,373
Total Pay Cost		15.40	£687,165
Non pay cost at 3%			£20,615
Overheads at 15%			£106,167
Total Cost			£813,946

population figures for Control room triage

	N	%	do nothing	option 2 BNSSG	option 4 24 hours
			229787	216919	380384
BNSSG	968314	56.38	129565.29	122309.6734	214479.3348
Somerset	545390	31.76	72975.93	68889.29913	120802.6367
BaNES	203623	11.86	27245.78	25720.02742	45102.02846
Total	1717327	100	229787	216919	380384
police contribution assumption at 50%			£114,894	£108,459.50	£190,192.00

Control Room Triage & Street Triage Business Case

Title	Police and Mental Health Triage Service
Description of proposal	Extension of Avon and Somerset Control Room triage and merger of existing Street Triage services to create BNSSG Street Triage.
Senior Responsible Director sponsoring the proposal	[redacted] - Programme Director, Community & Partnerships BNSSG CCG [redacted], Assistant Chief Constable, Avon and Somerset Constabulary
Commissioning Leads for the proposal	[redacted]- Commissioning Manager, BNSSG [redacted]- Transformation Project Manager for Mental Health & Learning Disabilities, BNSSG [redacted]- Deputy Programme Manager for Mental Health and Learning Disabilities, BNSSG [redacted]- Senior Commissioning and Policy Officer PCC Avon Fire & Rescue [redacted]- Commissioning Manager BaNES CCG & Council [redacted]- Interim Mental Health Commissioner, Somerset CCG
Provider Leads	Avon and Wiltshire Mental Health Partnership NHS Trust
Proposed Governance (e.g. Steering Group, Director Led Group, other Programme or Project Board, or not known)	Avon and Somerset Crisis Care Concordat Group Executive Commissioning Group (BNSSG CCG)
Author	[redacted], BNSSG CCG [redacted], BNSSG CCG [redacted], BNSSG CCG [redacted], AWP [redacted], AWP [redacted], AWP [redacted], BNSSG CCG [redacted], BNSSG CCG
Document Version and Date	V2.6, 05.01.2018

Part 1: Case for Change

1. Executive Summary

This paper details an options appraisal to merge the separate Bristol and North Somerset Street Triage services and to continue the Control Room Triage service across Avon and Somerset with the option to make this service operational 24/7. For the purpose of this paper, going forward the term 'triage' will encompass both the role of 'Control Room Triage' and 'Street Triage'.

The service is currently funded by Bristol, BaNES, North Somerset and South Gloucestershire CCGs, Avon and Somerset Constabulary and Avon Fire and Rescue. The funding agreements are in place for a two year pilot to finish in September 2018, except for Bristol CCG where funding for the Bristol Street Triage and contribution to control room triage ends in March 2018.

Analysis of demand nationally and locally shows a large proportion of daily Police business (20-40%) relates to mental health[1]. Additionally, there has been an increase in the use of Police powers under the Mental Health Act 1983 following amendments to the Policing and Crime Act 2017. This has precipitated the need for a joint problem solving early intervention approach for faster identification of vulnerable persons. Although the number of those individuals being detained in Police cells has reduced in BNSSG to almost zero in 16/17, the demand on health-based places of safety often outstrips supply. Opportunities are being missed to intervene prior to crisis point and to reduce unnecessary demand on NHS places of safety and importantly unnecessary distress for individuals.

The overarching objective by aligning the services is to reduce the use of police cells and Emergency Departments as places of safety for S136[2] detentions and to promote the appropriate use of S136 Health based Place of Safety facilities across the region. The Police and Crime Act (PACA) 2017, implemented on 11th December 2017, requires "*the police to consult a mental health professional (where practicable) before detaining a person under section 136*". The new PACA regulations have reduced timeframes for detention under S136 from 72 hours to 24 hours. This change necessitates better collaborative working to facilitate effective management of these individuals and reduce the inappropriate use of detention under S136 of the Mental Health Act. A system wide review of the Section 136 pathway was instigated in Autumn 2016 and this work is reporting through the

[1] Mental Health Crisis Care Concordat (2014)
[2] Section 136 Mental Health Act (1983) permits Police detention of a person at risk to themselves or to others in a public place.

System wide S136 Programme Board. This business case needs to be considered in the wider context of the proposed Section 136 system change including the Mental Health Support and Advice Service proposal (MHAS). This business case forms part of this work and will be aligned to ongoing discussions around the coordination and triage strand of work. The Programme Board has committed to delivery of the outcomes of the programme by April 2018 which is in line with the proposals put forward within this business case.

Provision of Street Triage and Control Room Triage services align to the national and local mental health crisis care concordat work programmes and delivers elements of the Mental Health Five Year Forward View.

2. Aims and Objectives

Aim:

The primary aim of the Triage service is to provide an appropriate response at the first point of contact that is right for the individual in mental health crisis and supporting the identification of the most suitable pathway at the earliest opportunity. The Triage function will have access to relevant health records enabling assessments to identify the most appropriate pathways based on individual needs. Irrespective of decisions, the Triage can provide advice, assessment and supported access to services. This integrated approach facilitates improved decision making by front line Police Officers. Where appropriate an individual who has been in contact with Triage may be contacted the following day by a member of the team to ensure they are fully sighted on their care pathway or the recommended onward referral. This will be an 18 years+ service that will redirect referrals for any under 18 year olds to CAMHS or social care services.

Objectives and anticipated benefits for Avon and Somerset Constabulary and health and social care partners:

Benefits achieved by the control and street triage services to date:

- Early identification of individuals not known to mental health services that are likely to require intervention to prevent them reaching crisis point.
- Deliver function 1 of the Mental Health Support and Advice Service (from the System wide S136 review): To provide Mental Health advice to the police in order to prevent any unnecessary S136 detention thereby enabling a service user to be cared for through the least restrictive means.
- Reduction in volume of individuals detained under the Mental Health Act S136
- Reduction in the amount of time Police/Ambulance/Fire spend on MH logs
- Reduced demand on health based places of safety and use of Police cells for s136 – police cell use is at zero
- Reduction in presentations to Emergency Departments (ED) by persons in mental health crisis by enhanced early intervention.
- Appropriate referrals into Mental Health, Health and Social Care services

- Improved information flow between partnership agencies, in terms of quality, quantity and timeliness, leading to greatly improved management of threat, harm and risk (to and from individuals).
- Faster identification of vulnerable persons for referral into the SCU/MASHs, thereby allowing problem solving approach to reduce demand.

Additional aims and objectives of the new service:

- Although there have been diversions from S136 detention the total number of detentions has increased during this period. This reflects the increase in demand across mental health services in the area.
- Compliment the introduction of Connecting Care - a proposed investment linking the police with Health organisations.
- Complimentary work programme around frequent callers has commenced. Control room and street triage would contribute to this.
- Option 4 allows for a rapid mental health response across Avon and Somerset this is a service not currently available in South Gloucestershire, BaNES and Somerset.

3. Background and Evidence Base

Strategic context

The strategic case for change is strong and evidenced. The Mental Health Crisis Care Concordat joint statement[3] dictates the ethos of the partnership initiatives provided below. This has provided the initial strategic framework for the production of the outlined business case and its objectives. The statement recognises that people in crisis in the community where Police Officers are the first point of contact should expect them to provide appropriate help but that the Police must be supported by health services (including mental health services), ambulance services and emergency departments.

"We commit to work together to improve the system of care and support to people in crisis because of a mental health condition by keeping them safe and helping them to find the support they need – whatever the circumstances in which they first need help – and from whichever service they turn to first.

We will work together and with local organisations to prevent crises happening whenever possible through prevention and early intervention. We will make sure we meet the needs of vulnerable people in urgent situations. We will strive to make sure that all relevant public services support someone who appears to have a mental health problem to move towards recovery.

Jointly, we hold ourselves accountable for enabling this commitment to be delivered across England". – Mental Health Crisis Care Concordat, 2014.

[3] http://www.crisiscareconcordat.org.uk/

Since September 2016, the S136 Project Board has been in operation across BNSSG. The purpose of the S136 Project Board is to improve experience for service users, clarify and simplify S136 pathways across the AWP footprint, address process and service gaps, ensure compliance with regulatory frameworks including CQC & PACA and co-ordinate action and maximise benefits via a partnership approach. Both the Control Room Triage and Street Triage Services form an integral part to continuing to improve the S136 pathway across the AWP footprint.

The NHS Mental Health five year forward view references early intervention, prevention, integration and the need for holistic care seeking collaborative opportunities beyond boundaries. With 75% of people with mental health issues not receiving requisite care, the plan articulates a vision for improving access to services to reduce these inequalities.

Additionally, the strategic case for change is further supported by the Care Quality Commission report "Right here right now – People's experience of help, care and support during a mental health crisis[4]" (June 2015). This highlights that between 2013 and 2015 the Department of Health funded nine Forces to run triage pilot schemes. Aside from the trial forces, a further 17 implemented triage schemes. Recent CQC inspections highlight pressures on the Places of Safety both in terms of flow and length of time on the units. Reducing the number of S136 detentions is a local priority.

The formal evaluation commissioned by NHS England recommends:

"Co-location of health and police staff (e.g. linked to a Control Room) or dedicated phone line(s) appear to be an important component of effective Street Triage schemes and could support a cost-effective roll out of the programme."

The report also summarises that "*Co-locating police and health staff was viewed as a positive means of assuring joint working and establishing the collaborative nature of the service. The value of information sharing between police and health was seen as one of the great successes of the schemes. The ability to access detailed information early on in the process was thought to allow police to make more informed and appropriate decisions for service users and therefore reduce their reliance on s136.*"

Triage allows an individual to receive support from a mental health professional, the police to access expert advice and the mental health trust to feel confident that people who are arriving at their health-based place of safety are likely to be those most in need. This directly aligns with the Mental Health Act 2015 Code of Practice which states "when deciding that detention may be necessary, the police may also benefit from seeking advice using section 136 powers in [5]cases where they are unsure that the circumstances are sufficiently serious for using these powers".

Triage schemes have shown locally to foster a spirit of closer working between the police and mental health trusts. Further work will assist with cost reductions by

[4] https://www.cqc.org.uk/sites/default/files/20150630_righthere_mhcrisiscare_full.pdf
[5] Street Triage : Report on the evaluation of nine pilot schemes in England, University College London. March 2016

decreasing inappropriate uses of section 136. By partners working together, information sharing is also embedded across agencies. In a period of financial pressure for all partners, it is important that evidence based services are commissioned locally. The Care Quality Commission Report recognises that triage schemes should be subject to a full evaluation on completion to ensure they realise the improved outcomes sought. It is recommended that future Triage services need to be evaluated.

The 2017-2019 NHSE operating framework stipulates delivery of partnership programmes for both the crisis concordat and the Police and Crime Act 2017.

Local evidence to date shows the Bristol city Street Triage Pilot has already proven beneficial. This is supported by the following information.

Bristol Street Triage service shows a diversion rate of 77% (Q2 2017-2018) which is consistent with all previous reporting of a diversion rate above 70%. This is represented by 203 S136 suite diversions out of 274 assessments within the first 10 month period of operation for Bristol Street Triage. Subsequently for April 2017-September 2017 Bristol Street Triage assessed 189 people and 43 were detained on S136.

The conversion rate for S136 under Bristol Street Triage (Q2 2017-2018) was 50%, meaning 20 of the 43 service users detained went on to be admitted to hospital. Notably for non street triage cases in the same period, the conversion rate was26%. 32 of 120 service users went on to be admitted to hospital.

Control room Triage data 1st Oct 2016 – 30th Sept 2017

- Control Room Triage has dealt with 10,918 mental health logs.
- Total number of calls in each area: Bristol 4742 (43.4 %), North Somerset 1519 (13.9 %), South Glous. 742 (6.7 %), Bath 931 (8.5 %) & Somerset 2984 (27.3 %)
- Of the 10,918 mental health logs 1,098 (10%) were resolved without police deployment
- 61 S136 diversions saving £108,580 (Approximate cost of £1,780 per S136)
- 7,766 of the 10,918 (71%) mental health log cases were known to mental health services

The following data accounts for the most tagged logs:

Concern for safety – 2661 logs 24.3 %
Suicidal – 2683 Logs 24.5 %
Missing person – 1092 logs 10%

Demand

The demand analysis below is based on Police data for the Control Room Triage service .

Table1 reports the number of STORM logs (calls for service) that have a mental health qualifier attached ie. an identified mental health need/presentation. These qualifiers are added at the end of the log once Officers have attended and therefore provide a relatively realistic overview of demand by geographic and temporal split but also trend analysis.

The table below summarises requests for service looking at the relative % of logs for each area. This data should be considered to help inform the debate about funding responsibilities and further supports the need for an on-going Control Room Triage Service.

The data period is from 01/01/17 to 30/11/17.

Table 1 Police calls with mental health qualifiers by local police area (LPA)

Geography - Police LPA	Logs with MH Qualifier	Total Logs	% of all Area logs that had MH qualifier	% of all logs with MH qualifier
BANES	1489	38270	3.9%	15.7%
Bristol	7288	161941	4.5%	18.2%
North Somerset	2179	50372	4.3%	17.5%
Somerset East	2050	56995	3.6%	14.5%
Somerset West	3450	69193	5.0%	20.1%
South Glos	2010	58194	3.5%	14.0%
Sum:	**18466**	**434965**	**4.2%**	**100.00%**

The data indicates that the profile is similar across each Local Policing Area – there is a range of 3.5% to 5.0% of all logs (with a MH qualifier) but this is not a significant difference in terms of the data set. Of all logs with the MH qualifier, 20.1% relate to Somerset West and to 14% for South Gloucestershire. This compares to the beginning of the pilot when 44.5% related to Bristol and 7.3% for BANES. The range is large but expected.

When do mental health requests for service occur?

The data clock below provides a summary by hour by day of the week and may help inform the debate to inform tailoring a bespoke Triage service in line with times of greatest risk balanced with financial implications.

The data suggests that calls are spread evenly throughout the week. Demand is highest from the early afternoon until 11pm. Depending on funding options, the suggested minimum requirement might be a Triage function that works seven days a

week covering 1300-2300. This would cover every hour time cohort with more than 3.0 calls with MH qualifiers per hour.

Table 2 Police calls with Mental Health qualifier by 24 hour clock

24 hour clock	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	hour cohort summary
0000-0100	1.8	2.0	1.8	1.6	2.0	2.2	2.5	13.9
0100-0200	1.3	1.6	1.4	1.3	1.5	1.7	2.0	10.9
0200-0300	1.4	0.9	1.3	1.3	1.0	1.3	1.3	8.6
0300-0400	1.0	0.8	1.0	0.9	1.1	1.5	1.6	7.9
0400-0500	0.9	1.1	1.0	1.1	0.9	0.8	1.4	7.2
0500-0600	0.8	0.4	0.8	0.7	0.9	0.8	1.0	5.3
0600-0700	0.9	0.8	0.7	0.8	0.8	0.9	0.9	5.8
0700-0800	1.0	1.0	1.0	1.1	1.2	1.0	1.1	7.4
0800-0900	1.3	1.6	1.5	1.9	1.4	1.3	1.1	10.2
0900-1000	2.1	1.9	1.7	2.2	2.1	1.6	1.3	12.8
1000-1100	2.7	2.2	2.3	2.6	2.4	2.2	1.8	16.1
1100-1200	2.9	2.2	2.5	2.6	2.7	1.8	1.8	16.3
1200-1300	2.3	2.6	2.6	2.7	2.5	2.4	1.8	16.8
1300-1400	2.7	3.0	2.7	2.7	2.9	2.0	2.2	18.1
1400-1500	2.6	2.6	3.0	2.8	3.6	2.3	2.4	19.3
1500-1600	3.2	2.5	2.9	2.9	3.4	2.5	2.9	20.4
1600-1700	3.1	3.3	3.7	3.4	3.4	2.8	2.7	22.2
1700-1800	3.1	3.3	2.9	3.2	3.5	2.4	2.6	21.0
1800-1900	3.2	2.9	2.9	3.1	2.5	2.7	2.9	20.1
1900-2000	2.6	3.3	3.1	3.2	2.8	2.6	3.2	20.8
2000-2100	3.1	2.7	3.3	2.9	2.9	2.6	2.5	20.0
2100-2200	3.4	3.2	2.5	3.0	2.6	2.4	2.2	19.3
2200-2300	2.5	2.6	2.7	2.8	2.4	2.6	2.8	18.5
2300-0000	1.9	2.6	2.4	2.4	2.5	2.8	2.4	17.0
Sum:	51.9	51.0	51.6	53.0	52.9	46.9	48.6	356.0

Table 3. Overview of the top 10 log 'disposal codes' by area

MH qualifier disposals	BANES	Bristol	North Somerset	Somerset East	Somerset West	South Glos	Total

CONCERN FOR SAFETY	738	3403	1094	1127	1810	1010	9182
CONTACT RECORD	157	839	232	200	323	283	2034
Anti social behaviour - NUISANCE	93	379	90	76	219	113	970
MISSING PERSON	71	413	115	115	166	77	957
SUSpicious CIRCumstances / INSECURE PREM - VEH	66	287	78	79	115	74	699
HOAX CALLS	48	315	71	42	92	89	657
ASSAULT	38	213	102	59	97	47	556
DOMESTIC INCIDENT	32	126	57	67	103	55	440
ABANDONED CALL TO Emergency services	29	183	59	30	68	43	412
HARASSMENT	32	156	41	38	58	36	361
Top 10 total	1304	6314	1939	1833	3051	1827	16268
All	1489	7288	2179	2050	3450	2010	18466

Chart 1. Logs with mental health qualifier daily rate December 2016 – Nov 2017

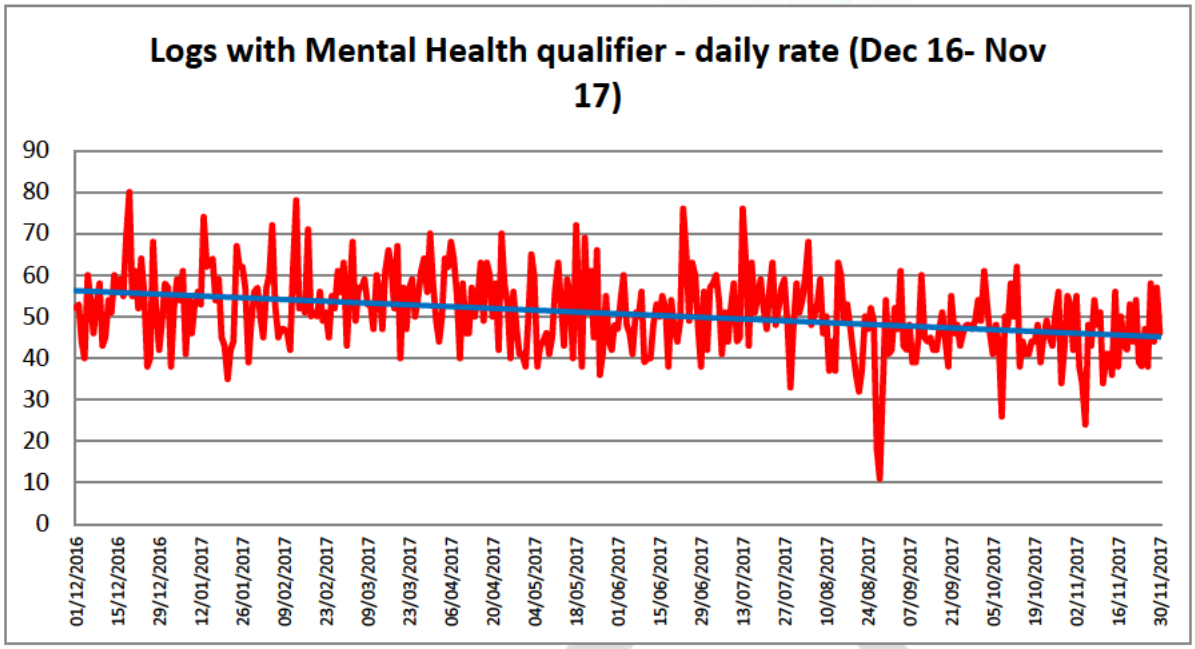
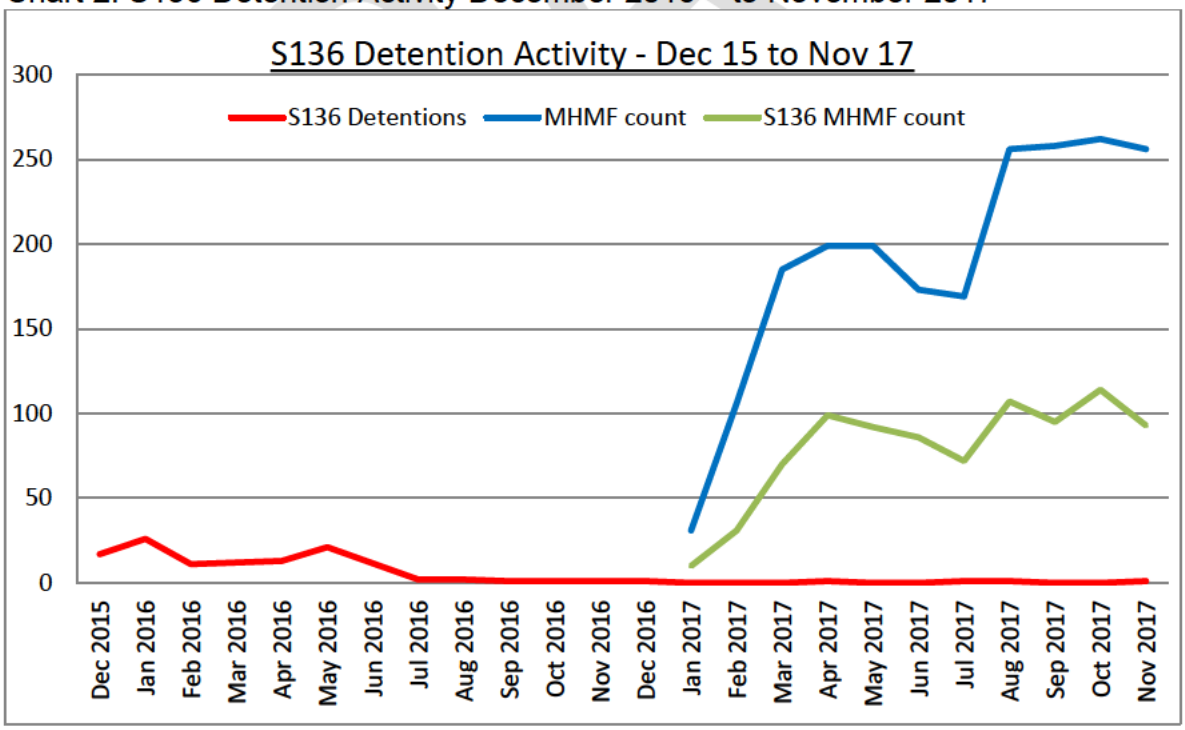


Chart 1 shows the trend of logs with MH qualifiers over a one year period. The daily number of calls is plotted. The blue line is a logarithmic trend line and shows marginal reduction through the last twelve months. This is in contract to the daily log rates at the beginning of the pilot which showed a marginal increase over the 2015/16 period.

Chart 2. S136 Detention Activity December 2015 – to November 2017



The red line S136 activity based solely on those individuals brought into Custody for mental health act assessment. There is a gap in data between July 2016 and January 2017 when the Mental Health Monitoring Form police NICHE occurrence

system was introduced. The 'MHMF' holds the data the Home Office requires. These numbers are likely to be an under-recording of the true impact of mental health on the constabulary as not all forms are submitted. The green line reflects the numbers of recorded S136s and the blue line reflects the larger number of incidents where a S136 was not used. The chart demonstrates that Avon and Somerset system partners have achieved an almost zero admission rate to police custody suites for mental health act assessments. This supports compliance with the Police and Crime Act 2017, which permits admissions to the custody suite for S136 detentions only in exceptional circumstances.

[insert place of safety data here – AWP and Sompar]

Chart 3. AWP Place of safety data – admissions to Mason Unit (BNSSG)

Chart 4. Somerset Partnership Place of safety data – admissions to Rowan and Rydon

Chart 5. Avon and Somerset Section 136 and Section 135 detentions to a place of safety

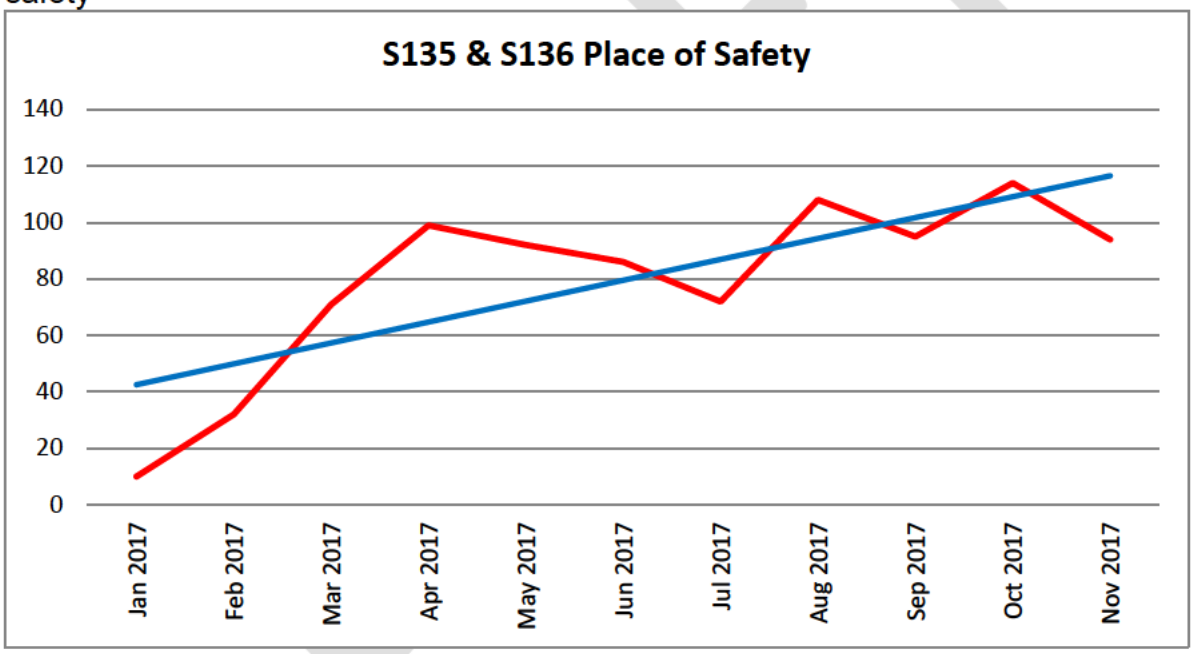


Chart 5 shows that there is a relatively steep trended increase in the numbers over people detained during 2017. The increase in admissions to health places of safety outstrips the decrease in detentions into custody. Overall demand relating to mental health s135/6 is increasing.

The ambition of partners is to reduce the level of s135/6 admissions that do not "convert" into an admission under the Mental Health Act. A triage function will result in more intelligent dispatch decisions potentially preventing incidents escalating to a point where admissions are necessary. There is recognition that Police use Section

136 to detain individuals where the individual needs 'immediate care and control' and are will not require detention under section 2 or 3 of the Mental Health Act. Mental Health Crisis Home Treat Team (CRHTT) are not an emergency service but operate within a maximum 4 hr response time.

Street Triage Service is not universal across the Avon & Somerset region. Bristol Street Triage began in September 2015 and North Somerset Street Triage began in October 2017.So far each service has delivered positive results with a significant number of diversions from s136.

Demand in Emergency Departments

Chart 6. Number of NBT ED attendances with MH coding

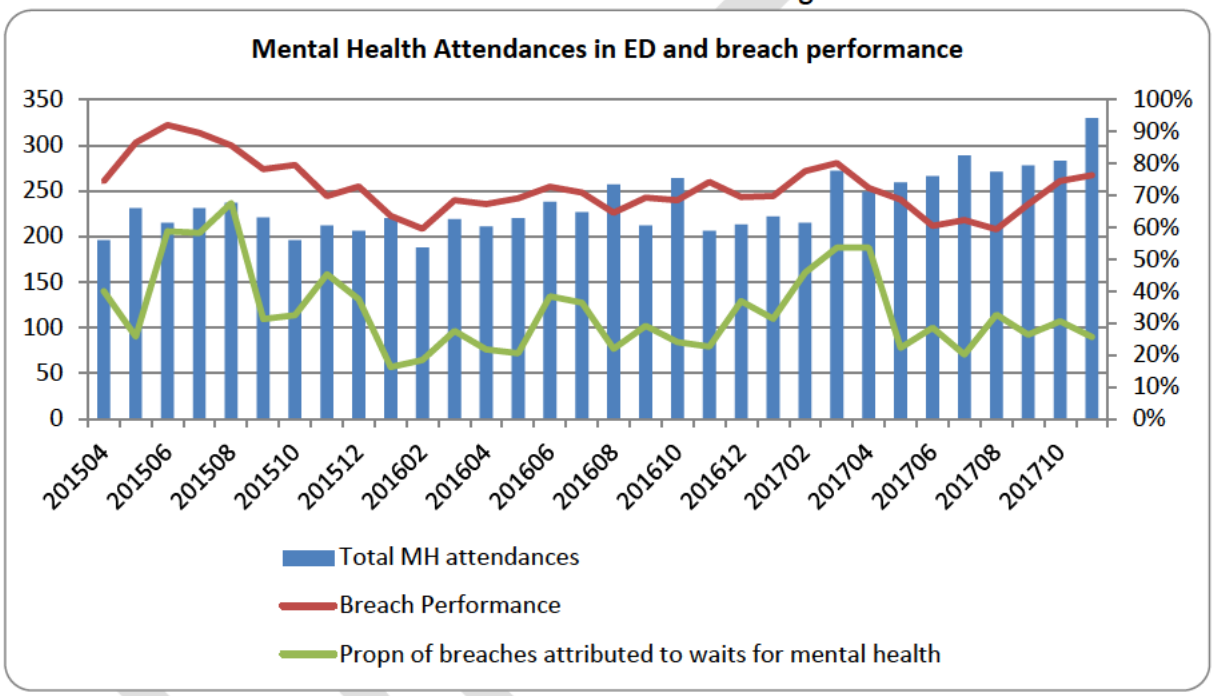


Chart 6 shows the Number of ED attendances in NBT with mental health presentation. It shows that overall there has been an increase from 2015 to 2017 of ED attendances with mental health coding.

Chart 7. Number of UHB ED attendances with MH coding

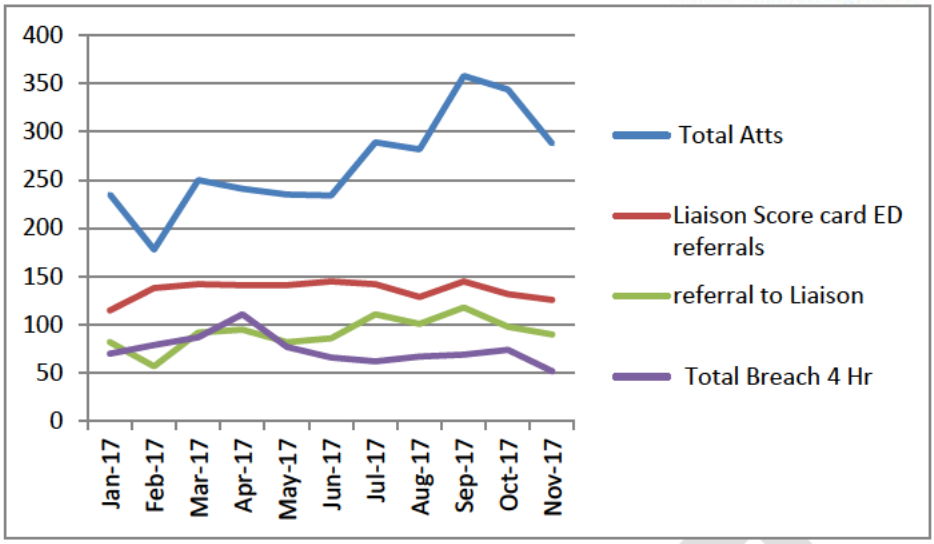


Chart 7 shows equivalent data for UHB from January 2017 – November 2017. This shows a significant increase in total attendances with a mental health code during the summer and autumn. Previous data demonstrates variance between months.

Duty of care

Triage delivers improvements for duty of care and operational efficiencies. A primary benefit of the Force Service Centre (FSC) transferring calls/logs to integrated mental health practitioners (MHPs) is that need can be determined before it reaches other front line resources.

The integrated response provides early access to services for those with mental health issues before they reach crisis point. The location of mental health practitioners in the Force Control Room, means access to services is immediately facilitated. The MHPs will have the relevant knowledge of current services available, access to an individual's health records and are qualified to make direct referrals. Cohesive partnership working has other benefits. Increasing Police and Fire services' awareness of the MHPs approach will improve the Police and Fire Services' response at first point of intervention enabling appropriate referral pathways to be identified at an earlier stage in the individual's care journey. Regular joint training sessions have been delivered with the Integrated Mental Health Triage function to improve general mental health knowledge and awareness of staff in the FSC so that relevant calls can be easily identified, training has also taken place with police officers and response units. This has improved the confidence and ability of Call Handlers to provide effective resolutions and is especially pertinent in the case of repeat callers.

Operations

Triage impacts on a range of regular operational demands as described below.

Critical incidents involving persons suffering mental ill health including:

- Persons in mental health crisis (including Section 135 and Section 136 of the Mental Health Act)
- Reduction in the need to detain individuals under Section 136 of the Mental Health Act by providing information, advice and alternatives to Officers
- Firearms & siege type incidents
- Calls relating to self-harm and potential for suicide
- High risk missing persons
- Negotiator call outs

Calls for service falling outside of the 'critical incident' criteria which result in Police attendance including:

- Confused callers (e.g. dementia)
- Calls for service for pre-arranged mental health assessments
- Persons reporting missing from psychiatric hospitals (low or medium risk)
- Concern for welfare reports

Persistent and / or repeat demand for Police and Fire services

- Small cohort of people not always requiring unit attendance but often calling the 999 or 101 non-emergency line. When this occurs it places disproportionately high demand on resources from the first point of contact through to operational staff. There is a separate but complimentary multi-agency work programme supporting this.

Partnerships

- The Policing and Crime Act 2017 requires a high level duty to collaborate on all three emergency services. Inter-service collaboration presents a real opportunity to increase efficiency and effectiveness, maximise available resources, enhance local resilience reduce duplication within the system and improve the service delivered to the public. Critically it stipulates police officers must contact mental health services prior to detention under S136.

4. Overview of Benefits

Street triage and the control room triage services have proved to be hugely successful in reducing S136 detentions. The Control Room tTriage service has diverted 61 S136 detentions since October 2016. The data shows initially admissions to the Mason Unit (place of safety) decreased for 5 of the first 6 months of the 2 year pilot. This will also be contributed to through the work of the Street Triage services. The use of police custody suites has reduced to zero. Police time deployed on MH call outs has reduced but the number of MH calls has increased and 10% of all MH

logs have been resolved without police deployment. The triage service delivers the following benefits:

1.S136 suite diversions
The evaluation of the Bristol Street Triage service showed 143 diversion within the first 10 month of operation, equating to an approximate saving of £254,540.

There is possible duplication within these results as some of these diversions may have been accounted for by both teams however a merged model would allow for more accurate data collection and increased cost savings to both health and the police The control room triage evaluation data was compared with the place of safety data and Street triage data and it clearly shows that there has been a reduction in the use of the place of safety which is likely to indicate an overall reduction in the number of times section 136 was applied as a direct result of the Control room triage and street triage teams.

2. Multi-agency working
Street triage and the control room triage services have positively contributed to the working relationships between mental health and police services and the wider mental health crisis system. The proposal to merge the teams to provide one overall structure to provide mental health support with the police would in effect be more consistent, collaborative and there would be an expectation of a quicker, prioritised response to meet the needs of BNSSG.

3. Use of appropriate resource at the appropriate time within the crisis care pathway
The Policing and Crime Act 2017 states that a police officer must speak with an appropriate clinician prior to using their powers to detain someone on a section 136. Continuation of triage service would assure compliance with this element of the Act. If the control room and street triage functions are combined then the service can filter and risk assess the situation to prioritise the use of the mental health specialist within Street triage resulting in the team resourcing the right need at the right time.

4. Effective deployment of staff and use of resource
Currently the model does not allow the resources to be effectively deployed. The two Street Triage teams cannot cross boundaries and support increases or spikes in activities across the localities. The new model would allow the control room to direct the resource to the need which would provide a more rapid coordinated response. Operationally the service will be managed to minimise the time staff spend travelling across the patch.

The current model does not have an operational hub and the team members in Bristol are at times deployed without the knowledge of the control room. The proposed model would allow for clear coordination and clinical support around decision making and rationale and geographical management. Centralised management would provide a transparent structure with strong, links with secondary mental health services and clinical pathways to ensure the service user is signposted to the most appropriate support. It would also avoid duplication of data collection and accurate attribution of reductions in police deployment and S136 reductions.

5. Integration within AWP Access Services

The proposed structure would include greater integration within the access services across BNSSG or if option 4 is selected across Avon and Somerset. It would improve relationships with the police and knowledge of the service as a whole given that clinicians would be expected to rotate shifts through the control room. The variety within the role would provide flexibility around shift cover, improved backfill for sickness and other absences therefore improving job satisfaction. The integration of the team should help recruitment and retention hence potential longer term cost savings.

Current Provision and Proposed Service Development

Control room triage commenced in September 2016 for a two year pilot period. The service is co-commissioned by Bristol, North Somerset, South Gloucestershire and BaNES CCGs and Avon and Somerset Police and Crime Commissioner. The service covers the above CCGs and Somerset CCG who is a non-contributing partner. Avon and Somerset PCC is contributing the Somerset CCG finance element. Avon Fire and Rescue also contribute funding and are able to access the service.

There are many possible permutations of the service [I would like to reduce the options below to 3]

In all options (unless the service is stopped) the triage would act as the hub and triage all logs within the police Command and Control system Webstorm. It would allow the deployment of the triage staff to respond to emergencies more quickly and efficiently across the BNSSG or in option 4 Avon and Somerset footprint.

There will be an integrated management structure, leading to greater clarity and support for practitioners, the police and other services about the service pathway and signposting. Improved team working with a shared focus on the standard operating procedure and quality of services provided. A bigger team offers greater flexibility with rotas e.g. with annual leave and sickness cover allowing a better work life balance for the practitioners. As a consequence this improves staff recruitment and retention.

Future Models

To continue to meet the need and demand of the BNSSG population and the wider population served by Avon & Somerset Constabulary, 5 options have been identified to future proof Control Room Triage and Street Triage services.

Options to be considered:

Option 1 – Existing model

The existing model provides separate Street Triage services in both Bristol and North Somerset. The Bristol Street Triage service operates 7 days per week

between the hours of 08:00am – 00:00am. The North Somerset Street Triage service operates from 3pm-11pm, 5 days per week (Thursday – Monday inclusive).

Control Room Triage provided through the current model is a 7 days per week service that operates from the Police control centre between the hours of 08:00am – 10:00pm.

This model is fully funded until end of March 2018, Bristol CCG funding ends in March. All other funding partners have agreements in place until September 2018. Potentially Bristol CCG could continue funding to ensure that the two year pilot can complete and this will provide additional time for staff consultation and recruitment for the agreed future model.

It is not the recommendation of the steering group to continue this model after the end of the pilot to enable standardisation of street triage across BNSSG.

The total cost for operating the existing service is £544,949/annum across all partners. Somerset CCG do not currently contribute to the cost of the control room triage service.

Option 2: 24/7 service model (Gold)

This model would provide a BNSSG wide Street Triage service. The Street Triage service would operate 7 days per week between the hours of 0800 and 2400.

This model would provide a 24/7 Avon and Somerset Control Room Triage service.

The steering group considers this option to be the gold standard model of provision.

The total cost of operating this suggested model would be £813,946/annum. Across all partners.

Option 3: Police & Mental Health Control Room with Police Rapid Response 24/7 - recommended option (Silver)

This model would provide an Avon and Somerset wide control room and rapid response service. The service would operate 24/7. The hours of operation would be enabled through rostering two members of staff on at peak times. The members of staff would be deployed according to need across Avon and Somerset and Police Transport would be available to rapidly deploy them to areas of high need.

This model would provide a 24/7 Control Room Triage service.

This is considered the silver standard of delivery. Control room would be fully operational 24/7 across the Avon and Somerset area. Mental Health rapid response would be available and deployed from the control room at Portishead HQ. However, there would be limited capacity in street triage. Currently at peak times in Bristol and

North Somerset there are 3 members of street triage deployed 5 evenings a week. This model would provide one operating model for the Avon and Somerset Constabulary area. It would extend rapid response to BaNES and Somerset CCG areas. At present BaNES will maintain their current financial contribution. Discussions are ongoing with Somerset CCG regarding financial contribution.

The total cost of operating this suggested model would be £768,328/annum.

The cost structure for option 4 could be amended to cover 12noon – 12 midnight which would represent the peak hours of the service.

Option 4: Extended hours model (Bronze)

This model would provide a BNSSG wide Street Triage service. Street Triage service would operate 7 days per week between the hours of 0800 and 2400.

This model would provide a Control Room Triage service between the hours of 0800-2200, 7 days per week.

The total cost of operating this suggested model would be £667,036/annum across all partners.

This would provide a BNSSG Street triage service and Control room for Avon and Somerset.

<u>Option 5 – stop Control Room Triage & Street Triage services</u>

No Street Triage service or Control Room Triage service would operate across BNSSG.

The total cost of operating this suggested model would be £0/annum.

Options appraisal

Option	Advantages	Disadvantages
1 – Existing model	- services already established with staff in post - on-going consistent diversion rates through street triage service delivery - continued reduction in S136 suite admissions	- duplication of contact by both Street Triage & Control Room Triage for an individual service user - staff not being deployed according to highest level of priority as demand cannot be met

		- missed opportunities for case allocation & time wasted by clinicians (ie. clinician deployed to scene when another colleague may have been more local & able to manage the situation) - Lack of capacity to respond to all Police storm logs with a mental health identifier
2 – Extended hours model	- seamless allocation of a clinician to a case based on priority need - pooled resources to ensure strict levels of business continuity ie. annual leave cover, sickness cover & staff vacancy cover	- no control room triage facility between the hours of 10pm & 8am and hence limiting compliance with PACA - reduction in ability to have full oversight of need for street triage intervention across BNSSG - potential relocation of AWP depending on proposed SOP for street triage component of service
3 – 24/7 service model	- meet the standards set out by PACA for all Police Officers to consult with a Mental Health professional prior to using S136 24/7 - Potential capacity for Control Room Triage to review all Police storm logs with a mental health identifier - potential to pilot accepting SWAST logs with MH identifier Potential long term savings	- increased initial cost to deliver service - dependent on proportionate financial contributions from all partners
4 - Police & Mental Health Control Room with Police Rapid Response 24/7	- As option 3 + mental health clinician deployed with support of Police escort & vehicle to highest level of need in short time frame - increased productivity and reduction in 'wasted' police time as police officer on sight with clinician reducing the need to make an additional call out to police offer if required thereby reducing the risk of escalation in service user presentation	- ensuring Police vehicle capacity to meet need alongside business as usual - dependent on proportionate financial contributions from all partners - only one member of staff available for deployment so capacity will be limited. This will reduce the amount of street triage available in Bristol and North Somerset

	- central co-ordination of MH response	
5 – stop control room triage & street triage services	- recurrent cost saving of £129,565.29 to BNSSG CCG	- poor service user experience - non- compliance with standards outlined by PACA 2017 - increased number of presentations to A&E - higher level of calls to 999 services out of hours - breakdown in relationship between Police Staff & Mental Health Clinicians - increased number of admissions to S136 suite - service users directed to inappropriate services

Option	Total Cost to all partners FYE	BNSSG cost pressure in 18/19 – [finance to confirm]
Option 1	£614,277	
Option 2	£756,582	
Option 3	£911,959	
Option 4	£768,329	
Option 5	-	

Full year effect for all partners given below. Based on top of scale pay and midpoint non pay and overheads. It is unlikely that all posts will be recruited at top of scale and costs would reflect actual costs.

Options	**top of scale (£)**	**non pay (£)**	**Overheads (£)**	**Total cost (£)**
Option 1 - extend current service to September 2018 (Bristol & NS Street triage and Avon and Somerset Control room)FYE	529395	13802	71080	614277

Option 2 - BNSSG Street triage and Avon and Somerset Control room	652683	16894	87005	756582
Option 3 - 24/7 control room and BNSSG street triage	785177	20615	106167	911959
Option 4 (recommended) 24/7 control room and rapid response Avon and Somerset	648652	19460	100217	768329
Option 5 stop service	0	0	0	0

Recommended Option

Option 4 – Silver model of Avon and Somerset Mental Health and Police triage service with rapid deployment 24/7.

Full investment with a trajectory over 3 year period from 1st April 2018 to 31st March 2022 with a view to explore options for investing in option 4 after the 1st 2 year period

Cost breakdown by option and partner detailed in section 14 below.

Critical success factors

There are a number of factors considered as critical in support of a Street Triage and Control Room Triage and these are listed below. The Crisis Care Concordat should look to ensure there is mitigation against each of these areas to ensure risks do not evolve into issues and prevent the timely introduction of Triage.

- Agreement on model by all partners and confirmed respective financial contributions and timeframes.
- The teams are currently recruited to, but any changes will need to be subject to staff consultation.
- An updated standard operating procedure for the Triage Function developed and signed off by all parties
- Information sharing protocols reviewed and signed by all parties
- Governance arrangements reviewed and agreed by all organisations , including inter-trust governance (Somerset/AWP) and Police & Crime Commissioning
- Pathway agencies should be identified, with consultation and engagement so that they are aware of a implications of the newly commissioned model
- A formal evaluation process (Cost benefit analysis) designed, agreed and delivered

It is anticipated that the greatest Street Triage demand will come from urban areas in Bristol, Weston and South Gloucestershire suburbs. Location of the team will need to be confirmed pending spatial analysis of current demand, although the control room will continue to be based at Police HQ in Portishead. The control room will be key in

deployment of the team across the geographical area. Bases will be confirmed in the service specification and SOP.

SWAST

Currently there is no formal agreement to allow access through the control room triage service to SWAST. Discussions have taken place and SWAST anticipate that additional calls from SWAST would be minimal. AWP have confirmed that there are mental health logs which are not currently being met [awaiting data]. Commissioners are recommending access for SWAST based on a trial basis if the model becomes 24/7 control room triage. Currently practitioners have access to the professionals' line in Bristol.

5. Scoping

5.1 All within Scope

Control Room Triage supports all ages including children & young people covering the Avon and Somerset Constabulary area: BNSSG, BaNES & Somerset. Street Triage covers BNSSG (from 16 years in Bristol, currently 18 years in North Somerset and South Gloucestershire.

5.2 Out of Scope

Full details of what areas of service are out of scope will be dependent on the option chosen.

5.3 Assumptions

It is assumed in the costings that Avon and Somerset Constabulary will continue total investment in Triage services £158k and Avon Fire and Rescue £5k, this will be calculated by CCG population. It is assumed that Somerset CCG and BaNES CCG will make a proportionate financial contribution based on population.

5.4 Dependencies

The successful delivery of the control room and street triage services is dependent on the strong partnership working across the mental health crisis system.

5.5 Constraints

All partners are subject to financial constraints and this service model is dependent on proportionate financial contributions. AWP staff will be subject to a 3 month staff consultation and recruitment as necessary to fully operationalise a new service model.

Part 2 - Implementation Plan and Key Performance Indicators

6. Timescales for Delivery

Milestone	Completed Date	Owner
Complete business case	20th December 2017	[redacted]
Control Room Triage steering group to sign off business case	5th January 2018	[redacted]
BNSSG Executive Team & Avon & Somerset Police and Crime Commissioner sign off on business case	19th January 2018	[redacted]
Financial agreement & funding contribution agreement	1st February 2018	[redacted] (Chief Finance Officer, OPCC)
AWP staff consultation commences	1st February 2018	[redacted] AWP
Review of service specification & Standard Operating Procedure for the service	16th February 2018	[redacted]
Operational service	1st April 2018 (dependent on staff consultation)	AWP

7. Outline Evaluation Plan

Quantitative evaluations can take place by implementing a scorecard and using the same quantitative data as the initial street and control room evaluations. If a full independent evaluation is required this will cost an additional £20k and has not been at this stage included in the costings.

8. Approach

Due to the multi-agency nature of the service the implementation and monitoring of the service is held by the Control room triage steering group. In terms of governance, it is recommended that this continues and that the steering group will feed into local Crisis Care Concordat groups and individual partner structures.

The Section 136 Programme Board will be provided with contractual assurance and operational development up-dates.

The business case will be respectively presented to the Police and Crime Board and the CCGs Executive groups for oversight and sign off for an agreement of a sustainable service model.

The Crisis Concordat groups will be kept informed of the work carried out by the 'Control Room Triage Steering Group' and report to respective Health and Wellbeing Boards.

This business case is a core element of the delivery of the S136 whole systems work programme. It sits alongside the Core 24 Liaison Psychiatry work and the joint work on 'Frequent Users' and 'Serenity Integrated Mentoring Programme'

9. Stakeholder Analysis

Name	Title	Role and Organisation	Why important
[redacted]	Chief Finance Officer	BNSSG CCGs	Executive Lead for Mental Health
[redacted]	Chief Executive	BNSSG CCGs	Chair of S136 Programme Board
[redacted]	Assistant Chief Constable	Avon and Somerset Constabulary	
[redacted]	Superintendent	Avon and Somerset Constabulary	Mental Health Lead
[redacted]	Programme Lead Mental Health	BaNES CCG and Council	BaNES Commissioning Lead
[redacted]	Interim Programme Lead Mental Health	Somerset CCG	Somerset Commissioning Lead
[redacted]	Operational Manager for North Somerset	AWP	Operational Lead AWP
[redacted]	Commissioning Manager	BNSSG CCGs (South Gloucestershire)	Control room triage steering group chair
[redacted]	Deputy Mental Health Programme lead	BNSSG CCGs (Bristol)	Bristol Street Triage commissioning lead
[redacted]	Transformation project manager	BNSSG CCGs (North Somerset)	North Somerset commissioning

			lead

[please could all steering group members add to this list?]

10. Patient and Public Involvement Implications

- Feedback to be incorporated from stakeholders (correspondence received from Police Officers, AWP staff etc)
- Feedback to be incorporated from service user feedback collected through S136 Project Board (Family & Carers views represented)

11. Outline Equality Impact Assessment

An equality impact assessment will be completed once the preferred option is agreed by both BNSSG CCG Exec Team and PCC Exec Team.

12. Legal Implications

The legal implications are that the Police and Crime Act 2017 could be breached by not agreeing to a model that ensures Police Officers are able to consult with a Mental Health Professional prior to considering the use of S136 detention. Compliance with the Mental Health Act code of practice is also a statutory duty for all partners.

13. Other Implications

Variation to contracts required.

14. Costs / Investment Summary

	Population	%	Avon and Somerset contribution
BNSSG	968314	56	89349
Somerset	545390	32	50325
BaNES	203623	12	18789
Total	**1717327**	**100**	**158463**

options	BNSSG	BaNES	Somerset	Avon & Somerset Constabulary	Avon Fire	Total
Option 1 - extend current service to September 2018 (Bristol & NS Street triage and Avon and Somerset Control room)FYE	411683	10005	29126	158463	5000	614277
Option 2 - BNSSG Street triage and Avon and Somerset Control room	553988	10005	29126	158463	5000	756582
Option 3 - 24/7 control room and BNSSG street triage	647574	25444	75478	158463	5000	911959
Option 4 (recommended) 24/7 control room and rapid response Avon and Somerset	341023	71737	192105	158463	5000	768328
Option 5 stop service	0	0	0	0	0	0

15. Savings Summary
Please provide a summary of the savings noting full year and part year effect if relevant, and whether the savings are one off or recurring

BI analysis of MH crisis in ED and analysis from evaluations.

16. Net Benefit / Net Costs and QIPP Contribution (if applicable)
Please indicate whether net savings or costs are provided from the proposal. If there are net savings are they cashable and could they contribute towards QIPP?

- Saving of £178,000 over a 24 month period through continued implementation of the Control Room Triage service in its current operating format
- Saving of £305,448/annum through Bristol Street Triage in its current format

17. Additional Resources (if required)
(e.g. Provide an outline of any additional resources required that are already part of the CCG overhead / running costs e.g. Programme Manager, Project Manager, Project Support, IT, Business intelligence)

Title	Band (if appropriate)	Duration Approx. (if known)
N/A		

This project will be run within existing establishment from each organisation.

Part 4 Risks, Mitigations and Contingency

Risk of not investing	Mitigating Actions	Score

Failure to meet PACA regulations	Resources would still be needed as part of the AWP access or crisis services to respond to police enquiries. This would mean reducing services currently available in the community.	16
Continued increased pressure in S136 and failure to meet demand	AWP transformation work is reviewing access services and looking at community services for people in crisis. Demand is however increasing.	16

20. Approval

Partners with delegated approval to be listed with date.

Appendices

Street Triage Evaluation_Final.doc› Bristol Street Triage

BNSSG CCG	£62,064	2990%	29	2900
BANES CCG	£9,319	449%	5	500
Somerset CCG	£30,336	1461%	15	1500
Avon and Somerset Police and crime Commissioner	£101,720	4900%	49	4900
Avon Fire and Rescue Service	£4,166	201%	2	200
	£207,605			10000

Evaluation Specification Timeline

Evaluation Report Timeline

From: [redacted] (NHS BRISTOL, NORTH SOMERSET AND SOUTH GLOUCESTERSHIRE CCG)
To: [redacted] (NHS BRISTOL, NORTH SOMERSET AND SOUTH GLOUCESTERSHIRE CCG)
Subject: FW: Control Room Evaluation
Date: 28 November 2018 09:03:22
Attachments: image002.png
image003.jpg

Hi [redacted]

Sorry to chase, see below

Bw
[redacted]

From: [redacted] (AVON AND WILTSHIRE MENTAL HEALTH PARTNERSHIP NHS TRUST)
Sent: 28 November 2018 08:18
To: [redacted] (NHS BRISTOL, NORTH SOMERSET AND SOUTH GLOUCESTERSHIRE CCG)
Subject: RE: Control Room Evaluation

Hi [redacted]

We had an evaluation done at the six month point. Unfortunately there was no funding to complete an evaluation at the end of the 2 yr pilot.
I am meeting with [redacted] to discuss this today so will feedback to you. We have large amounts of data covering the last 2 years.

I have not heard anything about the winter pressures money as yet so it would be helpful to know if this is going to happen as it will take a long time to get people through the police checks to get them started.

Will email you later with an update.
Do you want me to send you the 6 month evaluation?

Best wishes
[redacted]

[redacted]
Interim Operations Manager

Avon and Wiltshire Mental Health Partnership NHS Trust
The Coast Resource Centre
Diamond Batch
Locking Castle
Weston-super-Mare
BS24 7FY
[redacted]
[redacted]

Working together, living our best lives

From: [redacted] (NHS BRISTOL, NORTH SOMERSET AND SOUTH GLOUCESTERSHIRE CCG)
Sent: 27 November 2018 21:09
To: [redacted] (AVON AND WILTSHIRE MENTAL HEALTH PARTNERSHIP NHS TRUST)
[redacted]
Subject: Control Room Evaluation

Dear [redacted]

Hope you are well
Have you heard from [redacted] re: Winter funding for Street Triage? Do say if not & I will chase as it has been agreed.

Do you have any evaluation around control room? I have not yet seen the A&S one, but BANES are asking for any AWP evaluation completed.
We have the reporting you have provided which I have shared and I need to look through old files to find any evaluation reports, but wished to check if AWP has done one recently.

Sorry I am not aware, but am relatively new to this area and apologies this has taken so long!

Best wishes
[redacted]

[redacted]
Transformation Manager – Mental Health & Learning Disabilities
NHS Bristol, North Somerset & South Gloucestershire CCG
South Plaza
Marlborough Street
Bristol
BS1 3NX

[redacted]
-
[redacted]

www.bnssgccg.nhs.uk


BNSSG CCGs
Ideas Template

Title of Proposal:	BNSSG street triage review
Summary Description of Intended Action:	Not to proceed with commissioning street triage service in North Somerset To continue to commission street triage in Bristol as an invest to save to consider economies of scale from operating across a wider patch
Control Centre:	MH & LD
SRO Name and Contact Details:	[redacted]
Control Centre Lead for this proposal.	[redacted]
Document Version and Date:	V0.1 13.2.17 Vol 2 15.2.17

1. Describe your proposal **(max: 150 words)**
The NS street triage service was planned to go live in 2016/17, but start was delayed due to recruitment issues within control room triage. The go live plan is now for Q1 2017/18 but this plan could be ended. The money is already identified in the budget and included in the AWP SLA for 2017/18 so recouping this money would be through negotiation with AWP. It is proposed Bristol continues to fund its street triage service as an invest to save and the opportunities to expand the service in the south of south gloucs and possibly Weston are explored.
2. What evidence have you got that your idea is likely to be effective? (max 150 words)
There is strong evidence for Street Triage services, and in North Somerset this service was going to complement the control room triage service. It potentially prevents ED attendance, S136 usage, and strengthens the MH crisis response. The investment in the north Somerset service was in response to our Crisis Care Concordat, and wasn't based on any projected or guaranteed savings. In Bristol the investment was mapped to cost avoidances for A&E and police. Bristol CCG have asked the police and Council to contribute to the service but the Police have said they cannot decide until after the 136 improvement work is complete and the Council have not responded.
3. Which lines of which contracts will your idea target? (max: 100 words)
North Somerset AWP contract
4. What is the level of recurrent saving to be made?
North Somerset £60K
5. From which month will the savings start to be delivered?

April 2017 (depending on contract terms and negotiating timeframe)
6. Has this been proposed or tried before? What happened? (max: 150 words)
NA
7. What key quality measure will be monitored for identifying changes to patient outcomes?
There will be no change to current service provision
8. What metrics will you use to monitor your idea and specify the data sources.
There will be no change and no monitoring required

Please submit completed templates to the BNSSG PMO using BNSSG.PMO@nhs.net. The deadline for Ideas template submissions in this first cycle is Friday 17th February at 12pm.
Any questions on completing this template either use this PMO email address or contact [redacted]

From: [redacted] (NHS BRISTOL, NORTH SOMERSET AND SOUTH GLOUCESTERSHIRE ICB - 15C)
To: [redacted] (NHS SOMERSET CCG); [redacted] (NHS BATH AND NORTH EAST SOMERSET, SWINDON AND WILTSHIRE ICB - 92G); [redacted]
Cc: [redacted]; [redacted] (NHS BRISTOL, NORTH SOMERSET AND SOUTH GLOUCESTERSHIRE ICB - 15C)
Subject: RE: Control Room Triage Service Qtr 2 meeting dates
Date: 26 August 2020 11:30:00
Attachments: image001.png

Dear [redacted]

Further to my email below and the resumption of contract management processes across the NHS, [redacted] and I would like to set up a meeting to discuss the Control Room Triage Service with you all as associate commissioners.

We would like to do this in September so we can bring you up to speed with progress to date and plans for the rest of year, with further meetings then taking place to review, Qtrs. 2,3 & 4.

Please could you suggest dates or a contact within your organisation we can liaise with to co-ordinate an appropriate time. If you do not wish to attend we can provide minutes of the meeting for you.

[redacted]

If you are no longer the lead for this service or have a representative please let us know the details, and if you have any questions please do not hesitate to get in touch.

Best wishes and my colleague [redacted] (cc in here) will make the meeting arrangements.

[redacted]

[redacted]
Transformation Manager – Mental Health & Learning Disabilities
NHS Bristol, North Somerset & South Gloucestershire CCG
South Plaza, Marlborough Street, Bristol, BS1 3NX

[redacted]

[redacted]-
Website: www.bnssgccg.nhs.uk

From: [redacted] (NHS BRISTOL, NORTH SOMERSET AND SOUTH GLOUCESTERSHIRE CCG)
Sent: 27 May 2020 12:39
To: [redacted] (NHS SOMERSET CCG); [redacted] (NHS BATH AND NORTH EAST SOMERSET CCG)'; [redacted]
Cc: [redacted]
Subject: Re: Introduction from BNSSG for year ahead - Control Room Triage Service

Dear [redacted]

I hope you are all well. I am writing to briefly introduce myself as I am temporarily overseeing commissioning of the Control Room Triage on behalf of BNSSG [redacted]

Over the past months [redacted] and I have been meeting regularly with AWP. The main focus of the work has been to remodel the service which has been led by colleagues [redacted] from Avon & Somerset Police Force. In addition, further work is ongoing to improve the data recorded as part of performance management. These changes are designed to ensure the sustainability of the service.

[redacted] and I had planned to provide an update to you all by April 1st in line with the new financial year. As I am sure you will appreciate, these timescales have been delayed by Covid-19 but we are still progressing.

[redacted] and I propose that we meet in July to review Qtr1 activity. I can set up a virtual meeting for us all, with AWP included for at least part of the meeting, for questions etc. We may also want a closed (commissioner only) part of the agenda. This agenda can be developed nearer the time, but the first meeting would include proposed service changes, revised data set and review of activity. The changes and dataset will be shared with you before any changes are confirmed.

As the proposal I have outlined above means that we will not meet until July, I wanted to share with you the following paragraph from the internal BNSSG and OPCC memorandum of understanding, which we intend to use again for this financial year;

Contract Management Arrangements

- During 2020/21, BNSSG CCG will, as lead commissioner, co-ordinate quarterly contract monitoring meetings which will include all commissioning partners of the Control Room Triage service. These meetings will review a revised dataset jointly developed with the OPCC, and agreed with other associate commissioners, that will provide the detail required for commissioners to

monitor the service outcomes throughout 2020/21. The first of these meetings will discuss commissioner expectations for staffing and service delivery operating hours and acceptable thresholds that would trigger any changes to payment for the service within 2020/21. Where concerns are raised regarding the service, these should be done so formally and recorded at the quarterly contract meetings. BNSSG CCG will lead the discussion with AWP on these concerns, and agree any reductions on the full contract value where there are significant grounds to do so.

With this process in place, it is envisaged that payments from each commissioner can be made with confidence in a timely manner

Please review this paragraph and inform me if this poses any problems for your respective organisations. In addition, given we have not completed this work or met to agree , and that contract management has been stood down, in line with NHSE guidance we propose that Qtr. 1 is not subject to any acceptable thresholds and changes to payments, and that instead we look to begin this process in Qtr 2 depending on the context of service delivery from July onward, if that is reasonable at the time.

Please could you confirm that the above arrangement is acceptable to your organisations. We hope that by Qtr2 we will be in a position to review activity and discuss this as commissioners of the service, agreeing a process to go forward which works throughout the remainder of 2020/21.

We are planning that the service will run throughout all of 2020/21 and we use our meetings to plan thereafter. Again, should there be any deviation to this from your respective organisations please let me know as soon as possible.

I look forward to hearing from you and speaking with you in the near future. Please let me know if you have any questions.

Best wishes

[redacted]

[redacted]
Transformation Manager – Mental Health & Learning Disabilities
NHS Bristol, North Somerset & South Gloucestershire CCG
South Plaza, Marlborough Street, Bristol, BS1 3NX

[redacted]

[redacted]
Website: www.bnssgccg.nhs.uk

NHS
Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Group

Evaluation specification tender template

Shaping better health

Title of project	**Evaluation of The Avon and Somerset Control Room and Street Triage Service**
Date	**March 2019**
Author	[redacted]
Project Leads	[redacted]

Version control			
Date	**Version**	**Author**	**Comments**

Draft Service Specification for Quantitative and Qualitative Evaluation of The Avon and Somerset Control Room and Street Triage Service Pilot

Lead Commissioner: Bristol North Somerset and South Gloucestershire CCG

Section 1: Purpose

The Avon and Somerset Control Room and Street Triage (CRST) Service was commissioned as a pilot in September 2016. This pilot is due to end in September 2020. The Control Room Triage covers the population of Bristol, South Gloucestershire, North Somerset, BANES and Somerset with deployable Street Triage within Bristol, North Somerset and South Gloucestershire (BNSSG) only.
An external qualitative and quantitative evaluation is required to assess the impact the service delivers against the predetermined aims to help inform a decision on the future viability of the Service after September 2020.

Section 2: Background

National Context
It is noted that there have been a number of national pieces of research relating to Control Room and Street Triage. Some examples have been provided here but these are not an exhaustive list and do not consider more recent publications. Any evaluator may well wish to consider other national reports. A key consideration for commissioners is that national reports have often made a level of assumption or counter factual scenarios in relation to potential benefits and savings generated from the service. This evaluation should focus explicitly on what can be clearly evidenced as benefits and costs saved or avoided.

The Crisis Care Concordat was a national policy driver published in February 2014 which called for local partnerships to collaborate to improve care for people experiencing a mental health crisis. The Concordat included patient experience evidence gathered from across the country and also included specific case studies around initiatives such as street triage with evidence of impact. The Concordat case studies can be found here.
University College London have led on an evaluation of 9 street triage pilots across the country which concluded that they are effective and that the greatest benefit would be gained from 24 hour services. The evaluation can be found here

The BMJ published an article in February 2016 by Dr Margaret Heslin of Kings College London. Heslin et al conducted a cost analysis of street triage and concluded that the savings generated by the service meant that it was cost neutral. The article can be found here and the financial appendix with detailed costings here.
The Sainsbury Centre for Mental Health paper '*Diversion: A better way for criminal justice and mental health*' indicates arrests which are subsequently not followed up cost the police approximately £1,780. The paper can be found here
The Royal Collage of Psychiatry paper '*Police liaison and section 136: comparison of two different approaches*' suggests that in a comparison of two neighbouring and demographically similar areas, face to face triage evidences reductions in the use of section 136 to detain and take people to a place of safety whereas telephone triage does not. The full paper can be found here

Local Context

Street Triage

In January 2015 Bristol CCG was successful in bidding for Operational Resilience and Capacity Planning funds to pilot a mental health street triage service. Mental health street triage places qualified mental health nurses within police stations to support police officers when they are considering using section 136 of the Mental Health Act to detain and take people to a place of safety. The majority of cases involved mental health nurses attending the incident either with or in place of the police to support the police officer to reach an appropriate outcome for person presenting with mental ill health. The pilot was initially funded as evidence from national street triage pilots indicated they lead to a reduction in the use of Section 136 and therefore a reduction in the use of 136 suites and A&E departments which are used as the backup 'places of safety' when 136 suites are full. The pilot commenced in September 2015 with the service operational 7 days a week between 2pm – midnight. An initial internal evaluation of the Street Triage service delivered by AWP in September 2016 led to this service being extended to March 2018 with extended hours from 8am- midnight to create an early shift (appendix 1).

Aside from the direct benefits of extended hours part of the reason for the extension was to allow the service to be adequately staffed as staffing an evening only service was challenging.

In addition, North Somerset CCG commissioned a 5 day a week 8 hours a day street triage service from XX

The Street Triage element of the Control Room and Street Triage Service remains solely commissioned by BNSSG.

Control Room Triage

In June 2015, local partners and signatories of the Crisis Care Concordat (Police, Health and Fire service providers) agreed unanimously to explore the feasibility of establishing a mental health Control Room Triage system, whereby Mental Health professionals are seconded in the Police control room i.e. as employees of the Mental Health Trust (not Police). The service model agreed upon was that 4 Mental Health staff would be based in the Control Room, between them providing cover between 0800 – 2200 7 days / week. The Service is commissioned by the Office of the Police and Crime Commissioner, Avon Fire and Rescue, BNSSG CCG, Somerset CCG and B&NES CCG.

This service went live in XX

Control Room and Street Triage merger

- .

An independent evaluation is required to inform a decision on the future viability of the service after September 2020.

Section 3: Our Requirements – Evaluation

Commissioners of the service wish to commission an external organisation/individual to undertake a mixed methods evaluation of the CRST service using baseline data already generated, data gathered following implementation of the service, and new data in the form of qualitative interviews with staff and service users. The evaluation should be structured against the objectives outlined below. These objectives have been agreed by commissioners. The evaluation should also ensure the outcomes of previous evaluation should be considered (outlined in appendix 1). The recommendations from the evaluation will help inform a decision on the future viability of the CRST after September 2020.

Aim of the Evaluation

The primary aims of the evaluation is as follows:

1. To assess the impact the Control Room delivers for service users across Bristol, North Somerset and South Gloucestershire (BNSSG), Bath and North East Somerset (BANES) and Somerset.

2. To assess the impact Street Triage delivers for the service users within BNSSG.

3. To assess the impact a combined Street Triage and Control Room Service has on service users within Bristol, North Somerset and South Gloucestershire (BNSSG), Bath and North East Somerset (BANES) and Somerset.

Other aims of the evaluation are to evidence whether:

- The service has enabled diverts of individuals who have come into contact with police but do not require a criminal justice response to the appropriate pathway for support.
-
- The service has supported the use of Section 136 in cases where it is deemed clinically necessary, and avoided the use of Section 136 in others
- The service has supported the appropriate and efficient use of police deployment.
- The service has educated the system about the purpose of the service to ensure it is used appropriately.
- The service has ensured there are clear communication pathways between blue light services and Mental Health services.

Objectives of the Evaluation

The objectives of the evaluation are closely linked to the service outputs and outcomes and the required data and evidence required of the service in line with NHS Funding requirements, as shown below in Table 1. Please note this list is indicative. It will need to be collated pre and during service delivery to demonstrate the impact of the CRT & ST Service.

Table 1: Evaluation objectives, service outputs/outcomes and data requirements.

Evaluation objective		Data required for collation	To evidence
1	To track the types of triage provided by the service E.g - Text Liaison between Control Room Triage and Police Call handler - Phone Advice (Control Room Triage)	Number of each type of triage Track of triage types is not currently covered in the pathway map	What types of triage are being undertaken, and if some of these methods are being done more than others.
2	To track the outcomes of triage provided by the Control Room service. E.g - Information and Advice only - Practitioner to Police - Practitioner to Client	Number of each type of outcome of triage Lots of outcomes are on the pathway but with no method listed for tracking them.	What the outcomes of the triage are, and if some of these outcomes occur more than others.
3	To track the type of onward referral for users triaged by the service. E.g - Arrested - General Hospital - CRISIS team	Number of each onward referral type. Not covered.	What the type of onward referral are and if some of these outcomes occur more than others.

4	To track service demand	Number of service user contact(s) per month Not covered.	Whether there seems to be more service user contacts in some days/months compared to others (i.e., any trends).
5	To assess the effectiveness of the CRT service's risk assessment procedure.	- Sample review (n=100) of CRT/STORM Log call handler incident notes - % of incidents with multiple outcomes (assuming this is a measure of unclear outcome) - Number of each type of outcome of Triage - Focus group with Frontline Police - Focus group with AWP CRT staff	The advice provided by CRT on the level of risk individuals presenting on the street to the police increases the accuracy in the police choosing the most appropriate pathway for support.
6	To assess the effectiveness of the CRT service shared decision making process	- Number of each type of outcome of Triage - Number of each type of triage - Evidence of number of high impact user care plans shared with police (known to services) - Sample review (n=100) of CRT/STORM Log call handler incident notes - Focus group with AWP CRT staff - Focus group with Frontline Police	The shared-decision making methods undertaken by CRT and frontline police officers, and whether this helps to inform what the most appropriate patient pathway is.
7	To assess the effectiveness of the communication methods between CRT and the service users	- Number of each type of triage - Sample review (n=100) of CRST/STORM Log call handler incident notes - Focus group with individuals who have interacted with the service in the past	What type of communication methods are undertaken by the CRT service and the extent to which direct communication between CRT service and the people the police are supporting are used.

8	To assess the proportion of service time devoted to police officers who are considering using section 136	- Percentage of calls received by the Control Room Triage service, where section 136 was considered - Percentage of calls received by the Control Room Triage service, where section 136 was used - Length of calls received by the Control Room Triage service comparison between: - Calls where section 136 was considered and used, - Calls where section 136 was considered but not used incidents - Calls where section 136 calls were not considered	What proportion of the CRT service time is devoted to s136 related incidents and whether these trends have changed over time.
9	To track the CRT service's ability to provide clear advice to police officers on whether there is a viable alternative to the use of S136 for an individual	- Percentage of calls section 136 was considered - Percentage of calls section 136 was used - Sample review (n=100) of CRT/STORM log call handler incident notes - Focus group with individuals who have interacted with the service in the past. - Focus group with Frontline Police	What type of advice is being provided by CRT service and whether some types of advice are being provided more than others

10	To assess the support CRT service can provide to police call handlers on the level of risk	- Percentage of calls where Control Room Triage team prevented police attending scene - Sample review (n=100) of CRST/STORM log call handler incident notes - Focus Group with Police Call handlers Focus group with AWP CRT staff	What type of advice is being provided to police call handlers to help them assess the level of risk of the incident and whether some type of advice are being provided more than others.
11	To track serious incidents and near misses	- Identify and review any serious incidents relating to the service	What type of information is stored and establish whether there any future learning for the providers.

Evaluation objective		Data required for collation	To evidence
1	To track the types of incident Street Triage are deployed to	Number of each type of triage	What types of incidents are being attended
2	To track the outcomes of Street triage provided by the Control Room service. E.g - Practitioner to Police - Practitioner to Client	Number of each type of outcome of triage	What the outcomes of the triage are, and if some of these outcomes occur more than others.
3	To track the type of onward referral for users Street triage. E.g - Arrested - General Hospital - CRISIS team	Number of each onward referral type.	What the type of onward referral are and if some of these outcomes occur more than others.
4	To track service demand	Number of service user contact(s) per month	Whether there seems to be more service user contacts in some days/months compared to others (i.e., any trends).
5	To assess the effectiveness of the ST service's risk assessment procedure.	- Sample review (n=10) of Nurse incident notes - Focus group with Frontline Police - Focus group with AWP ST staff	What impact Street Triage has on the risk approach taken by frontline police officers.

6	To assess the effectiveness of the ST service shared decision making process	- Sample review (n=10) of Nurse incident notes - Focus group with AWP ST staff - Focus group with Frontline Police officers	The shared-decision making methods undertaken by STT and frontline police officers, and whether this helps to inform what the most appropriate patient pathway is.
7	To assess the effectiveness of the communication methods between ST and the service users	- Sample review (n=10) of Nurse incident notes - Focus group with individuals who have interacted with the service in the past - Focus group with Frontline Police officers	What type of communication methods are undertaken by the ST service.
8	To assess the proportion of ST service time devoted to police officers who are considering using section 136	- Percentage of Street triage incidents attended, where section 136 was considered - Percentage of street triage incidents attended where section 136 was used	What proportion of the ST service time is devoted to s136 related incidents and whether these trends have changed over time.
9	To track the ST service's ability to provide clear advice to police officers on whether there is a viable alternative to the use of S136 for an individual	- Sample review (n=10) of CRT/STORM log call handler incident notes where street triage was used and Nurse incidents notes - Focus group with individuals who have interacted with the service in the past. - Focus group with Frontline Police	What type of advice is being provided by ST service and whether some types of advice are being provided more than others
10	To track serious incidents and near misses	- Identify and review any serious incidents relating to the service	What type of information is stored and establish whether there any future learning for the providers.

Impact of a combined Control Room Triage and Street Triage Service			
Evaluation objective		**Data required for collation**	**To evidence**
1	To assess the awareness about the purpose of CRST amongst frontline police officers.	- Number of calls into CRST per area - Police workforce survey Police workforce focus groups	The level of awareness about the CRST service and whether this varies between different local areas.
2	To assess the frontline police officers' understanding of the purpose of use of the CRST service.	- Police workforce focus group - Police workforce survey - Sample review (n=100) of CRST/STORM log call handler incident notes. Review of STORM data to understand number of each type of trigger to call police.	To establish trends within the reasons why police officers are using the CRST and assess whether these trends fit with the aims of the service.

Evaluation approach

The evaluator will be required to:

- Conduct a local cost benefit analysis for the CRST services.
- Engage with key stakeholders and conduct staff and service user feedback sessions to collect qualitative data
- Undertake qualitative data analysis
- Undertake quantitative data analysis
- Ensure all governance and ethics requirements are addressed at the outset and monitored throughout the duration of the project.
- Produce a report identifying the learning from the evaluation which includes recommendations on the changes to the service required to better meet the outcomes of the service.

Evaluation requirements

There is some flexibility in how the findings are presented back, the following reports are suggested and the final approach will need to be agreed with commissioners:

- A draft final report outlining the findings and any barriers to be shared with the CRST Steering group by January 2020. (required)
- A presentation to the steering group in January 2020 which should be used to present the findings of the draft report (required)
- A written final report to include an executive summary, introduction, methodology section, results section, discussion, conclusion, recommendations, action plan and references to be submitted by March 2020. (required)
- To provide a 1 page bullet point update on the progress of the evaluation a week before the 6 weekly steering group meetings. (required)
- To provide monthly informal updates of progress to commissioners of the evaluation as well as potentially participate in ad hoc teleconferences or face to face meetings. The format of these updates will be agreed with the commissioners on award of the evaluation. (required)
- To engage in a data discussion session with AWP within the first month of the evaluation process to understand how the data is collected and establish the support and information you will require from AWP to carry out the evaluation of the CRST service (desirable).
- To engage in a data discussion session with Avon and Somerset Police within the first month of the evaluation process to understand how the data is collected and establish the support and information you will require from Avon and Somerset Police to carry out the evaluation of the CRST service (desirable).
- To engage in a data discussion session with the BNSSG BI Team within the first month of the evaluation process to establish the support you will require to carry out the evaluation of the CRST service (desirable).
- Any risks/issues must be escalated in a timely manner to commissioners (required).

- Develop appropriate mechanisms to feedback findings to a wide audience including those who took part in the evaluation (required)

Timeframe

See appendix 2

Resources available to support the Evaluation

The project manager for this work in Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group (BNSSG CCG) will fully support the evaluation in relation to initial set up and ongoing queries. In return they expect regular monthly updates on progress and any risks/issues to be escalated in a timely manner for resolution.

BNSSG CCG Business Intelligence will be able to support:

- Interpreting data provided by AWP
- Cleansing of data provided by AWP and Avon and Somerset Police.

The Providers Business Intelligence and Performance teams will work with the evaluators to ensure the right data is collated and reported on a regular basis. It is expected the following providers will provide the following:

Avon and Somerset Police:

- Raw data extracts from the STORM Database (Any person identifiable information removed)
- Time for staff to participate in focus groups

AWP

- Raw data extract Raw data extracts from the AWP Database (Any person identifiable information removed)
- Time for staff to participate in focus groups
- Support to evaluator in locating service users to participate in focus groups

Governance for the Evaluation

- The evaluators will provide a 1 page bullet point update on the progress of the evaluation a week before the 6 weekly steering group meetings.
- Evaluator's reports will be shared with the Local CRISIS concordat as well as, provider and commissioner decision making bodies.
- The evaluators will report back to the commissioners in line with timeframes outlined in appendix 2 and within the Format of Reports and Milestones section above.
- The evaluators will not be provided with any patient identifiable information.
- The evaluators may be required to attend and present on findings at senior level commissioner meetings on a limited but ad-hoc basis.

Appendix 1: Previous Evaluation Objectives

CRST Service Description_Final for

17.39 AS Control Room Triage (3).pdf

Bristol Street Triage Evaluation 2016.docx

Appendix 2:

Evaluation Report Timeline