South East Clinical Senate

South East

Clinical

senate

Review of the

Centralisation of Section 136 Health Based Places of Safety (HBPoS) in Kent and Medway

Pre-Consultation Business Case

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Foreword

The Mental Health Crisis Care Concordat[1] is a national agreement between services and agencies involved in the care and support of people in crisis which details how organisations will work together better to make sure that people experiencing mental health crisis get the help they need. Mental health services are required to develop inter-agency crisis care pathways in accordance with local resources, geography, pattern of service delivery and population need. These pathways must ensure that a mental health crisis is treated with the same urgency as a physical health emergency and that people are treated with dignity and respect, in the appropriate therapeutic environment.
Every day, people in mental health crisis need our public services to respond quickly to protect them and keep them safe. These services save lives but to do so police officers, paramedics, mental health nurses and doctors and the Approved Mental Health Professionals must work together in response to mental health crises. As part of their improvement work for the Mental Health Urgent and Emergency Care (MHUEC) pathway NHS Kent and Medway are working with system partners to improve the Section 136 Pathway and Health Based Places of Safety (HBPoS), a critical component of the MHUEC. A health-based place of safety is a space where people detained and transported under Section 135/136 (S135/136) of the Mental Health Act can be managed safely while an appropriate assessment is undertaken by a psychiatrist and an approved mental health professional (AMHP).

The South East Clinical Senate were requested by the NHS England regional reconfiguration assurance team to review proposals aimed at improving the experience and outcomes for patients through creation of a centralised HBPoS service for Kent and Medway. The improvement work addresses workforce, estate and facilities, access to assessment and reduction in the period of detention in a HBPoS.

A multi-disciplinary independent clinical review panel of health and care professionals with a wide range of expertise and experience, including specialist mental healthcare professionals and patient and public partners, was brought together to review the pre-consultation business case (PCBC). Following this review the Clinical Senate have produced a range of recommendations for how the business case could be potentially improved.

This review was a retrospective review of the final PCBC and unusually the Stage 2 meeting occurred prior to the findings and recommendations of the Clinical Senate panel being shared with the programme team. The Kent and Medway team have therefore

[1] Department of Health and Concordat Signatories. Mental Health Crisis Care Concordat – Improving outcomes for people experiencing mental health crisis. February 2014. Available from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/281242/36353_Mental_Health_Crisis_accessible.pdf

requested that this report be read in conjunction with their responses to the points raised following the Stage 2 assurance meeting.

The request was for a rapid review, and I would particularly like to thank all the members of the clinical senate panel for giving of their own time so readily to participate in this review.

Finally, a thank you to the support team of the clinical senate for coordinating the review and bringing the report together.

Dr Paul Stevens, Chair South East Clinical Senate

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1. Introduction and context of the Kent and Medway section 136 HBPoS service reconfiguration proposals.

The NHS Long Term Plan[2] emphasised a renewed focus on mental health and outlined an ambition for significant transformation of mental health care. A nationally, ring-fenced local investment fund, the Mental Health Investment Standard (MHIS),[3] was created which aimed to enable healthcare providers to create further service expansion and faster access to community and crisis mental health services for service users.

The Mental Health Act (1983) is the main piece of legislation that covers the assessment, treatment, and rights of people with a mental health disorder. Under the Act, a Section 136 allows the police to take a person to, or keep a person at, a place of safety.[4] The police can do this without a warrant if a person appears to have a mental disorder and they are in any place other than a house, flat or room where a person is living, or garden or garage that only one household has access to and that person needs immediate care or control. Before using a Section 136, where practicable to do so, the police must consult a registered medical practitioner, a registered nurse, an approved mental health professional (AMHP), paramedic, or a person of a description specified in regulations made by the Secretary of State. A Section 135 allows the police to enter a person's home and take a person to, or keep a person at, a place of safety so that a mental health assessment can be done.[5] Whilst a place of safety could be a hospital, care home, or any other suitable place where the occupier is willing to receive the person while the assessment is completed, having a dedicated health-based place of safety (HBPoS) is preferable. A HBPoS provides a physical environment in a purpose-built facility which is conducive to recovery and provides a co-located, dedicated team with the skills, knowledge, and experience to carry out a timely assessment whilst assuring the safety of the individual and the safety of others. Although Accident and Emergency departments are also a place of safety, they do not generally provide an environment that lends itself to a Mental Health Act assessment and dedicated mental health staff may not be immediately available.

In 2014 the Care Quality Commission's (CQC) 'A safer place to be'[6] report set out the role of effective partnership working, inter-agency training and support in helping to reduce the use of section 136 and, as a result, the demand for places of safety. It describes emerging evidence from innovative triage schemes that joint working between the police and health staff to provide people in crisis with the right help and support can contribute to reducing the use of section 136 overall. However, there will continue to be a need for section 136 HBPoS to which distressed and vulnerable individuals can be taken by police officers and

[2] NHS Long Term Plan
[3] NHS England » Mental Health Investment Standard (MHIS): Categories of Mental Health expenditure
[4] Mental Health Act 1983, Section 136. Available from: https://www.legislation.gov.uk/ukpga/1983/20/section/136
[5] Mental Health Act 1983, Section 135. Available from: https://www.legislation.gov.uk/ukpga/1983/20/section/135
[6] A safer place to be - Care Quality Commission (cqc.org.uk)

these places must be fit for purpose. The original 72 hour permitted period of detention in a place of safety under section 135 or 136 was reduced to 24 hours by the Policing and Crime Act 2017, extended by another 12 hours if under certain circumstances, such as physical illness, it is not possible to assess them during that time.[7] Importantly the Act also requires the use of a HBPoS instead of a police station. The time of detention starts when a person arrives at the HBPoS and the authorisation of any extension of time may only be given by the registered medical practitioner who is responsible for the examination of a person detained under section 135 or 136.

NHS Kent and Medway are working with system partners, to improve the current Mental Health Urgent and Emergency care (MHUEC) pathway and are focusing on developing proposals to improve the Section 136 Pathway and Health Based Places of Safety, a critical component of MHUEC.

As the mental health equivalent of an emergency service the HBPoS will be used for people at a point of extreme distress, at least some of whom will be at a very acute stage of illness, when risks to self and others are highest. In addition to an excellent clinical service, facilities need to be designed to provide a comfortable therapeutic environment and adhere to safety standards. As access to the service is likely to be urgent, the facility must have sufficient capacity to deal with times of peak demand and the professional staff resources to effectively assess people's needs. A person detained at a HBPoS will have a Mental Health Act assessment by an Approved Mental Health Professional (AMHP) and ideally two Section 12 doctors (a doctor trained and qualified in the use of the Mental Health Act 1983, usually a psychiatrist), one of whom should be independent. Following assessment, the person may be discharged with signposting to community services for ongoing support, offered an informal admission for treatment or detained under another section of the Mental Health Act. If someone is offered an informal admission for treatment or detained under another section of the Mental Health Act, they will be transferred to another ward. If they are transferred to another ward or setting their local residence will be taken into account. Transfer back to a ward in their home area would be the preferred option. Friends or relatives would then be able to visit. If a person is discharged from a HBPoS under S136, and is not staying in hospital, the person will be offered transport home.

Following the success of a capital funding bid a Pre-Consultation Business Case (PCBC) for the transformation of the Kent and Medway HBPoS service has been developed by Kent and Medway Integrated Care Board (K&M ICB) working together with Kent and Medway NHS and Social Care Partnership Trust (KMPT). The PCBC details the preferred proposal to create a centralised HBPoS service based at the KMPT Maidstone site with the aim of improving the experience and outcomes for patients by addressing workforce, estate and facilities and access to assessment and reduction in the period of detention in a

[7] Periods of detention in places of safety etc. Policing and Crime Act 2017. Available from: https://www.legislation.gov.uk/ukpga/2017/3/section/82/enacted

HBPoS. To access the capital funding work needs to begin in financial year 23/24 and be completed by the end of 24/25, to meet the national deadline.

Kent and Medway were a national outlier for incidence of Section 136, having one of the highest rates of detention in the country. Over the last 18 months however, section 136 incidences have significantly decreased as a consequence of improved partnership working, the introduction of a Clinical Advice Line for Kent Police and delivery of joint health and police training.

The proposed new, facility will be available to anyone who needs it wherever they live in Kent and Medway and will replace the five 136 assessment spaces that are currently spread across the three following HBPoS sites:

- Two at Priority House, Hermitage Lane, Maidstone ME16 9PH
- One at Littlebrook Hospital, Greenacres Site, Bow Arrow Lane, Dartford DA2 6PB
- Two at St Martins Hospital, Littlebourne Road, Canterbury CT1 1TD

The current three locations and five assessment spaces/rooms, provided by KMPT in Kent and Medway are spread across its three main hospital sites at Canterbury (2 spaces), Maidstone (2 spaces) and Dartford (1 space).

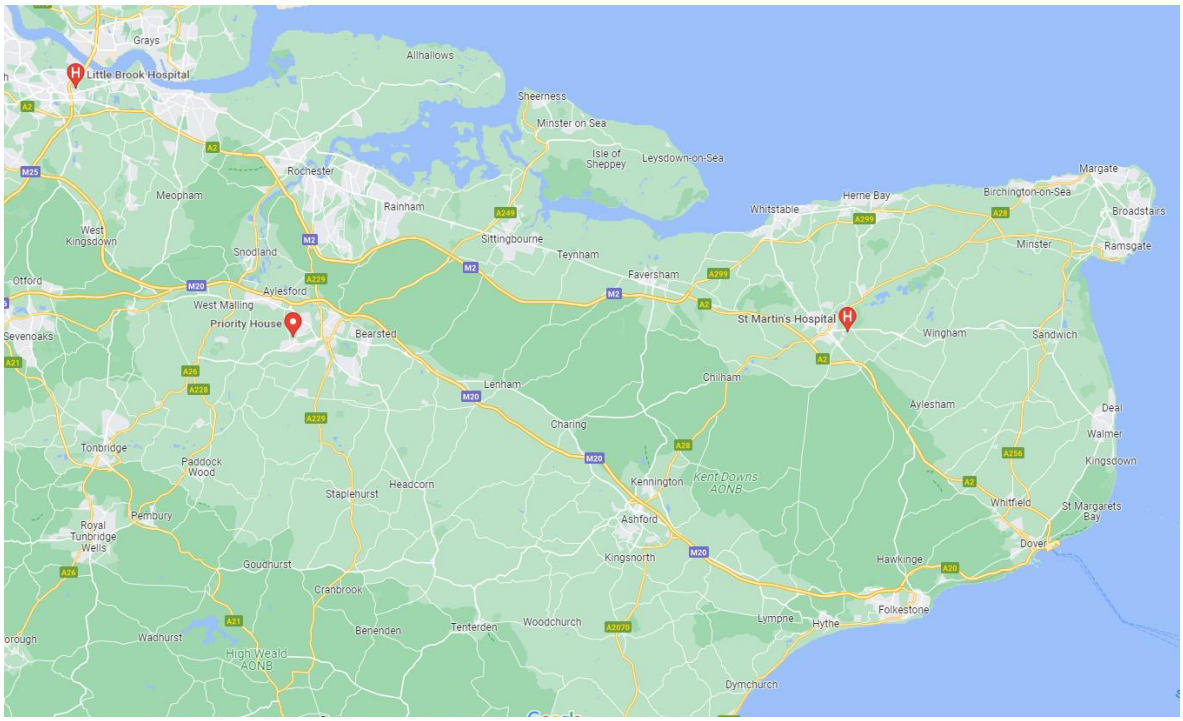

Figure 1 - Location of current Health Based Places of Safety

2. Review Methodology

This review is unusual because it is a retrospective review of a final PCBC following a public consultation. The Clinical Senate in response to the request from the NHS England regional reconfiguration assurance team completed a rapid retrospective focused desktop review of the centralisation of section 136 HBPoS in Kent and Medway. A 'Focused Review' approach is used by the clinical senate where the reconfiguration of a single clinical specialty pathway or model of care is proposed.

The expert clinical review panel is listed in Appendix E. Great care was taken to ensure the review team's declarations of interest and confidentiality agreements were valid. To further eliminate any conflict of interest review panel membership was also sought on this occasion from our national sister senates.

The initial documentation supplied was the final PCBC together with appendices and accompanying information (Appendix D) with additional documents being supplied by the senate management team to assist panel members in their review.

To aid the desktop review Key Lines of Enquiry (KLOE) (Appendix B) were developed by the senate management team and shared with the Clinical Senate review panel on 5th April 2023. Panel members were asked to assess the documentation and provide feedback on the proposals, together with any recommendations for consideration by the System (a pre-populated pro-forma KLOEs template was devised for consistency and to ensure the questions asked of the Senate in the Terms of Reference could be sufficiently addressed).

Panel notes were reviewed by the Senate Chair and Head of Senate with key messages provided verbally by the Head of Senate to the Stage 2 assurance panel on 19th April 2023. To note at the time of the Stage 2 meeting, panel notes had not yet been received from Urgent Emergency Care (UEC) and ambulance colleagues.

Panel notes were then synthesised into a first draft, which was circulated to the panel for comment. The final draft was then prepared for submission to Kent and Medway ICB for matters of accuracy on 9th May 2023, and for review, comment then sign off by the clinical senate council.

3. Key areas for consideration

The commitment of the Kent and Medway programme team to providing an improved HBPoS facility is evident. The ambitious plans to transform mental health and health and welling services described in the PCBC are commendable. The South East Clinical Senate review panel felt that the Kent and Medway team had undertaken considerable work with regards to the proposals for centralisation of HBPoS however there are some areas that could be further strengthened. In this report the Senate panel have outlined key areas for consideration and a number of recommendations. The recommendations for each section are tabulated for ease of review in appendix A and should be seen as an adjunct to, and not detract from, the significant work undertaken to date to develop and drive the reconfiguration and transformation ambition.

3.1 Clinical evidence base

The documentation provided for this review identifies the clinical evidence base for the proposed centralisation of HBPoS in Kent and Medway and makes reference to the positive outcomes for patients, staff and partner services as a result of the South London and Maudsley (SLaM) centralisation.[8] However, throughout this report the Senate panel refer to areas where the use of data to support assumptions and ambitions would further strengthen the proposal, most notably with regards to inpatient capacity, patient flows, workforce and ambulance conveyance both to and repatriation from the centralised site. Such evidence needs to be included in further iterations of the business case.

3.2 Workforce

A safe and consistent workforce is crucial for the effectiveness and positive outcomes of the centralisation proposals to be realised. The Senate panel was not sufficiently assured that the current workforce model set out in the PCBC will be able to meet the requirements of the new centralised service described. The workforce model in the proposal requires further development and consideration of the workforce requirement in its entirety; for the centralised HBPoS itself; adjunct services such as 24/7 liaison psychiatry, crisis cafes and home care teams. Assumptions about staff willingness to travel further to the centralised HBPoS need to be more thoroughly tested. In addition, impact on staff is broader than travel requirements and this would benefit from further exploration.

[8] SLaM-Centralised-Health-Based-Place-of-Safety-Evaluation-Nov-2017.pdf (transformationpartnersinhealthandcare.nhs.uk)

3.3 Ambulance/transport and police conveyance

There was a degree of anxiety expressed amongst panel members with regards to the documented principle that a short stay unit with transport to and from ongoing care or return home should mitigate the distances travelled for users and the teams that support them. Centralisation of HBPoS poses a potential risk to local hospitals as due to geography and having to travel 'out of bases' first responders may default to the option of local emergency departments. Emergency departments lack privacy, are high stimulus and their facilities are not conducive to meeting the needs of s136.[9] Conversely, travel further away from normal operating areas may potentially denude ambulance cover available locally. Engagement with the police and SECAmb needs to be robust,and the articulation of verbal engagement expressed at the stage 2 meeting requires clearly documenting in the PCBC.

4. Clinical case for change

The Senate review panel noted that there was a clear clinical case for change based on national guidance and best practice to provide an improved quality of service for patients in Kent and Medway. In addition, there is a clear rationale from a population health perspective. Narrative and photographic evidence is provided in the PCBC describing all three current HBPoS sites with descriptions about the service change from moving to one site.

The Senate panel acknowledge that the creation of three newly refurbished sites which meet current standards would be a more expensive option in terms of estate and staffing. However, the proposal could be strengthened by positioning the clinical case for change front and centre. At present it is overshadowed in the PCBC by the practical and financial perspectives, with the preferred option's current financial imperative being evident and the improvement in patient experience, quality of service and reduction in impact on first responders less so. A shorter and more focused executive summary that leads with the key quality improvements and reduction of repetition in the PCBC would facilitate this.

R1. The clinical case for change is compelling; the Kent and Medway ICB proposal would benefit from a greater emphasis on the clinical case in the business case.

[9] Hayhurst, C and Boyle A. The term "health based place of safety" is meaningless and hides the problem. *BMJ* 2017;357:j1844 doi: 10.1136/bmj.j1844 (Published 2017 April 11).

5. Clinical Model

The Senate panel were asked to judge if the proposed option provides safe, effective, clinically appropriate care which provides opportunities for the best possible clinical outcomes. This included consideration of any adverse effect on inpatient capacity, impact on flows of activity and mitigations supplied. Overall, the panel believe that the preferred model represents best practice and will adhere to the HBPoS standards[10]. If consistent 24/7 staffing proposals can be achieved the model will be safe and effective (see workforce p16 for more specific panel feedback and recommendations regarding the staffing model).

5.1 Centralisation of the HBPoS

It is clearly articulated in the PCBC how the proposals adhere to agreed standards for HBPoS, with reference to the evaluation of South London and Maudsley (SLaM) centralised services and improved outcomes for patients. It is evident that the proposed option would deliver an improved environment for patients and staff with improved patient access as a result of a reduction in closures for repair. In the staff feedback supplied the main concern was regarding robust doors; damage to doors in HBPoS suites lead to closures and staff and patients need to feel safe in their environment. The PCBC suggests the proposals would also lead to improved quality of care (such as timelier assessment and less rapid tranquilisation), improved staffing and reduced waiting times for patients and other professionals such as the police and paramedics.

The inclusion of more data and evaluation from centralisation of HBPoS in a geography and socio-economic environment more similar to Kent and Medway than South London would further assure the panel of the appropriateness of the model being proposed. The Senate has the following questions.

1. How many times have the current HBPoS facilities had 5 patients (at capacity), 4 patients and 3 patients at any one time over the last 2 years?
2. What is the current policy for HBPoS breaches (>36 hours) and potential Approved/Responsible Clinician cover for the patients in the daytime and out of hours?
3. Will patients who have received their Mental Health Act assessment, require admission but cannot be found a bed continue to occupy the HBPoS?
4. During the expansion of the Maidstone site to create the new 5 HBPoS rooms what plans are in place to ensure safe and timely treatment of patients on the Maidstone site or on one of the other current HBPoS sites that will subsequently close?

[10] Kent and Medway Crisis Care. Available at: mgconvert2pdf.aspx (medway.gov.uk)

R2. Inclusion of data in answer to the questions posed above to further strengthen the case is recommended.

R3. The SLaM evaluation suggests the potential for clinical benefit of a single site,[11] albeit in a smaller geographical area with better road transport compared to Kent and Medway. The Senate panel recommend incorporating clinical evidence from comparable geographies such as the southwest centralisation.[12] Conversations with in-region colleagues with regards to the Surrey centralisation may also yield further insight (introductions can be made via the Senate management team if desired).

5.2 Inpatient capacity and patient pathways

The daily challenges of inpatient capacity for KMPT are acknowledged in the PCBC. Given the nationally recognised challenges regarding inpatient capacity there is a risk the new HBPoS is perceived as being well staffed, has the potential to manage patients for several days and becomes a de-facto inpatient unit. Greater detail is required for the Senate panel to be fully assured with regards to the impact on supporting services and inpatient capacity. As the unit is collocated with the inpatient facility there is the opportunity of de-escalation/escalation and timely transfer of patients, although more information is required concerning sufficient psychiatric intensive care capacity on the Maidstone site. The PCBC details that in the preceding 12 months the average time spent in the HBPoS was 33.5 hours, the obvious implication being that nearly 50% of patients breach the extended 36 hour permissible stay.

The impact on patient flow has been described in a positive way in terms of improved flow for patients with a centralised site for HBPoS with inpatient psychiatric services also on site, however whilst this has potential for improved flow it will be reliant on staff availability to treat mental health crisis patients in a timely and therapeutic way and there is currently little data other than the SLaM evaluation data supplied to support these assumptions. Again, it would strengthen the case to also include additional outcome data from other areas where HBPoS have been centralised.[13]

There was concern amongst the panel that general mental health demand is growing, this concern is echoed in recently published papers[14] and whilst s136 numbers may have

[11] SLaM-Centralised-Health-Based-Place-of-Safety-Evaluation-Nov-2017.pdf (transformationpartnersinhealthandcare.nhs.uk)

[12] Places_of_safety_Evaluation_Report_September_2019.pdf (wiltshire.gov.uk)

[13] Evaluation Report on the temporary closures of Health Based Places of Safety in Swindon and Wiltshire. Available here: Places_of_safety_Evaluation_Report_September_2019.pdf (wiltshire.gov.uk)

[14] Mind warns of 'second pandemic' as it reveals more people in mental health crisis than ever recorded and helpline calls soar - Mind
Subjective experiences of the first response to mental health crises in the community: a qualitative systematic review | BMJ Open

decreased across the region triangulation with the acute emergency departments to ascertain whether they are seeing increased mental health crisis numbers because of s136 not being undertaken would help to understand both direct and indirect pressures and increase confidence in the future proofing of the proposals. 24/7 presence of mental health liaison teams is also required to help mitigate patient risk due to delayed waits to see a mental health specialist, increase in rapid tranquilisation and absconsion.

There was similarly a concern that centralisation of HBPoS on any site co-located with an Accident and Emergency service will mean that once someone is at a HBPoS if it becomes clear they will need physical medical care they will be taken to the nearest emergency department. The inference being that the emergency department at Maidstone will absorb all Kent and Medway s136 patients who need acute medical care following successful centralisation of HBPoS at Maidstone.

In addition, Police data (PCBC, Appendix 1, slide 4) suggests that HBPoS capacity has been an issue in the last few months with an increase in numbers of users taken to an emergency department. Analysis to match this data against times when units have been forced to close will mean the demand and capacity data represents a true picture of the current situation.

Further work is also necessary to determine if the centralisation would impact on s136 sites in southeast London and Sussex. Presently 62 patients are from outside Kent, with a further 18 of unknown location, which equates to approximately 10% of all attenders.

Currently patients requiring inpatient psychiatric care whilst not always treated in the nearest HBPoS to home are then admitted to an inpatient facility as close to home as possible. With the centralisation of HBPoS will the location of inpatient admission be at the centralised unit? The future location of inpatient psychiatric services in Kent and Medway is not made clear in the PCBC. Is it the expectation that alternatives such as crisis houses, and enhanced home treatment will supersede the requirement for inpatient care? If so, then data to support this would be helpful together with further clarity concerning the extended pathway for admitted patients from the centralised HBPoS unit. The panel felt consideration of the wider impacts on service users and their families of potential admission further from home requires increased attention in the proposals.

The PCBC does not address provision for children and young adults (18-25 years). Panel clinical experience is that at times young people are placed in an acute Trust as the only place of safety option. Clear articulation with regards to the patient pathway for this group in the PCBC would be helpful. Have transitional arrangements been considered for children and young adults experiencing mental health crises?

R4. Consideration of the risks posed and the operational leadership required when there is lack of inpatient capacity need to be explored and clearly articulated in the future business case.

R5. The Senate panel recommend the consideration of the Kent and Medway ICB bed commissioning policy relating to sec 140 MHA to the proposals.

R6. Clarity on location of inpatient admissions from the proposed centralised unit and exploration of the wider impacts on service users and their families of admission further from home is necessary.

5.3 Community services and prevention

The Kent and Medway ICB and KMPT have ambitious plans for mental health transformation and reducing the need for people to be admitted to an acute ward which is to be commended. The panel welcome the inclusion in the PCBC of the community support pathways and work with the voluntary sector to prevent people from getting into crisis. The inclusion of plans to expand the crisis cafes to 24/7 with psychiatric cover and a 24/7 home treatment team expressed at the stage 2 meeting are to be applauded. In addition, the PCBC describes Crisis Houses with a 24hour supervised supportive therapeutic space as an alternative to admission. It would be beneficial to the whole patient pathway if these ambitions were realised simultaneously with the implementation of the centralised HBPoS as preventing the use of s136 is preferable and will have a direct impact on mental health inpatient capacity.

The configuration and specification for the Rapid Response Service which is also listed as part of the wider mental health transformation plans would benefit from being articulated more comprehensively. Currently SECAmb is not commissioned for such a service, and further funding would need to be supplied if this were to be a viable option.

R7. Further articulation in subsequent business cases regarding the preventative offer and its effects on the s136 pathway.

6. Workforce

6.1 Workforce planning

There was acknowledgement by the Kent and Medway team in the meeting with Senate Chair and Head of Senate and at the Stage 2 meeting of the critical importance of the workforce and a recognition that current proposals need strengthening.

Currently there is insufficient data provided on staffing establishments now and in the future with current establishment numbers appearing low. The staffing tables provided in the PCBC detail the nursing workforce only with limited details being provided in the narrative regarding psychiatrists and Approved Mental Health Professionals (AMHPs). The absence of robust arrangements for dedicated s136 and HBPoS medical cover is a

concern; ambulance colleagues note medical clearance is often a key component and delaying factor when s136 patients are received.

Proposals show a reduction in the nursing staff required and there is an assumption there will be no staffing issues in the new service. However, it is not evident in the current narrative if the present workforce establishment is fully recruited to or supplemented with agency. In addition, it is unclear if projected future whole time equivalent numbers include capacity for annual leave and training.

R8. Detail on current and proposed workforce models for all staff groups in future documents is required in order to fully assess the safety and effectiveness of the proposed model.

6.2 Training and development

The panel note the theoretical benefits with a one site model and the hope that centralisation will facilitate teaching and learning, however the skills and competencies required for meeting the physical health needs of patients in the centralised HBPoS have not been fully explored. Significant emphasis is placed on both prevention of mental health crisis, training first responders to both reduce requirements for transfer to HBPoS and to know when and where to signpost people to alternatives. The SLaM evaluation[15] is encouraging, suggesting staff have increased confidence in managing physical health issues and there is a better culture of recognising this as their 'business as usual' activity. As the unit will be co-located on the current Maidstone Hospital site presumably this support will be available, how this may affect demand on acute physical care at Maidstone needs to be articulated in the proposals.

R9. Meeting staff skills and physical health competencies require further consideration and greater articulation in the PCBC.

7. Travel and Transport

As a point of accuracy reference is made in the documentation to Kent Ambulance however, since reconfiguration in 2012 Kent Ambulance no longer exists and therefore these proposals will have implications for the entire SECAmb area (Kent, Surrey, Sussex). In relation to SECAmb it should be understood that the ambulance service do not have local control rooms in the same way as the police do therefore any ambulance reporting availability for further calls may be allocated to respond to a case outside their normal operating areas. This requirement to travel further when transferring patients following

[15] SLaM-Centralised-Health-Based-Place-of-Safety-Evaluation-Nov-2017.pdf (transformationpartnersinhealthandcare.nhs.uk)

application of section 136 powers and removal of ambulances from their planned operating area potentially depletes cover and threatens response times. The response time target nationally for Category 2 is a mean of 18 minutes and within 40 minutes in 90% of cases for conditions such as chest pain and breathlessness. The panel acknowledge the small numbers of patients requiring section 136 conveyance however having crews needing to travel further has the potential to impact on patient outcomes in the community. Congestion on the M20 is a concern and may prolong transfer times. It needs to be clear that the new arrangements will result in decreased off-load and handover times thus freeing SECAmb resources for waiting calls.

The PCBC states an average of 75% of people are discharged from a HBPoS and conveyed home by patient transport. The description of the patient transport for those taken to the centralised HBPoS and subsequently discharged is unclear. Plans for what happens should patient repatriation transport not be operating or be at capacity have not been articulated.

R10. The senate panel recommends consideration of the commissioning arrangements that are or will be in place with SECAmb to transport patients to Maidstone rather than the closest emergency department that includes the exploration of a commissioned service for HBPoS conveyances that negates the need for a frontline ambulance.

~~R11.~~ The Clinical advice service for Kent Police is to be applauded and consideration should be given to extending this service to include SECAmb, recognising a paramedic cannot use a section 136 and the helpline would need to be expanded beyond its current configuration.

R12. Clear articulation in the PCBC of how increased transfer times for SECAmb may be mitigated is required. For example, how the centralisation of the HBPoS will result in decreased handover times.

R13. The challenges of repatriating patients after discharge from the centralised HBPoS need to be acknowledged and mitigation plans require describing in the business case.

8. Engagement

In meetings that have occurred post submission of the documentation the Senate Chair and Head of Senate have heard about the extensive consultation and engagement that has been carried out. Unfortunately, the evidence presented in the documentation provided for the review does not reflect this. The recommendations below are in response to the submitted documentation, and it is hoped together with the work the Kent and Medway team have subsequently carried out further iterations of the proposals will be refined and improved.

8.1 Clinical engagement

The clinical engagement documented in the PCBC and associated appendices while encompassing a range of staff groups and grades is limited and the senate panel are unclear with regards to the clinical opinion in the region. The one reported staff meeting documents staff security concerns and the improvement the centralisation will make to these and the risk of the HBPoS being used for seclusion space for the main unit. The impact of the proposed change on staff has been partially addressed and is largely documented as positive with the exception of increased travel times for some staff. No evidence has been provided that existing staff would be prepared to commute further. Nevertheless, the impact on staff is broader than only travel requirements and is in need of further exploration.

The Senate panel particularly request inclusion in the business case of evidence to demonstrate engagement with and the support of ambulance services and emergency departments and have the following questions.

1. Are all acute services Chief Executive Officers aware of and in support of the proposals?
2. Have all impacted emergency departments in the region been engaged with and included in consultation plans?
3. Has SECAmb been engaged with and included in consultation plans?

R14. Impacts of the proposed change on staff require further exploration and evidence in the PCBC.

R15. Further engagement with key stakeholders such as SECAmb and emergency departments is strongly recommended. Letters of support from SECAmb and impacted urgent and emergency care services in the region would undoubtedly strengthen the business case.

R16. Inclusion in business case proposals of the verbalised engagement that has taken place.

R17. The opportunity should be taken to build on the consultation feedback received from staff, service users and their families to ensure a level of co-creation and true engagement in developing the service to be the best it can be.

8.2 Patient and public engagement

The consultation paper posted on the ICB website is of good quality with clear explanation of the changes proposed, and clear diagrams, maps and photographs used to support the descriptions. However, review panel comments mainly related to patient and public engagement not being sufficiently addressed in the co-creation and co-design of the proposals. The data presented appeared related to engagement work undertaken for another purpose over the last few years. While consideration was given to some areas, for example a clear plan of engagement during consultation and the commitment to providing information in different languages, details or data to support described activities was inconsistent and limited. The senate review panel wish to signpost the Kent and Medway team to a study published in 2019[16] which provides rich insights into service user experience of being detained under s136 in Sussex.

It is acknowledged that engagement plans had not yet been enacted fully and will form part of the public consultation. The Head of Senate heard at the stage 2 meeting of the extensive engagement carried out as part of the public consultation with roughly 700 people being made aware of the proposal. The engagement described inclusion of those seldom heard; visiting safe havens and having supported conversations with service users; working with MIND mental health charity and their 'speak up' and 'better mental health' programmes; online surveys; targeted engagement with those who have complex emotional disorders; engagement with Black and minority ethnic communities; those with drug and alcohol problems; those with neurodiversity; the homeless and people living in areas of deprivation. All of the above are to be applauded and should now be included in the business case.

R18. The business case needs to include descriptions, data and documented feedback from the extensive engagement work verbalised.

R19. The voice of carers and families need to be well documented in the proposals.

[16] Bendelow, G Warrington, C, Jones A and Markham, S (2019) Police Detentions of 'mentally disordered persons': A multi-method investigation of section 136 use in Sussex. *Medicine, Science and the Law* 59(2) 95-103

9. Population health / health Inequalities

Service re-design gives an opportunity and carries a responsibility to think broadly and inclusively. The PCBC describes a clear understanding of the population demographics, health challenges and deprivation, however the calculation for the potential change in individuals requiring section136 is a little simplistic as it uses a whole population growth assumption (although may still be valid for this purpose) rather than the age profiled population that currently uses the service.

The current Equality Impact Assessment (EQIA) states all changes as positive. A greater understanding of the demographics of the current service users would enhance the proposals. Currently it is broken down by sex, with a higher number of female service users but no mention of this in the narrative. Studies suggest the higher number of women detained under s136 powers may be the result of unresolved trauma.[17] It would be beneficial if the number of service users could be broken down further by age and ethnicity so this more detailed insight may be incorporated into the EQIA and design and of the new service. It is surprising that ethnicity was not mentioned in the EQIA.

It is hard to deduce the impact of travel times from table 2 in the PCBC because it does not state the location of the traveller, in order that this can be related to a specific location that potentially may be worse off. This is then further explored in tables 13, 14, 15, 16 and 17 and the summary tables 18 and 19 having the important location missing to identify the two to three areas that will have increased travel times. Patient transport offers a mitigation for increased travel times; transparency would be increased if the specific locations negatively impacted around travel times were made explicit. The Head of Senate heard at the stage 2 meeting that the missing location details were a transcription error and will be corrected in future publications.

The PCBC section 9.2.2. states, ‘There will be minimal impact on the wider society and health inequalities due to the small cohort of patients that access the HBPoS within the Kent and Medway area’. The Kent and Medway team may wish to change this statement after consideration of the panel’s public health representative who suggested that there is a small positive impact on health inequalities as people needing access to a S136 are often likely to be experiencing wider health issues/inequalities so improving the service will have a positive impact on this specific population.

[17] Warrington C (2019) Repeated Police Mental Health Act Detentions in England and Wales: Trauma and Recurrent Suicidality Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6926771/
Bendelow, G Warrington, C, Jones A and Markham, S (2019) Police Detentions of 'mentally disordered persons': A multi-method investigation of section 136 use in Sussex. *Medicine, Science and the Law* 59(2) 95-103

R20. The current EQIA is limited and would benefit from further development. It does not include details normally seen for such a business case. There is evidence of data for some of the protected characteristics such as age and gender that could be included. The Senate panel recommend the current EQIA is updated and expanded.

R21. More detailed analysis of s136 detentions, such as the higher incidence of women detained, is recommended as it may have subsequent service planning implications.

R22. NHS England 2023/4 priorities and operational planning guidance[18] has prevention and health inequalities as a key objective. The Core20PLUS5 approach to tackling healthcare inequalities lists mental health as one of its 5 targeted areas. Some of the areas impacted by the proposals are the most deprived in Kent.[19] The Core20PLUS5 approach enables the biggest impact on avoidable mortality in the most deprived populations and contributes to an overall narrowing of the health inequalities gap. It would be helpful to be able to see how the Kent and Medway's understanding of its Core20PLUS population feeds into the centralisation of HBPoS proposals.

10. Sustainability

Due to the timeframe of the review feedback was not specifically sought from the panel on sustainability. However, the NHS has identified reducing its carbon footprint and healthcare sustainability as a key priority[20]. The impact on the environment is briefly mentioned in the PCBC; the opportunity to demonstrate how the centralisation of HBPoS will address healthcare sustainability should not be missed. For further information

[18] https://www.england.nhs.uk/wp-content/uploads/2022/12/PRN00021-23-24-priorities-and-operational-planning-guidance-v1.1.pdf
[19] The Index of Multiple deprivation (IMD2019): Headline findings for Kent
[20] NHS England. (2019) The NHS Long Term Plan. Available online from https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf
NHS England. (2022) 2022/23 priorities and operational planning guidance. Available online from https://www.england.nhs.uk/wp-content/uploads/2022/02/20211223-B1160-2022-23-priorities-and-operational-planning-guidance-v3.2.pdf
NHS England. (2023) 2023/24 priorities and operational planning guidance. Available online from https://www.england.nhs.uk/wp-content/uploads/2022/12/PRN00021-23-24-priorities-and-operational-planning-guidance-v1.1.pdf
NHS England. (2022) NHS Standard Contract 2023/24. Service Conditions. Available from https://www.england.nhs.uk/wp-content/uploads/2022/12/03-nhssc-service-conditions-full-length-2324.pdf
UK Public General Acts. (2022) Health and Care Act 2022. Available online from https://www.legislation.gov.uk/ukpga/2022/31/contents/enacted

regarding sustainable healthcare we recommend the South East Clinical Senate report ‘Embedding healthcare sustainability in major service change’ (supplied by the Senate team to Kent and Medway ICB at time of issuing this report); information from the Centre for Sustainable Healthcare and the Greener NHS programme.

R23. To demonstrate how the centralisation proposals will address healthcare sustainability and involve the ICB Greener NHS team in assessment of the proposals.

11. Conclusion

There has been considerable work undertaken in constructing the draft PCBC. Further iterations of the business case for the centralisation of HBPoS in Kent and Medway would benefit from a reduction in repetition of the narrative and a clear focus on the clinical case for change, which is compelling. The clinical senate panel have made a number of recommendations and identified three key areas for further action to assist in refining and improving the current proposals. Clinical evidence is provided in the narrative with regards to the proposals however this could be strengthened through consideration of the southwest and Sussex centralisations and consideration of the published research on s136 detentions and HBPoS. There are several areas, particularly in relation to the inpatient capacity, patient flows and the EQIA where further analysis and application of data is required. A safe and consistent staffing model is an area of challenge across the NHS; the workforce model in this proposal predominantly details the nursing staff, thus further development and consideration of the workforce in its entirety is now required. For patients to receive the best possible treatment when detained under s136 powers conveyance to a designated HBPoS (that is not the emergency department) for assessment and appropriate clinical care is crucial. The Senate panel acknowledge that this is the aim of the Kent and Medway proposals however to meet this critical aspect of the pathway further engagement with the emergency services involved is strongly recommended.

Clinical senate recommendations are not mandatory but reflect the considered opinion of a group of independently acting clinicians and others after reviewing the material shared with them within the timescales required. It is hoped that the range of recommendations in this report will help to ensure that the proposals going forwards are clear, supported by the evidence provided, address quality and safety requirements, and are shown to improve the quality of care for patients requiring HBPoS in Kent and Medway.

The unusual nature of this review has been highlighted in this report. This review was a retrospective review of the final PCBC and unusually the Stage 2 meeting occurred prior to the findings and recommendations of the Clinical Senate panel being shared with the programme team. The Kent and Medway team have therefore requested that this report be read in conjunction with their responses to the points raised following the Stage 2 assurance meeting.

Appendix A – Recommendations

Number Ref.	Recommendations
Clinical Case for Change	
R1.	The clinical case for change is compelling; the Kent and Medway ICB proposal would benefit from a greater emphasis on the clinical case in the business case.
Centralisation of HBPoS	
R2.	Inclusion of data in answer to the questions posed above to further strengthen the case is recommended.
R3.	The SLaM evaluation suggests the potential for clinical benefit of a single site,[21] albeit in a smaller geographical area with better road transport compared to Kent and Medway. The Senate panel recommend incorporating clinical evidence from comparable geographies such as the southwest centralisation.[22] Conversations with in-region colleagues with regards to the Surrey centralisation may also yield further insight (introductions can be made via the Senate management team if desired).
Inpatient capacity and patient pathways	
R4.	Consideration of the risks posed and the operational leadership required when there is lack of inpatient capacity need to be explored and clearly articulated in the future business case**.**
R5.	The Senate panel recommend the consideration of the Kent and Medway ICB bed commissioning policy relating to sec 140 MHA to the proposals.
R6.	Clarity on location of inpatient admissions from the proposed centralised unit and exploration of the wider impacts on service users and their families of admission further from home is necessary.

[21] SLaM-Centralised-Health-Based-Place-of-Safety-Evaluation-Nov-2017.pdf (transformationpartnersinhealthandcare.nhs.uk)

[22] Places_of_safety_Evaluation_Report_September_2019.pdf (wiltshire.gov.uk)

Community services and prevention	
R7.	Further articulation in subsequent business cases regarding the preventative offer and its effects on the s136 pathway.
Workforce	
Workforce planning	
R8.	Detail on current and proposed workforce models for all staff groups in future documents is required in order to fully assess the safety and effectiveness of the proposed model.
Training and development	
R9.	Meeting staff skills and physical health competencies require further consideration and greater articulation in the PCBC.
Travel and transport	
R10.	The senate panel recommends consideration of the commissioning arrangements that are or will be in place with SECAmb to transport patients to Maidstone rather than the closest emergency department that includes the exploration of a commissioned service for HBPoS conveyances that negates the need for a frontline ambulance.
R11.	The Clinical advice service for Kent Police is to be applauded and this service should be extended to include SECAmb if it doesn't already do so.
R12.	Clear articulation in the PCBC of how increased transfer times for SECAmb may be mitigated is required. For example, how the centralisation of the HBPoS will result in decreased handover times.
R13.	The challenges of repatriating patients after discharge from the centralised HBPoS need to be acknowledged and mitigation plans require describing in the business case.

Engagement	
Clinical engagement	
R14.	Impacts of the proposed change on staff require further exploration and evidence in the PCBC.
R15.	Further engagement with key stakeholders such as SECAmb and emergency departments is strongly recommended. Letters of support from SECAmb and impacted urgent and emergency care services in the region would undoubtedly strengthen the business case.
R16.	Inclusion in business case proposals of the verbalised engagement that has taken place.
R17.	The opportunity should be taken to build on the consultation feedback received from staff, service users and their families to ensure a level of co-creation and true engagement in developing the service to be the best it can be.
Patient and public engagement	
R18.	The business case needs to include descriptions, data and documented feedback from the extensive engagement work verbalised.
R19.	The voice of carers and families need to be well documented in the proposals.
Population health and inequalities	
R20.	The current EQIA is limited and would benefit from further development. It does not include details normally seen for such a business case. There is evidence of data for some of the protected characteristics such as age and gender that could be included. The Senate panel recommend the current EQIA is updated and expanded.

R21.	More detailed analysis of s136 detentions, such as the higher incidence of women detained, is recommended as it may have subsequent service planning implications.
R22.	NHS England 2023/4 priorities and operational planning guidance[23] has prevention and health inequalities as a key objective. The Core20PLUS5 approach to tackling healthcare inequalities lists mental health as one of its 5 targeted areas. Some of the areas impacted by the proposals are the most deprived in Kent.[24] The Core20PLUS5 approach enables the biggest impact on avoidable mortality in the most deprived populations and contributes to an overall narrowing of the health inequalities gap. It would be helpful to be able to see how the Kent and Medway's understanding of its Core20PLUS population feeds into the centralisation of HBPoS proposals.
Sustainability	
R23.	To demonstrate how the centralisation proposals will address healthcare sustainability and involve the ICB Greener NHS team in assessment of the proposals.

[23] https://www.england.nhs.uk/wp-content/uploads/2022/12/PRN00021-23-24-priorities-and-operational-planning-guidance-v1.1.pdf
[24] The Index of Multiple deprivation (IMD2019): Headline findings for Kent

Appendix B - Key Lines of Enquiry (KLOEs)

Clinical Senate Desktop Review of Kent and Medway S136
General
Is the case for change clear from a clinical perspective?
Is the clinical evidence set out in the PCBC for the proposed option clear?
Has the sponsoring organisation described what the service looks like in each geographical area in Kent and Medway and how it will change under the new arrangements?
Clinical Model
Does the proposed option provide safe, effective, clinically appropriate care which provides opportunities for the best possible clinical outcomes?
Will there be any adverse impact on mental health inpatient capacity following centralisation of HBPoS? If so, are the mitigations described?
Is there any further clinical evidence that NHSE should consider in making a final decision on the options?
Will there be any impact on flows of activity (both into and out of Kent and Medway)?
Workforce
Have the workforce impacts been clearly described including staffing establishments, staff re-location, staff retention and recruitment and staff education and continuing professional development opportunities?
Will the HBPoS staff have the requisite physical health competencies to ensure physical health needs are addressed?
Engagement
Has the sponsoring organisation taken reasonable steps to assure themselves and key stakeholders, including the patients and public, that these changes are beneficial for future care provision?
What has been the breadth and depth of clinical engagement?
What has the engagement been with patient and public involvement (families using the services) in coming to the options being proposed?
How has the engagement to date sought to be inclusive of seldom heard, minority and deprived population groups?
Health Inequalities
Has sufficient mitigation to possible health impacts, particularly travel times and use of alternative HBPoS that might otherwise increase inequities been made?
Has the effect on services that support HBPoS been considered and where necessary mitigations been described?

Appendix C – Glossary

Term	Explanation
A&E	Accident and emergency unit, sometimes referred to as emergency department.
Acute	Services which treat patients (usually in hospital as in-patients) for a certain condition for a short period of time.
AMHP	Approved Mental Health Professional
Approved Mental Health Professionals (AMHPs)	Someone who has had specific training in the legal aspects of mental health assessment and treatment. AMPHs are approved by their local authority social services department to organise and carry out assessments under the Mental Health Act 1983 (MHA).
Community Mental Health Framework Transformation (CMHF)	This Framework provides an historic opportunity to address this gap and achieve radical change in the design of community mental health care by moving away from siloed, hard-to-reach services towards joined-up care and whole population approaches and establishing a revitalised purpose and identity for community mental health services. It supports the development of Primary Care Networks, Integrated Care Systems (ICSs) and personalised care, including how these developments will help to improve care for people with severe mental illnesses.
CRHT	Crisis Resolution and Home Treatment Team
Crisis House(s)	Delivered by VCSE organisations, crisis houses are houses in the community that provide 24/7 overnight crisis support and intervention for up to seven days as an alternative to going into hospital.
Crisis Resolution and Home Treatment Teams (CRHT)	The CRHT is a team of experienced mental health staff which includes nursing, psychology, social care, pharmacy and psychiatric staff. If someone is experiencing a mental health crisis, they can provide urgent assessment and home treatment in a person's own home as an alternative to inpatient admission.
Enhanced Home Treatment Team	A revised model of home treatment whereby the team will solely deliver home treatment as opposed to both urgent assessment and home treatment.
HBPoS	Health-based place of safety

Term	Explanation
Health and care system	A system 'consisting of all organizations, people and actions whose primary intent is to promote, restore or maintain health'. This includes efforts to influence wider determinants of health, as well as more direct health-improving activities. A health system is therefore more than the pyramid of publicly-owned facilities that deliver personal health services. (WHO 2007)
Health-based places of safety (HBPOS)	An assessment unit where people are brought in, detained under the Mental Health Act for an assessment. People are brought in under either Section 135(1) or Section 136.
ICB	Integrated Care Board
Inpatient	A patient who has been admitted to hospital for treatment and is occupying a hospital bed.
Integrated Care Board	An integrated care board has the function of arranging for the provision of services for the purpose of the health service in England.
Intervention	An action taken to improve a medical disorder
Kent and Medway Health and Social Care Partnership Trust	Provides secondary mental health services across Kent and Medway, both in the community and within inpatient settings.
KMPT	Kent and Medway Health and Social Care Partnership Trust
Lived-experience experts	People with people who have lived experience of mental ill health
Mental Health Act 1983	This act is the law in England and Wales that covers the assessment, care and treatment of people with a mental disorder and the rights of the person and their family.
Mental Health Act assessment	A Mental Health Act Assessment is an assessment to decide whether you should be detained in hospital under the Mental Health Act to make sure you receive care and medical treatment for a mental disorder. Mental Health Act Assessments are usually carried out by: - an approved mental health professional (AMHP) - a doctor who's had special training (known as a section 12 approved doctor) - a registered medical practitioner (another doctor)
Mental health ambulance	A vehicle equipped with clinical staff who are able to respond to a person in mental health crisis on scene.
MHA assessments	Mental Health Act assessment

Term	Explanation
Model of care	Broadly defines the way health services are delivered. It outlines best practice care and services for a person, population group or patient cohort as they progress through the stages of a condition, injury or event.
NHS 111	NHS 111 helps people get the right advice and treatment when they urgently need it, be that for their physical or mental health, 24 hours a day, seven days a week. To get help from NHS 111, you can: • Go online to nhs.uk (for assessment of people aged five and over only). • Call 111 for free from a landline or mobile phone.
NHS Kent and Medway	NHS Kent and Medway is the NHS organisation that plans and buys healthcare services to meet the needs of people living in Kent and Medway.
NHS Kent and Medway Integrated Care Board (ICB)	NHS Kent and Medway Integrated Care Board is known as NHS Kent and Medway. It is the NHS organisation that plans and buys healthcare services to meet the needs of people living in Kent and Medway.
Pathway	The route or path a patient takes for treatment. A pathway gives an outline of what is likely to happen on the patient's journey and can be used both for patient information and for planning services.
Rapid Response Team	A team whose sole function is to respond to request for urgent mental health assessment.
Safe Haven	Safe Havens offer face-to-face mental health support. Canterbury, Maidstone, Medway and Thanet Safe Havens, run by Mental Health Matters, are available 6pm to 11pm, 365 days a year, for people aged 16 plus. No appointment or referral is needed. Anyone who lives in Kent or Medway can use the service, regardless of where you live. The Folkestone and Hythe Safe Haven, run by Hestia, offers an open access walk-in service for residents of Folkestone and Hythe, aged 16 plus, and is open from 6pm to 11pm weekdays and 12noon to 11pm weekends and Bank Holidays, 365 days a year.
SECAmb	South East Coast Ambulance Service NHS Foundation Trust

Term	Explanation
Seclusion	Seclusion refers to the supervised confinement and isolation of a patient, away from other patients, in an area from which the patient is prevented from leaving, where it is of immediate necessity for the purpose of the containment of severe behavioural disturbance which is likely to cause harm to others (Mental Health Act 1983 Code of Practice 2015, 26.103)
Secondary care	Patients whose needs are too complex to be managed in primary care are referred to more specialist services. Secondary care includes local hospitals and treatment given away from the hospital setting, such as mental health services, learning disability services and help for older people.
Section 135	Section 135 of the Mental Health Act requires a magistrate to issue a warrant allowing a police officer to enter premises to remove a mentally disordered person to a place of safety or allows an assessment to take place in the premises/home under certain circumstances.
Section 136	Section 136 of the Mental Health Act allows a police officer to detain a person who appears to be suffering from a mental disorder from anywhere, apart from their private dwelling and bring them to a HBPoS for a mental health assessment. The person will be deemed by the police to be in immediate need of care and control as their behaviour is of concern. It is important to point out that a person is not under arrest when the decision is made to remove the person to a place of safety. The police power is to facilitate assessment of their health and wellbeing as well as the safety of other people around them.
South East Coast Ambulance Service (SECAmb) NHS Foundation Trust	SECAmb is part of the National Health Service (NHS). We respond to 999 calls from the public, urgent calls from healthcare professionals and provide NHS 111 services across the region. As part of the NHS we are regulated by the Care Quality Commission (CQC).
VCSE	Voluntary, community and social enterprise

Term	Explanation
Voluntary, community and social enterprise (VCSE)	An incorporated voluntary, community or social enterprise organisation which serves communities solely within England and which is either a charity, community interest company or community benefit society, registered with the relevant registry body or an unregulated organisation which has a clear social mission; recognised charitable purpose and offers its products and services for general public benefit without restrictions and barriers, such as affordability.

Appendix D - Documentation provided by the Kent and Medway Team

Document Number	Document Name
1	Centralisation of Section 136 Health Based Places of Safety (HBPoS) in Kent and Medway. Pre-Consultation Business Case
Appendix 1	Kent Police S 136 Data
Appendix 2	KMPT Section 136 Demand and Capacity Data
Appendix 3	Community Mental Health Framework
Appendix 4	Short list cost feasibility report
Appendix 5	Preferred option full cost feasibility report
Appendix 6	HBPoS Engagement and Communication Log
Appendix 7	Staff engagement meeting 11.01.23
Appendix 8	Review of Insights and feedback on mental health
Appendix 9	Consultation plan
Appendix 10	HBPoS Proposed Programme
Additional documents	
1	EQIA HBPoS 2022-2023
2	Kent and Medway Crisis Care. Section 136 Pathway Standards and Health Based Place of Safety Specification
3	KMPT health based places of safety consultation document
4	SLaM Centralised Health based places of Safety Evaluation Nov 2017
5	A multi method investigation of S136 use in Sussex*

* Document provided by South East Clinical Senate to review panel members.

Appendix E - South East Clinical Senate Review Group membership and declarations of interest

1. Review Group Membership

Name	Roles
Paul Stevens	Clinical Senate Chair
Michael Baker	Deputy Director of Healthcare, NHS England, South East
Timothy Edwards	Consultant Paramedic, London Ambulance Service
Tracey Faraday-Drake	Director for children and young people, all age LD and autism, Frimley Integrated Care Board
Rebecca Foxhall	Clinical Director/clinical lead for liaison psychiatry services, Nottinghamshire Healthcare NHS Foundation Trust
Des Holden	Chief Executive, Kent Surrey Sussex Academic Health Science Network
Gill Manning	Patient and Public Partner
Sarah Markham	Patient and Public Partner
Rachel Oaten	Medical Director, South East Coast Ambulance Service
Patience OKorie	Clinical Director Children and Maternity Services, NHS Sussex
Sarah Rafferty	Deputy Dean for Secondary Care, Health Education England, Kent Surrey Sussex
George Theodoulou	Consultant Psychiatrist, Oxford Health NHS Foundation Trust
Frances Verey	Emergency medicine, North Bristol NHS Trust
Senate Management Team	
Emily Steward	Head of South East Clinical Senate
Helen Bell	Programme Manager South East Clinical Senate

2. Declarations of Interest

Name	Personal pecuniary interest	Indirect pecuniary interest	Personal family interest	Non-personal pecuniary interest	Personal non-pecuniary interest
Paul Stevens	None	None	None	None	None
Michael Baker	None	None	None	None	None
Timothy Edwards	None	None	None	None	None
Tracey Faraday-Drake	None	None	None	None	None
Rebecca Foxhall	None	None	None	None	None
Des Holden	None	None	None	None	None
Gill Manning	None	None	None	None	None
Sarah Markham	None	None	None	None	None
Rachel Oaten	None	None	None	None	None
Patience OKorie	None	None	None	None	None
Sarah Rafferty	None	None	None	None	None
George Theodoulou	None	None	None	None	None
Frances Verey	None	None	None	None	None
Senate Management Team					
Emily Steward	None	None	None	None	None
Helen Bell	None	None	None	None	None