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| A Prevention and Early intervention  |
| This action plan is all age and is inclusive of people with a learning disability, autistic spectrum disorder and dementia. Where there are specific services or actions required for people from identified groups these have been detailed separately within the plan.Solihull recognised that it was not doing enough by way of prevention and early intervention . Most of the providers of low level support services had been given little attention or little new investment. Not much had been done to forge links with the MH care pathways and it was recognised that we were not making best use of our local community assets and social capital. Over the last two years prevention and early intervention has been given a high priority locally and is a discrete work stream within the Integrated Care and Support Solihull programme for Solihull. Solihull Council and Solihull CCG are signed up to the ethos of ‘lives not services’ looking at how it can provide early support to the 25,000 with needs not just the 5,000 who meet FACs criteria and this approach is being strengthened through the ‘Better Together for Solihull’ programme. All third sector organisations providing information, advice and low level support have been re-tendered against an outcomes based prospectus – the first phase tenders were awarded in December with the new service models live from 1st January 2015. The following two phases to be completed during the first half of 2015/16. ***Emotional Health and Wellbeing services for children and young people***. There has been a recent tender of this service against a new outcomes based service specification. We will be scoping the potential to move resources out of higher tier provision to support a greater range of universal provision locally. The successful bid is a partnership between the BSMHFT and Bernardos.***Strong multi-agency approach*** across Solihull with, for example, the Police and Fire service developing strong links with the health and social care economy to better support vulnerable people within the community. Solihull has a strong Venerable People Harm and Reduction Forum where partners from across Solihull come together to discuss complex cases and work together to find better solutions which benefit both the service user and agencies involved. |
| A1 | Access to advice and information | An Information and Advice Hub operating out of Chelmsley Wood Library. A second hub to be developed in 2015.Access to more specialist mental health and dementia advice and advocacy through Solihull Mind, Alzheimer Society, Independent Advocacy and Age UK.Dementia Information Guide Produced and offered to all people on the dementia registers of practices. Now being given out to all patients going through the Memory Assessment Service.Access to specialist disability advocacy through Solihull Action Through Advocacy.Learning Disability Partnership Board | * Third sector mental health information, advice and low level support providers now formally linked to local health and wellbeing hubs within Solihull**.**
* A bid to pilot a MH information, advice and crisis Line linked to 111 has been approved. Initial pilot phase February 2015 – end April 2015 with opportunity for extension subject to interim evaluation**.**
* Develop a Solihull web-portal which holds up to date information about all services and support within Solihull and details Ensure that there are good links within the portal to other agencies information sites ie Police, third sector etc.
* Police to be encouraged to refer people to hubs.
* Information and advice available in formats that are most appropriate to age, ethnicity, disabilities etc for people who have need of them.
* Improved signposting of people to specialist web-sites such as B-EAT, Youthspace, Solihull Healthy Minds etc so that people can access information and advice more tailored to their specific needs.
 | First hub operational June 2014. Second hub April 2015.February 2015 April 2015January 2015On-goingOn-going | Early Intervention Commissioner - accountable to ICASS.MH CommissionerReources Directorate, SMBCWMP, SolihullAcross all agencies/servicesAcross all agencies/services | * I will have access to appropriate information, advice, advocacy and support to help me to remain independent and enable me to play a more active role in finding my own solutions and/or support me in my caring roles.
* I will have more involvement in planning my own support.
* I will feel less isolated and vulnerable and more connected with my local community.
 | * Better informed public & staff
* Building social capital and localism
* Holistic, low level assessment of needs.
* Better understanding of people with complex needs in low level provision
* Reducing stigma.
* People accessing the right help sooner – reducing number of people moving to crisis.
* Better quality of life (WEMWEB)
* Improved links between services.
* Police less likely to take punitive action if know hub will respond.
* Customer journey developed across Connect, the Hubs/ASC to ensure maximum linkage through the Care Act preventative services.
* Reduction in the number of suicides and incidents of self harm.
 |
| A2 | Access to peer support | * Solihull Mind Drop in Service
* Solihull Mind Horticulture Service
* Family Care Trust Befriending Service
* Bosworth Partnership Centre
* Alzheimer Society Memory Cafes
* Alzheimer Society Dementia Cafes
* Wellbeing Headquarters for children and young people.
* Early Intervention Service – Peer Support
 | * To continue to encourage the development of peer support opportunities within Solihull- building on what is already available and maximising the opportunities afforded through the hubs**.**
* Independent Advocacy to offer training programmes for experts by experience to gain City and Guild qualifications with a view to them becoming advocates or personal assistants of the future. First training programme (15 places) to commence April 2015.
* To continue to roll out dementia friends training across Solihull and to exceed the target of 4,500 dementia friends by April 2015.
* To develop communications strategies to raise the profile of mental illness and reduce the stigma associated with it to encourage more people to volunteer as be-frienders locally.
 | On-goingApril 2015April 2015April 2015- | M H and Early Intervention Commissioners accountable to ICASSIndependent Advocacy | * 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 feel that I have value.
* 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.
 | * Increased numbers of personal assistants and advocates with lived experience.
* Improved employment opportunities for people with severe and enduring mental illness.
* People supported to stay well so reduced use of primary and secondary care services.
* Increased numbers of people volunteering to support people with mental illnesses locally.
* Increasing numbers of dementia friends within Solihull.
* Reduction in the number of suicides and incidents of self harm.
 |
| A3 | Access to social prescribing | * Social prescribing linked to GP Practices in the North of the Borough.
* Continued development of the social prescribing directory – expanding the range and choice of support options and activities that people can access.
 | * To encourage the use of social prescribing in the support of people with mental health needs.
* To roll out Social Prescribing to be Borough wide.
* To continue to develop the links between Health Exchange, the Health and Wellbeing hubs and local mental health services.
* To ensure that social prescribing is formally aligned to the re-designed MH pathway.
* To open up referral for social prescribing to social workers, Community psychiatric and community LD nurses.
 | On-goingApril 2015On-goingApril 2015Referrals opened up to CPN’s and MH SW from July 2015 | Senior Specialist in Public Health.MH and Early Intervention Commissioners. | * My GP will recognise the impact that my social needs are having on my health and wellbeing.
* I will have access to a holistic assessment of my health and social care needs and I will be encouraged to look at opportunities that will help me to address the issues that are negatively impacting on my wellbeing.
* I will have confidence that if I am becoming mentally unwell that any support organisation will know how to get me the help that I require.
 | * People supported to stay both physically and mentally well. Resulting in a reduced use of wider primary, community and secondary care services.
* People with a MI becoming more connected with their communities thereby reducing the feelings of isolation and the stigma of mental illness which in turn reduces use of MH services.
* Providers and agencies becoming more aware of what each other does and working in a more integrated way to better support the needs of people presenting.
 |
| A4 | Access to a single point of access to a multi-disciplinary team | The BSMHFT implemented a single point of access into their services in April 2014.Autism diagnostic pathway produced which is integrated across social care and health.Draft autism strategy and an agreement to have social worker autism leads within each team. | * 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 scope the potential for a Solihull specific SPoA as part of the re-design of MH services within Solihull.
* For Learning Disability services – explore the opportunities for integrating specialist health workers with learning disability social workers.
 | SPOA established April 2014Interim review November 2014Full review September 2015September 2015 | BSMHFTBSMHFT & CommissionersBSMHFT & commissionersCWPT and LD Commissioner | * 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.
 | * Simple referral process
* More efficient and effective use of CMHT/HTT services.
* GPs sending through more detailed information to help inform the service offer to the patient.
* Clear response times for each type of referral.
 |
| A5 | Access to respite | * Limited dementia respite
* Ad-hoc use of vacant capacity within MH residential service.
* Limited use of vacant capacity within Birmingham

MH respite units.* Access to sitting services for people with dementia and older adults with functional MH needs.
* Access to both health and social care commissioned residential and community based respite for people with a learning disability.
 | * To identify current respite capacity gaps for both functional and organic conditions within Solihull and to measure the impact that such gaps have on the wider MH system within Solihull.
* Results of this audit to inform the MH Urgent Care Business case and the wider MH re-design plan for Solihull.
* Learning Disability Commissioner to review current respite provision.

  | November 2014November 2014-September 2015September 2015 | MH CommissionerMH CommissionerLD Commissioner | 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.
 | * Reducing admissions into MH acute assessment services (functional and organic).
* Supports earlier discharge so reduced length of stay in both Acute Hospital and MH wards. (functional and organic).
* Ensuring better flow through the system and reducing the requirement for out of area placements.
* Support to carers
* Supports people to remain living at home.
 |
| A6 | A joined up response from services with strong links between agencies.A joined up response from services with strong links between agencies (continued) | * MH Social Workers are integrated into the CMHT’s within Solihull.
* Solihull Integrated Addiction Service (SIAS) which is a partnership between the BSMHFT, Aquarius and Welcome.
* COMPASS provide dual diagnosis training to staff both BSMHFT and other MH/Substance Misuse support agencies.
* Street Triage service which responds to people in crisis and has Police Officer, CPN and Paramedic working together out of a car.
 | To work with partners to develop a more integrated approach and to forge strong links between agencies in the treatment and support of people with a mental illness. We will do this by:* Strengthening the role of the GP in the delivery of MH care within Solihull. Through enhanced training for GPs and easy access to advice and support from specialist MH staff.
* Continuing to roll out dual diagnosis training to mental health staff through Compass and to improve the links between the CMHT’s, the Solihull Integrated Addiction Service, RAID and acute hospitals.
* Explore opportunities for integration between learning disability and health and social work teams.
* Encouraging the police to have direct links into the neighbourhood hubs and to encourage them to refer people that they identify with low level MH needs.
* Specialist MH providers supporting the training needs of agencies who regularly come into contact with people with a MI ie Police, Fire, community and voluntary sector etc.
* Identifying a series of approaches to make it easier for people from disadvantaged or marginalised communities to access information and advice services. This will include audit of current use, identify current barriers to access and match against expected prevalence to identify gap.
* Ensuring that all services, support agencies and wider community capacity that support people with MH problems are formally linked to the MH pathway.
* To review community and voluntary sector (CVS) capacity and to work in partnership with the sector to maximise opportunities for new sources of funding into Solihull.
* To work in partnership with families and schools in the delivery of multi-agency training on emotional wellbeing for children and young people.
 | On-goingDuring 2015 \*On-goingPilot project started October 2014Training programmes already delivered and will continue.April – September 2015April – September 2015On-goingOn-going | MH Programme Board and ICASS.MH GP Lead and the Clinical Director for Solihull within the BSMHFT.Substance Misuse Commissioner.Early Intervention Commissioner and Solihull Police Lead, Response TeamCommissioners, Solihull Observatory and CSUCommissionersCVS CommissionerBSMHFT from April 2015 | 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.
 | * Improved service user satisfaction
* Less duplication – ie service users only having to tell their story once.
* Reduced use of secondary care services for people with co-morbid needs.
* All GP’s referring appropriately
* GP’s reporting that they are more confident in managing MH needs within primary care.
* Teachers Police Officers, Fire officers etc receiving regular training in MH awareness.
* Strong links developed between the Police and the Hubs.
* Evidence of good systems of partnership working and signposting between agencies and organisations linked to the MH pathway.
* Building social capital and localism.
* Schools much better able to spot early signs and support pupils to access the specialist help and support required.
* Information sharing protocols.
* Shared care protocols.
* Harm reduction.
 |
| A7 | Dementia Action Alliance  | * Both the Council and CCG are members of the Dementia Action Alliance with agreed action plans identifying how, through what they do, they can improve the experiences of people with dementia.
* There are also 17 other organisations and key council directorates signed up as Alliance Members with their action plans loaded onto the National Website.
 | * All agencies involved in the delivery of the Crisis Care Concordat for Solihull will become members of the Dementia Action Alliance and will develop their own dementia alliance action plans to meet the Call to Action outcomes. Most of the organisations signed up to the Crisis Care Concordat Declaration for Solihull are already Dementia Action Alliance members.
 | By March 2015 \* | Dementia Commissioning Officer accountable to ICASS | * I have personal choice and control or influence over decisions about me.
* I know that services are designed around me and my needs.
* I have support that helps me live my life.
* I have the knowledge and know how to get what I need.
* I live in an enabling and supportive environment where I feel valued and understood.
* I have a sense of belonging and of being part of family, community and civic life.
 | * Increasing numbers of organisations across Solihull being members of the Dementia Action Alliance.
* Use of the dementia logo (kite mark) for those organisations who are meeting the requirements of the Alliance.
 |
| A8 | Access to help at home services | * Solihull has a Home treatment Team, an Assertive Outreach team and an Early Intervention service all of which will provide support to people in their own homes.
* Promoting Social Inclusion and Independence (P.S.I.I.) team
* Limited number of providers with MH expertise on the Home Care Framework.
* Target response times for AMHP’s are met in the majority of cases.
* Specialist learning disability domiciliary care providers.
* Specialist community learning disability team functions including enhanced support function for people with very complex and challenging behaviour.
 | To address the current gaps in services that support people with a MI within their own home. This will include:* Encourage homecare providers with MH specialisms and expertise to be aligned with the Homecare Framework for Solihull.
* To evaluate the recent re-design of the Promoting Social Inclusion and Independence (PSII) team to ensure that it is delivering improved outcomes and experiences for people accessing the service.
* To review current ASC MH services to ensure that an Approved MH Professional (AMHP) will continue to be able to respond within agreed timescales.
* To audit whether the BSMHFT is achieving the target that 50% of people experiencing a first episode of psychosis will be treated with a NICE approved care package within two weeks of referral.
* Creating a ‘safe haven’ to avoid hospitalisation or home situation breakdowns.
 | September 2015July 2015July 2015During 2015/16During 2015/16 | Operational Commissioning Lead.Head of MH Services, ASC.Head of MH Services, ASC.MH CommissionerMH and LD Commissioners | 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.
* if I am experiencing a first episode of psychosis that I will only have to wait two weeks from the referral being made to receiving treatment.
 | * HTT providing pre-emptive support to reduce numbers of people moving to crisis.
* EIS, HTT and AOT capacity appropriate for presenting levels of need.
* Increased numbers of people accessing support from PSII Team and achieving their stated goals.
* AMHP’s meeting agreed 4 hour response time in the majority of cases.
* Increased numbers of MH specialist providers on the home care framework within Solihull.
* Reduction in the number of suicides and self harm.
* Reduced numbers of people not in education, employment or training.
 |
| A9 | Access to liaison and diversion services for people with MH problems who have been arrested for a criminal offence. | * Pathways pack on arrest for all offenders - officers identify the cause of criminal activity and signpost to the relevant agencies for further follow up work to be completed. This includes Mental Health as well as substance misuse.
* Offender managers link in with the MH trust, to ensure any individual who is being managed receives the appropriate support from the relevant agency
 | To improve access to liaison and diversion servicesfor people with MH problems who have been arrested for a criminal offence. This will be achieved by:• Pathway cards are to replace the current pathway packs to make the process simpler. Every person leaving custody will be given a card which can be used as a point of reference if they feel that they need assistance going forward.* Over the phone referrals will be completed with the Offender Management Team if the offender is prepared to engage with the service.
* Consolidate existing reporting process for failures.
* Police to work with statutory MH service providers to improve awareness of West Midlands trigger plans (Corvus) so that they can be better utilised to ensure access to crisis management plans as appropriate.
* Police to improve the availability of communication tools to help them assist vulnerable people – scope roll out of this to other non specialist MH service agencies and providers.
 | June 2015 \* | West Midlands Police | 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.
 | * Upfront information about the potential support needs of victims, witnesses or offenders.
* Officers better equipped to respond effectively and appropriately.
* Improved quality of care for people in mental health crisis
* Quicker response to identified crises
* Reduced number of inappropriate people taken into custody, the ED and 136 suite.
 |
| A10 | To reduce the stigma associated with Mental Illness | * Annual community engagement events across Solihull.
* The Dementia Friends programme is a key priority for both Solihull CCG and Council. A target has been set for there to be 4,500 dementia friends in Solihull by the end of 2015. But on-going programme.
* Local events for: MH Awareness day, Black MH week, International Womens day, Dementia Awareness week etc.
* Solihull 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 Ashram – significant proportion of their time spent in promoting MH awareness and reducing stigma across all age groups.
* Awareness raising in schools.
* Gay and bisexual mens group, providing peer support and working with people to report hate crimes.
* Domestic violence awareness programmes.
 | * To agree with Public Health and Communications a programme for the delivery of MH awareness campaigns across Solihull.
* To continue work with schools to promote emotional wellbeing awareness so that young people will be more likely to seek help early.
* To encourage conversations about mental illness and take every opportunity to raise awareness and dispel myths.
* Promotion of healthier workplaces across Solihull and encouraging more organisations to become Mindful Employers.
* To improve awareness of community safety as a result of hate crimes perpetrated against people.
 | April 2015 On-goingOn-goingDuring 2014-15June 2015\* | Public Health and communicationsBSMHFT & BernadosEVERYONEPublic Health, Chamber of CommercePartnership Supervisor, Solihull Police; Head of Equality and Diversity, SMBC; Community Safety Officer, SMBC | * I am not ashamed or worried about telling people that I have a mental illness.
* I am not ashamed or worried about telling people that I have dementia.
* I am not ashamed or worried about telling people that I have autism.
* I have a better understanding of mental illness, dementia, LD and autism and will do all that I can to support family, friends and colleagues who have these conditions.
* I have a better understanding of mental illness, dementia LD and autism 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, dementia, LD and autism.
 | * More informed and respectful Public- Solihull is known as a MH ‘Friendly Borough’.
* Solihull is a Dementia Friendly Borough
* More companies identified as ‘Mindful Employers’ providing mental health supportive environments locally resulting in fewer work days lost as a result of MH difficulties.
* Employers across the Borough understand the significant benefits that employing people with a MI, LD and or those on the autistic spectrum can bring.
* Employers who are already benefitting from employing people with a LD,MI and/or ASD share these positive experiences with other employers locally.
* Reduced numbers of hate crimes against people with a MI, LGBT, LD, dementia etc.
* Increased numbers of people from communities with ‘Protected characteristics’ seeking early help.
* Victims and perpetrators of domestic abuse more confident about seeking early help.
 |
|  | **B Urgent and Emergency Access to crisis Care** |  |
| When we refer to people in MH crisis within this plan this is inclusive of people with LD, dementia, autistic spectrum needs or substance misuse . Where there are specific services or actions for people with an LD, dementia or autistic spectrum disorder, or substance misuse these have been separately identified within the plan. Mental health services delivered by the BSMHFT and ASC are already well integrated and service response times for people in crisis across Solihull are within agreed targets. There are excellent examples of integrated working across agencies to support people in crisis in the form of initiatives such as street triage and RAID. An interim evaluation of the Street Triage Service after 48 weeks of operation has identified that it has delivered impressive wider system impacts ; it has halved the number of S136 detentions, it provided physical health interventions to 601 people who would otherwise have been taken to A&E and reduced the need for ambulance conveyance in 266 cases. We have worked closely with the Birmingham Joint Commissioning Team and have ensured MH representation within the System Resilience Group which has supported the development of MH pilots across Birmingham and Solihull such as the Psychiatric Decision Unit, and discharge nurses both of which improve system flow, significantly reduced MH breaches in the 4 hour ED target and reduced the numbers of patients requiring admission out of area. RAID operates across all Heart of England Foundation Trust sites and this service currently supports MH and substance misuse clients who attend at A&E and those who have been admitted. Solihull is working with the BSMHFT and wider stakeholders to transform MH services within Solihull, with new service models and pathways being developed during 2015/16.**Children and young People:** We are concerned at the rise of self harm in children and young people (CYP) and the reduction in such activity is a priority for Solihull. Although Solihull has access to a Place of Safety for children and young people, there has been no local out of hours support available and therefore A&E was identified as the place to go in crisis. The new service specification for children and young peoples (CYP) services which was awarded to the BSMHFT and which is to be implemented from April 2015 requires there to be out of hours provision for CYP in crisis. There are concerns about CAMHs T4 bed capacity issues and pathways and we will look to work with NHSE and other CCGs to develop more integrated strategies to deliver improved outcomes for children and young people in crisis. The focus on early intervention and prevention, alongside intensive community provision and out of hours support should support CYP to stay well and reduce the numbers of CYP moving to crisis.**Learning Disability** – Solihull has very few admissions for MH assessment and treatment for people with a LD. Enhanced community services provide responsive, pre-emptive support to people becoming unwell and are able to avert the majority of crises that would necessitate admission. Solihull is signed up to the Green Light Toolkit and will assess service requirements based on need not diagnosis. MH and LD teams work together and deliver shared care to people with complex needs who require a mix of MH and LD specialist expertise. |
| B1 | Responses to people in crisis should be the most community-based closest to home, least restrictive option available and should be the most appropriate to the particular needs of the individual. | Solihull has:* Single Point of Access into MH Secondary Care services.
* Psychiatric Liaison services delivered through RAID operating within all Birmingham and Solihull Acute Hospitals.
* Home Treatment team
* Emergency Duty Team
* Inpatient MH assessment beds
* Street Triage service pilot.
* Place of safety – both for adults and children and young people.
* 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.
* Piloting a MH Information, Advice and Crisis Line linked to 111.
* Enhanced support team for people with complex and challenging learning disability support needs.
 | To develop capacity more local to Solihull using the resources currently supporting out of area provision. There may still be a requirement for some people to access services outside of Birmingham and Solihull but this will be where there is a need for highly specialised treatment or where it is a more appropriate solution for the person presenting. We will achieve this by:* Further re-designing the current MH system and pathway in Solihull.
* 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 and capacity especially provision after 9pm.
* Continuing the Psychiatric Decision Unit pilot and evaluating it’s impact.
* Opening of a new female MH acute admission ward and monitoring impact on out of area admissions.
* Developing and implementing out of hours provision for children and young people.
* Scoping potential wider system impacts of more intensive community support through Solihull MH Re-design and BSMHFT New Dawn projects.
* To scope the need for out of hours responses for people with a learning disability.
* Reviewing current training of Personal Safety Training (PST) 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 2016As aboveApril 2015 +March 2016June 2015 – March 2016November 2014During 2015April 2015April 2015April 2015- March 2016October 2015During 2015On-going | MH Project BoardMH Project BoardMH CommissionerForce MH LeadBSMHFTBSMHFTUrgent Care BoardBSMHFTC&YP CommissionerMH Project BoardLD CommissionerMH Lead, WMPPolice Custody and MH Leads | I can be confident that:* all but 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.
 | * No out of area placements for people requiring MH acute assessment unless it is in their best interest or clinically indicated.
* Reduced numbers of detentions under S136.
* Significant reduction in the number of people attending A&E where there is no physical requirement to do so.
* Reduced number of people requiring MH Act Assessments.
* Fewer people requiring admission into MH services against 2014/14 baseline.
* No A&E target breaches relating to MH.
* No clients accessing custody as Place of Safety.
* AMHP and S12 Doctor responses within 4 hours.
* Reported improved patient and carer experiences – compliments/real time feedback.
 |
| B2 | * We want to ensure equality of opportunity in the access s and outcomes for people across all protected equality characteristics in mental health crisis.
* We want to promote a culture in mental health services that challenges inequality to ensure that people are treated fairly and with dignity and respect.
* We want to empower engagement with marginalised or under-represented communities for them to be involved and help influence and shape the mental health improvement agenda.
* We want a workforce across Solihull that welcomes, values and promotes diversity and is competent in advancing equality and tackling discrimination both within and outside of their own organisations.
* We want to ensure that all premises out of which services are delivered meet the needs of all staff and visitors.
 | * SMBC commissions third sector organisations to engage with hard to reach groups including black minority and ethnic groups across the borough of Solihull including the Carers Centre.
* Ashram employs Community Development workers whose remit is to target hard to reach groups including BME, Mental Health and drug and Alcohol Abuse.
* We promote an equality and human rights culture in the values and principles in the way that mental health services are commissioned, planned and delivered.
* Contracts and specifications require providers to ensure that their services reflect the diverse needs of the population and awareness of the cultural differences to support and encourage equality of access into services.
* The development of the web-portal and information and advice services running out of local neighbourhood hubs including libraries, will support the engagement of local communities and support the signposting of people to services and support that can address any issues they have in a timely manner.

• Access to advocacy services• Access to interpreters* Fair Treatment/Equality Impact Assessments developed to identify and address inequity in services across all protected equality characteristics.
 | To improve the equality of access and outcomes for people in MH crisis from communities across all protected characteristics we will:* Explore local approaches to engagement to increase service user and carer involvement and present ideas on how this improved approach can be achieved
* Consult and engage with communities early on when commissioning services.
* Work in partnership with service users, carers, families and colleagues to develop and provide care and interventions that make a positive difference to their wellbeing.
* Make sure that staff are delivering person-centred care that takes into account the cultural needs of service users.
* Ensure that services commissioned can deliver a range of care options that meet a diverse range of needs.
* Empower people across all protected equality characteristics, to have control over their care and treatment by providing appropriate information and access to advocacy services
* Expect that commissioners and providers meet with community leaders to understand any barriers that may get in the way of people accessing the help that they need.
* Commission Healthwatch to support us in getting a better understanding of the experiences of accessing MH services from people whose voices are under represented in MH services and identify what we need to do to improve.
* Identify and apply targeted or specialist interventions to improve pathways of care between community and mental health services.
* Review service access data against demographic and prevalence data to identify the gaps in data collection or access rates across a number of protected equality characteristics.
* Review local and national data to identify any unequal distribution of factors relating to MH crisis care in Solihull.
* Ensure that we have an improved framework for effectively reporting and responding to hate crime in Solihull.
 | On-goingOn-goingOn-goingOn-goingOn-goingOn-goingDuring 2015By end 2015By October 2015 \*By October 2015By June 2015By June 2015 \* | All Partners to the DeclarationCouncil and CCG Equality and Diversity Leads.Statutory, community and third sector providers.All providersMH CommissionerMH CommissionerBSMHFTMH CommissionerBSMHFTSolihull ObservatorySolihullObservatoryPartnership Supervisor, Solihull Police; Head of Equality and Diversity, SMBC; Community Safety Officer, SMBC | I am confident that: * all services and agencies within Solihull are inclusive of, and more sensitive to, my MH needs regardless of my equality group - they will understand my needs and make ‘reasonable adjustments’ where the need has been identified.
* Regardless of my identity, social group, or the community that I belong to, I feel empowered to engage and influence the design of MH services within Solihull.
* I can access all MH services based on my health needs and feel safe to do so.
* I have a voice in directing my care and treatment and that my views are valued and listened to by those services providing my care.
* I can confidently raise concerns about my care and treatment which are valued and listened to by those services providing my care
* I will not be discriminated against because of my identity or the equality group I belong to.
* All involved in the commissioning and provision of MH services will in-reach into my community to try and 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.
 | * Crisis services and residential alternatives to hospital admission are inclusive and culturally competent and accessible to people across all protected equality groups.
* Gap between expected prevalence and service use narrowed for people across a number of protected equality characteristics.
* Increased numbers of people across all equality groups accessing early help services and support.
* Reported improved patient and carer experience – through compliments and real time feedback systems.
* People feel safe and confident in the MH services we provide - any cases of discrimination and hate crimes are reported and effectively investigated.
* Programme of MH awareness raising and training targeted to those communities who are marginalised or under represented in MH services
* Marked increase in people from targeted equality groups who are involved and influencing the mental health improvement agenda.
 |
| B3 | Access and new models of working for children and young people | Solihull has CAMHS emergency assessment and support during working hours, and access to a Place of Safety both in and out of hours.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.CAMHs and universal provision for children and young people is being tendered. Clear specification and model developed in support of the tender and this will inform future service models and pathways for the successful provider.The successful provider will be expected to deliver to the new specification from the 1st April 2015, unless otherwise agreed. | 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 comprising young people, 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 reviews via CRG
* Formal review to inform future commissioning and potential requirement to re-tender
 | April 2014April 2015April 2014.April 2015February 2015During 2015During 2015On-goingQuarterlySeptember 2016 | BSMHFTBSMHFTBSMHFTBSMHFT MH CommissionerCYP CommissionerHoEFT until 31 March - BSMHFT thereafterCYP Commissioner CYP Commissioner | * 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.
 | * CAMHS Out of hours provision in place locally.
* MH Crisis Plans for young people do not include A&E as place to go in crisis out of hours unless appropriate for physical reasons.
* Reduced numbers of young people requiring admission.
* Reduced numbers of young people requiring Place of Safety.
* More young people having their needs identified earlier and signposted/referred to the most appropriate place to receive early help and support.
* Gap between identified prevalence rate for our population and the numbers of young people

diagnosed is narrowed.* Reduced number of suicides and episodes of self harm
 |
| B4 | All staff should have the right skills and training to respond to MH crises appropriately. | ***Police:**** Multi agency mental health training has been completed with all front line officers. Solihull has a Mental Health lead and a Vulnerability officer who are SPOC's for the LPU and knowledgeable in current practices and policies. A mandatory Ncalt package is also in place.

***WMAS:*** * partnership agency training taking place. Concerns raised with University Paramedic curriculum as now limited MH training in degree course. This is being taken up by the Association of Ambulance Chief Executives who are insisting that minimum standards for MH awareness are taught.

***HEFT Staff:**** The RAID team has provided training across the three HEFT sites. Training for Good Hope Staff has primarily been in respect of older adult MH training.
* Heartlands: Dr George Tadros has delivered 2 day training courses for staff on the 4 D’s (depression, dementia, delirium and dignity) c 60 staff have undertaken this training.

***Voluntary Sector:**** Solihull Mind ensures that workers have information on the appropriate agencies/referral systems for people in crisis (including drug and alcohol, and domestic/sexual abuse); and Advocates can support people to access the appropriate service.
* Solihull Mind staff have training in dealing with people in distress/crisis; and have a specific Policy/procedure for dealing with people with inappropriate/difficult behaviour. Policies are reviewed bi-annually (or following an incident) by the Mind Trustees.
 | * Mental health awareness training will be encouraged for all providers delivering care and support across Solihull.
* 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.
* To ensure that there is a regular review of the skill mix, competency and training needs of staff volunteers and peers within the neighbourhood hubs and low level support provision.
* Provision of action learning sets and on-line resources to enhance training and development opportunities for staff.
* 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.
* Learning disability and autism multi-agency training.
 | During 2015 and on-goingJan-March 2015Feb-end April 2015During 2015 and on-goingApril 2015 \*October 2014. Mandatory annual MH awareness training September 2014April 2015 and on-going thereafter \*On-goingOn-going | MH Commissioner Project Lead for 111 PilotProject Lead for 111 pilotMH Learning and Development Leads from partner agenciesPolice MH L&D Lead Early Help and Prevention Commissioner and contract reviewing officer.MH Learning and Development LeadsLearning and development leads | 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 Solihull.
* 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.
 | * Improved customer satisfaction through experience of a safe and improved quality of service.
* Reduced officer time on scene.
* Improved access to the right service at the right time – efficiently and safely
* Improved understanding about the roles and responsibilities of each service.
* Improved, informed response to service users who need and immediate response at the time of crisis.
* All Police and Ambulance supervisors will receive additional education re MH issues.
* Management support from Police Supervisors will be available 24/7 for front line staff.
* Staff across the Solihull Health and Social Care system will be more informed about mental illness, will be better able to spot early signs of deterioration and will ensure that there is support offered to the person to get the advice or support that they require. MECC.
* Acute hospital staff better able to support people with MH and or dementia – impacts will include reducing average length of stay, increased patient, carer and staff satisfaction.
 |
| B5 | People in crisis should expect an appropriate response and support when they need it | Single point of entry into secondary care services – people who have urgent needs are seen same day.* Home treatment Team – same day
* RAID response is within an hour if the person is within A&E (Heartlands 24/7 but Solihull only 8-8) and within 24 hours if admitted.
* Street Triage Service – but pilot until end March 2015
* No specific 24 hour helpline staffed by MH and social care professionals but there is access to the single point of entry during working hours and the emergency duty team out of hours.
* Timely response (usually within 4 hours) for AMHP’s unless clinical reason why this is not appropriate.
* Solihull Mind’s weekend Open Access Support and Information Service (OASIS) is also used by people in crisis as an access point to other services to help manage the crisis until other services are available.
* Contingency (crisis plans) included within all care plans.
* Cross Border AMHP Protocol agreed with Birmingham
* Enhanced support team for people with a LD.
* Inpatient settings acute liaison (specialist learning disability) nurse available to advise and support.
 | * To audit that all services that deliver crisis responses are linked to the appropriate pathways (MH, LD, substance and CYP) and are 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 (MH, LD and CYP).
* To audit AMHP response times for MH Act Assessments. To review capacity requirements if response times are outside of accepted timeframes.
* To audit the use of the MH Act, identifying changes in its use and looking to benchmark against other comparable authorities.
* To implement an information, advice and crisis helpline linked to 111.
* 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.
* Audit the use of A&E/999 for patients becoming mentally unwell or in crisis – work with patients to identify and agree use of alternative support solutions.
* To review cross border AMHP protocol in light of recent incidents to ensure that it is watertight and owned by AMHP’s across Birmingham and Solihull.
* To scope requirement for out of hours acute liaison nurse for LD.
 | October 2015On-goingMarch 2015 \*February 2015 \*March 2015End April 2015October 2015On-going through RAID monitoringJune 2015 \* | Solihull MH Project BoardSolihull MH Project BoardHead of MH Services, ASCHead of MH Services, ASC111 Pilot Project Lead111 Pilot Project Lead Solihull MH Project BoardRAID Head of MH Services, ASC | 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.
 | * Appropriate and timely response for people who are in crisis.
* Reduced use of A&E for people with a primary presentation of MI.
* Easy access to help and support in a crisis.
* Integrated approach to the delivery of services to people in crisis
* Reduced use of S136
* Better use of the third sector in supporting people in crisis.
* Clearly identified and accessible contingency (crisis) plans for people known to services.
 |
| B6 | People in crisis in the community where police officers are the first point of contact should expect them to provide appropriate help. The Police should be supported by health services including MH, ambulance and emergency department services. | * Street Triage – current Birmingham and Solihull Home Office funded pilot – due to end January 2015.
* Place of safety service – 2 adult places available for Birmingham and Solihull. When POS established it had been identified that Solihull would require approximately 53 POS admissions p.a.
* Place of safety available for young people aged up to 16.
* Local POS protocol developed and agreed with police, BSMHFT and WMAS.
 | * To continue to review and monitor the use of place of safety and to ensure that there is sufficient capacity to meet presenting needs across Birmingham and Solihull.
* 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 MH Re-design Programme Board to identify system gaps which if filled would provide a more effective and efficient MH pathway across Solihull. Re-aligning commissioning resources to deliver early help to reduce the numbers of people experiencing crisis.
* To scope the need for an out of hours place of safety for people with a learning disability.
 | Bi-monthlyBi-monthlyOctober 2015During 2015-16During 2015-16 \* | MH Lead, WMPMH Lead, WMPMH Lead, WMPMH CommissionerLD Commissioner | I can be confident that:* I will not be criminalised just because I have had a mental health crisis.
* if the police are the first to respond that they will ensure that I have access to a service that can deliver an appropriate assessment of my MH and physical health needs.
* If I have a LD or I am on the Autistic Spectrum I can be confident that the police officers who respond will understand my needs and how to engage with me.
* at all times I will be treated with dignity and respect.
* if I require to be moved to a safe place this will not be into police custody unless this is warranted.
* if I am taken to the Emergency Department because I need a physical health intervention, that I will not be treated differently to other patients who do not have a mental illness, a LD, ASD or dementia.
 | * Appropriate use of the Place of Safety
* Police Custody no longer used as a place of safety for people who have not committed an offence.
* Appropriate use of A&E for people in crisis.
* Police cells never used as a place of safety for children and young people.
* Police aware of other services that can provide support to the person experiencing crisis and they know how these services can be accessed.
* Police staff who attend have a good awareness of MI, LD, autism and dementia and can respond appropriately.
 |
| B7 | When people in crisis appear (to health, social care professionals or the police) to need urgent assessment, the process should be prompt, efficiently organised and carried out with respect. | * AMHP response times are good in Solihull, usually within 4 hours.
* Section 12 doctors more problematic to access but still not a significant issue within Solihull.
* HTT Consultant who is S12 trained has developed a SMART phone app to identify S12 Dr’s who have registered to the app and to check their availability.
* The app will also enable AMHPs to view the S12 Dr profile to see their specialisms (particularly useful to identify CAMHS specialists) including languages spoken and also a potential rating system based upon view of the AMHP.
* Business case submitted to move all AMHPs to smart phones.
* Improved conveyance policy
* Street triage service (but only pilot with funding until January 2015)
* Street triage car – ordinary vehicle so no stigma.
 | * 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 audit the use of the patients own GP in MHA assessment process.
* 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 the number of MHA assessments and to look at what could have been done earlier to have prevented the person becoming so unwell.
* 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.
* 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 2015 \*July 2015 \*July 2015 \*July 2015 \*September 2015 \*March 2015March 2015July 2015 \*October 2015October 2015October 2015During 2015-16January 2015 | Head of MH Services ASCHead of MH Services ASCHead of MH Services, ASCBSMHFTHead of MH Services ASCMH Lead, WMPHead of MH Services, ASCCYP CommissionerMH CommissionerMH CommissionerMH Learning & Development teamMH Lead, WMP | * 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 be supported to stay well.
* I can be confident that my age will not be a barrier in getting the treatment and support that I require.
* I can be confident that having a disability (physical or Learning) will not be a barrier in getting the treatment and support that I require.
 | * Robust multi-agency protocols in place and good evidence of use across all partner agencies.
* AMHP and S12 Doctor responses within 4 hours.
* Appropriate consideration of alternatives to admission
* Safe and robust care plans in place for people who are not admitted.
* Appropriate use of the place of safety
* Police custody no longer used as a place of safety for people who have not committed an offence
* Appropriate use of A&E for people in crisis.
* Police cells never used as a place of safety for children and young people.
 |
| 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 and input all their daily case reporting onto RIO (the health system)
* Police can now access the RIO system via the street triage team.
* RAID Teams based in Acute Hospitals have access to RIO.
 | * 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.
* MH health SW and the Police via the street triage service have access to RIO. This is not currently accessible by the Emergency Duty Team (EDT) so current BSMHFT and Solihull MBC information sharing protocol needs to be revised.
* To consider mental health social care staff to do all case recording 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.
* To scope the development of an information sharing protocol between BSMHFT and CWPT.
 | June 2015 \*June 2015 \*October 2015February 2015September 2015 | Head of MH services ASCHead of MH services ASCHead of MH Services, ASCWMP MH and Intel leads Information Governance Leads | 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.
 | * Robust information sharing protocols in place and evidence of appropriate use and application.
* Evidence of real clarity across staff groups re sharing of information.
* Mutual understanding of roles across partner agencies.
* Evidence of improved patient management, outcomes and experiences as a result of staff being able to access patient records when dealing with a person in crisis.
 |
| B9 | People in crisis who need to be supported in a health based place of safety will not be excluded. | * Street triage service operational across Birmingham and Solihull.
* Access to commissioned Place of Safety Service
* Local S136 policy agreed
 | * To review admission criteria for POS.
* WMP to cease use of intoxilyser as a method for assessing drunkenness.
* 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.
 | September 2014September 2014April 2015 \*April 2015 \* | Local LPU MH LeadsForce MH Lead | 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.
* Being drunk or having taken drugs will not automatically exclude me from accessing the Place of Safety.
* I will not be refused access to the Place of Safety just because I have a learning disability or I am on the autistic spectrum.
 | * Services such as street triage ensuring that there is an appropriate use of S136 and PoS.
* Robust and safe procedures for dealing with people under the influence of alcohol or drugs.
* Staff in the PoS able to deal with the physical conditions of patients not requiring A&E.
* A&E only used when the patient has an appropriate physical requirement for attendance.
* Paramedic available in street triage team so robust physical health assessment to inform decision for appropriate place of safety.
* Appropriate consideration of alternatives to admission
 |
| 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. | * Psychiatric liaison delivered through 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 and will respond within 4 hours in most cases.
* LD acute liaison nurse but only available in hours.
 | * To agree the model and update the service specification for Psychiatric Liaison services within Acute Hospitals and to secure the arrangements for funding these services recurrently. RAID is funded up until June 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 scope the need for an out of hours acute liaison service for people with a LD.
 | June 2015June 2015 \*July 2015 \*July 2015 \*June 2015 \*June 2015 \*October 2015October 2015 \* | Urgent Care BoardHoEFTHoEFT & RAIDHoEFT and RAIDHoEFT & BSMHFTHoEFTand BSMHFTMH commissionerLD Commissioner | 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.
* 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.
 | * Robust psychiatric liaison provision in place within all emergency departments (ED).
* ED access to MH patient records to inform management and treatment plans.
* That there are robust processes in place to ensure that people who attend the ED and who do not require a physical health intervention are discharged or moved out to more appropriate services within the shortest possible time.
* ED staff more aware and knowledgeable about mental health conditions and know what services are available to provide support to the patient outside of A&E.
* Good signposting of ED staff to alternative services and support to prevent or at least reduce future attendances at A&E.
 |
| B11 | People in crisis who access the NHS via the 999 or 111 system can expect their needs 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.
* MH information, advice and crisis line linked to 111 to ensure improved disposition to the services best able to meet presenting needs.
* BSMHFT provide training to ambulance staff and the police to ensure that they know how best to approach and treat people with a MI, particularly those who are in crisis. – this has been completed with Solihull officers.
* National Ambulance Leads Group (supported by AACE Association of Ambulance Chief Executives) have a national policy mandating the emergency response for all s136 patients.
* MH nurses now being utilised in WMAS ambulance emergency operations centre.
 | * To pilot a MH crisis line across Birmingham and Solihull 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 Police training and education programmes for staff across non MH specialist agencies. (refer to B4)
* Scope the potential for the 111 service to access patient notes for people known to services who are regular users of 111, 999 and ED services.
 | Feb – April 2015November 2015September 2015April 2015April 2016On-goingJuly 2015  | MH CommissionerForce MH Lead, WMP WMASASC, BSMHFT, CCG HoEFT, WMPForce MH Lead, WMP111 Commissioner and BSMHFT | * 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.
 | * Robust links established between 999, 111 and services such as MH crisis line and street triage.
* Robust information sharing protocols in place.
* Good signposting to alternative services and support through the Directory of Service held by 111.
* Fewer 111 dispositions back to GP and ED.
* 111 staff more aware and knowledgeable about MH conditions and feel more confident and competent in handling calls from people with a MH condition.
* Reported improved experiences for people accessing 111.
 |
| 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. | * The street triage car is an unmarked vehicle so non stigmatising.
* Where secure and escorted patient transfer is required to a different hospital, services such as Rapid and Secure are commissioned. This is currently on a spot basis.
* Transfers to the POS service located in Birmingham will either be via the street triage car or via ambulance in line with agreed conveyance policy.
 | * 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.
 | April 2015June 2015 \*June 2015 \* | WMASWMASMH Commissioner | I can be confident that I will at all times be transported safely and in an appropriate non stigmatising vehicle. | * People are transported in a non stigmatising manner.
* Transport is available with a minimum of delay.
* Where physical care is required for the patient being transported ambulances provide the transport.
 |
| 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. | * The Street triage car will convey those who require transfer who they have assessed.
* Conveyance policy agreed in support of S136 policy with WMAS – 20 minute response time in operation.
 | Review that our local S136 ambulance protocol is in line with the National Protocol issued April 2014. | Completed | Force MH Lead, WMP | I can be confident that I will at all times be transported safely and in an appropriate non stigmatising vehicle. | * People detained under S136 powers are conveyed using the street triage vehicle.
* Robust conveyance policy in place locally.
* Conveyance Policy response times targets met.
 |
|  | **Quality of treatment and care when in crisis** |  |
| Robust quality monitoring and inspection services are in place locally. Monthly Clinical Quality Review Groups for the BSMHFT, HoEFT and CWPT Contracts with CCG Quality Team representation on these groups. The BSMHFT were one of the first Trusts to go through the new CQC Inspection process and were identified as ‘good’ – issues identified for improvement have been pulled into an action plan and implementation of this plan is being monitored through the Clinical Quality and Contract Review Group meetings. There are robust monitoring and inspection processes in place within the Council for Residential and Nursing Care Home services and providers of home care services. For homes that support older adults with MH and/or Dementia we have a care home liaison service commissioned which supports care home staff in the care and treatment of people in their homes and to provide on-going training to staff to improve their knowledge and skills in supporting people with MH and dementia who live at the home. |
| C1 | People in crisis should expect local MH services to meet their needs appropriately at all times. | * Increased staff to bed ratio within MH inpatient services.
* On-going MH training for staff across agencies within Solihull who are likely to come into contact with people in crisis.
* Single Point of Access into MH services with direct access to Home Treatment Team services for those in crisis.
* Multi-agency Safeguarding Hub.
* Strong MAPPA function
* Multi-agency Strategic and Local Liaison forums locally.
* MDT Review Process for LD
 | * Through quality monitoring and inspection processes we will regularly seek assurance that all staff supporting people in crisis will have the right knowledge and expertise to provide the best response.
* Through investigation of complaints and serious untoward incidents to continue to ensure that services are delivering clinically effective and safe care.
* To implement new contract management processes which will enable us to measure performance, quality and best value and allow us to terminate contracts where these are not delivering to agreed outcomes.
* Through Joint Agency Forums, processes and protocols we will ensure that agencies work together in the support of people

with a MI.* To ensure that all policies and protocols are up to date and that all relevant people are aware of them and operating in accordance with them.
 | On-going \*On-goingApril 2015On-goingJune 2015 \* | CCG and Provider Quality LeadsCCG and Provider Quality LeadsStrategic Contract Leads from Council and CCGHealth and Wellbeing BoardHead of MH Services - SMBC | I can be confident that:* all staff and agencies supporting me are properly trained and have the experience required to support me most effectively.
* all staff and agencies that I come into contact with are aware of the agreed policies and procedures in place and are operating in accordance with them.
* complaints will be taken seriously and appropriately dealt with.
* that all serious untoward incidents and incidents of self harm will be thoroughly investigated and that actions will be taken to ensure that such issues do not occur in the future.
 | * Evidence of on-going training and development of staff
* Robust contract management and quality monitoring processes and protocols are in place.
* Whole system clarity of relevant protocols and processes
* Multi-Agency Safeguarding Hub.
* MAPPA
 |
| C2 | People in crisis should expect that the services and quality of care they receive are subject to systematic review, regulation and reporting | * CQC monitoring and inspection processes
* Internal Trust monitoring and review of service quality.
* Monthly Clinical Quality Review Group meetings between NHS providers and commissioners.
* Real time patient/carer feedback stations available in MH facilities.
* People in care homes and those receiving support from homecare providers have their services regularly inspected by SMBC Quality Monitoring Officers.
* MH Advocacy services available to support people to address issues of concern.
* Dementia advocacy provision commissioned.
* MDT Review Process for people with LD.
 | * To regularly review service user satisfaction/ experiences and to ensure prompt action where the reviews identify poor quality provision and practice.
* Through the regular review of contract performance to identify issues of concerns and trends and work with the provider to address them.
* To establish a contract performance and review process for all providers who have services commissioned by the Council.
* 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-going \*On-goingJanuary 2015September 2014(on-going)April 2015 \*February 2015 | CCG Clinical Lead through CQRGCommissioners through CRGStrategic Contracts LeadForce MH Lead, WMPMH and Custody lead, WMPMH Lead and Local LPU Leads. | * I can be confident that across Solihull 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.
* I can be confident that the services that I access will be safe.
* I can be confident that all complaints and untoward incidents will be thoroughly investigated and action plans developed to prevent such incidents occurring again.
* 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.
 | * Reduction in the number of complaints and serious untoward incidents.
* Improved patient confidence and experience.
* Improved carer confidence and experience.
* Fewer serious untoward incidences and safeguarding concerns across all services locally.
* The views of service users and carers used to inform on-going service delivery and future service developments.
 |
| 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.
* CWPT training in physical management techniques.
* Staff are not trained in face down restraint but such restraint does sometimes happen and all such occasions are reported as incidents.
* BSMHFT have increased the staffing levels on all inpatient wards in line with Francis Report recommendations.
* 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.
* Increased resources invested to support work around DOL’s following Supreme Court Ruling.
* RAID staff do not access the 5 day restraint training as it is expected that they call on Acute Hospital Security to restrain patients.
 | * 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.
* On-going critical review of every incident of physical management and all incidents are reported to senior management team.
 | February 2015July 2015 \*June 2015 \*On-going | Force MH Lead & NHS Protect LeadBSMHFTCCG Quality Lead | I can be confident that:* Restraint will only be used when this is appropriate and in line with locally agreed restraint policies and guidelines.
* When restraint is used it will be proportionate and lawful in use.
 | * Restraint only used when appropriate.
* Restraint will be safe, evidence based and delivered by trained staff.
* Reduced use of restraint within MH inpatient units.
 |
| C4 | Quality, treatment and care for children and young people in crisis.  | * Service working with West Midlands Quality Review Service on CAMHS Standards
* Intensive Community Outreach Service (ICOS) prevents admission to inpatient mental health services.
* Commissioned Place of Safety service for children and young people up to age 16.
* Designated Professionals Group for children and young people established in Solihull.
 | * To act in compliance of the legal and policy frameworks.
* To include WMQRS standards as requirement in the specification for the new service from April 2015.
* To implement recommendations and standards as agreed by Solihull Safeguarding Adults and Childrens Board, Safer Solihull (Community Safety Partnership), Care Quality Commission/ Ofsted Inspections and reviews and Solihull CCG.
* 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.
 | April 2015 \*April 2015 \*April 2015 \*April 2015 \* | Rosie Luce, Head of Safeguarding and Designated Nurse. | * 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.
 | * Robust policies , procedures and protocols in place that are owned by all partners.
* All staff aware of policies, procedures and protocols and operate in line with them.
* Children and young people in crisis will receive a timely, age appropriate service.
* Reduction in the number of complaints and serious untoward incidents.
* Improved confidence and experience of children and young people and their families.
* Fewer serious untoward incidences and safeguarding concerns across all services locally.
* The views of children and young people and their families are used to inform on-going service delivery and future service developments.
 |
|  | **Recovery and staying well/preventing future crises** |  |
|  The recovery model is embedded in all commissioned services. There are strong working relationships with the Police through MAPPA (L1 and 2), MASH, ASB Case Conference Forum and Strategic and local liaison Forums. Agencies such as the Police, Fire, Ambulance, Neighbourhoods, MH Trust and Third Sector are all partners at the Harm Reduction Forum which identifies people with multiple and complex health and social care needs and looks at how these needs can be better met through a more joined up approach across agencies. There are opportunities locally for people to access low level support services as outlined in section A and these will support people to maintain their recovery. |
| D1 | Recovery, staying well and preventing future crises. | * Care plan for all service users which include agreed contingency plan.
* Transitions protocol for 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 and MH social workers are integrated with the BSMHFT CMHT’s.
* Working with third sector providers to ensure that their services are properly aligned to the MH pathway and third sector providers have been encouraged to re-market their services to SW’s and CMHT’s.
* Compass team provide dual diagnosis training to MH staff across the Statutory and Third Sector.
* RAID incorporates MH and substance misuse staff within the team.
* Solihull Integrated Addiction Service is a partnership between the BSMHFT, Aquarius and Welcome so that MH, substance and social needs of clients can be well supported.
* Solihull Mind provide OASIS/ MH drop in services (including out of hours and weekends) and also provide advocates to help access MH services.
* Employment support services available locally – good links between IAPT and the Employment Support Service which is supporting people to remain in work or to return to work.
* Supported employment service for people with a LD.
* Early Intervention services supporting people to remain in education, training or employment.
* Promoting social inclusion and independence team supporting people to maintain recovery and achieve identified goals.
* Access to social prescribing to help people become more connected with their local communities, stay well and preventing future crises.
* Information and advice hubs helping people to address social issues that may be having a negative impact on their mental health.
* Solihull Council signed up to the healthy workplace charter and encouraging other organisations and business across Solihull to become members.
* Development of a new supported living scheme in Solihull to replace an existing MH residential care home.
* Homecare support that is enabling.
* High percentage of MH clients (51.1%) who have chosen a direct payment to meet the outcomes identified within their care and support plan.
* LD, PD and older adults (functional and organic) day opportunities programmes
* Development of a range of supported living services and houses for people with MI, LD and/or ASD.
* For people overcoming addiction Solihull has brought together organisations under a partnership organisation called Solihull Integrated Addiction Service (SIAS). SIAS supports people to overcome alcohol, drug and gambling dependencies helping them to rebuild their lives while at the same time making a positive contribution to local communities. SIAS through it’s partners deliver:- Alcohol and drug detox- Counselling- individual and group support - rehabilitation - supported housing- peer mentoring for offenders- homeless outreach services- charity shop and warehouse- community centre and café
* SIAS also supports young people using drugs or solvents and those caring for parents who are misusing substances.
 | * To ensure co-production at every level between people with personal and professional experience of MH problems.
* To work with partners to effect major cultural and organisational change to deliver recovery focussed models of support.
* 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 Solihull
* MH Information, Advice and Crisis Line linked to 111
* Social Prescribing
* Employment support services – bid for ESF monies to further develop local services
* Mental Health Drop in Services
* Solihull Integrated Addiction 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.
* To ensure that all providers of mental health services and support are linked to the MH Pathway.
* To continue to work with employers locally to encourage them to become mindful employers and be supportive of people with MH and other disabilities within their workforce.
* To monitor the outcomes of people using a direct payment to meet their care and support needs against those accessing more traditional services.
* To continue to identify support opportunities for older adults with functional and organic MH needs and those of their carers so that people can be supported to remain independent and living at home.
* To work with providers to develop more respite capacity for older people with functional and organic MH needs.
* To work with providers to develop more dementia nursing home provision locally.
* To work with providers to develop a range of day opportunities so that people have a greater choice of support options including employment and voluntary work.
	+ LD Day services review
	+ Older adult day services review
 | On-goingOn-goingOn-goingPilot June 2014 Enhanced support links from Jan 2015Pilot starting March 2015April 2014 During 2015On-goingOn-going On-going October 2015 On-going On-going \*On-goingDuring 2015During 2015 On-going Completed 2014During 2015  | AllMH Project BoardAll providersPEI CommissionerMH and 111 CommissionersPublic HealthEconomic DevelopmentMINDSIASRelevant commissionersSolihull MH Project BoardPublic Health – Healthy Workplace LeadHead of MH Services, ASCMH Project BoardMH CommissionerOlder People Services CommissionerLD CommissionerMH & OP Commissioners | * I know who my nominated key worker is at times of crisis and I know how to access them.
* I can be confident that there will be recognition of the equal importance of both ‘professional expertise’ and ‘lived experience’
* There are a range of support options available to me to help me stay well.
* That I will be allocated resources based upon my assessed need which I can use to design my own support solutions tailored to my specific needs.
* I can be confident that the 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.
* The services that I access will focus on recovery and helping me to become more resilient and an expert in managing my mental health.
 | * Care plans will include contingency planning.
* Care plans will be recovery focussed
* Increase in the numbers of people exercising choice and control through for example direct payments.
* Fast track re-access process established for people discharged from services.
* Reduction in the numbers of people moving to crisis.
* Increased time between relapses of mental illness.
* People reporting that they are more expert in the management of their MI.
* Increased numbers of employers more aware and supportive of people with MH problems within their workforce.
* Increased numbers of people with a MI in employment.
* Increase in the number of people moving off sick pay and benefits.
 |