

**Mental Health Crisis Concordat**

**Review, Action Plan and Declaration**

**Bath and North East Somerset**

**Updated June 2016**

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| **Multi-agency forums that support delivery of services/review crisis concordat plan** | | | | | |
| **Forum name** | **Membership** | **Frequency** | **Discussed** | **Seen plan** | **Commented** |
| Adult Mental Health and Learning Disability Offenders Forum | **AWP** – Intensive team; CARS; **Commissioners (CCG/LA/NHS England):** MH, LD, substance misuse, health and justice (MH)**; Probation; Sirona –** complex health needs/LD/adult autism services**; Police; Bath MIND**  **DHI** (criminal justice/substance misuse); **and Julian House (Criminal Justice and Housing)** | Quarterly | **C:\Users\andream\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\DHZCTDNK\MC900434713[1].wmf** | **C:\Users\andream\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\DHZCTDNK\MC900434713[1].wmf** | **C:\Users\andream\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\DHZCTDNK\MC900434713[1].wmf** |
| Mental Health and Wellbeing Provider Forum | **Commissioners (CCG/LA) –** MH**; AWP –** various**; Sirona –** various; **St Mungos Broadway; Bath MIND; Rethink; Soundwell; New Hope** (SU group); **Keep Safe Keep sane** (carers group); **Creativity Works;**  **Knightstone Housing; CAB; The Care Forum; Second Step; Julian House. Commentary provided by Homeless health care team even though they are not represented at this meeting. (see action plan)** | Bi-monthly | **C:\Users\andream\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\DHZCTDNK\MC900434713[1].wmf** |  |  |
| Mental Health Care Pathways Group | **GP –** St Chads**,** St James**,** Catherine Cottage  **AWP –** Clinical Director, Managing Director, Head of Professions  **Commissioners (CCG/LA) –** GP Lead and MH CSM  **Sirona; MH &W Forum -** rep**; Practice Manager -** rep | Bi-monthly | **C:\Users\andream\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\DHZCTDNK\MC900434713[1].wmf** |  |  |
| Mental Health Collaborative meeting | **RUH –** Director/Assistant Director of Nursing/LD Lead/ A&E consultant;  **CCG –** Director of Nursing/MH SCM; **AWP –**  Clinical Director/managing Director/Access and liaison services lead/Liaison team manager. | Bi-monthly | **C:\Users\andream\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\DHZCTDNK\MC900434713[1].wmf** |  |  |
| Crisis Concordat Task group | **AWP –**  Clinical Director/managing Director/Access and liaison services lead; **RUH –** A&E Consultant; **Police;** **Commissioner (CCG/LA);** **AMPH Lead, SWAST clinical lead.** | Monthly | **C:\Users\andream\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\DHZCTDNK\MC900434713[1].wmf** |  |  |

| **Positive practice** | | | | |
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| **Service** | **Background and need it addressed** | **Resources** | **Impact and challenges** | **Sustainability** |
| **Mental health liaison services in the acute trust – A&E and across wards – dementia and AOWA** | The core service has been established for at least 8 years in the RUH. It has been expanded over that time to include older adults and is now joint funded with Wiltshire CCG. In addition the Intensive team in provides overnight cover (for last two years)  Enabled joint development of risk matrix for mental health clients.  Provided training for general staff | NHS funding (PCT/CCG) into the specialist mental health trust. Consultant nurse, psychiatrist, psychiatric nurses, admin.  Joint working with A&E consultants. | **Impact:** Has enabled the earlier identification and treatment of people with mental health problems and supported diagnosis and care of older clients with dementia (with or without co-morbidity) as well as supporting discharge.  Increased staff skills and understanding.  **Challenges:** the consistent implementation of processes with aligned capacity to provide care within the A&E 4 hour target.  Managing risk (and hospital capacity/flow) for those clients needing a MH Act assessment – especially out of hours.  Provision of a suitable environment for those clients waiting for a MH Act assessment. | Continued lack of clarity nationally about how much of this function should be supported through the acute tariff. Therefore growth of service to meet demand reliant upon mental health funding stream only. Needs national clarification.  Future work around Parity of Esteem will require workforce initiatives to increase skill sets of staff. Recruitment of staff will affect sustainability.  Reciprocal arrangement for medical liaison into mental health facilities needs to be developed for true sustainability and parity of esteem. |
| **Community Hospital and Care Home liaison service** | Initially started with psychiatrist input into specialist dementia care home - a “ward round” every 6 weeks with GP (providing weekly “ward rounds” under LES). Supported with close relationship with MH team leader (LA social worker as part of integrated MH team).  Further development 4 years ago to increase support into the community sector – especially to improve the care of older people with dementia in order to prevent crisis and hospital admission.  Dementia challenge fund monies supported programme of training into Care Home sector on dementia and dementia care. | Psychiatrist.  Team leader (SW qualified)  2 Bd 6 nurses.  Recurring CCG funding.  Dementia challenge money used for training element currently annual. | Increased capacity in the care home sector to manage complex clients thereby preventing admission into or delay in hospital beds.  Prevented older adults being admitted to hospital in crisis.  Enabled more people to end their lives in the care home.  Increased awareness in the care home sector of dementia and how to care for people.  Improved discharge form community hospitals. | This is built into the block contract arrangements for specialist mental health services.  More support put into this service by targeted resilience monies (see action plan) for people with a secondary diagnosis of dementia with the aim of employing RGNs and social workers into the team. |
| **Care Home Local Enhanced Service - GP** | Provision of GP support into “attached” care homes in order to support health, manage long-term conditions, prevent admission to hospital in a crisis and enable a good death | Funding provided to GP practices by CCG on a fixed term basis currently  Recurrent funding agreed for three years from April 2015. | Improved quality and continuity of care and interventions. Prevented people being admitted to A&E. Enabled people to die in the ‘home’ where they are residing. | Funding agreed for three years from April 2015. |
| **Alcohol liaison team in the RUH** | Alcohol Liaison Service was set up at the Royal United Hospital (RUH) from April 2013.  The aim of this integrated (3rd sector/specialist) service is to stem the rise in alcohol related hospital admissions by reducing bed days and frequency of attendance and admission of high impact users as well as increasing detection of alcohol misuse across the hospital and engaging people in treatment services. | Funded by Clinical Commissioning Group (CCG) and Wiltshire Drug and Alcohol Team:  2 Alcohol Liaison Nurses  2 Recovery Workers  0.5 FTE Hepatology Nurse funded by RUH  An additional community detoxification bed for the sole use by the RUH is being piloted for 12 months. Within the first 6 months of operation the bed has had 60% occupancy. | **Impact**  4.4% drop in the Alcohol Specific Hospital Admissions from 765 in 12/13 to 731 in 13/14  63% reduction in client hospital spells 3 months post contact with the service compared to 3 months before contact  1,315 fewer bed day usage amongst the client group 3 months post contact with the service.  £399,134 tariff savings from the reduction in client hospital spells  An alcohol withdrawal protocol has been introduced and training provided to staff. This has led to a reported reduction in aggression amongst patients.  Significant rise in number of people accessing treatment.  Challenges  Roll out the use of AUDIT tool in the emergency department  Managing capacity within RUH and in community alcohol treatment.  The team is respected for their expertise by RUH staff. | Recurrent CCG funding is in place. Sustainability more dependent on widening the preventative initiatives available to us and thinking nationally about how to manage the market. |
| **Primary Care Mental Health liaison service** | To build upon the recognition that the majority of people who experience mental health difficulties will have their needs met within primary care and not within secondary specialist mental health services.  PCLS Teams set up with a view to improve mental health for individuals and society as a whole and work collaboratively with others to aim to improving care in the six outcomes identified within DoH’s publication, No Health Without Mental Health” (2011). These are:  •More people will have good mental health.  •More people with mental health problems will recover.  •More people with mental health problems will have good physical health.  •More people will have a positive experience of care and support.  •Fewer people will suffer avoidable harm.  •Fewer people will experience stigma and discrimination.  Team work closely with other health, social care providers and third sector. | Psychiatrist  Team leader  Band 6 mental health professionals | **Impact:**  Improved access for professional advice and support for on a spectrum of mental health issues.  Improved communication between mental health, third sector and statutory services  Inclusion of mental health professionals within primary care pathways, e.g. community ward rounds to enable timely interventions/ identify that potential mental health issue are considered at the same time as physical health issues (parity of esteem)  **Challenges:**  Prescribing accountabilities  Adaptation of the model from a primarily GP referral based system to an open access model.  Delivering sustainable service delivery within an open access model | Review and redesign of wider mental health “access service” to streamline process to ensure that right interventions are delivered in a timely manner |
| **Court Assessment and Referral Service (CARS) team** | Service in situ since 2007 but expanded considerably in 2014 in the context of Lord Bradley’s report. Function is to assess the mental health and learning disability needs of those coming into contact with the criminal justice system across Avon and Wiltshire, regardless of age, with a view to diverting those appropriate for diversion, out of the criminal justice system and liaising with the criminal justice system (assuming capacitated client consent) to inform that system of service users assessed needs and arrangements in place to meet those needs be that within or without of the criminal justice system. (We are currently working with SOMPAR to enable them to come up to Lord Bradley’s spec in Somerset also. I note some B&NES clients have been taken to Bridgwater super custody suite). | Across the whole service, that includes B&NES:  Team leader.  Administration.  2 children and young people nurses band 6.  1 learning disability nurse band 6.  6 mental health nurses band 6  1 social worker band 6  7 mental health nurses band 5  1 OT band 5  1 social worker band 5  2 engagement workers band 4. | **Impact:**  Improved and timelier outcomes for people with mental health and learning disability needs involved in the criminal justice system regardless of age.  Reduction in clients being remanded into custody for want of appropriate diversion. Reduction in need for mental health act transfers from prison.  Criminal Justice system (we see people in police custody, we see voluntary attenders and see people in Courts) better informed and informed in a more cost effective and timely manner about the mental health / learning disability needs of our clients (assuming capacitated consent).  As AWP also provide the mental health and learning disability provision in the 5 prisons in our cluster, timely handovers of the needs of those coming into prison and a reduction in the need to re-triage those already screened out by CARS (unless presentation changes significantly once incarcerated).  **Challenges:**  The large geographical area we cover and being able to consistently provide practitioners often at short notice given PACE timeframes.  To meet the Lord Bradley Spec the Team has been required to make a significant number of developments over a short period of time although the team is now fully compliant with the spec and so can now consolidate.  Sometimes the prompt identification of Psychiatric beds for those detained under the mental health act while in police / court custody  A potential challenge maybe working out how street triage and CARS interface in a way that ensures our criminal justice partners get a clear and consistent message | Commissioned by specialist commissioning (NHS England).  Funding also gratefully received from B&NES CCG  NHS England contract due for review 2017. |
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| **Julian House Homeless Hospital Discharge Service,** | The JH service will be working with people who are likely to have on-going and potentially crisis MH needs in addition to current physical health needs.  Will work alongside the Liaison Teams (alcohol, A&E and Primary Care) | Funded by the local authority  Update June 2016: Homeless Hospital Discharge Service funded by Julian House until late 2015. Funding (and service) have ceased. | Challenges are to ensure the service is well integrated into local provision. | Funded on a 3- year basis |
| **Gypsy and Traveller Outreach and Engagement Pilot Service** | Pilot to find out the best ways of engaging with this client group – which include high numbers of “boaters” – in order that they can design service responses, the outcomes they want from services and how to ensure good out of hours access | CCG funded | **To be determined with service users.** | Pilot project for 17 months until April 2016 |
| **Mental Health adult of working age reablement team** | The Reablement service provides a pre and post crisis intervention – depending on where in the MH system service users are. It undertakes an initial assessment, develops a support plan and then implements the plan. The episode of support is normally completed within 6-8 weeks and the case is closed once the service user’s needs have been met and any onward signposting – i.e. to community networks or another provider – has been completed. | Funded via Sirona’s main service contract | **Impacts:** The service helps to prevent people escalating into acute clinical need. It also helps people who are recovering from an acute episode to reintegrate into the community.  **Challenges:** In some cases support is required beyond the time-limited service – i.e. for more than 6-8 weeks. However this can be managed through signposting.  There are also occasions when a client is registered with a GP but resident in another local authority area and so pathways of care can be complicated. | The service has recently been redesigned (effective July 1) and so far it seems to be achieving its expected outcomes within the agreed timescales. Performance in relation to the redesign specification will be kept under review. |
| **Respite beds pilot (Wellbeing House)** | A respite house is being developed to offer short stays. The aim is to provide a therapeutic experience that will help people manage their mental health and keep them out of states of acute need. The respite pilot model will be developed in conjunction with the MH service teams to ensure there is a safe staffing model focused on supporting the individual pre or post crisis.  The service will be jointly run with Curo and will include a peer support worker and support from peers. The Wellbeing House has opened in July 2015 after extensive refurbishment. | Quality Innovation Productivity and Prevention (QIPP) investment funds. | **Impacts:** The service will be one of the few of its kind in the country. Demand for it is expected to be high. Links to other services will be numerous. The scope for innovation is considerable. The therapeutic value of the service to the user should be substantial – which should result in reduced demand for other MH services.  **Challenges:** The main challenge so far has been finding a suitable location for what is a sensitive service. However a Curo owned property was found in Bath and its previous supported living use may mitigate challenges in the reception of the new service within its host community. | The respite project is a pilot. Its continued funding is entirely dependent upon its performance during the pilot phase. |
| **In-patient peer support worker – acute mental health services** | This is a year’s pilot with a partnership arrangement between AWP and St Mungo’s Broadway  To improve discharge processes by using the ‘Move On ‘ methodology  To prevent delays and preparing people for change | Funding Via CCG | Impact on length of stay A more coordinated approach to discharge planning better and supported approach  This is a new way of working for both organisations and identifying pathways quickly | One year’s pilot so request for recurring funding to be made if services appears to be cost effective. |
| **AMHP Service – LA** | Need to ensure collaboration between services in situations which require a Mental Health Act assessment or related interventions. | AMHP office co-located with AWP services with LA and AWP computer access. Dedicated AMHPs and Lead plus Rota staffing. | **Impact**: Enables close collaboration between AWP’s Intensive Service, MH Liaison Service, PCLS and Hillview Lodge Inpatient Unit.  **Challenges:** The increased rates of Mental Health Act assessments and geographical barriers such as out-of-area placement for beds and location of the Place of Safety Suite at Southmead Hospital put pressure on the AMHP service and collaborative working | AWP has agreed a move to a larger office space within HVL. These developments will help ensure sustainability. |
| **AMPH service** | LA recently agreed funding for increased AMHP staffing | LA recently agreed funding for increased AMHP staffing.  I team leader F/T; Ix Deputy F?T. All AMPHs rota-ed on during the week | As above. Extra capacity is in line with national indicators | Continued funding from the local authority. |
| **SWASFT – South West regional Mental Health Joint protocol** | The South West Regional Mental Health Joint Protocol has been created and agreed with the 5 police forces that cover the South West region to allow for an agreed understanding with our emergency colleagues across the South West.  The Mental Health Clinical Guideline is also attached. |  | **Challenges**  Integrating knowledge of this police/ambulance service agreement into local practice. | Review in 12 months. |
| **Standard Operating Procedure for Mental Health A&E Liaison response times** | There was a need to ensure that people receive mental health assessments within the urgent care quality standards of four hours in the ED department. As it was also crucial that the Royal College of Psychiatrists Guidance on Best Practice Liaison Services was followed, our local services agreed a SOP. | *SOP to be embedded.* | **Impact**  This has a positive impact in terms of ensuring a shared understanding of protocol and practice. | Review in 12 months. |
| **Section 136 protocol facility and funding** | There was insufficient capacity for assessments under 136. The Avon Commissioners and all associated provider organisations agreed a shared protocol and the CCGs provided increased funding to operate a 4 bedded assessment suite based in Southmead. | 135k for 0.67% occupied bed base | **Challenges**  The suite is receiving many clients who are assessed as having no mental health problems where there is no further follow up and a proportion of these clients are intoxicated. (Please see action plan). Positively the numbers of assessments in police cells has reduced. | Recurrent funding. |
| **Work force development in the RUH – mental health training.** | The RUH and AWP recognise the need to increase competence and confidence in managing people’s mental health problems which has resulted in the training of emergency department staff, their development of a risk matrix and bespoke training for healthcare assistants across the hospital. Training was provided by the liaison team and for the HCAs gives skills for health accreditation. | Delivered within the funded liaison service envelope. | **Impact**  Increased awareness and skills in managing mental health problems. | Part of an on-going drive for workforce development (See action plan). |
| **Production by service users and community staff of the Hope Guide** | It was recognised that there was no single source of information on mental health services and points of contact. The service user and carer groups alongside community organisation have developed and distributed the Hope Guide which is updated quarterly. | St Mungo’s Building Bridges Service, which is funded via Local Authority, supports the New Hope Group which produces the Hope Guide. | The impact has been huge in terms of an increased awareness of what is available.  **Challenges**  The challenge is to keep it live and connected to other forms of information. |  |
| **Oxford Health NHS Foundation Trust.**  **CAMHS paediatric liaison service to the Royal United Hospital.** | All young people up to the age of 18 who present at the Royal United Hospital following an act of deliberate self-harm and who are admitted to either the Paediatric ward or the Observation Ward are assessed the following day by a clinician from the CAMHS Team. A full assessment of their mental health needs and mental state is undertaken and follow up assessment / intervention offered as appropriate to their needs. Where a child / young person does not live in BANES a referral on is made to the most appropriate agency to support the young person.  This is in compliance with the RUH protocol. | Liaison rota in place. Senior Mental Health Practitioner available each day to carry out assessment on the ward. Consultant Child and Adolescent Psychiatrist is available to offer consultation and joint assessment if needed | All young people admitted to the RUH following DSH including alcohol / illicit drug poisoning are given a comprehensive mental health assessment and offered appropriate follow up / intervention.  There are some times difficulties arranging follow up care when young people live outside the catchment area for Banes CAMH Services |  |
| **Oxford Health NHS Foundation Trust**  **CAMHS Out Of Hours Service.** | CAMHS have a 7 day a week 24 hours a day service. Out of hours a Senior Mental Health Practitioner and Consultant Child and Adolescent Psychiatrist are available to offer advice to professionals who have urgent concerns about a child or young person’s mental health. Where necessary mental health assessments can be carried out in a place of safety. | Senior Mental Health Practitioners, Consultant Child and Adolescent Psychiatrist, Team Manager, Service Managers, Directors. | Professionals have access to mental health advice 24 hours a day ensuring that young people’s mental health needs are appropriately addressed. |  |
| **136 Diversion** | Work has recently begun in developing a similar agreement to that held in Wiltshire between the local police force and CAMHS. This is a formal agreement whereby OHFT CAMHS provide front line officers with direct contact to a Duty Clinician within CAMHS. This is available both in and out of hours whereby officers can contact the duty person for advice when a young person is picked up in a state of distress and presenting with apparent mental health issues.  Following discussion on the phone an appropriate course of action between the Mental Health clinician and the officer can be agreed. This may be a recommendation to take the young person to a safe place for a mental health assessment which the Duty person can arrange or may require a Place of Safety whereby a Mental Health **Act** Assessment will take place (if it is thought the young person needs to be detained for mental health reasons).  A further recent development is a Standard Operating Procedure agreement between AWP, police, CAMHS and other agencies which sets out terms of provision for young people under 18 and under 16 to enable access to the 136 facilities provided at Southmead Hospital in Bristol.  This will enable young people access to a place of safety with clear protocols about their care for the duration of their stay to ensure appropriate and effective interventions are available. | Senior Mental Health Practitioners, Consultant Child and Adolescent Psychiatrist, Team Manager, Service Managers, Police officers | The impact of using the protocol in a neighbouring area has been to provide a supported service to the police force in the management of young people with mental health issues in an effective and appropriate way and has seen a significant reduction in the number of Section 136s in the county.  It is anticipated that a similar working protocol being agreed in the Banes area will also support police officers and help to reduce the inappropriate use of S136 with those young people under the age of 18.  The impact will be to enable young people appropriate and safe care when they are detained on a S136 in the community with facilities that are fit for purpose.  The challenge will be to ensure adequate and appropriate resources are readily available as required and managing risk and flow for those clients needing a MH Act assessment |  |

| **Action plan** | | | | | |
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| **Section 1 - Commissioning to allow earlier intervention and responsive crisis services. To include:**  **A:** Matching local need and demand with a suitable range of services; **B:** Improving mental health crisis services; **C:** Ensuring the right numbers of high quality staff; **D:** Improved partnership working in | | | | | |
| **Scheme** | **Includes** | **Action** | **Timescales** | **Led by** | **Outcomes** |
| Mental health commissioning – widen organisational engagement/involvement structures | A,B,C,D | **a)** Ensure that the homeless healthcare team is involved in the mental health and wellbeing forum as well as the offenders mental health meetings.  **b)** In addition to the local SRG meeting ensure that local contacts are made with SWAST for the development of services. This rep will be attached to the crisis concordat task group. | From January 2015.  **Complete** | **AM** | The homeless healthcare team are more influential in shaping commissioning for this homeless and marginally housed client group who often have unstable and/or untreated mental health needs who can often slip into crisis  That the links to the front line ambulance staff in terms of understanding and influencing local mental health service commissioning are strengthened. |
| Intensive Team – AWP  Review the notion of a “virtual ward” with a capacity of 20 people in. | A, B, C | Completion of review of role and function of intensive service within context of service provision and delivery | 6 months - review to inception.  **Update 15/05/2015**: on-going. Waiting to recruit a Band 6 worker.  **Update 30/09/2015**: Band 6 vacancy is changing to a police and homeless liaison post.  **Update 20/10/2015**:  At present the capacity of team to provide “virtual ward” is approx. 17-25 people.  Currently In the process of recruiting 2 days per week psychology dedicated to intensive.  Also recruiting to 2 Wte band 6 equivalents.  Providing care teams to from named individuals is challenging in the context of reduced staffing levels.  We recently recruited to a band 5 rotational post.  To develop internal training opportunities, post to commence within the intensive team.  **Update 29/04/2016:**  Recruitment challenges are on-going.  Team have successfully recruited a psychologist to the team.  Police and Homeless liaison post in situ. | **JE** | Increase capacity of intensive team to deliver home treatment in the context of a virtual ward  Improve the quality of home treatment delivered  To develop care teams to enable service users to have care from named individuals.  To increase access to psychological therapeutic intervention in home treatment  To review point of access to home treatment with a view to earlier intervention |
| **Dual Diagnosis Support**  To provide a dedicated mental health nurse giving OOH advice and support to Police, Ambulance service and to 3rd sector organisations with focus on dual diagnosis and transitions. This is an ageless service which will include the Early Intervention service, Psychiatric Liaison and Intensive Services | A, D | Recruitment of Band 6 Nurse with substance misuse expertise to provide OOH advice and support to the Police, Ambulance and B&NES Street Homeless project (run by Julian House) also provide assistance with referrals on appropriate pathways to other services. | Recruitment – January/February 2015  Training Implementation: February/March 2015  Full implementation and review of service: March 2015 onwards  **Update 15/05/2015:** Unsuccessful in targeted resilience money bid. Continuing to try and get funding. Researching and investigating how to evidence that service will pay for itself.  **Update 30/09/2015:** Band 6 Intensive team vacancy being converted into a police and homeless liaison post within contracted budget as part of a local model.  **Update 29/04/16:**  Police and Homeless liaison role has strengthened relationships between organisations and more positive relationships are building. Need to develop role further and explore possible alternate funding streams to develop provision further. | **JE** | Increase number of contact with services related to substance misuse.  Increased confidence in local providers with providing advice and assisting with/ managing issues regarding dual diagnosis.  Longer term reduction in the presentation of services users to ED/ 136 suites.  Reduction in attendance times for ambulance and police services for service users with mental health problems  Only people with mental health problems are detained in 136 suites |
| Development of workforce in RUH | C, D | A sub group of the RUH nursing workforce group is meeting to discuss training and skill sharing opportunities with AWP. | January 2015 onwards  Also optimising care for physical needs of patients in Sycamore and Ward 4 without having to transfer to an acute setting. A consultant physician will be available from 8am-8pm to call and help with making decisions on pathways. Potential go live date: 1st June 2015.  Pilot has already been carried out to give mental health training to healthcare assistants.  There has been a joint bid from RUH and AWP to the South West Education Fund for a competency framework development allowing staff training on Ward 4 and Sycamore for physical health needs. Awaiting decision.  **Update 15/05/2015:** RMNs to be supported with training in physical needs to allow RMNs to look after a patients’ whole needs. Supervised by AWP Mental Health Team.  **Update 30/09/2015**: 7 month pilot to start once person is in post. This will allow a senior mental health practitioner to work within the senior nursing team at the RUH. This will allow mental health needs and challenging behaviour to be addressed. The mental health practitioner will also help with training, raising awareness of mental health and support staff with risk matrixes.  A project manager is in place to look at expediting discharges.  12 healthcare assistants and a further 12 are undertaking mental health awareness training.  Pilot is being run with simulation training and liaison staff to target attitudes to dementia.  Combe Ward has received the National Quality Mark for Elderly Care.  **Update 29/04/2016:**  Simulation training has commenced in the RUH.  The pilot post was working well and has been extended for a year. The previous post holder has left and we are currently recruiting for a replacement.  The healthcare assistant training is completed. The liaison services are currently rolling out Dementia training for healthcare assistants. | **ML/RR** | Increased confidence in physical healthcare staffs’ ability to manage mental health problems and vice versa. |
| Support for the Police through supervision | B, D | Understand and then replicate a South Gloucestershire initiative to provide mental health case supervision to the police. This would be in line with our current dual diagnosis supervision support provided by AWP to community services. | 2015/16  **Update 15/05/2015:** Considering having mental health champions within the Police service and this would allow for cascade training or offering a point of contact for advice  **Update 30/09/2015**: AWP are looking at providing police training on rotation. There are 5 teams that can be offered training every 10 weeks. Meeting to take place in November to look at rolling this out.  Information sharing has improved.  Early intervention has improved.  Sarah Treweek and Will Stephens have become local mental health champions within the Police.  120 people have undertaken Mental Health Awareness Level 2 training. A further 40 (with a potential extra 30) people are to also undertake the training in 2016.  A national training package is being finalised. B&NES mental health training will be supplementary to this.  **Update 29/04/16:**  Local training package has been developed in conjunction with AWP, Local Authority AMHP service and there is also the possibility to have service user involvement.  The training has started to be delivered to local police officers.  In addition the police liaison and homeless nurse spends time with local officers to provide specialist mental health advice, support and guidance. | **CS/AM/Paul Bunt** | Increased confidence and competence in police to manage people presenting with mental health problems in an appropriate way. *(We will enter into discussions about the possibilities of doing this for ambulance staff, although recognise their capacity to attend training is stretched).* |

| **Section 2 - Access to support before crisis point. To include:**  **A:** Improve access to support via primary care; **B:** Improve access to and experience of mental health services | | | | | |
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| **Scheme** | **Includes** | **Action** | **Timescales** | **Led by** | **Outcomes** |
| Personality disorder community support (AWP – UJ ) | A | Investment bid to be submitted to CCG by December 1st  Once approved staff training to be completed as per timescales opposite  Ensure that, given the high prevalence of Borderline and other Personality Disorders within the homeless population, the Homeless Health Care Team are involved. | (Subject to CCG funding approval for scheme)  December 2014 on earlier if funds are available  STEPPs training will be available January 2015. The First course to start February 2015.  **Update 15/05/2015**: First cohort have started STEPPs programme. All going ahead although not all materials have been delivered by training body.  **Update 30/09/15:** Delivery of the programme continuing. All materials have now been delivered to deliver training.  **Update 29/04/2016:**  Programme continues to be delivered on a quarterly basis with all courses being fully attended. | **Ursula James** | Increased liaison with CAMHS and children’s services for young people therefore earlier intervention.  Increased awareness of other support the community for service users.  Increased confidence in staff across organisations in supporting people with personality disorder.  Reduction of repeat presentation within primary care services. |
| Improving level of resilience through increasing self-management initiatives in the community | A | Implement the Wellbeing College pilot in B&NES. | January 2015-2017  Update 15/05/2015: All going ahead. 95 different learning opportunities on offer. [**http://wellbeingcollegebanes.co.uk/**](http://wellbeingcollegebanes.co.uk/)  **Update 10/10/15:** Continuation of an extra year to 2017 agreed in order to evaluate effectiveness. Project now linked to social prescribing initiative (local) and data integration project and funded by Innovate UK | **AM/BW** | Increased ability of the B&NES population to manage their long term conditions as well as their mental health at an earlier stage than is currently possible and before people need to use health services. |
| Mental health support in perinatal pathway | B | Improve the perinatal pathway | **Update 30/09/2015:** Looking at developing the perinatal pathway to include mental health support. Still awaiting details of funding to support. Referrals to be accepted from midwives. Consideration to be given to how the pathway will look in a crisis situation and where would a crisis occur? To align with pathway developed in Wiltshire as shared services.  **Update 29/04/2016:** Local perinatal pathway has been reviewed and provisional pathway has been developed which shares many similarities with Wiltshire, but takes into account local perinatal healthcare provision. Currently there is an AWP trust-wide review of perinatal mental health. | **AWP** | Improved services for women receiving perinatal services and support. |
| CAMHS | A, B | Improve services for children and young people experiencing mental health problems. | **Update 30/09/2015**: There is national funding available for CAMHS transformation. A ring-fenced proportion of this is to be spent on eating disorders and the rest is available for spending on other areas. Funding will be provided for 5 years. B&NES has a higher incidence of eating disorders than in neighbouring areas. Looking to develop both preventative and specialist work – including supporting children to eat in their own homes. Service will provide early intervention, including giving better advice to GPs and school education. Looking into joint commissioning a service with Swindon and Wiltshire.  Also considering using some of the funds to facilitate training around the new assessment protocol for young people under the mental health act. | **Margaret Fairbairn** | Improved services in line with national expectations.  Liaison and crisis services in B&NES able to provide appropriately timed and high quality response.  Improve early intervention and specialist mental health approaches in order to prevent or smooth out transition into adult services where able. |

| **Section 3 – Urgent and Emergency access to crisis care. To include:**  **A:** Improve NHS emergency response to mental health crisis; **B:** Social services’ contribution to mental health crisis services; **C:** Improved quality of response when people are detained under Section 135 and 136 of the Mental Health Act 1983; **D:** Improved information and advice available to front line staff to enable better response to individuals; **E:** Improved training and guidance for police officers; **F:** Improved services for those with co-existing mental health and substance misuse issues | | | | | | |
| --- | --- | --- | --- | --- | --- | --- |
| **Scheme** | | **Includes** | **Action** | **Timescales** | **Led by** | **Outcomes** |
| Street Triage (AWP – JE) | | A, D, F | Submit bid for investment to CCG as the request to NHS England was unsuccessful.  Learn from the Devon Partnership/SWASFT Partnership initiative in order to improve practice.  Continue work with other commissioners to ascertain whether a single AWP/ SWASFT initiative can be developed in the longer term. **To include 111 providers** | **2015/16 depending on funding agreement.**  **Update 15/05/2015**: Did not get targeted resilience monies. Continuing to try and get funding. Researching and investigating how to evidence that service will pay for itself.  **Update 30/09/2015**: Found that there were no cost benefits of having a street triage service as the numbers in B&NES are small.  Instead looking to increase training and supervision and looking at implementing control room triage.  Also found that activity and need with s136 admissions, ED admissions and 111 calls in relation to mental health, is in OOH during weekdays. At the moment, most services are following the GP working pattern (opening 9-5pm). Rotas are being looked at by ED staff to reflect need. Services have been encouraged to think about changing their hours of working in accordance with service need.  **Update 29/04/2016:** The police and homeless liaison post has highlighted that there is a demand for this service and there is scope to develop the service further.  Currently the plan is to identify further areas of development within the current post and to explore alternate streams of funding to further develop service provision. | **AM/JE/AMPH Lead/EDT Lead** | **Links to rapid response service redesign.**  Patient receives specialist service response at the point of presentation rather than needing further assessment (unless clinically indicated that further specialist assessment needed).  Greater partnership will reduce multiple hands-offs and improve patient experience.  Holistic approach taken to need therefore improvement in joint care planning and outcomes. |
| Qaaqq | A, F, D | | Although local SOP in place there remains work to be done supporting discharge especially in terms of locating appropriate placements as well as mental health acute bed provision. We want to continue the DTOC review and action plan and request regional information on mental health bed state. Consider CQUIN to support transformation | December/Jan 2014-15  **Update 15/05/2015**: Improved flow through system though there are still issues with Ward 4, timescales for moving to community placements, patients being transferred out of area and placements for children and young people.  **Update 30/09/15:** DTOCs have returned to under 7% for mental health service users although current issues still reside with older adult populations and the need for specialist dementia nursing home beds. Plans in place to review accommodation pathway for adults of working age. Acute care pathway work in the acute trust has improved bed management and patient flow. | **AM/BB-J/ML/DC** | Improve the experience of people with dementia and mental health problems in both mainstream and mental health urgent care pathways.  Reduce the number of delayed transfers of care. Reduce length of stay in the acute mental health wards. |
| Working in collaboration with SWASFT as regular 1st point of contact for those in crisis. | A, C, D | | SWASFT keen to involve partnership working in improving mental health care.  We aim to develop:  \*direct referral pathways  \*Access to mental health advice (see street triage project)  \*Access to care plans and escalation plans (see single patient notes project)  \*Access to health based places of safety | 2015-16  **Update 15/05/2015**: AWP have looked at documents that David had produced. Work is on-going. Mental health is included on annual mandatory training.  **Update 30/09/2015:** AWP have received Trust agreement to have paramedics spend time with the mental health team if they would like to. | **David Partlow** | Improved level of care.  Lower the number of Emergency Department admissions. |
| AMPH service | B | | Review arrangements for out of hours AMHP provision and ensure this is effective and meets need  As we have combined the OOH services with children’s safeguarding and across 4 counties we need to, in consultation with the police and mental health providers, ensure that AMHPs can be available within locally agreed response times.  Explore the potential for better integration of AMHP and EDT services with out of hours crisis provision of health and other partners. | **2015/16**  **Update 30/09/2015:** All 4 counties are looking at OOH AMPH provision.  At the moment there are 3 AMPH members of staff working until 1am. The team are prioritising their response as best as possible. The team find that their options are very limited OOH as there are very few services that are open or professionals that are available.  There is a growing culture of working together. The team are also working with the police on individuals and identifying any mental health issues.  **Update 01/06/2016:** Service level agreement for Emergency duty service has been agreed by all four Local Authorities. There are no changes to our of hours AMHP provision from EDT. Lack of resources out of hours continue to present a challenge. | **TL/AM/LH** | A more responsive out of hours emergency duty service so that coverage over 24 hours is equitable and efficient. |
| Identify the frequent attenders at services with alcohol usage as part of their presenting features. (See Section 4, scheme 1) | A, F | | To combine the information we have from the Blue Light data with other sources of information e.g. from community services to identify the size of client group for a revised pathway response. | **Q1 2015/16**  Update 20/10/15: Cost of Blue Light clients in B&NES has been scoped. Of the total cost, 37% is attributed to mental health services. Also found that 14% of people with a mental health disorder are likely to be a dependent drinker. Currently exploring how a multiagency response to support and planning for Blue Light clients might operate locally. | **CS/AM** | More targeted and tailored responses to the needs of clients with co-existing mental health and alcohol issues. |
| Avon and Somerset Police response to s135/136 | C, D, E | | Review of suitable places of safety and patient transport | **26/3/15** – “Think Ambulance” protocol launched force-wide to ensure that persons detained under s135/6 are conveyed to a place of safety in an Ambulance in all but the most exceptional circumstances. Since introduction Ambulance use for conveyance has increased hugely (350% increase in the first month alone), with figures continuing to improve.  **11/5/15** – Police introduced a protocol that under 18’s detained under s135/6 MHA would no longer be accepted into police cells. Negotiations between partners across the force area have identified alternatives to the 136 suites should they be full/unavailable. Since that date, no children have entered the cells whilst detained under the Act.  The Office of the Police and Crime Commissioner has arranged a meeting with force-wide acute hospital representatives on 18/9/15 to ensure Hospital involvement in negotiations around S136 use.  **23/7/15** - Under 18 S136 protocol being developed for BANES in conjunction with BANES CAMHS (Oxford Health). Aide memoir and Memorandum of Understanding (MOU) has been adapted from Wiltshire Police documents, in use already by Oxford Health. Awaiting signoff by partners and then to be rolled out to officers in the BANES district. The MOU will ensure that CAMHS are consulted prior to the use of S136 MHA, with the aim of reducing unnecessary detentions that could have been diverted to a less restrictive option.  **Update 30/09/2015:** Criminal justice suites will have a single point of contact for partners to be identified.  New protocol being used for u18’s which has been signed off by the assistant Chief Constable. Where young people are detained, a consultation will take place with CAMHS where possible. Training is due to be delivered and an aide memoire has been produced.  Work is being carried out by Tom Lochhead and Fiona Beech to look at having wrap around services to give an individual response.  CAMHS are looking at where u16s are able to go when they are detained by the police. Discussions taking place with Oxford Health taking into consideration the legislation.  B&NES have some extra capacity with Priory beds.  Wiltshire have declined B&NES use of their s136 suite. | **Avon and Somerset Police** | Improved quality of response and level of care for those who are detained under Section 135 and 136. |
| Mental health support in Police Control room/ Control room triage | C,D,E | | Other areas have seen benefits from having mental health staff available in control rooms. This allows access to patient medical records and mental health expertise to give those in crisis the best possible support. | **3/6/15** - A meeting was held between CCG senior leaders, NHS England, senior leaders from AWP and Somerset Partnership, the PCC and Chief Constable whereby unanimous support was given to exploration of a control room triage scheme within the force area.  **23/6/15** – Norfolk Police gave a presentation on control room triage to local Police/NHS/Fire/Ambulance partners, proposal to create a business plan to obtain funding to introduce locally. Information being sought on possible benefits to all partners to be incorporated into a force-wide business case, for presentation to each CCG in the next funding cycle.  **Update 30/09/2015:** Business case draft has been put through SRG for non-recurring funds to be used specifically for liaison purposes. Considering using the monies to implement control room triage. The liaison role will feed into PCLS.  **Update 29/04/2016:** Final business case for control room triage nearly completed with all partner agencies.  Financial contributions from all agencies have been tentatively agreed.  Further analysis also required as street triage schemes appear to have been successful in reducing number of s136/diverting from custody. However, there appears to have been an increase in the number of mental health attendances to emergency departments. | **Avon and Somerset Police** | Increased support for police staff allowing for forces to respond in the most appropriate way.  Improved quality of care received from the police when responding to crises with advice from mental health professionals. |
| Raising staff awareness of Mental Health | D, F | | Mental health awareness training to be rolled out amongst Sirona staff. | **Update 30/09/2015:** Sirona mental health training is underway. Aiming to train 98% of staff. 100s of staff have already been through the training and training is now included in the corporate induction.  Now starting to consider how the training will be utilised going forward. |  |  |

| **Section 4 - Quality of treatment and care when in crisis. To include:**  **A:** Review police use of places of safety under the Mental Health Act 1983 and results of local monitoring; **B:** Service User/Patient safety and safeguarding; **C:** Staff safety; **D:** Primary care response | | | | | |
| --- | --- | --- | --- | --- | --- |
| **Scheme** | **Includes** | **Action** | **Timescales** | **Led by** | **Outcomes** |
| Investigate new provision/ pathway for intoxicated clients. | A, | Explore need; look at existing services (s136 suite and RUH) and community; SDAS/DHI/Julian House.  Scope for pathway, services and facilities for rapid and intensive support to address around 200 individual impact alcohol clients, on top of work that is already happening for high impact patients. Specifically addressing 20-25 people that attend ED once a month on average.  Explore the service provided by street marshals/ street pastors/ fast ambulance. Discuss potential for bidding to expand service.  Investigate numbers for s136 suite.  Alcohol related ED attendance = ±15% of all ED attendances. Investigate number of those intoxicated. (Piece of work being done by Wiltshire to estimate numbers). | **Pathway for Intoxicated/Mental health clients meeting set for 22/12/2014. Complete.**  **Update 30/09/2015:** There has been a lot of work taking place around ‘blue light’ clients. Looking at the possibility of providing blue light information and training to the police.  Harm reduction work has also taken place and training can be provided.  There is a ‘damp’ house provision with 4 beds to help clients who have relapsed. | **CS/AM** | **± 200 individual clients = £10m per annum cost.**  **20-25 Mental Health /Alcohol patients = £3.7m cost. Averaging 1 visit to ED per month.**  **Improved pathway/facilities will look to reduce number of ED visits.** |
| Review ability to provide S136 suite in area in the longer term | A | Scope into re-design for in-patient beds. | December 2014 | **AM/BB-J** |  |
| Include in impact assessment process | December 2014 |
| Present to Wellbeing PDS as part of impact assessment and proposal paper  Define next steps if approval gained. Consider whether this can be part of a wider assessment suite that could also work with children and young people. | January 2015  **Update 15/05/2015**: work on-going looking into having a s136 suite in B&NES and addressing issues with access for under 18s and under 16s. |
| Instigate rapid response service in existing Specialist mental health services | D, B | Produce paper analysing opportunities within existing service configuration- paper in draft format at this time  Currently we are near to completing the review of access service function which is likely to separate assessment and home treatment functions of intensive and more closely align the assessment functions across PCLS, intensive, with some linking to the intensive hospital liaison interface.  Meeting timetabled for December to agree on final model.  Pathway might look something like this:    Also work to commence in 2015 to explore if we can increase productivity of assessment functions of access service though a reduction of the “burden” of RiO system. | January 2015  **Update 15/05/2015**: Paper has been completed and this is now being piloted with PCLS. This will be reviewed in June 2015 with the intention of including the intensive team as well.  **Update 30/09/2015**: Rapid access is underway and is no longer a pilot. Improvements to be made to joint working between PCLS and Recovery teams.  **Update 29/04/2016:** Rapid access is now fully integrated into PCLS core business | **JE** | **The model is potentially linked to street triage investment bid**  Patient receives specialist service response at the point of presentation rather than needing further assessment (unless clinically indicated that further specialist assessment needed).  Greater partnership will reduce multiple hand-offs and improve patient experience.  Holistic approach taken to need therefore improvement in joint care planning and outcomes. |
| Working in collaboration with SWASFT | B, C, D | SWASFT want to be engaged with work in relation to conveyance of PoS.  Have committed to 30min response time for section 136 requests.  In addition we need to discuss with SWASFT the numbers of private transport conveyances for patients detained under section of the Mental Health Act. | **Currently in operation as green 2 response time.**  **Update 15/05/2015:** David Partlow has been in contact with Liz Richards at AWP. Scoping exercise is being carried out to look at demand and develop a model.  **Update 30/09/2015:** Agreement is currently in place with private ambulances for conveyance. To be reviewed when contract is due for renewal. | **SWASFT** | **This needs to be assessed in light of SWASFT ability to respond to all green 2 priorities in the face of capacity demands.** |
| Service User Charter | B | Document is being developed in partnership between New Hope/St Mungos, Healthwatch and Making it Real. Providing ‘I’ statements that service users can apply to practice. | Document is in draft form.  Focus groups are being held between August and October 2015. | New Hope/St Mungos, Healthwatch, Making It Real | Supporting service users to gain an insight into their wellbeing. |

| **Section 5 - Recovery and staying well / preventing future crisis. To include:**  **A:** Joint planning for prevention of crises | | | | | |
| --- | --- | --- | --- | --- | --- |
| **Scheme** | **Includes** | **Action** | **Timescales** | **Led by** | **Outcomes** |
| Liaison for older adults. | A | Funding approved.  Negotiation/ exploration of roles with Sirona.  Development of job description for RN (adult)/ RGN. | ***November / December***  *Liaison with partner organisations**regarding model implementation.*  ***December/January:*** *Recruitment*  ***February onwards:*** *Full implementation and review/evaluation*  **Update 15/05/2015:** Recurring funds received.  **Update 29/04/2016:** Funding was fixed term and has now come to an end. Some aspects of this role have been developed and incorporated into the pilot project post with the RUH. | **JE/KG** | Parity of esteem for people with physical and mental health problems.  More people treated by services with which they are familiar.  Reduced admission to hospitals. |
| Working in collaboration with SWASFT |  | Plan to develop a facility to feedback into primary care and secondary mental health services with appropriate patient contacts made by SWASFT.  This will involve presentation on the SWASFT electronic clinical record due to be rolled out in B&NES in the summer of 2015. | **Update 15/05/2015**: Looking at how to link in EPCR with other systems. Implementation date: Autumn 2015 | **David Partlow** | Often patients will present and not be conveyed, this may be an early indication of a degree of instability which could be managed earlier. The ability to feedback into services will allow for continuity and a higher level of care. |
| Further develop shared patient notes to join up GP, Acute, ambulance and MH services | **A** | Special patient notes project in moving forward and mental health is part of that project. Again, this could link in the future to SWASFT work with the enhanced summary care record and their ability to access this via the SWASFT electronic record.  Already being used in some instances. | 2015-16  **Update 10/10/15:** Next phase of work on special notes for people with mental health problems has begun with Katia Montella leading it in B&NES | **AM/CP/DP** | Ensure that all services have access to appropriate care plans for people who use services in an emergency or crisis situation |
| Implement social prescribing project to prevent escalation of non-medical conditions |  | The aim of this service is to redirect suitable patients away from the NHS and towards opportunities in the local community which can support their needs. People referred to the service may have mental health needs, long term conditions or other practical issues which affect their mental and physical wellbeing.  This service will operate mainly within GP practices, as well as links to, e.g. A&E and Health visitors.  Priority will be given to people who are identified by GPs as frequent attendees, or those identified where the involvement of the service may reduce future health service attendance. | The new commissioned service will start on 1 Jan 2015 and will aim to begin effective delivery by April 1st 2015. The commission initially is for 27 months to 31 March 2017 and any extension is dependent on good outcomes and continued CCG funding.  **Update 15/05/2015:** Service has now been implemented on a two year pilot.  **Update 20/10/15:** uptake by GPs very positive. It is already clear that moving forward capacity will be an issue. Initially concentrating on high attenders at GP practices. | **AM/BW** | Be responsive in addressing health, practical and social issues that may negatively impact on the health and wellbeing of people who frequently make use of local GP practices.  Reduce the demand on costly health services and enable funds to be better targeted on people whose needs are purely clinical rather than practical or social.  Improve the patient’s quality of life  Encourage and enable people to better manage their conditions, take up of prescribed health related activities and access to mainstream services and community resources. |
| Support the revised multi-organisational approach to addressing social isolation in people with mental health problems | **A** | On a general level, the Mental Health & Wellbeing Forum provides a bi-monthly opportunity for commissioners, providers, service users and carers to meet together and discuss issues and future developments. Eg, the Wellbeing College specification was developed by Forum members.  The Social Prescribing Service (above) and Sirona Community Links Service (social prescribing element) both link and support people into a wide range of local funded and unfunded groups, activities & services in order to address their holistic needs. (Eg unfunded groups like Bath City Farm and Greenlinks).  New Hope (service user group) produce a 'Hope Guide' detailing opportunities that people can take up.  To further develop a multi-organisational approach in supporting people with mental health needs, service specifications were revised in 2014. A Building Bridges Forum was established, supporting services to work together, and meet monthly to share views and experiences, discuss issues and developments. Current members include -  **Sirona Community Links** -supporting networks in the community, to build resilience and help people live independently, with a strong social prescribing element.  **St Mungos Broadway** - Peer Mentoring Service trains and supports peers to support people within the networks and the wider community. This service is delivered collaboratively with **Sirona** and **Bath Mind**  **Creativity Works** - provide “taster sessions” in creative, supported activities. Creativity Works works with the groups to see how they can develop on a sustainable, peer led and supported basis.  **Bath Mind** - work collaboratively with St Mungo's to develop peer mentors. They also facilitate MOSAIC, a community focused club where people from diverse ethnic backgrounds living with mental distress are supported to achieve their personal wellbeing goals and become involved in community activities.  **Soundwell Music Therapy** - provides therapeutic music based activities across the community for people with mental health issues and works with a range of other organisations to achieve this.  ***It should be noted that there are many other organisations and groups working successfully in partnership across the locality to address peoples' social isolation and wellbeing.***  The **Wellbeing College** (below and set 2 above) takes a multi-organisational approach, developing and promoting a wide range of courses and activities from many providers, which support people’s wellbeing and promote prevention. In developing new courses and activities it will effectively act to bring people together with shared interests from the whole community, not just those meeting service criteria. | Service specifications were revised between April-July 2014, with commissions ending March 2016. It is the commissioners' intention at that point to put out to tender an overarching specification to provide a flexible and responsive multi-organisational approach to mental health and wellbeing support in the community. Social isolation will be an important element of this.  A Wellbeing College, if demonstrated to be successful, could be a central part of this overarching specification. It is currently being considered as to whether a Wellbeing College would take on a role as a commissioning body in terms of purchasing and developing early intervention, prevention, and self management courses and activities from 3rd party organisations. This aspect will be consulted on during 2015.  Wide ranging discussions will take place during 2015 with all interested parties to develop an agreed and effective specification for the proposed overarching commission.  The Wellbeing College and such developments as the Building Bridges Forum can be viewed as forerunners of the overarching commission, providing an opportunity in 2014-16 to gather evidence, experience and best practice in order to effectively support people and offer social interaction opportunities in the community.  Update October 2015:  The Your Care Your Way consultation process is currently underway, which will shape how future services are commissioned for the B&NES community. It is anticipated that a draft model will be determined by November 2015, with the model being operational by 2017.  It is being proposed to extend existing contracts for 1 year to fall in line with the Your Care Your Way process.  **Update 29/04/2016:** A local mental health alliance has been formed and development is underway around the mechanism to involve third sector and carer/service users as a part of this.  Your Care Your Way has progressed with multiple work streams.  There is mental health representation within these to ensure that parity of esteem is achieved. | **AM, BW, Providers, community groups, service users, carers** | To develop networks of support for social interaction within the community, outside of services, in order to improve health and wellbeing.  To support people to self-manage their conditions  To reduce social isolation within an appropriate supported environment.  To value and make use of shared experience in helping people to support themselves and manage their long term conditions.  To increase the range of people’s skills and interests and to support them to develop peer-led groups which meet those interests  To train and support people to become peer mentors to provide a positive experience for themselves and in helping others.  To provide a wide range of information and support to enable people to take up opportunities which increase their wellbeing and reduce social isolation |
| Assess elements of preventative self-management that can be delivered through Wellbeing College – 2 year pilot. | **A** | Independent evaluation taking into account both health and social outcomes – incorporating 5 ways to wellbeing, e.g. into more health based outcomes.  College will also assess courses themselves for style, content and effectiveness, getting feedback from participants.  Evaluation will inform a business plan for the format of any future Wellbeing College to be commissioned in 2016.  Link with social prescribing and social options into the community support. | The college is a 2 year pilot (2014-2016) with an independent evaluation spanning approximately 12 months. The college monitoring will take place over full 2 year period.  Update October 2015:  The Wellbeing College contract is being extended for 1 year to allow developments to take place and more effectively evaluate the model. | **All WC providers/LA/PH/CCG.** | People to self-manage their long term conditions and through peer support, enable them to share experiences and solutions and support.  To assess whether the educative, short term intervention approach to self-management enables people to avoid accessing higher level services - GPs, acute, MH services in crisis  To assess whether early intervention, through mainstreaming and appealing to the whole community, reduces the need for people to take up services subsequently. |
| Housing need for high risk offenders, sex offenders and IRIS clients. | **A** | To research, develop and consider partnership working within B&NES and also across authorities to address a need for housing where high risk offenders, sex offenders and IRIS clients are considered too high risk for the current supported housing options but do not meet the criteria for the dangerous offender protocol scheme, Homesearch.  This can result in individuals being homeless posing challenges with monitoring and managing risk in the community.  From conversations with Probation these clients pose a high risk of serious harm and having a monitored and supported environment is important to reduce the risk of offending and manage clients in the community to reduce severity and escalation of offending. |  | **Andy Busfield – Julian House** | To have appropriate supportive housing for high risk offenders allowing better monitoring and support resulting in reducing the risk, severity and escalation of offending and helping to create safer communities. |
| Wellbeing House | **A** | To provide short term respite beds within a safe environment and provide therapeutic interventions throughout their stay to prevent crisis and help people to better manage environments and situations that may cause stress and lead to crisis. | To be in operation by Summer 2015. 1 year pilot.  **Update 30/09/2015:** Wellbeing House is now open for referrals. Feedback on the house has been positive so far. Those in the house have received meaningful interventions. A holistic practitioner is working at the house and using a wellbeing options tool that uses the 5 Ways to Wellbeing. Also linking in with outside agencies, looking at what client’s would like to do and supporting their journey.  Looking at how to maintain the service in the longer term. | **PW/Sirona** | To provide short term respite to individuals, enabling them to be removed from stressful environments as a way of preventing people from reaching crisis. |

**The 2014 Declaration on improving outcomes for people experiencing mental health crisis**

**December 2014**

We, as partner organisations in , will work together to put in place the principles of the national Concordat to improve the system of care and support so that people in crisis because of a mental health condition are kept safe. We will help them to find the help they need − whatever the circumstances − from whichever of our services they turn to first.

We will work together to prevent crises happening whenever possible, through intervening at an early stage.

We will make sure we meet the needs of vulnerable people in urgent situations, getting the right care at the right time from the right people to make sure of the best outcomes.

We will do our very best to make sure that all relevant public services, contractors and independent sector partners support people with a mental health problem to help them recover. Everybody who signs this declaration will work towards developing ways of sharing information to help front line staff provide better responses to people in crisis.

We are responsible for delivering this commitment in by putting in place, reviewing and regularly updating the attached action plan.

This declaration supports ‘parity of esteem’ (see the glossary) between physical and mental health care in the following ways:

• Through everyone agreeing a shared ‘care pathway’ to safely support, assess and manage anyone who asks any of our services in for help in a crisis. This will result in the best outcomes for people with suspected serious mental illness, advice and support being available for their carers, and make sure that services work together safely and effectively.

• Through agencies working together to improve individuals’ experience (professionals, people who use crisis care services, and carers) and reduce the likelihood of harm to the health and wellbeing of patients, carers and professionals.

• By making sure there is a safe and effective service with clear and agreed policies and procedures in place for people in crisis, and that organisations can access the service and refer people to it in the same way as they would for physical health and social care services.

**•** By all organisations who sign this declaration working together and accepting our responsibilities to reduce the likelihood of future harm to staff, carers, patients and service users or the wider community and to support people’s recovery and wellbeing.

We, the organisations listed below, support this Declaration. We are committed to working together to continue to improve crisis care for people with mental health needs in .

**• Clinical Commissioning Group: ­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**• Commissioners of social service: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**• The Police Service:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**• Police and Crime Commissioner: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**• The Ambulance Service:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**• The Royal United Hospital Foundation Trust Bath:­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**• Avon and Wiltshire Mental Health Partnership Trust: \_\_\_****\_\_Iain Tulley, CEO; \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**• On behalf of Mental Health community sector providers: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**• On behalf of substance misuse services in :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**