Welcome

Implementing the Crisis Concordat in Yorkshire and the Humber

Collaborating to Improve Services

09:45 – 16:00
Thursday 17th July 2014
Patient Experience Story

On the Edge Video

We are currently waiting for confirmation of consent to share this video. Once received a link will be circulated to delegates.
Welcome and Introductions

Dr David Black
Medical Director
NHS England South Yorkshire and Bassetlaw Area Team
Yorkshire and the Humber
MENTAL HEALTH CRISIS
CONCORDAT – REGIONAL EVENT
17TH JULY 2014

Dr David Black
Medical Director
South Yorkshire & Bassetlaw
Area Team & host Area Team for SCN/SCNs/Senate
Housekeeping/Arrangements

• No Fire Alarms tests expected – if alarm activates please leave as indicated
• Please set mobile phones/tablets to Silent
• Toilets are as shown
• Full agenda- opportunity for plenary Q&A at the end of the morning session
• Table work in the afternoon – opportunity for discussion
• Please complete your evaluation forms at the end
• All slides will be emailed out to delegates
A Personal Perspective

- My experience working in the UK and overseas
  - New Zealand
  - UK mental health services
  - Public health and mental health

- Personal experience of mental illness

- What does it mean to me?
WHY ARE WE HERE TODAY?

Patient suicide: the impact of service changes:

“National confidential inquiry into suicide and homicide by people with mental illness” : November 2013

The five service changes associated with the biggest fall in suicide rates in implementing relative to non-implementing trusts are:

• crisis resolution/home treatment or
• assertive outreach teams
• information sharing with criminal justice agencies
• removal of low lying ligature points, and
• policy for dual diagnosis patients.
By March 2015, we expect measurable progress towards achieving true parity of esteem, where everyone who needs it has timely access to evidence-based services.

‘We expect every community to have plans to ensure no one in crisis will be turned away, based on the principles set out in the ……… Mental Health Crisis Care Concordat.’
Why does the NHS need to value mental health because mental ill health it is very common & it impacts on all outcomes

<table>
<thead>
<tr>
<th>How common is mental ill health</th>
<th>Common Conditions</th>
<th>Outcome impact</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary care:</strong></td>
<td>Depression &amp; anxiety&lt;br&gt;Substance misuse&lt;br&gt;Children’s conditions&lt;br&gt;Psychosis</td>
<td>Premature mortality: 15-25 years&lt;br&gt;Quality of life in LTCs&lt;br&gt;Recovery from illness&lt;br&gt;Patient safety</td>
</tr>
<tr>
<td>30-50% of daily workload</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Acute care</strong></td>
<td>Alcohol &amp; drugs&lt;br&gt;Depression &amp; self harm&lt;br&gt;Dementia&lt;br&gt;Psychosis relapse</td>
<td>Premature mortality&lt;br&gt;Quality of life for LTCs&lt;br&gt;Recovery from illness&lt;br&gt;Patient safety&lt;br&gt;Patient experience</td>
</tr>
<tr>
<td>40% of A&amp;E in London&lt;br&gt;40% acute beds in London&lt;br&gt;50% acute outpatient clinics</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Prisons &amp; offenders</strong></td>
<td>ADHD, ASD&lt;br&gt;Depression&lt;br&gt;Substance misuse&lt;br&gt;PD</td>
<td>Premature mortality</td>
</tr>
<tr>
<td><strong>Specialist mental health services</strong></td>
<td>Psychosis&lt;br&gt;Neurodevelopmental&lt;br&gt;Substance misuse&lt;br&gt;Personality disorders&lt;br&gt;Complex multi axial</td>
<td>Premature mortality: 15-25 years&lt;br&gt;Quality of life&lt;br&gt;Recovery from illness&lt;br&gt;Patient safety</td>
</tr>
</tbody>
</table>
### Mental Illness in Yorkshire & Humber 2012/13

*Source: PHE*

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Yorkshire &amp; Humber</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>% reporting long term mental health problems (GP Survey)</td>
<td>4.8%</td>
<td>4.5%</td>
</tr>
<tr>
<td>% Depression (QOF prevalence 18+)</td>
<td>6.2%</td>
<td>5.8%</td>
</tr>
<tr>
<td>% Severe Mental Illness (QOF prevalence all ages)</td>
<td>0.8%</td>
<td>0.8%</td>
</tr>
<tr>
<td>People entering IAPT services per 100,000 pop.</td>
<td>1,207</td>
<td>1,436</td>
</tr>
<tr>
<td>Attendance at A&amp;E for psychiatric illness/100,000 pop.</td>
<td>369.6</td>
<td>243.5</td>
</tr>
<tr>
<td>Suicide rate/100,000 pop.</td>
<td>8.4</td>
<td>8.5</td>
</tr>
</tbody>
</table>
What will you hear and learn today:

- Service users – what is important for them?
- A national perspective on the MH Crisis Concordat
- What is going on within the Y&H Region- how you can get involved
- Share best practice: “what good looks like”
- A Multi–agency approach to managing crisis care
- Commissioning crisis care
- Networking and find out what tools are available
- Other opportunities for learning more (further workshops etc)
Contact Details

Dr David Black
Medical Director
South Yorkshire & Bassetlaw Area Team

David.black4@nhs.net
Ministerial Engagement

Rt. Hon. Norman Lamb MP
Welcome Address from:
Norman Lamb MP, Minister of State for Care and Support

Ministerial Video

The full video is accessible via the following link (please copy and paste this into your internet browser):

http://www.youtube.com/watch?v=nTmsp25-YNo&feature=youtu.be
Setting the Scene

Guy Cross
Mental health and Disability
Department of Health
The Mental Health Crisis Care Concordat

Guy Cross
Mental Health and Disability
Department of Health

Crisis Care Concordat Event 17 July 2014
Closing the Gap: Priorities for essential change in mental health sets out our immediate ambitions for mental health.
The **Mental Health Crisis Care Concordat** is a shared agreement made by over 20 national organisations about how we respond to people in mental health crisis.
Signatory organisations

- Department of Health
- Home Office
- NHS England
- NHS Confederation Mental Health Network
- Mind
- Association of Ambulance Chief Executives
- Association of Chief Police Officers
- Local Government Association and ADASS
- Royal College of Psychiatrists
“We commit to work together to improve the system of care and support so people in crisis because of a mental health condition are kept safe and helped to find the support they need – whatever the circumstances in which they first need help - and from whichever service they turn to first.”
The Concordat is about joining up service responses to people who are suffering from mental health crisis.

In 2012-13 police made nearly 22,000 detentions under section 136 of the Mental Health Act.

Two thirds (14053) of these people were taken to hospital for a psychiatric assessment.

But a third of these people (7,761) were taken to police cells, often because the NHS could not respond quickly enough. Even allowing for pressures on NHS resources – we must all accept that this proportion is too high.
We have work under way

• The **Department of Health** and **Mind** are working on local implementation, the website and brand identity

• **NHS England** are taking forward their commitments as part of their Parity of Esteem programme, and are developing a Crisis Care Delivery Framework

• **Association of Ambulance Chief Executives** - have introduced a protocol for ambulance responses

• **CQC** – have surveyed and mapped health based places of safety
Making the Concordat a local reality
Thank you

contact@crisiscareconcordat.org.uk
www.crisiscareconcordat.org.uk
The Mental Health Crisis Care Concordat
Tools and Resources

Jim Symington and Naomi Phillips
Crisis Care Concordat Implementation Team
Improving outcomes for people experiencing mental health crisis in England

Yorkshire and Humberside

17th July 2014
‘Listening to experience. An independent inquiry into acute and crisis mental healthcare’, Mind 2011

“It feels like I literally have to have one foot off the bridge before I can access services.”
‘We commit to work together to improve the system of care and support so people in crisis because of a mental health condition are kept safe and helped to find the support they need…

‘We will work together, and with local organisations…

‘Jointly, we hold ourselves accountable…’
National context: evidence and policy
Growing evidence

- Mind’s *Listening to Experience* report
- HMIC/CQC *A Criminal Use of Police Cells?* report
- CQC survey on the use of s136 and map of health-based places of safety
- Mental health bed shortages and people shipped around country or held under Section
The five service changes associated with the biggest fall in suicide rates in implementing relative to non-implementing trusts are:

- crisis resolution/home treatment or
- assertive outreach teams
- information sharing with criminal justice agencies
- removal of low lying ligature points, and
- policy for dual diagnosis patients.
Year 1 priority:

‘...themed work on the experience and outcomes for people experiencing a mental health crisis.’
‘We are clear that we expect parity of esteem between mental and physical health services...

‘We are committed to achieving change by putting more power into people’s hands at a local level.’

No health without mental health. A cross-government mental health outcomes strategy for people of all ages. HM Government, 2011
‘By March 2015, we expect measurable progress towards achieving true parity of esteem, where everyone who needs it has timely access to evidence-based services.

‘We expect every community to have plans to ensure no one in crisis will be turned away, based on the principles set out in the soon to be published Mental Health Crisis Care Concordat.’
‘We are particularly conscious that any new system must be responsive to the needs of the most vulnerable people in society who rely on the urgent and emergency care system: people at the extremes of age, people with troublesome long-term health problems, people from deprived communities and people suffering mental health crises. ’
Making the Concordat a local reality
Local Crisis Care Declarations

- Concordat principles – partnership and co-production
- Essential signatories
- All age
- One vision and principles for ensuring an effective emergency mental health response system
- Action plan with timescales outlining operational protocols for working together
- Review progress and governance arrangements
What is a locality?

- Up to local crisis care partnerships to decide
- Perspective of a person experiencing a mental health crisis should be central. Unlikely to know which CCG or other boundary they fall in – just want to know they will get appropriate and quality help wherever they are
Local Declarations - who needs to be involved?

Many local organisations want to support the Declaration because of their commitment to improve mental health care and may want to make a specific contribution within the action plan for continuous improvements.

In addition, certain organisations have a formal (statutory) responsibility and/or a professional duty of care regarding people presenting in mental health crisis:

- Clinical Commissioning Groups
- NHS England Local Area teams (primary care commissioners)
- Commissioners of social services
- The Police Service
- Police and Crime Commissioners
- The Ambulance Service
- NHS providers of Urgent and Emergency Care (Emergency Departments within local hospitals)
- Public / independent providers of NHS funded mental health services
- Public / independent providers of substance misuse services
“What should I expect if I, or the people that depend on me, need help in a mental health crisis?”

- Access to support before crisis point
- Urgent and emergency access to crisis care
- Quality of treatment and care when in crisis
- Recovery and staying well / preventing future crises
Access to support before crisis point

• When I need urgent help to avert a crisis I, and people close to me, know who to contact 24/7.

• People take me seriously and trust my judgement when I say I am close to crisis, and I get fast access to people who help me get better.
Urgent and emergency access to crisis care

- If I am in mental health crisis this is treated as an emergency, with as much urgency as if it were a physical health problem. If I have to be taken somewhere, it is done safely and supportively in suitable transport.

- I am seen by a mental health professional quickly. If I have to wait, it is in a place where I feel safe. I then get the right service for my needs, quickly and easily.

- Every effort is made to understand and communicate with me. Staff check any relevant information that services have about me and, as far as possible, they follow my wishes and any plan that I have voluntarily agreed to.
Urgent and emergency access to crisis care (continued)

- I feel safe and am treated kindly, with respect, and in accordance with my legal rights.

- If I have to be held physically (restrained), this is done safely, supportively and lawfully, by people who understand I am ill and know what they are doing.

- Those closest to me are informed about my whereabouts and anyone at school, college or work who needs to know is told that I am ill. I am able to see or talk to friends, family or other people who are important to me if I so wish. I am confident that timely arrangements are made to look after any people or animals that depend on me.
Quality of treatment and care when in crisis

• I am treated with respect and care at all times.

• I get support and treatment from people who have the right skills and who focus on my recovery, in a setting which suits me and my needs. I see the same staff members as far as possible, and if I need another service this is arranged without unnecessary assessments. If I need longer term support this is arranged.

• I have support to speak for myself and make decisions about my treatment and care.
Quality of treatment and care when in crisis (continued)

• My rights are clearly explained to me and I am able to have an advocate or support from family and friends if I so wish. If I do not have capacity to make decisions about my treatment and care, any wishes or preferences I express will be respected and any advance statements or decisions that I have made are checked and respected. If my expressed wishes or previously agreed plan are not followed, the reasons for this are clearly explained to me.
Recovery and staying well

- I am given information about, and referrals to, services that will support my process of recovery and help me to stay well.

- I, and people close to me, have an opportunity to reflect on the crisis, and to find better ways to manage my mental health in the future, that take account of other support.

- I may need, around substance misuse or housing for example. I am supported to develop a plan for how I wish to be treated if I experience a crisis in the future and there is an agreed strategy for how this will be carried out.

- I am offered an opportunity to feed back to services my views on my crisis experience, to help improve services for myself and others.
Implications for health and social care commissioning: a pathway approach
Background to local declarations work – local data

- What does the joint strategic needs assessment tell you?
- S136 assessments, locations and outcomes
- Beds (e.g. acute, Child and Adolescent Mental Health Services (CAMHS), recovery, Psychiatric Intensive Care Unit (PICU, out of area)
- Non-medicalised settings (e.g. Crisis Resolution and Home Treatment Teams (CRHT), crisis house)
- Mental health presentations at A&E including frequent attenders?
- Crisis plans/Wellness Recovery Action Plans (WRAPs) /Rainy Day plans/Advance statements (% for those on Care Programme Approach
- User feedback
- Audit programme (e.g. CORE participation)
- Data gaps and data quality
NICE: Quality standard for service user experience in adult mental health. Quality Statement 6, access to services

- People in crisis referred to mental health secondary care services are seen within 4 hours;

- Service users have access to a local 24-hour helpline staffed by mental health and social care professionals;

- Crisis resolution and home treatment teams are accessible 24 hours a day, 7 days a week, regardless of diagnosis.
Law and existing Guidance

- Hospital, step-down and community services should be commissioned at a level that allows for beds to be readily available in response to a person in urgent need, as required by statute (s140 MHA)

- Police custody to be used only in ‘exceptional’ circumstances (s136)

- For people are already known to mental health services, crisis plan and any advance statements should be available and followed where possible (Care Programme Approach).
**Implications**

**An effective pathway to improve crisis care responses**

- **Support before crisis point**
  - Access to support before crisis point
    - Tele triage and tele health
    - Early Intervention Services
      - Suicide prevention
    - Personalised care budget
    - Helplines
      - Peer Support
      - Help at Home
    - Supported Housing
      - Adult placement

- **Urgent and emergency access to crisis care**
  - Urgent and emergency access to crisis care
    - 'Parity' between responses to physical or Mental Health emergencies
    - Single point of access to specialist mental health services 24/7
    - Crisis Home Treatment team
      - Crisis and respite house
    - Hospital Admission
      - See Effective Bed Management Pathway

- **Quality of treatment and care when in crisis**
  - Quality of treatment and care when in crisis
    - Physical assessment and treatment
      - Mental state assessment
    - Safe, competent treatment at home wherever possible
    - Timely ambulance transport to appropriate NHS Facility

- **Recovery and staying well / preventing future crises**
  - Recovery and staying well / preventing future crises
    - Crisis Plan
      - (NICE)
    - Self management and family involved crisis plan
    - All utilities working, food in house, debts and benefits sorted
    - Transition to GP led care (with 'fast track' access back)

- **Getting a life back**
  - Care and treatment (inc MHA, MCA, CPA)
  - Access to Liaison & Diversion from police custody or Court
  - Transition to GP led care
  - With 'fast track' access back

**Getting a life back**
Support to help local declarations and action plans
Co-ordination and support to the Concordat signatories

• Bi-annual meetings to track national signatories’ action plans and overall progress

• National annual conference to share good practice and problem solve

• Evaluate and report impacts of Concordat changes
Support to help local declarations and action plans

Supporting local developments

• Regional events to support development of local partnerships

• Website with good practice, useful contacts and templates

• Webinars and helpdesk

• Additional targeted support, for a fee

• Continuing role for national partners
Support to help local declarations and action plans

Mental Health Crisis Care Concordat
Welcome to the Crisis Care Concordat website.
This site is here to help your organisation and your partners create and submit a mental health crisis Declaration statement and an Action Plan and to make the principles of the Crisis Care Concordat a reality in your own area.

Submit a Declaration statement
Submit an Action Plan

ABOUT THE CONCORDAT  YOUR INVOLVEMENT  GET INSPIRED
Support to help local declarations and action plans
Support to help local declarations and action plans

Get inspired
Find out more about what excellent mental health crisis care looks like and how other organisations are putting together their Declarations and Action Plans.

An Ambulance Service and Police Conveyancing Policy in the North West
“The policy has brought clarity to a very complex area of service. It has dispelled a few myths and unrealistic expectations held between agencies and placed the vulnerable person at the centre of day to day responses to mental ill health” – Greater Manchester Police

Liaison psychiatry at Department of Psychological Medicine, Hull Royal Infirmary
The A&E mental health liaison team operates seven days a week from 8am until 10pm. It is a multidisciplinary team which includes a range of professionals who focus on people who deliberately self-harm and/or who have mental health problems within the acute care pathway.

Information Sharing and Police Training On Vulnerable People in London
“Since the Metropolitan Police Service (MPS) introduced the recording of vulnerable adult information in April 2013, there have been in excess of 20,000 reports, which show that there has been an unmet demand for a mechanism to record information on vulnerable adults” – Metropolitan Police Detective Inspector, Mental Health Team.
Website Phase 2 (from July)

Submit a Declaration statement

Submit an Action Plan

Cumbria
3 Declaration statements
1 Action plan
45 organisations
Website Phase 2 (from July)
Thank you

contact@crisiscareconcordat.org.uk
www.crisiscareconcordat.org.uk
Patient Experience Story

Healthy Minds Video

We are currently waiting for confirmation of consent to share this video. Once received a link will be circulated to delegates.
Yorkshire and the Humber Multi-Agency Mental health Collaborative

Angela Harris and James Barnes
Lead Nurse / Quality Improvement Manager: Mental Health
Yorkshire Ambulance Service / Strategic Clinical Network
Partnership to Improve Care
Yorkshire & Humber Multi-agency Collaborative

Working together with Yorkshire Ambulance Service and the region

**Angela Harris**, Yorkshire Ambulance Service, Lead Nurse for Urgent Care

**James Barnes**, Quality Improvement Manager – Mental Health, Yorkshire & Humber Strategic Clinical Network
1. **Background** - the role of Strategic Clinical Networks
2. **SCN for Mental Health** – supporting multi-agency collaboration
3. Working with CCGs

4. **Achievements to date** – Section 136
5. Opportunities for further integration
6. Challenges and next steps
What are Strategic Clinical Networks?

- SCNs operate as engines for change across complex systems of care, maintaining and or improving quality and outcomes.

- They bring primary, secondary and tertiary care clinicians together with partners from social care, the third sector and patients

- Within Y&H, SCNs are hosted by NHS England (South Yorkshire and Bassetlaw Area Team)
Links with other Networks

- We encourage development and links with informal local professional/clinical networks
- There are similarities with AHSN (Academic Health Sciences Networks) but they are more focussed on research, wealth creation and academia
- The SCNs cover wider, more complex pathways of care involving professionals from many different backgrounds
- Specific funding for patient and public involvement is identified within the SCN budget and genuine representation is pivotal to the process
Links with CCGs

- 24 CCGs within Y&H

- Three Collaborative Commissioning Fora to support decision making - SCN provides objective clinical advice and commissioning recommendations

- The same Area Team hosts SCG (Specialised Commissioning Group) into which the SCN provides advice and insight as required for national Clinical Reference Group specifications.
SCN Role in the Mental Health Collaborative

• Quality Improvement Manager and Clinical Lead formally joined the group in February 2014
• SCN co-chair collaborative and provide practical support
• Clinical Lead provides regional clinical perspective
• Support with regional CCG commissioner/provider engagement and representation.
• Support with patient/public engagement
• Sharing best practice - 11 other English Mental Health SCNs
What Has Changed?

Police …

…now ambulance
Red Flag Criteria

Police officer/paramedic triggers for conditions requiring treatment or assessment in an emergency department

Dangerous mechanisms:
- Blows to the body
- Falls > 4 feet
- Injury from edged weapon or projectile
- Throttling/strangulation
- Struck by vehicle
- Occupant of vehicle involved in collision
- Ejected from a moving vehicle
- Evidence of drug ingestion or overdose

Serious physical injuries:
- Noisy breathing
- Not rousable to verbal command
- Head injuries:
  - Loss of consciousness at any time
  - Facial swelling
  - Bleeding from nose or ears
  - Deep cuts
  - Suspected broken bones

Attempting self-harm:
- Actively head-banging
- Use of edged weapon (to self-harm)
- Ligatures
- History of overdose or poisoning

Psychiatric crisis with self-harm:
- Delusions/hallucinations/mania

Possible excited delirium:
Two or more from the following:
- Serious physical resistance/abnormal strength
- High body temperature
- Removal of clothing
- Profuse sweating or hot skin
- Behavioural changes/coherence
- Bizarre behaviour

Conveyance to the Emergency Department (ED):
- Should not be undertaken in a police vehicle when a Red Flag trigger is involved.
- This includes remaining in the ED until the person is medically fit for discharge to their place of safety, to a police station or to a S136 detention centre.
- It is the responsibility of the police to outline to the ED the legal aspects of detention; it is the responsibility of the ambulance service to outline the medical aspects.

When a clinician deems, in their opinion, that a patient requires assessment at the ED this overrides all other decisions and the patient must be conveyed to the ED.

Guidance for police - Taking the person to a police station should not be an automatic or default second choice and violent behaviour should not necessarily in itself lead to containment in police custody pending assessment.

The power to transfer should not be used purely for reasons of administrative convenience. For example where a person is detained under S136 and is taken to hospital, the healthcare staff should not request a transfer to another place of safety.
Success in One Area

**POLICE DETENTIONS UNDER s136 2 YEAR TREND**

- **June 2012**
- **August 2012**
- **October 2012**
- **December 2012**
- **February 2013**
- **April 2013**
- **June 2013**
- **August 2013**
- **October 2013**
- **December 2013**
- **February 2014**
- **April 2014**

Categories:
- **OTHER**
- **HBPoS**
- **CUSTOE**
“Partnership working is best supported by services working within catchment areas which are as co-terminus as possible, for example within the same area covered by local emergency departments and ambulance services”
Opportunities: 999 / NHS 111 integration

Patient dials 999

Care coordination within ambulance control room – assessment and referral through Directory of Services to appropriate care

Patient dials NHS 111
Multi-Agency: The Journey So Far….

Starting point
- Implemented joint 136 protocol between YAS, police forces across Yorkshire and Humber for mental health patients

Y&H multiagency improvement group

Now
- Multi-agency work programme:
  - Consistent policy and practice
  - Shared training resources
  - Pooled data

Today’s event

Future
- Continue to build and develop the multi-agency approach
What Next?

**Partnership**
- Mental health practitioners in EOC / NHS 111
- NHS 111/999 – jointly managing patients in crisis
- Joint street triage unmarked car police paramedic and MH practitioner

**Data – development**
- Investigate other information sharing
- Joint participation and accountability in managing frequent callers

**Train and develop**
- Staff support in Mental Health
- Train trainers – mental health first aid
- Voluntary sector – samaritans
“The greatest danger for most of us is not that our aim is too high and we miss it, but that it is too low and we reach it”

- Michelangelo
Yorkshire Ambulance Service

Angela Harris, Lead Nurse Urgent Care:  angela.harris@yas.nhs.uk

John Wooller – Clinical Excellence Manager :  john.wooller@yas.nhs.uk

Strategic Clinical Network

Alison Bagnall, Strategic Clinical Network Manager (MH, Dementia & Neurological Conditions): alison.bagnall@nhs.net

Dr Ian Aldridge, Consultant Psychiatrist / MH Clinical Lead: ian.aldridge@nhs.net

James Barnes, Quality Improvement Manager (MH), james.barnes4@nhs.net
Plenary Q&A to Morning Speakers
Lunch

Please be back at your tables for 12:45
Introduction to the Afternoon Session

Ms Della Cannings
QPM
Chairman
Yorkshire Ambulance Service NHS Foundation Trust
The Ambitions of the Crisis Concordat

Dr Geraldine Strathdee
National Clinical Director Mental Health
NHS England
Commissioning Crisis Care across the whole pathway

Implementing the Crisis Concordat & the Acute and Unplanned Care review

Geraldine Strathdee, National Clinical Director of Mental Health, NHS England

July 17th, Leeds 2014
Geraldine.strathdee@nhs.net
The ambitions of the Crisis Concordat

• What are the causes of crises
• What are the proven, safe, best outcome & Value models
• What metrics will measure progress, productivity & Value

• What transformation is being planned and delivered
  Commissioning for whole people, *(not body or brain parts)*
• Commissioning for the whole pathway
• Building unstoppable local partnerships for improvements in crisis care: exemplars
• Don’t ask what’s wrong with me,

• Ask

• ‘what happened to you, or is happening to you’?

Naomi Jacobs, NSUN
The very best crisis is one that has been prevented ..... So how can we do that

Let’s look at the main causes
Depression: the commonest causes in communities

...opportunities for prevention & early intervention of crises by a ‘smart’ society

- Elderly isolated & people with dementia
- Victims of domestic violence
- Key life cycle:
  - Divorce
  - Retirement
  - Redundancy
  - Menopause
- Isolated women with small children
- Dyslexia, Dyspraxia, ADHD, Autism, Asperger’s and Learning Disabilities
- Long term physically ill
- People with schizophrenia and sight and hearing problems
- Victims of school and employment stress and bullying
- Alcohol and drug addictions
Mental health crisis: Causes of presentations to A and E and acute hospitals

Mental health hospital presentations

- Dementia
- Self harm
- Alcohol
- Psychosis relapse
- Other
Commissioning to address causes & reduce repeat crises that can be prevented with care plan review the use of the mental health act part 2 and 3 by CCG area

So now, we can identify the local conditions that can lead to use of the act & address the CAUSES:

- transport hubs, homelessness, no recourse to public funds, cultural mores, link with unemployment & drug and other criminal activities, clinical management & practice variations, service configurations
Commissioning Upstream
mental health is society’s responsibility, not just the health services

Prevention & health promotion
Early identification & early intervention
Timely Access to services offering choice, quality outcome focus
Care at home or in the least restrictive settings,
Crisis response that is easy to access & expert

Parity for people with physical & mental health
Integrated physical & mental health & social care
Where every contact is a kind enabling, coaching experience
Crisis care across the care pathway: what works

1. Accessible information to prevent crises and get help early

2. Primary Care

3. One Stop shop Crisis call centre offering tele triage, tele health + 24/7 Co located unplanned care services

4. Crisis Home Treatment team fidelity model

5. A/E Liaison MH team Lifespan & whole person For dementia, alcohol, self harm, psychosis relapse, LTC

6. Alternatives to admission: Respite & Crisis houses & Day treatment services

7. Admissions to acute & MH hospital beds

NHS England
Crisis care in mental health: what NHS E with partners is doing to improve commissioning and care

- **Working with system partners to understand the causes** of crises & prevent

- **Mental health intelligence network** providing a review of crisis care nationally at the level of Area teams, SCNs, CCGs & economic re-modelling analyses

- **The top 10%** : Identifying in each CCG those who present in crisis repeatedly to help local areas prioritise for case & care plan reviews

- **CCG commissioning leadership programme** this coming summer

- **Commissioning what good looks like**: producing support tools to commission evidence based crisis service delivery models

- **Supporting innovation and transformation** in crisis response services

- **Our SCNs** are prioritizing implementation of the Crisis Concordat & 8 events planned

- **Our Academic Health Science Networks & NIHR programmes** are researching the best models and developing new 3 day training programme for managers, clinicians & commissioners

- And more.........
An effective pathway to improve crisis care responses

**Access to support before crisis point**
- Tele triage and tele health
- Early Intervention Services
- Suicide prevention
- Personalised care budget
- Helplines Peer Support
- Help at Home
- Supported Housing

**Urgent and emergency access to crisis care**
- ‘Parity’ between responses to physical or Mental Health emergencies
- Single point of access to specialist mental health services 24/7
- Crisis Home Treatment team
- Crisis and respite house
- Hospital Admission
- See Effective Bed Management Pathway

**Quality of treatment and care when in crisis**
- Physical assessment and treatment
- Mental state assessment
- Safe, competent treatment at home wherever possible
- Timely ambulance transport to appropriate NHS Facility
- Access to Liaison & Diversion from police custody or Court
- Care and treatment (inc MHA, MCA, CPA)

**Recovery and staying well / preventing future crises**
- Crisis Plan (NICE)
- Self management and family involved crisis plan
- All utilities working, food in house, debts and benefits sorted
- Transition to GP led care (with ‘fast track’ access back)

**Getting a life back**
Key questions for commissioners

6 conditions account for most mental health crises: dementia, alcohol, self harm & suicide, relapse of psychosis, CYP & social crises.

1. Have you information on key themes e.g. crisis care to monitor and support quality: what is the capacity and capability of your crisis services

2. What is your action plans to complete the declaration and then implement the Crisis Concordat, for people of all ages?

3. Have you seen the intelligence on your current capacity and fidelity to the evidence based model in your acute care liaison mental health services, crisis home treatment teams, early intervention teams to reduce admissions

4. Do you plan to introduce a single access number, tele triage and tele health, and an integrated crisis response, which includes GP, social care and MHT services?

5. Do you plan to develop alternatives to admission e.g. crisis houses, helplines, day treatment services, alliance

6. Has your CCG identified the top stratification of 100 most frequent attenders and are multi agency case review planned
What will be different if we get this right

• **National and local policy and politics:**
  
  • We will see a conversation where citizens tell us they want in: parliament, policy makers, the media, and in the ‘thinking’ leadership communities, with plans to tackle the causes, not just focus on impacts

• **Using knowledge and intelligence to change the front end**
  
  • There will be local plans on how to use the best of economic remodelling approaches to reengineer spend into prevention and early intervention

• **Access: fast and informative to the Right service, first time:**
  
  • The digital world will provide new knowledge on self assessment, self assessment and self management strategies
  
  • There will be one number to ring or a very visible easy to access system
  
  • Every provider who has a contract to provide care, will put an up to date, maintained description of the service they are proud to offer on NHS Choices, national crisis Directory of services, e Referrer, Choose & Book system & 111

• **Workforce** : Local partners will train together to address crisis in a conflict resolution way
Thank you for listening

• Can commit to working with us to develop a crisis concordat/UEA care implementation pack asap
• Would you be interested in learning sets as a way forward
• How can we get all the support tools on to your websites and support your commissioners
• How will this mental health work align with
  • Winter pressures funding
  • Better care fund
  • System Resilience groups
Street Triage
Developments via the Multi-Agency Collaborative

Inspector Bill Scott
North Yorkshire Police
Policing and Mental Illness in North Yorkshire

Insp Bill Scott

17th July 2014
North Yorkshire
Background

• Nationally, mental health-related incidents thought to occupy c. 20% of policing time
• Identification and recording issues
• Seen as core business
• Police are not experts in mental illness
• Consequence management
• Risk
Developments in North Yorkshire

• Co-ordination structures in place
• Health-Based Places of Safety
• Ambulance assessment / transport
• Scarborough Street Triage
• York / Selby Street Triage
• Third Sector collaboration
Successes

• Fewer detentions under MHA
• Improved patient dignity
• Greater patient safety
• Quicker referrals to appropriate services
• Reduced costs
• Excellent relationships between agencies
Street Triage
Developments via the Multi-Agency Collaborative

Jim Sheard
Mental Health Coordinator
South Yorkshire Police
South Yorkshire Police

Mental Health Triage Project

Jim Sheard
Mental Health Coordinator
The Challenge

- Improving the outcomes for people who call the emergency services
- Accessing appropriate intervention
- Avoiding unnecessary detention
- Improving and developing partnerships
- Crossing the funding boundary to access provision
- Reducing / removing the use of police custody
How Triage operates in SYP

- Two resources of a MH professional and a PC
- 2 NHS Trusts (RDaSH & SHSC)
- 3 CCG Areas
- 3 LA Areas
- 4 Police Districts
- 7 days per week
- 8 hours per day
- Deployed by SYP as a secondary resource, supporting officers already in attendance
- Introduced on 13th January 2014
Results

- Between 13<sup>th</sup> Jan & 29<sup>th</sup> May:
  - 446 Incidents attended
  - 248 Patients left at home with appropriate support
  - 85 diverted to A&E
  - 22 processed via the CJ system
  - 19 informally admitted to MH ward
  - 29 identified as medical incidents
  - 19 detained under S.136 MHA
  - 600 hours spent in direct contact with patients
What impact has this had?

- One CCG – 50% reduction in 136 detentions
- Significant reductions in other CCG areas (25-40%)
- Diversion from A&E
- Reduced demand for OOH MHA Assessments
- Rapid access to MH Services and interventions
- Becoming a ‘relied upon’ resource
- Increasing officers knowledge of MH
- Improved inter-agency relations
What’s next?

- Working with YAS to adapt & evolve the model to incorporate paramedic capability
- Expand the hours of operation
- Develop operational model (staffing and other resources)
- Long term future – embed the process, secure funding and resources
- Develop expanded and improved inter-agency training packages and CPD programme
- Ensure consistency in approach across SYP and adjoining boundaries
- Establish vulnerability based case management processes with health partners
Street Triage
Developments via the Multi-Agency Collaborative

Detective Chief Inspector Simon Atkinson
and
Inspector Wayne Horner
West Yorkshire Police
Street Triage
Developments via the Multi-Agency Collaborative

Det Superintendent Simon Atkinson
Inspector Wayne Horner
Dr Claire Flannigan
Overview.

• Street Triage
• Leeds Pilot
• Leeds Pilot results
• Impact upon the Police
• Street Triage - The future
Street Triage

- Launched 1\textsuperscript{st} December 2013
- 9 pilot sites nationally
  - Models vary
- 13 other sites self funding
- Early successes
  - Enhanced patient care
  - Reduction in S136 detentions
  - Closer parity of S136 to subsequent Sections
Street Triage

- Leeds model
  - 2 Mental health professionals
  - Daily cover 3pm to 1am
  - Based in the Becklin Centre
  - Provide telephone or direct assessment
  - Access to patient records
Street Triage

• Leeds results – the first six months
  • 464 Street Triage referrals
  • 70% seen, 30% advised
  • 25% of S136s subsequently detained in hospital
  • Represents 8% of Street Triage referrals
Street Triage

- Leeds S136 detentions
Street Triage

• Leeds results – Impact upon the police
• 49% reduction
Street Triage

• Leeds results – Impact for police & health
  • 19% reduction
Street Triage – the future

• The principle of Street Triage

• Seeking expansion across West Yorkshire

• Leeds – looking to mainstream

• Other CCG’s
  • Kirklees
  • Calderdale
  • Wakefield
  • Bradford
Questions ?
Street Triage
Developments via the Multi-Agency Collaborative

John Thirkettle
Criminal Justice Unit
Humberside Police
John Thirkettle
Criminal Justice
Hull
Humberside Police Mental Health

- Currently 3 areas, Hull, East Riding and South of the river Humber, Grimsby and Scunthorpe

- Population around 1.2m
- Hull 285k
- East Riding 590k,
Humberside 136 Arrests
Jan 13 - Mar 14

Jan - Mar 13: 33
Apr - Jun 13: 43
Jul - Sep 13: 31
Oct - Dec 13: 39
Jan - Mar 14: 28
- 1 person arrested every other day
- Around 25% of all non crime 136 patients go to the custody suite
- Why – Drunk or violent
- Quality of data collection?
Improving Services

- Local initiatives to develop a better experience
- Mental health expert support in Grimsby
- Transport by ambulance and not police vehicle, YAS and EMAS
- Women triage away from crime due to mental health,
Making Progress - Concordat

- Force Command structure April 2015
- Dedicated strategic lead for the Force
- Mental Health Expert
- Concordat progressed corporately,
Making Progress
Mental Health under review

- Mental Health and Mental Capacity
- Custody as a Place of Safety
- National training product – College of Policing and identified provider
- Better health service provision at 136 suites
- Information sharing,
The Mental Health Crisis Care Concordat
Thoughts from the Leeds Crisis Team

Dr Claire Flannigan
Consultant Psychiatrist
Leeds and York Partnership NHS Trust
Thoughts from the Leeds Crisis Team

The Mental Health Crisis Care Concordat

Improving outcomes for people experiencing mental health crisis

July 2014
Relevance for all MH Services
not just for crisis teams

- SPA / CAS
- ICS / home treatment
- CMHT
- Inpatients
- Liaison / RAID
- Gen Adult / Older People / CAMHs
- All Ψs - training grades/ NTGs / consultants
- Subspecialties
Core principles and outcomes

Access to support before crisis point

• Take me seriously
• Trust my judgement
• See me quickly
Core principles and outcomes

Quality of treatment + care when in crisis

• Treat me with respect and care at all times
• Staff who have the right skills + focus on recovery
• Same staff, avoid unnecessary reassessments
Core principles and outcomes

Recovery + staying well, preventing future crises

• Give me information
• Take opportunities to reflect on crisis + help me find better ways to manage my MH in future
• Support me to develop a plan
• Let me feedback to help improve services
Action plan – S136 and police cells

- reduce use of police stations as PoS
- half the 2011/12 by 2014/15
Leeds use of place of safety

% POS, plus up to 10% in ED or medical ward
Street Triage effect on S136
Street Triage effect on S136

Leeds and York Partnership
NHS Foundation Trust

Improving health, improving lives

2013/14
2012/13
2011/12
2010/11
S136 issues - Concordat Action Plan

Police cells
• Fast-track process whenever a cell is used
• Remove all barriers to use of S136 suite
• ↑ ST pilot to 24hrs
• ↑ rapid access by BTP
• Review each case where cell used
• “no exception” by intoxication – “sobering up” facility
• No children / YP in cells

Waiting times
↑ AMHP involvement in S136
  - ↑ number of CAS AMHPs + train non-SW AMHPs
Local Concordat Action Plan

Achievements to date

- 24 hr SPA referral on dedicated phone line - 4hr target
- 24 hr crisis assessment CAS + ALPS
- Ageless S136 service + ST pilot
- YAS conveyance
- LYPFT lived experience project + guidelines
- Court + prison inreach, street outreach
- CAMHs, drugs + alcohol rapid access services
- Gatekeeping and ↓ in OATS
Local Action Plan to be negotiated

Items for consideration and inclusion

↑ Carer involvement at time of crisis – SPA/CAS/CAU/ALPS
↑ Alternatives to admission – CAU
↑ access + ↓ detention in BME groups
↑ quality of PC health & wellbeing management
↑ alignment PC /2°MH services hours eg 8am – 8pm
↑ 7 day consultant working
↓ further + eliminate OATs – CAU

Coordinated and timely approaches
Local Action Plan to be negotiated

Other ideas from CAS

Unmarked cars for S136

More shared training between agencies

Join EDT (MH) + CAS for ↑ rapid 24 hr AMHP response

Negotiate improved response times from YAS

Other ideas from other areas?
Best Practice Case Study

Rob Cole
and
Sergeant Leanne Chapman
West Midlands Ambulance Service NHS Foundation Trust
and
West Midlands Police
Street Triage Pilot

T/Sgt Leanne Chapman
Robert Cole – Consultant Paramedic
Richard Clarke – Birmingham Place of Safety Manager
Triage Model

- Triage Car will work from 1000 – 0200/0300 based from Bourneville Lane Police Station
- 7 days a week Inc. Bank Holidays
- Staffing
  - Four band 6 MH nurses
  - Six Police Constables and One T/PS - on secondment
  - Three Ambulance Paramedics FTE
- Deployed in a plain ambulance responder
- Creates a vehicle able to deal with physical and mental health issues.
- Deployment under guidance of Police / AMBO Control rooms
- Started Friday 10th January 2014 for 12 months
- Have access to NHS systems
- Can transport patients as it is an ambulance vehicle.
Role of the MH Nurse

• To conduct a face to face assessment on the street
  – Undertake a mental health assessment
  – Undertake a review of risk, threat and harm to themselves and others with the members of the team to provide a holistic approach
  – Consider pathways for diversion if appropriate
  – Enhance the capacity of the service to deliver out of hours

• Create a conduit for information sharing and ensure pathways provided are acted upon

• Deliver a compassionate and caring approach to Mental ill health on the street
Red Flags

Some Example of Red Flags:
Extreme Aggression - Would go to the Police Station - Last Resort

• Falls
• Involved in a vehicle collision
• Postictal (Post seizure)
• Serious physical injury
• Loss of consciousness
• Possible excited delirium
• Alcohol and drug misuse - Common sense should prevail.

• Initially people suffering from any of the conditions above would need to be directed to Hospital or other services. Once they become medically fit, we will accept them for assessment
Following assessment the following outcomes are possible:

- Discharge back to GP
- No follow up
- Referral to CMHT (community mental health team)
- Referred back to CMHT
- Referred to specialist service
- Crisis access to Home Treatment
- Taken on to Home Treatment for further assessment/support
- Admission Informally
- Detained under the Mental Health Act
- Discharged back to E.D, if underlying or new medical problems are identified
- People can be discharged back to the police to follow the judicial process, if they are not deemed mentally unwell
1. Report from both police and ambulance of a 19 year old female self harming in the street. Threatening to kill herself. Extremely emotional and had consumed 2 glasses of wine. A check on mental health systems revealed she had an extensive history with services. The ambulance on scene wanted to take the female to the hospital.

Outcome - Street triage team deployed, all resources were cleared from the location. Her wounds were dressed by the paramedic on the car at the scene. A face to face assessment with the mental health nurse was conducted and an urgent referral was made to the home treatment team. She was given crisis access to services over night. Home treatment went to see her the next day.

She was safeguarded with her friend that evening who took her home and stayed with her through the night. This whole incident lasted 45 minutes compared to the hours she would have waited in an A and E department with the same outcome at the end.
2. Report from both police and ambulance that a male was on the roof of a hotel with a knife and a rope tied around his neck threatening to jump.

Police and ambulance responded and the male was talked down by a member of staff at the hotel. Triage were requested, a check of mental health systems identified he was not known to services. Upon arrival they cleared all resources from the location. Triage spoke to the male who stated his wife was having an affair, they had financial worries and his father had just been diagnosed with a heart condition. He felt his only option was to end it all.

Outcome – Triage face to face assessment conducted, male was safeguarded that evening with his children (18 and 20 years old). He was given crisis access to mental health services. He was referred to a community mental health team for long term support.

Before triage this male would have been detained under section 136 MHA. He would have spent hours at the place of safety waiting for an assessment which would have compounded issues and made him feel worse.

The family contacted triage expressing their thanks for the support and compassion they showed towards their father.
3. Reports a female was distressed in her home address saying her husband wouldn’t let her leave the house. She has a long history of suffering with mental health. Her husband had been abusing her physically/mentally/financially and sexually for years, he used her mental health to cover up the abuse he subjected her to. By being able to check mental health systems it was identified her husband would not let her talk to any professionals on her own. He controlled any interactions she had with the mental health teams and they had identified they were concerned about her welfare. Due to knowing this information the team asked her to come and talk to them in private outside in the triage vehicle where she disclosed the abuse. She agreed to attend the place of safety voluntarily for an assessment.

**Outcome** – street triage face to face assessment completed. She was taken to a place of safety. She has subsequently been sectioned under the mental health act. If the triage car had not been there then the officers said they would have left her in the house and believed what her husband was telling them.

This would have resulted in her being subjected to further abuse.

- In all instances the incidents were taken over by the triage car to release all emergency staff back to work. This resulted in a more effective use of police, health and ambulance resources but more importantly a ‘better service’ to the individuals involved.
Table Discussions
Where are you now with the Crisis Concordat?

1. What work has been done so far in your area?
   What progress has been made on the declarations and action plans?
   Are all the essential signatories involved?
   If not, who is missing?

2. What are the next steps?
   Who is going to take them, and when?

3. What are your challenges?
   What are your challenges, issues and concerns?

4. What support do you need/want to overcome your challenges and take your next steps effectively?
   What kind of support is needed and who is going to provide it?
   What support do the local declaration partners need from each other?
   How can the SCN support this work?
Plenary Feedback
Reflections on the Day

Jonny Glenn
Healthy Minds, Calderdale
Thank you for attending!