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|  | ***Access to support before crisis point – Early Intervention*** |   |  |  |  |  |  |  |
| A1 | Single point of access to a multi-disciplinary MH team | The BSMHFT implemented a single point of access into their services in April 2014.There is currently a single point of access at Birmingham Children’s Hospital for CYP under 16 years old. This includes Emergency Response and Assessment. | New pathway only implemented April 2014 so will need to keep it under review to ensure delivering expected outcomes.The CYP service only operates up to 9pm | * Single Point of Access (SPoA) to all BSMHFT services established in April 2014.
* As the SPoA is a newly commissioned service there is a requirement to monitor and evaluate the effectiveness of the service and the outcomes that are being delivered.
* To develop a model of 24/7 cover as part of the 0 -25yr contract
* Review the integrated access centre
 | SpoA established April 2014Interim review November 2015Integrated access centre established Oct 2015 March 2016 | BSMHFTBSMHFT and Joint Comm. TeamForward Thinking Birmingham (FTB)Maternity Commissioning Team and FTB | •My GP is required to complete a standard electronic referral form, providing all relevant information such as the extent of my difficulties and the urgency of the response required.•My GP only has to refer to the SPoA which will significantly reduce the risk of my referral going to the wrong service or team and delaying me getting the help that I require.•I can be confident that the SPoA will have sufficient information about me to enable them to identify the most appropriate team or service to meet my presenting needs and to determine how quickly I need to be seen.•I can be confident that if I am in crisis or at risk of moving to crisis that services will respond within agreed timescales..•I can be confident that if I am assessed as not requiring secondary care MH services that the SPoA will make contact with other agencies and/or services that are better placed to meet my needs. | GreenAmber |
| A joined up response from services with strong links between agencies.  | * There is an approved mental health practitioners (AMHPS) system operating Monday to Friday 9am to 5.15pm. The Emergency Duty Team (EDT) operates 4.15pm Friday to 8.45am Monday. Weekdays before 8.45am and after 5.15pm, available all Bank Holidays.
* Funding panel brings together commissioners, NHS and social services to agree individual packages of care
* COMPASS provide dual diagnosis training to BSMHFT staff.
* Street Triage service which responds to people in crisis and has Police Officer, CPN and Paramedic working together out of a car.
* Police Liaison & Diversion Pilot Project operating at Steelhouse Lane, where CPNs screen for mental health and learning disabilities and divert as appropriate. Partners include Police, BSMHFT, BCHC, CAMHS, Anawim, substance misuse service.
* Joint protocol for mental health and learning disabilities between BSMHFT and BCHC NHS Trust
* Funding panel for CYP including Commissioners from Health (NHSE and CCG), Education and Social care
* CAMHS support to MASH
 | * Ensure that services are available at the right time in the right place
* Police Liaison & Diversion service across the whole of Birmingham

Support to schools and colleges and frontline services | * Clarify role of each agency in the delivery of MH services and ensure that they are properly linked into the MH pathway.
* Scoping with BSMHFT what an enhanced primary care service would look like.
* Strengthening the role of the GP in the delivery of MH care within Birmingham through enhanced training for GPs and easy access to advice and support from specialist MH staff.
* Ensuring that all services, support agencies and wider community capacity who support people with MH problems are formally linked to the MH pathway.
* Continue panels and include 18 to 25 year olds
* Strengthened links with MASH
* Consultation and advice provided to schools and frontline practitioners
* Training for frontline staff
 | On-goingDuring 2015On-goingOn-goingOngoing December 2015During 2016 +During 2016+ | Joint Comm.TeamBSMHFT and Joint Comm.TeamJoint Comm.TeamMCYP team and FTBMCYP team and FTBFTB | I can be confident that:• wherever I present people will assist me to find the help and support that I need to keep me well.•all services will view me as a person rather than just the condition that I present with, working with other agencies to ensure that all of my needs are appropriately met.•the support offered will be tailored to my individual needs and circumstances.•where I have multiple needs mental, physical or substance related that this will not be a barrier to me accessing the help that I require.•all services will respect and make appropriate adjustments to support people with protected characteristics.•all services supporting people with a MI will be knowledgeable about the range of complementary support offered by other services and agencies.•the commissioners and the providers of services are working together to identify opportunities to improve the experiences of people with mental health problems locally. | AmberAmberAmberGreenGreenAmberAmber |
| Help at Home Services | * Birmingham has Home treatment Teams and Assertive Outreach teams all of which will provide support to people in their own homes.
* In addition CMHTs and Early Intervention will all visit patients at home
* Mental health care packages often involve domiciliary care and support self care and recovery
* Some tenancies offer wrap around support and/or housing related support
* Contracts with the Third Sector to support people living at home
* BCHC NHS Trust rapid response teams
* Home Treatment for under 18’s is available to support CYP who would be eligible for inpatient services but have the support available to remain at home
 | * Sufficient capacity within community based secondary care services
* Focus of Home Treatment on crisis work leaves insufficient resource for treatment at home.
* Sufficient capacity within the HTT
* Sufficient capacity within the AOT
* Intensive outreach for CYP crisis and support
 | * To scope out service capacity gaps and measure the flow of patients within the secondary care mental health system.
* To develop intensive outreach for CYP
* Development of recovery college
 | OngoingTBCTBC | BSMHFT and Joint Comm. Team FTBFTB | I can be confident that:•if I need homecare support that the staff supporting me will have an understanding of MI and will treat me with dignity and respect.•I will be encouraged to identify the goals that I want to achieve to help me in my recovery and that the focus of staff will be in helping me to achieve them.•I do not have to wait until I am in crisis to get the help and support that I need. Services will intervene earlier to maintain my mental health.•health and social care teams will work together, that they will ensure that all relevant information about my needs and my care plan are held on one system and can be easily accessed by health and social care staff actively engaged with my support and treatment. | Amber |
| Respite | * Range of respite options offered by BSMHFT in partnership with Servol and Future.
* Limited dementia respite
 | Access to single sex facilities ensures maintenance of privacy/dignity | * Review existing provision and evaluate sufficiency and appropriateness to client groups.
* Review provision of single sex respite
* To identify current respite capacity gaps for both functional and organic conditions within Birmingham and to measure the impact that such gaps have on the wider MH system within Birmingham.
 | April 2015April 2015November 2015 | Joint Comm. TeamJoint Comm. Team | I have somewhere safe to go: •if I need time away from my current living situation.•for a higher level of support in times of crisis and that this will reduce the likelihood that I will need to be admitted into hospital.•when my carer or family member needs a break.•when I no longer need hospital care but I am not quite ready or well enough to return home.•where I will be encouraged to continue to work towards the achievement of my recovery outcomes. | AmberAmber |
| Peer support | * Day service provision through MIND, Creative Support, Rethink and Golden Hillock Day Centre
* 3 recovery and well being hubs
* Stonham Carers support service
* Autism West Midlands Support Group
* Southlink Charter Centre service user led day service
* Asian Women’s Textiles Service
* For people with dementia - memory cafes
* STAR Service (BCC)
 | * Ensure that services are integrated
* People knowing what is available locally and how to access it.
* Currently none available for CYP
 | * Primary Care Mental Health transformation programme to address these issues (day service redesign test and learn pilots and Karis health centre Edgbaston well being hub pilot).
* Peer support for CYP to be linked to the developments of recovery college
* Peer support training for CYP developed and delivered
 | Redesign to be implemented by April 2017TBCTBC | Joint Comm. TeamFTBFTB | •I will be able to talk to someone who understands my condition, is tolerant, flexible, patient and persistent and who will help me to understand my strengths and my opportunities for amore fulfilled life.•I will feel empowered to take responsibility for my own recovery.•I will have the opportunity to use the expertise that I have gained in managing my own mental illness to help others and I know that this could lead to formal training and future employment opportunities if I so chose. | Amber |
| Access to liaison and diversion services for people with MH problems who have been arrested for a criminal offence | * Liaison and diversion team at Steelhouse Lane commissioned by Specialised Commissioning Team (SCT)
* Youth Offending (YOS) CAMHS provision – assess young offenders for MH and provides treatment
 | None for adults | * 12 months funding has been agreed
* To assess YP who come into contact with YOS for MH and neurodevelopmental disorders
* Multi-agency care planning and treatment provided
 | EstablishedEstablished | WMPBCH/ FTBBCH/ FTB | I can be confident that:•wherever I present people will assist me to find the help and support that I need to keep me from re offending. •The Triage team will be sought for advice wherever possible•The police will view me as a person rather than just the condition that I present with, working with other agencies to ensure that all of my needs are appropriately met.•any decision to prosecute me for offences will consider my individual needs and circumstances.•where I have multiple needs mental, physical or substance related that this will not be a barrier to me accessing the help that I require.•all services will offer culturally sensitive support.•all services supporting people with a MI will be knowledgeable about the range of complementary support offered by other services and agencies. | Green |
|  | To reduce the stigma associated with mental illness | * Annual community engagement events across Birmingham.
* The Dementia Friends programme is a key priority for in Birmingham A target has been set for there to be 4,500 dementia friends in Birmingham by April 2015.
* Local events for: MH Awareness day, Dementia Awareness week etc.
* Birmingham Mind part of the National Mind ‘Time To Change’ programme.
* MH employment service challenging stigma in employment.
* MH Advocacy services support the reduction of stigma and discrimination.
* Community Development Workers employed by MIND
* BCHC NHS Trust has rolled out Dementia Awareness training for all Trust staff, Suicide Awareness literature for staff
 |  | To work with public health in the delivery of MH awareness programmes in Birmingham.To develop the community cohesion programme to focus on domestic violence issues | During 2015 | Public HealthcommissionersProviders AgenciesJoint Comm. Team | •I am not ashamed or worried about telling people that I have a mental illness.•I have a better understanding of mental illness and will do all that I can to support family, friends and colleagues who have a mental illness.•I have a better understanding of mental illness and will use this knowledge to educate others.•I am aware of how my attitudes, behaviour or the words that I use can increase the stigma and discrimination of people with a mental illness. | Amber |
|  | **Urgent and emergency access to crisis care** |  |  |  |  |  |  |  |
| B1 | **People in crisis are vulnerable and must be kept safe, have their needs met appropriately and be helped to achieve recovery** | * Social care duty systems during the day, Emergency Duty Team (EDT) at night
* Place of safety – both for adults and one for children
* British Transport Police – Suicide Prevention work – pilot with no on-going resource identified
* Single Point of Entry into secondary care services
* RAID operating within all Birmingham Acute Hospitals
* Home Treatment Team
* In patient MH assessment beds
* Street Triage Service – pilot with no on-going resource identified
* During the winter of 2014/15 a psychiatric decision unit is being piloted based within the Oleaster Unit in Birmingham. Impact should be reduced number of patients requiring admission.
* Police Liaison & Diversion Pilot at Steelhouse Lane
 | * A&E still a crisis service access point – need a better way of dealing with MH emergencies in acute units. Need to make efficient use of MH assessment beds
* Efficient use of MH respite beds
* Recurrent funding for street triage and British Transport Police – Suicide Prevention work
* Out of hours services CAMHs and adults after 9pm.
* More intensive community support: - day hospital- urgent care centre- specialist MH domiciliary based care.
* Police Liaison & Diversion across the whole of Birmingham
 | * Close monitoring of outcomes for Street Triage and BTP Suicide Prevention work.
* Further re-designing the current MH system and pathway in Birmingham.
* Developing improved pre-emptive support services to reduce the numbers of people experiencing crisis
* Piloting and evaluating the MH crisis line
* Continuing the current street triage pilot
* Scoping the impact of respite capacity on improving system flow.
* Auditing current HTT caseloads, capacity especially provision after 9pm as part of the move to the New Dawn model.
* Continuing to deliver out of hours provision for children and young people.
* Scoping potential wider system impacts of more intensive community support – MH Re-design and New Dawn.
* Continuing to commission place of safety services for adults and children and young people.
* Reviewing current training of Personal Safety Training and restraint for people who are mentally ill or learning disabled. Formulate and deliver a programme of suitable training for staff – annual refresher courses.
* Ensuring that custody will not be used as a Place of Safety unless in exceptional circumstances. Review Safer Detention Policy to ensure that this directive is clear.
 | April 2015 – March 2017As aboveApril 2015March 2016June 2015 to March 2016November 2015April 2015April 2015 to March 2017On-goingTBCOn-going | Joint Comm. TeamJCT and BSMHFTBSMHFTBSMHFTCYP CommissionerBSMHFTCYP CommissionerCS Sean RussellCS Sean Russell | I can be confident that:•all specialist mental health services will be available locally.•I will not have to go out of area for acute assessment inpatient services•there will be a greater range of support options for me when I am unwell, more tailored to my individual needs and circumstances.•even when I am acutely unwell all services and agencies involved with me will treat me with dignity and respect.•when I need to be restrained that this will be done safely, supportively and lawfully by people who understand mental illness and know what they are doing.•I will only be taken into custody, the Emergency Department or a section 136 suite where this is appropriate. | AmberAmberGreenGreen |
| B2 | **Equal Access**The Concordat supports the guidance produced by Mind on commissioning crisis care services for BME communities | * The Joint Commissioning Team commissions third sector organisations to engage with hard to reach groups including black minority and ethnic groups across Birmingham such as Pattigift (African centered counseling), Chinese Community Centre (Counselling), Golden Hillock Day Centre (for Bangladeshi community) and Asian Womens Textile Centre (day centre for Asian Women).
* BSMHFT conduct a ‘Count me in’ survey of BME patients utilising their services
* All contracts and specifications require providers to ensure that their services reflect cultural differences to support and encourage access into their services.
* Access to MH advocacy services
* Access to interpreters
* Midland Mencap support for people from BME and hard to reach communities
* Multi – agency meetings that focus on BME Young offenders at risk and provide mental health screening
* Start again project with MIND looking at the experiences of young black men in mental health services

  | Current work around establishing a baseline position and gap analysis around commissioned services for BME groups.Recognition that some groups are over represented and some groups are under represented in MH services | * Recent launch of BME mental health service commissioners’ guidance will lead to a review of mental health services provided to BME groups in Birmingham
* Discussion around establishing a City wide task group to look at guidance implementation.
* New service specification for 0-25 service will look at hard to engage groups to deliver more effective early intervention
* Training frontline services on mental health
* Mental health screening for 0-25 who will be released into Birmingham to assess MH
* Primary care transformation will look at engaging hard to reach groups through a CCG commissioned approach
 | Ongoing OngoingNovember 2015From Jan 20162015-2016 | BME TaskforceBME TaskforceJCTMCYP teamFTBJCT | I am confident that:•All services and agencies within Birmingham are more sensitive to, and supportive of, people who belong to ‘protected characteristic’ groups and that they will make ‘reasonable adjustments’ where required.•People who belong to ‘protective characteristic’ groups feel empowered to influence the design of MH services within Birmingham.•All involved in the commissioning and provision of MH services will in-reach into my community to tackle any stigma and discrimination that may be a barrier to me accessing the help and support that I need.•there will be accessible information and advice to help me navigate my way through to the services and support that I require.•All services providing crisis care will ensure that my care and support is delivered in accordance with my protected characteristics. | AmberAmberAmberAmber |
| B3 | **Access and new models of working for children and young people.** | * CAMHS emergency assessment and support from 9am to 9pm, and a Place of Safety for CYP up to 16.
* Home treatment service for 12-18 year olds.
* A duty psychiatrist is on call to assess under 16s in acute care (assessments carried out at Birmingham Children’s Hospital)
* CAMHS service for young people with complex and enduring mental health needs is bespoke to their needs, and works with partners in a Multi-Agency Panel to identify the right support.
* RAID provides assessment for 16 – 18 year olds in A&E
 | * Patchy coverage, lack of crisis intervention for under 16s.
* Lack of beds for under 18s, NHS England is gatekeeper for this service.
* Unclear re commissioning arrangements for those over the age of 17, but under the age of 18
* Issue with transitions of young people from CAMHS to Adult services
* Out of hours CAMHS
* Link between Primary Care and universal services and specialist CAMHS
* RAID staff not specialist trained
 | Children and young people with mental health problems should have access to mental health crisis care. This will include:* Single point of access for MH services
* In hours and out of hours intensive support for children and young people most at risk of being admitted to hospital.
* Place of safety
* A&E will no longer be identified within care and support plans as a service to access when in mental health crisis unless urgent physical health intervention is required.
* To deliver access to MH information, advice and crisis support through 111.
* To develop robust partnership working between primary care and specialist CAMHS services
* Partners such as schools, youth services, police etc to be involved in the development of crisis strategies.
* Children and young people to be kept informed about their care and treatment.
* Monitoring, evaluation and review of new service.
* Interim review
* First year review
 | April 2015April 2015EstablishedOn-goingFebruary 2015On-goingOn-goingOn-goingApril 2016Oct 2016 | MCYP/ FTBMCYP/ FTBMCYP/ FTB CYP Commissioner JCTMCYP CommissionerMCYP Team | •I will know how to find the help and support that I need when I am becoming unwell and know that I can get this help quickly when I need it.•My crisis plan will not specify A&E as the place that I need to go when I am becoming mentally unwell.•I can be confident that when my mental health is deteriorating services will act quickly to try and prevent me needing to be admitted to hospital.•There is a single point of access into mental health services so I can be confident that my referral will be picked up by the service that can best help me.•I can be confident that my GP will work closely with services who are supporting me with my mental illness.•I will feel more confident talking about my mental illness as people within my school will have more of an awareness and understanding of mental health. •My care and support plan will be informed by me and will identify the goals that I want to achieve. •As a looked after child it is more likely that I will experience mental health issues but I can be confident that services will recognise this and provide the support that will keep me mentally well. |  |
| B4 | **All staff should have the right skills and training to respond to mental health crises appropriately.** | * Part of the role of the RAID team is to provide support and training to frontline and inpatient staff within Acute Trusts in the management of mental health presentations.
* Both police and WMAS have had training on dealing with people with MH issues. BCDA puts on a range of courses relating to MH and dementia available to all statutory, independent and third sector agencies.
* BCHC NHS Trust provides training and support relating to MH and LD plus joint protocol for service support is available between BCHC and BSMHFT in relation to meeting the needs of people with LD and MH needs
* Training has been provided to staff on Childrens Wards within HEFT to support CYP who are admitted with MH illness
 | * GPs need to be more aware of the availability of community services.
* Capacity in RAID teams to provide training is limited as referrals/demand for assessment at A&E front door has increased by 30%
* Training to acute trusts children’s ward staff
 | * Mental Health awareness training for all providers delivering care and support across Birmingham.
* Mental Health Information, Advice and crisis line staff within 111 will be provided with training to ensure that they have the skills and expertise to ensure an appropriate ‘warm’ handover to third and statutory sector mental health providers.
* During the pilot phase of the MH Information, advice and crisis line we will review the staff capacity and skill mix to ensure that we can meet the expected volume and complexity of calls received.
* To deliver a rolling programme of multi-agency, multi-professional mental health crisis pathway training. Encourage service user attendance at these training events so that the training can be informed by real life events.
* To provide crisis training as part of MH awareness training and to encourage a wide range of organisations to take up the training.
* MH awareness training to be delivered to staff as part of their induction. Police new recruits to have a common minimum standard of training accredited to the College of Policing. MH training to Ambulance staff identified as a gap and being addressed through the Association of Chief Ambulance Executives
* Regular auditing of calls and contact with people with a MI to identify gaps in the quality of service delivered and address deficits accordingly.
* Training to acute children’s ward staff
 | On-goingJan-March 2015Feb-end April 2015On-goingApril 2015April 2015 and on-going thereafterOngoingFrom Oct 2015 | JCTProject lead for 111 pilotProject lead for 111 pilotMH Learning and Dev lead MH Learning and Dev leadCI Sean RussellFTB | I can be confident that:•Staff within the services that I access have a good awareness of mental illness.•There will be a consistent approach to crisis across Birmingham.•Staff within any service that I access will know what to do and who to contact if they believe that I am experiencing crisis.•Police officers will be more informed about mental health and understand that I may not have control over the way that I am presenting and that they will treat me with dignity and respect.•The police and fire service identify mental health education and training to be a high priority and that the mental health training programme is overseen by senior officers within the police force and fire service.•I will feel safe.•The quality of services and support delivered and my experience of accessing them will be good. |  |
| B5 | **People in crisis should expect an appropriate response and support when they need it.** | * RAID operating within an hour if person within A&E (Heartlands, City and UHB 24/7) and within 24 hours if admitted.
* Access to the single point of entry during working hours and the emergency duty team out of hours.
* Single point of entry into secondary care services – people who have urgent needs are seen same day.
* Home treatment Team – same day (within 4 hours)
* BCHC NHS Trust Learning Disabilities Service also has a Single Point of Access and an Outreach team to support service users
 | * 24 hour EDT helpline, but this is not a crisis service
* No specific 24 hour helpline staffed by MH and social care professionals
* Out of hours crisis service for older adults
* Out of hours crisis service for CAMHs
 | * To audit that all services that deliver crisis responses to people with a MI are linked to the mental health pathway and joined up.
* That services commissioned can deliver their response within appropriate timescales and, where appropriate, in a location that best suits the needs and wishes of the person requiring help.
* To audit AMHP response times for MH Act Assessments. To review capacity requirements if response times are outside of accepted timeframes.
* Improve joint working for executions of warrants under Mental Health Act
* To implement a 24/7 helpline staffed by MH and social care professionals.
* To undertake an interim audit of the 111 MH Helpline pilot and to use the evaluation to inform the future design of the service that will deliver the most effective outcomes.
* To implement the recommendations of the audit of home treatment team capacity and caseloads to ensure that the team can provide more pre-emptive support to try and prevent people moving to crisis.
* Emergency response and assessment service to all DGH’s in Birmingham
* Single point of access for 0-25 7 days per week
 | April 2015On-goingMay 2015July 2015February 2015April 2016April 2016From Nov 2015From Nov 2015 | Urgent Care Delivery GroupUrgent Care Delivery GroupBCCBCC111 Pilot Project Lead111 Pilot Project Lead Urgent Care Delivery GroupFTBFTB | I can be confident that:•Wherever I present when in crisis I will be able to access the help and support that I need.•Wherever I present when in crisis that I can be guaranteed a warm and supportive response.•I will be supported by people who have a good understanding of mental illness and who know what is available to best meet my needs and how I can access it.•I will not have to wait a long time to be seen by the people who have the skills and expertise to help me.•When I am over my crisis I will be supported to find the right services and support that will help me to recover and will help me to maintain my recovery.•More support will be available to me to prevent me from becoming unwell.•More will be done to ensure that my needs can be met locally and that I will be less likely to need to go out of area if I need to be admitted. |  |
| B6  | **People in crisis in the community where police officers are the first point of contact should expect them to provide appropriate help. But the Police must be supported by health services, including MH services, ambulance services and emergency departments.** | * Place of safety service – 2 adult places available for Birmingham and Solihull. Birmingham have approximately 1.5 POS admissions per day.
* The British Transport Police – Suicide Prevention work will support people who are displaying risky behaviours on the national railway services and identified to the British Transport Police. *Note that this is a ‘C Division service covering much of England and all of Wales*
* Street Triage – current Birmingham and Solihull Home Office funded pilot – due to end February 2016.
* Place of safety available for young people aged up to 16.
 | * MH Urgent Care Centre- a more appropriate place to assess, treat/support people.
* Identification of recurrent funding to secure street triage.
 | * Scope POS capacity to determine how often there is insufficient capacity to meet S136 requirements.
* Development of an urgent care centre.
* To continue to evaluate the street triage service identifying wider system impacts to inform future funding streams when pilot ends in February 2016.
* To review whether there is sufficient capacity within the current street triage service and to evaluate whether there would be added realisable benefits through increasing the capacity of this service.
* Through the urgent care delivery group to identify system gaps which if filled would provide a more effective and efficient MH pathway across Birmingham. Re-aligning commissioning resources to deliver early help to reduce the numbers of people experiencing crisis.
 | Monthly | CI Sean Russell |  |  |
| B7 | **When people in crisis appear (to health or social care professionals or to the police) to need urgent assessment, the process should be prompt, efficiently organised and carried out with respect** | * RAID service has bed admission rights.
* Duty systems which feed into Raid and other urgent care systems
* Street triage service (but only pilot with funding until January 2015)
* Street triage car –unmarked specialist ambulance so no stigma.
 | * Lack of available beds to nominate patients to.
* Very few Section 12 doctors wiling to be called out at short notice
* CAMHs out of hours
* Recurrent funding for street triage service.
* Too little use of persons own GP in the MH Act Assessment process.
* HT workers should be present at all MHA assessments and facilitate admission to a secondary care MH bed
 | * When a patient requires admission to secondary care inpatient facilities out of hours, cases should be risk assessed by HTT to ascertain if they cannot wait until the next day for admission and not make admissions dependent on bed availability.
* Review all multi-agency policies and protocols that apply to people experiencing MH crisis .
* To review the timeframes for S12 Approved Doctor, AMHP and police responses for S136 and MH Act Assessments to ensure that they are within required 4hour timeframes for crisis assessment where here are no clinical grounds to delay assessment.
* To review AMHP capacity requirements in line with above review .
* Review impact of the SPoA in the improvement of emergency response times.
* To scope the potential benefits of the use of a S12 doctor application for Smart phones.
* To review Street Triage response times in line with RCoP guidance on commissioning for S136. Response time for S12 and AMHP's should be within 3 hours unless there are clinical grounds to delay the assessment.
* To review crisis responses for children and young people and ensure that such assessments are undertaken by a Child and Adolescent Psychiatrist or an AMHP with specialist knowledge of this age group.
* For older adults both functional and organic, to review crisis response services including timeframes for assessments and the current use of A&E in delivering the emergency response.
* To review impact of the care home liaison service in supporting care homes with the training of staff and timely advice to provide appropriate support to patients with functional and/or organic conditions to reduce the numbers of residents experiencing crisis.
* Review use of persons own GP in the MH Act assessment process.
* Develop an all age joint workforce strategy and action plan for AMHPs and S12 Doctors and look at how such professionals link with the wider mental health and substance misuse systems.

The Police, MH Trust and Local Authority to improve the timeliness of MH assessments for people in police custody. | July 2015July 2015July 2015Sept 2015March 2015March 2015July 2015October 2015October 2015 | BCCBCCBCCCI Sean RussellCI Sean RussellMCYP CommissionerJCTBCCMH Learning and development teamCI Sean Russell | •I can be confident that if I require a MH Act assessment this will be delivered in a timely way by staff with the specialist knowledge to determine the most appropriate response.•As a young person I can be confident that my MH Act assessment will be carried out by a CAMHs psychiatrist or an AMHP with specialist knowledge and experience of the needs of young people so that the right decision can be made about the treatments and support that I need.•Where appropriate my own GP will be the Doctor undertaking my MH Act Assessment.•I can be confident that there are strict multi-agency policies and procedures in place so that there is an appropriate response from all agencies who respond to me when I am in crisis.•As a resident in a care home I can be confident that the home will have staff who receive regular, high quality training in MH and dementia and that they will establish good links with MH and dementia services locally so that I can stay well.•I can be confident that my age will not be a barrier in getting the treatment and support that I require. |  |
| B8 | **People in crisis should expect that statutory services share essential ‘need to know’ information about their needs** | * Health and Social Care have full access to the clinical records.
* MH Social workers have full access to RIO
* Police can now access the RIO system via the street triage team
* RAID teams based in acute hospitals have access to RIO
 | * There is a contradiction between information governance and information sharing
* Health staff do not have access to BCC records.
 | * To review current inter-agency information sharing protocols and identify other organisations who need to be included. Particular issues re 111 MH information, advice and crisis line bid and links with third sector.
* The Police via the street triage service have access to RIO to get access to patient records. This is not currently accessible by the Emergency Duty Team (EDT) or all social care staff so current BSMHFT and BCC information sharing protocol needs to be revised.
* To consider mental health social care staff to record relevant case information on the BSMHFT RIO system so that there is a single narrative for all service users.
* West Midlands Police (WMP) to work with statutory health and social care providers to improve awareness of WMP special interest markers and Corvus Trigger Plans so that they can be utilised to ensure access to crisis management plans as appropriate. Ensure agenda item on multi-agency groups.
 | October 2015October 2015October 2015April 2015 | BCCBCCBCCWMP MH and Intel needs | I can be confident that:•I will receive a good quality service when I am in crisis•people who come to support me when I am in crisis have been able to access relevant information about my needs so that they are better able to identify the support and treatment that will best meet my needs and how quickly they need to respond•all relevant information about me and the support and treatment I am accessing is recorded on the same system so that more informed decisions can be made about what is working well for me or what needs to change.•there are strict protocols in place governing who has access to my information and the purposes for which it can be used. |  |
| B9 | **People in crisis who need to be supported in a health based place of safety will not be excluded** | * Street triage
* Local S136 policy
* Access to a commissioned POS
 | * No recurrent funding identified for the continuation of the street triage pilot.
 | * To audit POS referrals against admission criteria to identify any patients who were identified as not appropriate and the reasons why. If a high number to then review whether this was related to lack of capacity within the unit or whether it was that the patient didn't meet the admission criteria.
* To undertake a review of existing PoS policies.
* WMP to lead discussions with MH Trusts and security leads to agree time limit for police retention.
* WMP to cease use of intoxilyser as a method for assessing drunkenness.
 |  |  | I can be confident that •I will not be criminalised just because I have had a mental health crisis.• I will only be taken to the place of safety service where this is appropriate and that all will have been done to avoid this if at all possible.•At all times people will treat me with respect.•Police will stay with me until my care has been handed over to the place of Safety staff.•I will not be refused access to the place of safety service just because I am drunk or high on drugs. |  |
| B10 | **People in crisis who present in Emergency Departments should expect a safe place for their immediate care and effective liaison with MH services to ensure that they get the right on-going support.** | * RAID operates out of all Birmingham and Solihull Acute Hospitals although it is only 8-8 in Solihull.
* RAID is commissioned to respond within 1 hour to any MH issues identified within patients in A&E and to undertake a thorough MH assessment of the patient and agree appropriate next steps with the ED staff.
* Part of the RAID function is to identify services that will best support and follow up the patient post discharge from the Emergency Department or following a period of admission.
* AMHP’s operate 24/7
* Emergency Response and Assessment respond s within 4 hours and operates Mon – Fri until 8pm and Sat-Sun until 6pm
 | * Current difficulties meeting the presenting inpatient needs within current local commissioned capacity.
* RAID is not commissioned to support people under the age of 16 and no out of hours crisis provision for this age group.
* Lack of available inpatient provision means that people admitted are acutely unwell, over 60% detained, and such admissions will be longer
* Acute Trust and CCG commissioning intentions for RAID remain unclear, therefore so is future funding of the service
 | * Winter pressures finances funding additional psychiatric decision units for UHB & HoFT (24/7) at Oleaster site, and on site at City Hospital (from 10 – 22.00hrs)
* Scope the likely wider system benefits of more intensive specialist community MH services such as a MH urgent care centre, specialist home care/PA support readily available to avert crises.
* To agree the model for Psychiatric Liaison services (RAID) within Acute Hospitals and to secure the arrangements for funding these services recurrently. PH contribution to RAID substance misuse (£290K pa) withdrawn from May 2015.
* To ensure that all Emergency Department (ED) staff are aware of, and applying, the NICE quality standard and guidance for self harm.
* To audit patient experiences through ED following incidents of self harm and get a better understanding of the events leading up to it and what, had it been accessed earlier, might have averted the incident.
* To review the actions of ED staff when they identify MH needs in patients with physical health conditions and to use this to inform training and information sharing needs of ED staff to improve onward referral/signposting.
* To ensure that all staff are aware of lawful restraint protocols within their Acute Trusts.
* To ensure that ED’s have the facilities to allow for rapid tranquilisation of people in MH crisis where this is appropriate and required.
* To scope the likely wider system benefits of more intensive specialist community MH services.
* To extend ERA to 24/7
 | Operational from November & Dec 2014 (respectively) for 6 monthsMay 2015May 2015July 2015July 2015July 2015October 2015From Nov 2015 | BSMHFTBSMHFTUrgent Care Delivery GroupAcute TrustsRAID with Acute Trusts Acute Trusts and RAIDRAID and acuteJCTFTB | I can be confident that when I attend A&E in MH crisis or having self harmed that :•I will feel safe•The staff have been properly trained to ensure that they can support me appropriately.•That there will be specialist mental health support available to me within A&E.•If I need to be restrained or tranquilised there are clear protocols in place to ensure that this is required, appropriate, and delivered safely.•There will be regular audits of patient experiences to ensure that they are as good as they can be.•Staff within the ED and RAID will see me as a whole person and not just my presenting condition.•ED and RAID staff will be well informed about what is available locally so that I can be signposted to the help and support that I need to maintain my mental and physical health. | Amber |
| B11 | **People in crisis who access the NHS via 999 system can expect their need to be met appropriately** | * The Street Triage service is a car which includes a paramedic, a police officer and a CPN. Street triage ensures that there is a robust initial assessment of MH patients who are potential S136 cases and will identify most appropriate support / treatment for the individuals concerned.
* West Midlands Police and ambulance control room staff have access to street triage team who can be diverted to appropriate incidents.
 | * No recurrent funding yet identified to support Street Triage beyond the pilot phase.
* Street triage isn’t available 24/7.
 | * To pilot a MH crisis line across Birmingham linked to 111.
* To continue the street triage pilot and evaluate wider system benefits realised to inform recurrent funding streams.
* Ambulance Service nationally to look at mandatory enhanced levels of MH training for ambulance staff.
* Review and improve information sharing protocols in line with new MH service models and pathways.
* Evaluate the MH Triage model including Ambulance across WM Police footprint.
* Improve training and education programmes for staff across non MH specialist agencies. (refer to B4)
 | Feb – April 2015November 2015September 2015June 2015April 2016On-going | JCTCI Sean RussellRobert Cole, WMASBCC, BSMHFT, CCG, WMP,WMAS | •I know how I can get help early through 111 to reduce the chances of me experiencing crisis.•I can be confident that if I am responded to at home or in a public place that I will have a proper assessment of both my mental and physical health needs and that the most appropriate decision will be made about how best to meet my presenting needs.•I know that my information will be shared with other agencies who are part of the information sharing protocol but only where this is appropriate and required. | Amber |
| B12 | **People in crisis who need routine transport between NHS facilities or from the community to an NHS facility, will be conveyed in a safe, appropriate and timely way.** | * Where secure and escorted patient transfer is required to a different hospital, services such as WMAS are commissioned. This is currently on a spot basis.
* Private ambulances take people out of area
* The street triage car is an unmarked specialist ambulance so non stigmatising.
 | * No recurrent funding yet identified to support Street Triage beyond the pilot phase.
* Targeted Resilience Bid to extend the pilot until March 2016 applied for.
* Greater clarity needed in responsibilities to convey patients between different organisations (? Issues of parity of esteem for MH service users ).
 | * To review current routine transport arrangements for people in MH crisis between sites and identify the number of times that police cars are being used.
* To review the Conveyance Protocol with WMAS.
* To review commissioning of patient transport between inpatient units
* Improve arrangements for conveying people to hospital under MHA
 | April 2015July 2015 | Robert Cole WMASBCC, WMAS, WMP | I can be confident that I will at all times be transported safely and in an appropriate non stigmatising vehicle. |  |
| B13 | **People in crisis who are detained under S136 powers can expect that they will be conveyed by emergency transport from the community to a health based place of safety in a safe, timely and appropriate way.** | * Transfers to out of city are- purchased on a spot basis.
* Street triage car will convey those who require transfer.
 | * No recurrent funding yet identified to support Street Triage beyond the pilot phase.
* Targeted Resilience Bid to extend the pilot until March 2016 applied for.
* AMHPS are responsible for arranging transport under the MH Act
 | Review that our local S136 ambulance protocol is in line with the National Protocol issued April 2014. | Completed | WMP | I can be confident that I will at all times be transported safely and in an appropriate non stigmatising vehicle. |  |
|  | **Quality of treatment and care when in crisis** |  |  |  |  |  |  |  |
| C1 | **People in crisis should expect local MH services to meet their needs appropriately at all times** | * RAID operates 24/7 within Heartlands, SWBHFT and UHB, 7 days a week. The team comprises MH, substance misuse and older adult specialist staff and works closely with staff to improve the care of people accessing acute hospital services.
* Social services provide access to an Emergency Duty Team out of hours.
* AMHP’s are available 24/7.
* Home Treatment available 24/7
* Street Triage available until 02.00hrs
* Single Point of access 8 – 19.00hrs
 | * More appropriate environment within A&E/AMU for people with MH problems requiring physical health interventions.
* Access to a MH urgent care centre where no on-going need for physical health intervention/treatment.
 | * Psychiatric Liaison Services via RAID to operate out of all acute sites – still not recurrently funded.
* RAID model to be reviewed based on patient demographics to ensure that it tailored to presenting needs.
* Continue to monitor and review out of hours provision to ensure that there is the right support and capacity to meet presenting needs within agreed timeframes.
* To continue to monitor and review AMHP and S12 Doctor arrangements to ensure that MH Act Assessments for patients in crisis are delivered within 4 hours.
* Proposal to develop a strategy for needs of people with non-psychotic personality issues to include non-statutory crisis houses and appropriate assessment, support and management by secondary care
 | On-goingMarch 2015On-goingOn-goingOn-going | Urgent care delivery groupBCCBCCTBC | •I will get the most appropriate level of crisis intervention at the first point of service.•I can be confident that my mental health needs can be appropriately met within an acute hospital setting.•I can be confident that when I require an urgent MHA Assessment that this will be within 4 hours unless there are clinical reasons that delay the assessment. | Amber |
| C2 | **People in crisis should expect that the services and quality of care they receive are subject to systematic review, regulation and reporting.** | * People in care homes have their services regularly inspected by BCC Quality Monitoring Officers.
* CCG quality team undertake spot checks in wards and community teams
* CQC monitoring and inspection processes
* Internal Trust monitoring and review of service quality via Quality Support Visits.
* Monthly Clinical Quality Review Group meetings between NHS providers and commissioners.
* Real time patient/carer feedback stations available in MH facilities.
 |  | * MH Leads and Commissioners to link into the Acute hospital Urgent Care re-design to ensure that it appropriately considers the needs of people with a mental illness.
* To review the RAID model to ensure that they are tailored to meet the specific patient demographics.
* To review out of hours provision as part of the re-design of mental health services locally and flex resources as required to meet presenting needs.
* To ensure that at all times patients in crisis are treated with respect by whichever service they present to.
* To regularly review patient satisfaction and patient journeys and experiences and to ensure prompt action where the reviews identify poor quality provision and practice.
* The Police to review HMIC requirements and new responsibilities under the MH Code of Practice. Responsibility for essential standards shared amongst senior managers.
* WMP to establish a formal process for more involvement of MH service users through a focus group to shape and influence policy and operational practice.

- Creation of a Force Wide MH IAG | On-goingFebruary 2015 | JCTJCTMH leads MH leadsMH lead and LPU leadCI Sean Russell | •I can be confident that across Birmingham mental health conditions have parity of esteem with physical health conditions.•I can be confident that if I need to access acute hospital care that there will be provision available to me to support my mental health needs.•At all times my dignity will be protected and I will be treated with respect.•I can be clear that the Police will deal sensitively with me at the first point of contact •I am aware that as a service user I have a voice and that there are networks that I can engage with to share my experience. |  |
| C3 | **When restraint has to be used in health and care services it is appropriate** | * BSMHFT staff access the Restraint in Care Training programme – 5 day training in the management of aggression.
* Staff are not trained in face down restraint but such restraint does sometimes happen and all such occasions are reported as incidents.
* BSMHFT working to set staffing levels in line with recommendations of Francis Report, Berwick and NICE guidelines.
* Street triage provides a robust assessment of the person’s needs by CPN and paramedic, hopefully reducing the number of incidents that become problematic requiring restraint. Only the Police will be able undertake restraint
* Increased resources invested to support work around DOL’s following Supreme Court Ruling.
 | * Sufficient assessment capacity to support DOLS cases.
 | * To review whether there has been a reduction in restraint following increased staffing and fewer bed numbers on acute MH wards.
* To continue to review the numbers of times restraint is required and to look at whether there are particular patterns requiring further investigation ie particular ward etc
* To look at opportunities for other providers to access the same training as BSMHFT staff to ensure a consistent approach to restraint across Birmingham and Solihull.
* A formal policy review is taking place in relation to Police intervention in MH environments working with NHS Protect.
* Review whether RAID staff need to access the 5 day restraint training rather than rely on use of hospital security staff.
* Review whether there has been a reduction in the use of restraint on MH Acute Assessment wards following the increased staff ratio to bed numbers.
 | Feb 2015Ongoing | BSMHFTBSMHFTCI Sean RussellBSMHFTJCT | •When restraint is used it will be proportionate and lawful in use. |  |
| C4 | **Quality and treatment and care for children and young people in crisis.** | * Birmingham Children’s Hospital Home Treatment Team works with 12-18 year olds.
* Service working with West Midlands Quality Review Service on CAMHS Standards
* Current services from BSMHFT EIS & Youthspace
* BSMHFT Home Treatment assess 16+
* Emergency Response and Assessment service has been provided to patients who attend A and E.
* Place of Safety for CYP
 | * Primary Mental Health Service to help children and young people in their community before mental health problems become more serious and enduring
 | * To act in compliance of the legal and policy frameworks.
* To implement recommendations and standards as agreed by Birmingham Safeguarding Adults and Childrens Board, Care Quality Commission/ Ofsted Inspections and reviews.
* To establish quality assurance arrangements, including the development of a programme of comprehensive auditing to evidence the voice of the young person is heard and quality, treatment of care provided is at the standard required.
* To develop a single point of access with a crisis assessment team available 24/7
 | Oct 2015Autumn 2015 | MCYPMCYP Commissioners and FTB | •I can be confident that all services delivering crisis support for children and young people will be of high quality and safe.•I know that services want to hear about peoples experiences of using their services and that they will act on the information received to further improve what they do. |  |
|  | **Recovery and staying well/preventing future crises** |  |  |  |  |  |  |  |
| D1 | **Early intervention** | * Care plan for all service users which include agreed crisis plan.
* Transitions protocol for ADHD CAMHs to AMHs transition clients recently refreshed.
* Single point of entry established supported by a newly developed GP referral form.
* Fast track entry back into services agreed as part of the new MH pathway.
* ASC MH team re-design aligns with the BSMHFT pathway. Working with third sector providers to ensure that their services are also properly aligned to the MH pathway.
* Compass team provide dual diagnosis training. RAID incorporates MH and substance misuse staff within the team.
 | * Support services properly linked to/embedded within the hubs.
* Knowledge about what is currently available in local areas that can support wider health and wellbeing needs. Lots available but not well known so not as well utilised as they should be.
 | * Primary Care Mental Health Service transformation to address transitions between primary and secondary care, will promote rapid transition between services. To ensure that all providers of mental health services and support are linked to the MH Pathway.
* 0-25 service redesign
* Development of a Crisis Care plan CQUIN for 2015/16

To continually look at causation factors in clients presenting to services in crisis such as housing, social , economic and substance misuse and ensure a combined multi-disciplinary approach to support people to stay well. We will do this through:* Access to wider support via the information and advice hubs within Birmingham
* MH Information, Advice and Crisis Line linked to 111
* Social Prescribing
* Mental Health Drop in Services

To continue to monitor the effectiveness of the above and the capacity required within these services to ensure effective support to people to keep them well and maintain their recovery.* Public health well being hubs. The Lifestyle service redesign will expand provision to meet the lifestyle and wellbeing needs of vulnerable groups i.e those with low level mental health needs and will act as a triage into lifestyle services within the community. Services will be tailored for individuals with MH issues.  Services will include stop smoking, physical activity, health trainers, healthchecks and weight management.  It is envisaged that the Lifestyle hubs and the Primary Care Mental Health  service will be integrated and there will be cross referrals. A low level mental assessment will be conducted through the lifestyles hub to identify mental health needs and through the new referral system, the hub will refer into Primary Care Mental Health Service and vice versa.
 | Primary care transformation2015/60-25 redesignOctober 2015March 2015 | JCTJCT, BCC, MCYP JCT, BSMHFTPublic health commissioners | -I know who my nominated key worker is at times of crisis and I know how to access them.-There are a range of support options available to me to help me stay well.-I can be confident that services that I access will look at me as a whole person and not just see me as my illness.-I know how to access support that will help me to address other issues in my life impacting on my mental health. |  |