London mental health crisis commissioning: *Case studies*

NHS

London
Strategic Clinical Networks

October 2014

1. Mental Health Direct – 24 hour mental health support and crisis line

Aims

» To offer everyone a single recognisable telephone number they can contact to gain advice and support about any mental health issue or mental health service
» To offer signposting to local access and assessment team for advice, support or telephone triage and to offer out of hours support
» To offer out of hour's advice and support to all professionals

Rationale

Mental Health Direct (MHD) was set up in 2011 by North East London Foundation Trust (NELFT) at an initial cost of £197,300 (14 band 2 switchboard staff and 1 band 7 clinical lead). MHD evolved out of discussions with service user and carer groups and GP and PCT consultation following complaints about lack of out of hour's provision. It was also highlighted that mental health services were difficult for non-professionals to navigate, leading to inappropriately high use of A&E. The service was incorporated into the existing switchboard and clinical support supplied by access and assessment teams, clinical lead and home treatment team staff.

Development

MHD is available 24 hours to anyone who requires it. The switchboard element is operated by non-clinical staff who apply an algorithm process to callers to ensure they are directed to the appropriate service or given the correct advice. Telephone triage referrals will be completed by the relevant borough's access and assessment team Monday - Friday 09:00-17:00 hrs; during Monday - Friday 17:00-21:00 hrs (audited as peak time) calls will go through to MHD clinical lead; outside of these hours clinical support is supplied by the home treatment team.

Challenges

Initially, promoting the service and ensuring service cohesiveness was a challenge and then as people have become more aware of the crisis line, the challenge has been to manage the increase in demand (between October 2012 and October 2013 there was a 33 per cent increase in calls).

Benefits and outcomes

» Clarity and equity of service
» One recognisable telephone number for all
» Stakeholder and service user engagement
» Reduction in unplanned A&E attendance
» Robust out of hour's clinical advice and support
» Level of calls successfully answered remains at 100 per cent
» Number pro-actively promoted to all services: all known, new service users and carers are given number
» Earlier intervention and access to most appropriate services

Top tips for commissioners

» Engage with providers and key stakeholders
» Be involved in promotion of service via Clinical Commissioing Group/PTI
» Have one dedicated number for all boroughs/areas
» Appropriate customer care and algorithm training (e.g. Samaritans)
» Email messaging service to alert appropriate teams/service of caller
» Call recording system to maintain quality, governance, supervision and any conflict/complaint resolution

Contact

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2. Sunderland and South of Tyne Initial Response team

Aims

» The primary aims of the Initial Response Team (IRT) are to offer an efficient 24/7 response, through a single point of access, to urgent telephone requests for help from people of all ages and conditions, and to offer triage and routing or signposting to appropriate services within and without Northumberland, Tyne and Wear (NTW)

Rationale

NTW is one of the largest mental health and disability trusts in England serving a population of approximately 1.4 million and providing services across an area totalling 2,200 square miles. Sunderland was chosen for the development of a new access model following discussions with service users, carers, GPs and commissioners.

Development

Working collaboratively with commissioners and other partners the transformation of access to NTW for urgent referrals was implemented and tested, developing telephone triage and a rapid response function as a first point of access for the public, service users, carers and referrers, supported in its first year through the imaginative use of the CQUIN attached to the contract.

Challenges

Lessons learned were primarily in relation to stakeholder communication. GP feedback suggested a lack of awareness of IRT and suggested that more PR work would be beneficial. Operationally, there were initial issues with data collection which made activity monitoring challenging. Also some of the training offered to staff needed to cover a broader spectrum of topics or be delivered in greater depth to realise the intended benefits.

Benefits and outcomes

IRT reduces clinician administration burden in the crisis response and home treatment teams, freeing time to care for service users with the greatest need, while also improving personal and clinical outcomes for people in crisis with mental ill health by reducing harm and premature mortality, improving safety and experience.

Service users receive a timely response to urgent requests for help and are now being seen and routed to the most appropriate service. Feedback from service users has been very positive, clearly indicating that IRT staff are polite, show kindness and empathy, and behave in a professional manner. Remarkably feedback from service users has shown that 100 per cent would recommend the service to a friend in need of similar help.

Contact

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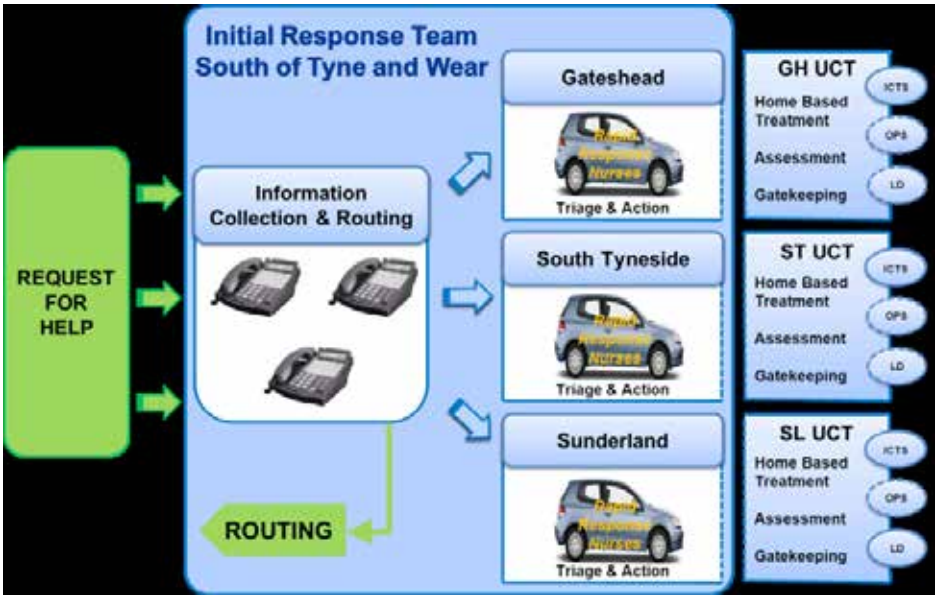

3. Northumberland, Tyne and Wear Initial Response service

Aims

» The Initial Response Service (IRS), providing a single point of access to Northumberland, Tyne and Wear NHS Foundation Trust (NTW), will ensure service users are referred to the right service and placed on the right pathway without any delay, keeping them fully informed of this process. If service user needs cannot be met by one of our services they and their referrer are signposted to the most appropriate service elsewhere, with an explanation as to why this is happening.

Rationale

NTW is one of the largest mental health and disability trusts in England serving a population of approximately 1.4 million and providing services across an area totalling 2,200 square miles. IRS is a key development within the Principal Community Pathways (PCP) programme. PCP will design and implement new, evidence-based community pathways for adults and older people.

Development

NTW's strategic direction is one of transforming services in order to ensure a sustainable future of higher quality services and clinical effectiveness, reducing overall costs of delivery by 20 per cent. This will be delivered through the PCP programme, funded through transition reserves and incentivised through CQUIN.

Challenges

The volume and complex design of existing teams made accurate baseline measurements difficult. Adapting the wider organisation's culture to embrace the lean approach will take time and there may be a delay in fully realising benefits while the new ways of working are embedded. Public sector financial pressure will continue. This must be considered when developing a new model which must be sustainable in the medium to long term.

Benefits and outcomes

Services will be easier to access. This new "front door" to NTW will be available 24/7 and receive requests for help for both urgent and non-urgent referrals as well as providing advice and information. This new front end will be more integrated with partner organisations to ensure that residents receive the help and support they need. Where appropriate, previous patients needing to re-engage with services are quickly and easily put back in touch with the support team they are familiar with.

Tips for commissioners

Acknowledge that every system has inefficiencies and that your support is needed to identify and address these. Form relationships in which providers can be honest about difficulties around these challenges. Make imaginative use of CQUIN to incentivise innovative developments attached to the contract.

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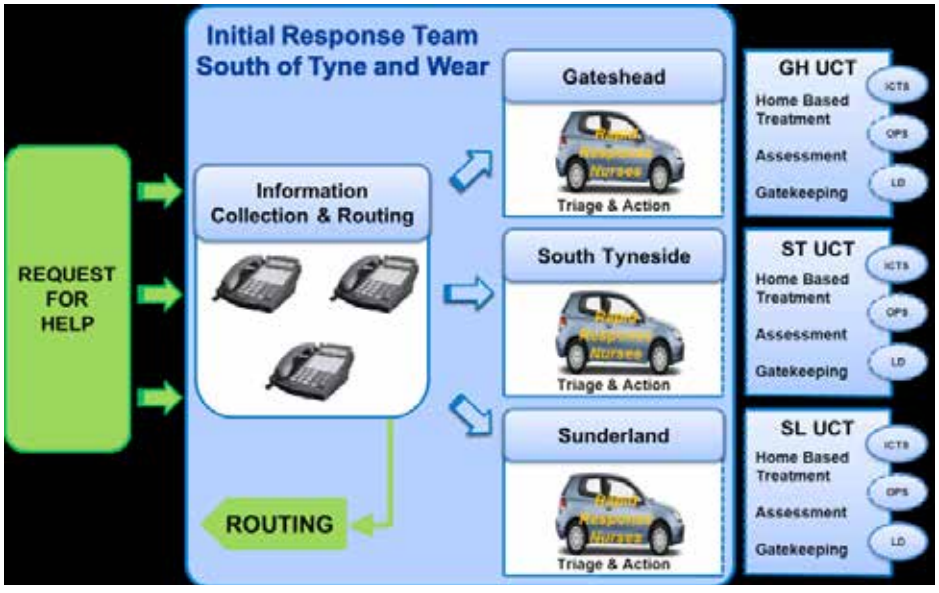

Aims

» The aim is to improve the experience of, and outcomes from, mental health urgent assessment and care across North West London, including increasing the management of the health and wellbeing of people with mental health problems in primary care. There is a need for rapid access to assessment and care for those in crisis, to be provided when and where the service user most needs it.

Development

Initial approaches to improve crisis assessment and care include:

» Rolling out and embedding of a common access and care standards policy
» A review of the local skill mix, competency and training needs of staff
» Progress to align mental health services to those in primary care - covering the period 8am – 8pm as a minimum. Extension of home visiting for crisis resolution work, providing 24/7 cover every day of the year
» Simplification of the 'route in', with a single telephone number, available 24/7 every day of the year

Projected outcomes

» A single phone number for accessing urgent mental health assessment and care. Accessible 24/7, with access to clinical consultation and advice, including telephone advice, especially for people who are experiencing crisis
» Facilitate rapid access to specialist mental health assessment for those most in need complimented by mobile clinical response, delivering urgent response including home based urgent response
» Reduced reliance on MHA assessments via the EDT as the only alternative means of urgent assessment out of hours if service users are unwilling or unable to attend A&E. Much needed support for colleagues in police and probation services to help identify mental health issues, refer for and receive support
» Increased home visiting for crisis resolution, 24/7/365, reducing the likelihood of inpatient admissions and the distress of visits to A&E
» Direct access to the treatment team for those known to the service removing multiple assessment layers that exist currently

(Projected outcomes, cont'd)

» Prioritise people who cannot be managed within the primary care mental health teams setting because of need complexity or a lack of necessary resources
» Continue to be available to the primary care team after care has been returned to the primary care provider, to maintain continuity of care for both the primary care provider and the individual
» Provide information on available community resources and assist with access to these services through mapping local 3rd sector, voluntary and statutory provision into a single web based directory of services to promote recovery and self-management
» Promote 'Recovery' and enablement through co-produced service design, delivery, and review. The service user, their carer, family and friends at the centre of care and support planning, with treatment provided to those most in need as close to home as possible in the least restrictive environment
» Discharge from specialist mental health services to local GPs for on-going management and monitoring, based on a comprehensive plan that has been developed in consultation with the person's GP
» Interface with the acute care pathway (including crisis teams and recovery houses) and support adherence to the urgent care standards

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5. Integration of CAMHS into a single point of access for children

Aims

» To develop the existing single point of access (a council led initiative) to improve assessment and triage so that appropriate referral is made to Tier 2 Primary Mental Health Services, Tier 3 services or redirected to Tier 1 services

Rationale

The background is one of dissatisfaction of current services, long waits, bounce back of referrals to GPs or bouncing of patients from one service to another. The aim was that no child should fall through the net and that the child is directed to the correct service first time around.

Development (in progress)

The development is a joint collaboration between the Clinical Commissioning Groups and local authorities of of two boroughs (Richmond and Kingston) and South West London and St Georges mental health trust (the provider). Still at the negotiation and implementation stage the principles of the service have been agreed and all participants are supportive. A number of 'Emotional Wellbeing Forums' were organised for consultation, with attendees from a wide range of backgrounds and services. Similar local models were also considered to give an indication of likely numbers going through the service, costing and possible pitfalls.

Challenges

The main pitfall so far has been through lack of communication and a failure to clearly specify from the outset what was required from the provider. This resulted in the provider proposing a 'gold standard' service which was unaffordable and impractical. The availability of data from existing services enabled agreement of a more appropriate level of service.

Benefits and outcomes

The new service has not been implemented yet but the aim is to have a single access point for all children's emotional and behavioural services. The referral will be assessed by a psychologist from Tier 2 with input from a Tier 3 psychologist and a plan made as to the best management of that child. The child will therefore reach the most appropriate service first time around reducing waiting time and bounce around. The GP would have the knowledge that their referral has been accepted and the child will be seen by the correct service – there will be feedback to the GP to this effect so that all parties are kept fully informed.

Tips for commissioners

Communication and honesty is key. What is it you want and what can you afford. Look at your own data and look at other local services to see what their experience has been.

Contact

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6. Big White Wall digital mental health service

Aims

» Big White Wall, the digital mental health service, is being offered on a self-referral basis to all adults in Southwark, with the aim that this will increase access to mental health services, particularly for people who are unwilling or unable to access other options. This includes supporting people who are in crisis and require immediate support, as well as those who need support on a longer-term basis.

Rationale

Unplanned admissions due to mental health crises are hugely expensive for the NHS and very distressing for individuals, family and carers. Out of hours, many people use A&E services for mental health emergencies, which will often not be the most supportive place for them. Many people experiencing acute mental distress are not in contact with mental health services and will not have a crisis plan. There is therefore a need for alternative models to support people with immediate mental health need.

Development

NHS Southwark CCG has received funding from the NHS England Regional Innovation Fund to provide Big White Wall to 500 local residents in 2014/15, plus evaluation from UCL.

Although not exclusively a crisis service, Big White Wall offers instant access, 24/7 crisis support from trained counsellors through the 'Ask a Wall Guide' function, safe and moderated peer support, and self-management materials. The service is fully anonymous, meaning that it is more acceptable to people who are unwilling to access support due to stigma.

Members are protected through clear house rules and real-time moderation. Big White Wall members frequently make use of the network at times of distress, to resist urges to self-harm or to cope with suicidal thoughts – many then continue to use it for support with longer-term issues.

Desired outcomes

NHS Southwark CCG hope that the use of Big White Wall will help identify unmet need in the local population, provide a self-referral service which is attractive to service-users and reduce unplanned mental health admissions to A&E and mental health services. In addition it is hoped that feedback from this pilot will inform the scope and design of future services in the area.

Contact

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7. "Evolve" – a navigator service

Aims

» Support adult service users with a serious mental illness in their discharge from secondary to primary care
» Ensure service users attend appointments - GPs/practice nurses to monitor mental and physical health
» Using a person-centred recovery focus, support clients to reduce any social isolation they may be experiencing by increasing access to a variety of local opportunities/services

Rationale

'Evolve' is part of CREST, a local voluntary sector charity in Waltham Forest and was commissioned to provide 4 navigators and a team leader in April 2012 by Waltham Forest Clinical Commissioning Group for the annual sum of £187,000.

Development

Working with a designated navigator for a period of 12-18 months, clients attend 3 to 4 20-minute appointments where GPs and practice nurses monitor their mental and physical health. Taking a person-centred recovery focus builds a solid and trusting relationship between client and navigator and enables the navigator to detect early signs of crisis and prevent relapse.

During periods of crisis, clients have increased contact with their navigator and GP; for those needing specialist input protocols for re-referral to secondary care have been developed. Where the discharge period is within 6 months the navigator makes a direct referral to the respective clinic for an urgent out-patient appointment. Navigators also encourage clients to complete a Wellness Recovery Action Plan (WRAP) as part of their recovery.

Resources: team leader and 4 full-time navigators; installation of a shared drive; 10 2 hourly weekly education workshops for GPs and staff on mental illness including psychotropic medication protocols; GPs paid £200 per client for undertaking 3 to 4 20-minute assessments including a discharge meeting.

Challenges

Ensuring communication between primary and secondary care practitioners is firmly established requires continual monitoring by the navigators.

Benefits and outcomes

Initial outcomes of the pilot have shown that the Evolve team has contributed to:

» An overall reduction in the number of clients in crisis where regular contact with navigator is maintained
» A reduction in the duration of a crisis episode through quicker access to intervention and treatment
» A reduction in time spent back in secondary care if a client has required input/re-referral
» Reduced stigma associated with receiving a depot injection at a mental health venue through clients accessing a practice nurse in generic setting

Tips for commissioners

Establish regular dialogue between primary and secondary care practitioners to ensure effective management of these clients in the community and reduce risks of mental health crisis.

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8. Leeds survivor led crisis service

Aims

» To provide an alternative to statutory services within a homely environment
» Provide services both for those in crisis, at the point of crisis and for those seeking to prevent the onset or escalation of crisis
» Provide a place of sanctuary at times of immediate crisis

Rationale

The Leeds survivor led crisis service was set up in 1999 by a group of service users, who had campaigned for an alternative to hospital admission for people in acute mental health crisis. Initially, the service was run in partnership with social services, becoming a registered charity in 2001.

Development

The service was established, and continues to be governed and managed by people with direct experience of mental health problems. The service therefore has been developed based on this knowledge and experience, while responding to the needs articulated by visitors and callers.

It is funded by the three Leeds NHS clinical commissioning groups, Leeds City Council, the Leeds Personality Disorder Clinical Network and also receives small amounts of charitable trust funding from time to time.

It runs a telephone helpline Connect (also available online), offers a place of sanctuary for people in acute mental health crisis called Dial House and provides person centred group work including peer-led support, a men's group, hearing voices, LGBT, self-harm and a 'coping with crisis' group. The team consists of people trained in the person-centred approach, some of whom are counsellors or therapists. The helpline receives around 5,000 calls a year and supports people in crisis, as well as preventing crises by supporting people before they reach crisis point. All services are accessible to deaf people. Dial House @ Touchstone is a partnership between Leeds survivor led crisis service and Touchstone supporting people from BME groups. The project opened to new visitors on 1 October 2013 and has received £500k in lottery funding for five years. It is available for anyone from a BME group, including refugees and asylum seekers.

Challenges

Managing the huge surge in demand with existing resource and capacity: call numbers have doubled.

Desired outcomes

» Successfully worked with people in acute states of crisis who have been excluded from other services or who have been difficult to engage with services
» Reducing risk / preventing suicide
» Supporting people to resolve or better manage their crisis
» Reduced use of statutory crisis and emergency services
» Service monitors against the 6 outcomes in 'no health without mental health'

Tips for commissioners

It can be cheaper to locate crisis services in the voluntary sector, than providing statutory services, including inpatient services. For service users it is a much more positive experience to be in a community based homely environment.

Contact

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9. Solidarity in a crisis

Aims

» To reduce isolation during out of hours by providing support that is respectful and non-judgemental
» To support people using the empathy and knowledge gained through lived experience
» To support the person in distress before they reach crisis point and help guide them towards appropriate professional support

Rationale

Certitude launched 'Solidarity in a Crisis' on 1 April 2012. It is a peer support service for Lambeth residents over 18. Co-designed and co-delivered by service users and carers in Lambeth; by sharing their experience and providing social support to people in distress, peer supporters aim to promote recovery, enhance feelings of belonging and hope to those in distress, whilst helping to prevent people reaching crisis point.

Development

The service operates out of hours (Monday - Friday 8pm to 12am, Saturday and Sunday 8pm to 2am) with peer supporters providing crisis support over the phone and through meetings in the community to help them move on from the acute stage of their mental health crisis, in a mutually agreed location (public place). It is an alternative service to conventional medical services or hospital. Peer supporters have gone through a training programme and receive regular supervision and support.

Challenges

Finding activities and services that are open out of hours.

Benefits and outcomes

» Less reliance on A&E for some individuals
» Less hospital admissions for some
» Preventing suicides
» Helping people stay in work who would have normally struggled
» Confidence building
» Resilience in facing long term crisis
» Connectivity with the wider community through signposting as well as supporting to make new friends and re connect with family
» Confidence for the peer supporters
» Peer support opportunities for those being supported
» Employment and volunteering prospects for the peer supporters
» New skills and training attained

Tips for commissioners

Use the same people you aim to support in the design, implementation as well as assessment of the services.

Contact

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10. City and Hackney CCG mental health training

Aims

» To improve mental health care provided by primary care professionals by addressing the 3C's' – confidence, competence and capacity

Rationale

Good crisis management in primary care needs a rapid assessment for those people presenting there, referral with comprehensive information, rapid response by the crisis service and fast communication back to the referrer. Primary care thus needs to have the confidence and competence to identify crisis and know how to manage it well to ensure optimal outcomes. Primary care also has a responsibility to try to prevent crisis by understanding individual stressors, encouraging compliance with medication where appropriate and supporting carers and families.

Development

City and Hackney CCG have begun a comprehensive training programme for all primary care staff. All GP reception staff have been offered free Mental Health First Aid Lite courses and more than 100 have completed this training to date. Reception staff who would like further training will be offered the 2 day course. Practice nurses, district nurses and healthcare assistants have been encouraged to attend the mental health training offered by UCLP (see case study 12, *Bespoke mental health training for practice nurses*). The course includes face to face modules and e-learning, ensuring that nurses completing this have a thorough and wide-ranging understanding of mental health in primary care, including crisis management. Forty nurses have completed this training.

GPs have continued the usual education sessions that have been running for many years but the CCG have also run additional workshops and will offer mental health master classes again next year. Mental health training has also been incorporated into the current locally enhanced service (LES). Practices are given bursaries - £0.45 per patient - and have to complete a number of hours of mental health training according to list size. GPs are also required to follow up all episodes of self-harm in under 18s by offering an appointment to all patients identified from A&E attendance, this enables early identification of stressors and offering interventions before crisis point is reached. GP practices are required to ensure that all reception staff have child and adolescent mental health crisis training to be able to respond better to young people who need urgent access to primary care.

The CCG have received a HENCEL grant to develop a community mental health education and training hub which will promote good mental health training across professions in City and Hackney. Joint training opportunities will be available between schools, workplaces, health, police and the local authority with the aim of building a strong sense of community resilience, empowering more people to help those in crisis.

Tips for commissioners

» Ask people what training and at what level is needed
» Use voluntary sector expertise
» Contact local resources, schools, faith groups, community workers
» Involve pharmacists in primary care mental health prescribing and compliance initiatives
» Consider better use of peer support or expert patients for crisis management in primary care

Contact

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12. Bespoke mental health training for practice nurses

Aims

» For patients seen in primary care to be treated by a health care professional who understands their mental, physical, emotional, spiritual and social needs and can respond appropriately and effectively
» To create a sustainable model of capacity building through the creation of a community of nurse educators engaged with improving the capability for mental health in primary care
» To improve integration between primary and secondary care for mental health patients

Rationale

To understand the training requirements of practice nurses regarding mental health and wellbeing, a national needs assessment was undertaken in the format of a survey. Responses were attained from 390 nurses. The key findings were that 82 per cent of practice nurses have responsibilities for aspects of mental health and wellbeing in which they have not had training with 98 per cent of these nurses stating they would like to undertake at least one aspect of training in mental health and wellbeing.

Development

The project was funded by the Health Education North Central East London (HENCEL); £250,000 was secured to establish a sustainable network of nurse educators, develop a 10 module training and train the trainer programme and educate practice nurses in the region. A steering and expert reference group (ERG) were set up with representatives from all participating partners (HENCEL; the Academic Health Science Network, UCLPartners; the Mental Health Trusts, Barnet, Enfield and Haringey Mental Health NHS Trust, Camden and Islington NHS Foundation Trust, East London NHS Foundation Trust, North East London NHS Foundation Trust; and GP practices). Practice nurses views from the survey have been used to help shape the programme of learning (consisting of 10 RCGP accredited modules, five of which are available as eLearning through the BMJ), developed by Dr Sheila Hardy, with the support of the ERG. Mental health nurses from the four trusts were trained to become Nurse Educators and they delivered the programme.

These Nurse Educators have been supported by UCLPartners to develop a network, which has initially been achieved through creation of action learning sets. In doing so, they have created a system of support and ongoing learning. To create a sustainable solution to capability and capacity building for mental health in primary care, this network is being supported to form a community of practice (COP) to help practice nurses and nurse trainers to continue their development in mental health.

To achieve implementation at pace and scale, a tool kit has been developed to enable replication. This includes: train the trainer and educational materials; a guide to creation of the COP; operational guidelines and evaluation tools.

Benefits and outcomes

A bespoke mental health and wellbeing package for practice nurses has been developed. A community of nurse educators has been trained to deliver the package to improve both the capability for mental health in primary care and integration between primary and secondary care for mental health patients. The practice nurses are taught to understand the patients' mental, physical, emotional, spiritual and social needs. This has the potential to prevent crisis and when a crisis occurs, increase recognition with appropriate and effective response.

Tips for commissioners

Use of the adoption tool kit enables creation of a highly cost effective, sustainable approach to building capacity for mental health in primary care, while improving integration, through building relationships between primary and mental health trusts nurses.

Contact

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13. Time to Change: Mental health training for GPs

Aims

» To improve healthcare professional's knowledge, attitudes and behaviour towards mental health

Rationale

The BIG Lottery funded a focused training programme for GPs and primary care staff. This funding was awarded to create an opportunity to learn from the Education Not Discrimination (END) targeted training element of Time to Change phase 1 (September 2007 – September 2011) and seek to develop a training model that is targeted and aligned with the needs of GPs and primary care staff, as well as meet the objectives of the new commissioning framework. This project was designed to try and improve attitudes and behaviours in GP practices towards people with mental health problems through improving knowledge.

Development

The programme saw the delivery of bite-size, face-to-face training for all staff in GP practices to improve knowledge and understanding of mental health and how to support patients with mental health problems.

The training was intended to fit into a 10 minute appointment slot and was delivered by a trainer with direct experience of receiving mental health care from their own local GP. At the end of the 10 minutes, trainees were given learning materials to support the session and a link to the website where they could access e-learning materials and 'talking head' films. The website had three core modules:

» Being mental health aware
» Making adjustments within the practice (Equality Act)
» Meeting people's mental and physical health needs

The training website can be found online: www.ttcprimarycare.org.uk

Challenges

The key consideration was developing a model that would align with the availability of staff within a GP surgery. This is why the 10 minute 'bite size' model was so effective.

Benefits and outcomes

The face to face training yielded positive results. There was a statistically significant improvement in attitudes following the training across all groups of training attendees: there was an increase in knowledge and 35 per cent of people felt more confident about working to promote mental health following the training.

Tips for commissioners

The main reasons the training was positively received were due to the duration i.e. short enough to incorporate into general practice and the trainers sharing their personal stories.

Contact

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15. Liaison psychiatry in north west London

Aims

» Improve the delivery of integrated care for patients with mental health needs in the acute hospital setting
» To provide a rapid response for people presenting with urgent mental health needs
» To provide training and supervision for non-specialist acute hospital staff in the identification and management of mental health needs

Rationale

A quarter of acute trust inpatients have mental health problems. Mental health problems account for 30 per cent of acute inpatient bed occupancy and 30 per cent of acute readmissions. Early identification and treatment of the mental health needs of this group has a direct impact on recovery. As well as improving patient outcomes, there is a growing body of evidence which shows that liaison psychiatry services in acute hospitals can lead to savings as a result of reduced length of stay and fewer re-admissions.

Development

The benefits of effective liaison psychiatry have spurred the recent development of services across the UK but availability remains patchy and where such services exist, there is no consistent model. In NW London there are six acute hospital trusts but only two had established liaison psychiatry services. Two providers working in partnership, Central and North West London NHS Foundation Trust and West London Mental Health NHS Trust, secured 'winter pressures' funding at the end of 2011 which enabled the establishment of pilot services at four acute trusts: North West London Hospitals NHS Trust (Northwick Park and Central Middlesex Hospitals), Hillingdon Hospital NHS Trust, Ealing Hospital NHS Trust, and West Middlesex University Hospital NHS Trust. A working group involving mental health providers, acute trust staff, commissioners and service users developed an 'optimal standard' model for a hospital of 500 beds that provided an integrated multidisciplinary service with 24-hour input to A&E and inpatient populations.

Challenges

The challenge has been determining an appropriate and sustainable funding mechanism. Liaison psychiatry is currently excluded from the mental health tariff proposals. The estimated cost savings leave open the question of whether savings are mainly of financial benefit to the acute trusts or to the CCGs.

Benefits and outcomes

» Improvement in the mental health diagnosis, treatment and care of patients in acute hospitals with co-morbid physical and mental health problems
» Improvement in response times (1 hr in A&E; 24 hrs inpatients)
» Reduction in A&E waiting time breaches
» Contribution toward reductions in overall lengths of stay on wards for people with dementia, co-morbid mental health problems and alcohol-related admissions
» Improved patient experience and referrer satisfaction
» Increase in capacity and capability of all hospital staff in managing MH needs effectively

Tips for commissioners

Engagement with both acute and mental health commissioners is essential.
Consideration of long-term funding from the start of any pilot project is key to future viability.

Contact

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16. Hull and East Yorkshire Hospitals Trust: The mental health team

Aims

» To offer a full psychosocial assessment to patients referred from either Hull Royal Infirmary or Castle Hill Hospital, who have presented with acute mental illness, self-harm, attempted suicide or extreme distress. Dependent upon the nature of the referral our response rates are 30 minutes the same working day or within 24 hours. A further aim is to educate staff within the acute trust to enable them to recognise mental health problems early and refer appropriately.

Service description

The team is multi-disciplinary and assesses patients with a range of mental health problems, but principally self-harm, within the acute care pathway. The team also assesses patients who have self-harmed and present to minor injury units throughout Hull and East Yorkshire, in the first instance via a telephone triage. The team provide an ageless service to patients who have self-harmed. They offer specialist psycho social assessment to all patients and follow up where appropriate.

Development

The team has developed incrementally since 1997. Today it consists of 15 practitioners and assesses approximately 3,700 people per year.

Good working relationships with commissioners have enabled further developments to occur. For example, in 2006, it was recognised that the service received by young people attending A&E who had self-harmed was inconsistent with the adult service and a business case was submitted to enable the team to provide an ageless service for patients who self-harm. In 2012, the team expanded to integrate the older people's liaison service. More recent developments include extended hours with the aim of becoming 24 hours. Another significant development is an extension from only seeing self-harm patients, to assessing all patients aged 18 and above presenting with mental health problems.

Challenges

» Different commissioning arrangements for aspects of the service, for example the team see patients below the age of 18 for self-harm but not for other acute mental health problems.
» Potential for burn out of staff due to demanding, high risk nature of work.
» Service providers and stakeholders may have different agendas, which can create tensions.
» Accommodation within the hospitals

Benefits and outcomes

The team is seeking PLAN accreditation and hopes to have collated extensive feedback from patients, carers, acute colleagues and liaison practitioners. This information will be used to inform future developments and make service improvements.

Tips for commissioners

It is essential to establish good dialogue with clinicians in the acute and mental health trusts; also close working relationships with commissioners and acute staff; accommodation within the general hospital setting is paramount; regular meetings between liaison, acute and community colleagues.

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17. Birmingham rapid assessment, interface and discharge (RAID)

Aims

» The service aims to meet the mental health needs of all patients over the age of 16 including those who self-harm, have substance misuse issues or mental health difficulties commonly associated with old age including dementia. With an emphasis on rapid response, it has a target time of one hour within which to assess referred patients who present to A&E and 24 hours for seeing referred patients on the wards. The service puts an emphasis on diversion and discharge from A&E and on the facilitation of early but effective discharge from general admission wards.

Rationale

The inception of the RAID model of liaison psychiatry – initially as a pilot at City hospital in December 2009 – saw a paradigm shift in the liaison model. Overnight, all patients of the acute hospital were offered access to mental health clinicians irrespective of the type of mental disorder, the department where the patient was treated or the time of day. RAID also embedded itself in the acute hospital 24 hours a day, 7 days a week.

Development

The pilot was evaluated internally[1] and externally[2] by academics from the London School of economics, who found that RAID saved 4 times what it cost. RAID was then rolled out across Birmingham. Clinicians work in partnership with acute hospital clinicians to assess, diagnose, formulate and plan treatment for those who are 16 years of age and above suffering with a mental health problem. Using an extensive knowledge of the broader primary and secondary care support services available, patients are placed on the correct pathway upon discharge from the hospital.

Challenges

There have been challenges in the roll-out of the RAID model across Birmingham and Solihull. These include the recruitment and delivery of a multidisciplinary team with the clinical experience and balance of skills required as well as practical issues such as finding accommodation within the acute hospital and becoming embedded in organisational structures and systems.

Benefits and outcomes

RAID saves money as well as improving the health and well-being of its patients. The London School of Economics reported that RAID saves 44 beds per day in a 600 bed hospital which equates to about £4 million per year. It also reported that in discharging more older people back to their homes rather than to care homes the service has saved the wider economy £60,000 per week.

Tips for commissioners

A RAID specific cross city commissioning group was set up to manage the commissioning of RAID enabling partnership working between the acute trusts and the mental health trust.

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1 George Tadros, Rafik A. Salama, Paul Kingston, Nageen Mustafa, Eliza Johnson, Rachel Pannell and Mahnaz Hashmi. Impact of an integrated rapid response psychiatric liaison team on quality improvement and cost savings: the Birmingham RAID model. Available at http://pb.rcpsych.org/content/37/1/4#BIBL, accessed 8/10/13

2 M Parsonage and M Fossey 2011; Economic evaluation of a liaison psychiatry service; Centre for Mental Health. Available from www.centreformentalhealth.org.uk

18. Hackney 24 hour AMHP service

Aims

» The London Borough of Hackney (LBH)/ East London Foundation Trust (ELFT) out of hours Approved Mental Health Professional (AMHP) service aims to respond to requests for Mental Health Act assessments (MHA's) which arise outside usual working hours. That is, between 5pm and 9am week days and 9am to 9am on bank holidays and weekends. The service aims to respond in a timely manner usually within 2 hours, and to provide consistency and continuity of care to people requiring this intervention.

Rationale

Reliance on an emergency duty service (EDT) out of hours service to respond to any urgent situation which arises, including safeguarding children and crises in adult social care, has led to MHA assessments being deemed low priority and consequently people waiting in 136 suites for several hours, on occasions up to the 72 hour duration of a section 136. LBH were concerned to address this and to provide a service staffed by AMHP's familiar with the people using services and with local arrangements. As well as benefitting the service user and colleagues in the other emergency services, it was also likely to lead to a better use of alternatives to admission.

Development

The service was developed over 10 months and involved a comprehensive scoping exercise and consultation with various stakeholders. The development included the decommissioning of the EDT service and the need to ensure that adult social care referrals out of hours received a prompt and robust service. Hackney already had a children's out of hours service in place. Discussions with AMHP's in Hackney were focused around the boundaries of the service, the interface with the daytime rota, payment and risk management.

Challenges

The challenges were to ensure that all tasks previously undertaken by the EDT were covered, that pathways for referral were clear and understood by all stakeholders and users of the service, and that staff were properly supported to do this work out of hours safely and professionally. As the provision of an AMHP service is a legal responsibility of the local authority delegated to the trust, LBH needed to give assurance to senior management in both organisations that this service was professionally robust and would lead to better outcomes.

Benefits and outcomes

The service became operational in July 2013 and undertakes approximately 25 assessments out of hours per month. There has been improvement in response times with 100 per cent compliance with the 4 hour response target. Discussions with referrers has suggested that the service is more accessible and responsive than the previous EDT arrangement and has also been able to undertake some planned assessments out of hours when circumstances are appropriate. There is now a single 24 hour phone number. The service operating costs are less than the previous EDT.

Tips for commissioners

A 24 hour AMHP service staffed by professionals employed in the day time service is generally more responsive and consistent in service delivery than EDT arrangements. It is also frequently less expensive. Robust planning and consultation with all stakeholders is essential, the service should have a single manager and have clear operating boundaries. It is essential that AMHP's working at night have access to a manager on call.

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19. Vulnerability Assessment Framework training tool

Aims

» To enable and support the Metropolitan Police and partners to identify individuals who are becoming vulnerable far earlier and thereby enable early intervention and prevent crises.

Rationale

Police officers and other emergency services encounter individuals on a daily basis for which they may have concerns for and identify as vulnerable. The Vulnerability Assessment Framework (VAF) provides a simple tool to use to identify those that are vulnerable and possibly in need of further help. A report is completed and if appropriate shared with partners.

Development

The VAF was introduced in April 2013 within the Metropolitan Police. The tool used within the framework was developed by Dr Karen Wright and Professor Ivan McGlen at University of Central Lancashire (UCLAN), originally called the Public Psychiatric Emergency Assessment Tool (PPEAT). The tool covers 5 areas:

A. Appearance and atmosphere: what you see first including physical problems such as bleeding.
B. Behaviour: what individuals in distress are doing, and if this is in keeping with the situation.
C. Communication: what individuals in distress say and how they say it.
D. Danger: whether individuals in distress are in danger and whether their actions put other people in danger.
E. Environment: where they are situated, and whether anyone else is there.

The Metropolitan Police Service (MPS) have furthered its use in conjunction with UCLAN so that it is used by officers in every encounter they have, if the officer identifies three or more of the areas or on professional judgement the minimum they must do is complete an Adult Coming to Notice Record on a computer system known as Merlin. This is the same system on which we record vulnerable children. For those that are identified as needing immediate care, the appropriate legislation would be used to assist that individual, such as section 136 Mental Health Act and a report would also be completed. UCLAN continue to work with the MPS in the assessment of the tool.

(Development, cont'd)

Since this system went live over 55,000 reports have been completed, this figure in itself speaks volumes about the success of the VAF. Once the report is on the system it is further assessed by officers working within the Multi Agency Safeguarding Hub/Public Protection Desk and where appropriate the report is shared with partners. Many of the reports that have been shared the individual is already known to partners, and may add additional information which enables the individual to get help before they reach crisis.

Benefits and outcomes

The VAF is enabling the Metropolitan Police and partners to identify individuals who are becoming vulnerable far earlier and enabling early intervention. The PPEAT also has further uses as a communication tool between partners as it gives a structure when passing information between services. The PPEAT is used within a Partner Training DVD on section 136 Mental Health Act "Safety in Mind" which is to be launched in October 2014. The DVD is the result of the hard work of South London and Maudsley Mental Health Trust, the Metropolitan Police and London Ambulance Service. The DVD[1] tells the story of a young man's journey through the section 136 process, and details what each partners' role is within this journey.

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1 http://www.slam.nhs.uk/media/films/safety-in-mind. Contact: richard.morley@slam.nhs.uk

20. London street triage pilot

Aims

» ‘Street Triage’ aims to improve the experience of people who are in crisis and come into contact with the police. The project also aims to reduce the use of section 136 of the Mental Health Act (MHA) amongst the police and reduce the amount of time that officers spend dealing with people who are in crisis due to mental health problems.

Rationale

The Secretary of State for Health established an innovation fund to support a programme of work with other government departments, as part of the Department of Health’s (DH) contribution to the government’s growth agenda. The DH set aside £15 million to fund three distinct projects as agreed with Home Office and Ministry of Justice. One of the key programmes funded was street triage projects in nine English police forces across the country.

Development

NHS England (London region) together with the Mayor’s Office for Police and Crime (MOPAC) have commissioned a street triage project in London. The street triage project has been piloted in the boroughs of Lambeth, Lewisham, Croydon and Southwark. These boroughs were chosen as the local mental health trust serving the 4 boroughs – South London and Maudsley - showed to have the highest rates of detention under section 136 of the MHA across London.

The triage service consists of mental health practitioners accompanying police officers to mental health related call outs and providing dedicated telephone support to officers on the ground who are responding to people in crisis. The mental health practitioners are deployed specifically to help officers decide on the best option for individuals in crisis by offering professional, on the spot advice and assessment, accessing health information systems and liaising with other care services to identify the pathways for those individuals in need of support. The objective of street triage is to demonstrate that this approach can lead to more timely intervention by mental health professionals which will help reduce unnecessary detentions for people, particularly in police stations and ultimately reduce the time officers spend dealing with people in mental health crises.

Challenges

» Speed of engagement
» Staffing capacity
» Data collection
» Police/Clinical Commissioning Group/NHSE geographical boundaries
» Sustainability

Benefits and outcomes

The aim is for better outcomes for these individuals as well as achieving a substantial cost saving for police services.

Tips for commissioners

» Strong partnerships between local commissioners, the police and police and crime commissioners
» Common understanding of the use of section 136
» Shared vision of the desired outcomes for each partner
» Plan for sustainability

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21. Integrated mental health team based within police headquarters

Aims

The aim of the project is to have an integrated mental health team based within the control room at police headquarters in Norfolk. The objectives of the project are to:

- Improve safeguarding for those suffering from mental ill health
- Introduce and provide early access to services for those with mental health issues before they reach crisis point
- Provide an improved police response to those in mental health crisis by identifying appropriate intervention and referral pathways
- Provide an improved response to repeat callers with mental health issues and thereby reduce demand on the police services
- Improve joint working between Norfolk Constabulary and Norfolk and Suffolk Foundation Trust (NSFT), East of England Ambulance Service and Norfolk County council when responding to mental health issues due to co-location and sharing of expertise
- Reduce demand across NSFT and Norfolk constabulary. This will be evaluated by randomised controlled trials and the University of East Anglia are doing a full academic evaluation

Rationale

As Norfolk is a large rural county it was felt that street triage would not have as much of an impact as having a mental health team based within the control room. A funding request was sent to the Police Innovation Fund who approved funding for a trial period to scope the project and its value.

Development

The project is a joint partnership between NSFT. The NSFT seconded a senior nurse to scope the project, which provided many benefits and efficiencies (see 'outcomes'). Following the success of the scoping bid a full bid has been submitted to the Police Innovation Fund for 1 x Band 7 Clinical Team Leader and 3 x Band 6 Mental Health Practitioners. The bid has requested funds of £170,000 to enable the project to be implemented. Due to the success of the pilot, the Chief Constable has agreed to release money from the constabulary ahead of the bid results to enable the project to be implemented. A band 8a Nurse has continued to be seconded to the project with the funding coming from the NSFT and the Constabulary. Year 2 funding has been applied for and the project is engaging with commissioners about the longer term funding.

Challenges

The development phase has been very successful. There have not been any pitfalls or significant challenges. Norfolk is the only Police force to have an initiative such as this and it has forged strong partnership links with NSFT and other agencies.

Benefits and outcomes

The scoping project has shown many benefits such as cost reductions for the Constabulary and the NSFT as a result for example a reduction in S136 detentions. The welfare of service users was enhanced by them being able to obtain a more appropriate and timely service with early referrals made to more suitable agencies. There has been improved confidence and skills of staff when responding as first contact within the control room. Other police forces are showing interest in this project as we have demonstrated real time benefits. Police officers have direct access to a mental health professional whilst at the scene of incidents enabling an improved response by the police, a reduction in harm, threat and risk in the most vulnerable communities, improving professional understanding across the police and the NSFT leading to an enhanced working relationship and finally increased confidence and knowledge of mental health by police officers and staff.

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22. British Transport Police (BTP) suicide prevention project

Aims

» "From Crisis to Care"
» To prevent public access to known vulnerable areas of the railway
» Proactively look for people in distress
» To have a joint approach between police and health

Rationale

In February 2013 a suicide prevention project (Operation Partner) was set up between BTP, NHS London, Barnet Enfield and Haringey and West London Mental Health Trusts with Department of Health and Royal College of Nursing support. This involved BTP staff and community psychiatric nurses working together to implement and review suicide prevention plans for people at risk.

Development

In 2014 the project secured ongoing funding from NHS England and London Underground and is commissioned by the Health in the Justice team at NHS England. The pilot scheme provided:

» Medical operational review of BTP Suicide Prevention Plans
» MHPs working in the custody suite to provide screening
» Deployment of mental health practitioners (MHPs) to provide outreach assessment
» Fast access to information -MHPs have access to NHS national systems and can respond to police queries in relation to vulnerable people in real time
» A specific MHP with social care skills in two boroughs (Hillingdon and Ealing)

One of the key objectives in this joint working was to get to the stage where the BTP Suicide Prevention Plan is succeeded by an NHS agreed care plan, ensuring the individual has access to the right type and level of service. Some recent research in Sussex[1] has revealed that 50per cent of people assessed following detentions under section 136 are not followed up after release despite this being a code of conduct standard.

(Development, cont'd)

Following significant rises in the number of suicide events on the railway, BTP gave a national directive to local offices to proactively look for people in distress under 'Operation Avert' with BTP, network rail operating staff and local police working together to reduce suicide on railways. Railway staff account for 20 per cent of the intervention and are trained by Samaritans. Operation Avert was launched for the third time on 10 September 2014. In attempt to reach those who are not already known to services there is a suicide prevention hotline – 0300 123 9101, for use by rail staff, health workers and volunteers who may have concerns for someone's safety.

Challenges

Tackling the perception that railway suicide is lethal: of suicide events on the main line railways of the UK 75 per cent will result in death and 25 per cent in serious injury; whilst on the London Underground network, 50 per cent will be fatal and 50 per cent result in serious injury. The majority of victims usually live near the railway therefore it is a part of their daily life.

Benefits and outcomes

During 2013/14 631 people received life-saving interventions on the railway. During Operation Avert 1 and 2 the daily life saving intervention rate doubled and the numbers of fatal and injury suicide events reduced.

Tips for commissioners

Partnership working and collaboration between police and health is essential.

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1 http://www.sussexpartnership.nhs.uk/gps/policies/finish/2339/9034

23. Highbury Grove crisis house

Aims

» Provide an alternative service to hospital admission for people experiencing mental health crisis in a community setting
» Support with crisis resolution or crisis prevention together with a personalised, solution focussed recovery plan to help prevent possible future crises
» Provide 24 hour access for people in a mental health crisis

Rationale

The service was established in 1996 by the mental health charity Umbrella following a survey by the King's Fund to establish the needs of service users in Islington experiencing mental health issues.

Development

Highbury Grove crisis project was commissioned in 1995 after the closure of the Friern Barnet Hospital. Service users were consulted as to what type of crisis services they felt they needed and suggested a non-medical model residential project and a drop-in 'out of hours' service at night.
In 2011 the mental health charity Umbrella merged with One Housing Group, and the crisis house service joined the One Support Mental Health services portfolio.

Based in Islington Highbury Grove crisis service consists of three components:

12 bed residential service: Supporting people with their primary mental health needs and secondary support needs including drug and alcohol dependency. One to one support for 2 weeks offers regular structured morning programmes and activities; support with developing independent living skills; accessing social and community facilities. Post-discharge, 6 "in reach" meetings are offered as follow up support to the service user.

Crisis night centre: In 1999 a nine month service review was commissioned, as a result the service was re-launched as the crisis night centre. Now the evening service remains available 7 days a week to provide a safe place for service users to meet and socialise therefore minimising social isolation, while providing support where necessary.

Crisis phone line: The service is provided 7 days a week 5pm to 6am. The crisis phone line is provided by staff at the crisis house and is the only phone line available to those who experience mental health problems within the borough of Islington.

Challenges

» Managing and re-assuring service users anxieties during cycle of change
» Increased demands of the NHS in providing much valued bed spaces
» As a voluntary sector provider we have restricted access to the NHS RIO system

Benefits and outcomes

» The residential service supported 242 customers
» The crisis night centre conducted 4464 interventions with services users
» Crisis phone line received 1033 calls
» Increase in complex cases with higher needs, including self-harm and substance misuse issues
» Excellent partnership working especially with the crisis pathway

Tips for commissioners

The critical success factor in the up-scaling of the crisis service has been formal joint working with the Camden and Islington NHS Foundation Trust acute services and crisis teams, together with joint working protocols with the local housing authority and local drug and alcohol services. The service has also recently agreed to accept Camden referrals (from NHS Camden and Islington acute services).

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24. Camden crisis houses

Aims

» Camden crisis houses were established to provide an alternative to acute inpatient hospital admissions based on a person-centred recovery model. Both houses offer a range of treatment and support to enable people to manage their own crisis in a community setting where possible.

Rationale

Camden service users had campaigned for over 10 years for a local crisis house. The growing evidence base shows that people tend to prefer staying in crisis houses than on inpatient wards because they can leave voluntarily, there is a higher staff to guest ratio and they feel safer as there is less likelihood that fellow guests will be disturbed, more peer support and the environment is calm and homely[1]. The north Camden crisis house is a six bedded facility that was opened in 2008. The Rivers, a six bedded crisis house located in south Camden on the St Pancras Hospital site, was opened in December 2013. The overall spend was £1 million.

Development

The Camden crisis house model includes a crisis team who support people in their homes and act as gate-keeper for admissions and a structured acute day treatment programme, where guests are encouraged to participate in therapeutic groups. The houses are accessible for people and their carers to get support. Service delivery is informed by an understanding of the experience of service users and their carers. People are admitted to the houses at the height of acute crises for brief stays of on average two to 10 days. Most people (74-78 per cent) are discharged to their homes. The north Camden crisis house was a joint partnership between Camden Council and Camden and Islington Foundation Trust.

Challenges

Financing the Rivers was challenging from the outset as building work coincided with a Trust reorganisation and the world economic downturn. There were challenges during the building of both Houses with maintaining a balance between a design which was homely and welcoming, yet safe with minimal ligature risk.

Benefits and outcomes

People report that they are managing better with everyday life, and experiencing fewer symptoms, when they return home from the crisis houses.

An evaluation of the service revealed that it was a cost-effective alternative to inpatient hospital stay: client rated outcome measures are high with a mean of 26 – 28 out of a maximum rating score of 32 when compared to 21 for inpatient wards (2010 evaluation).

Tips for commissioners

Establish more crisis houses in more residential locations. Stay involved in the project. Service user involvement is paramount to the success of both houses. Evaluation is also crucial as it proves effectiveness, dissipates any myths about the houses, helps to motivate staff and maintain high standards of care. Having a diverse and multidisciplinary staff group to match the service users also fosters better therapeutic alliances.

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1 Gilburt et al 2010; Osborn et al 2010; Sweeney et al 2014

25. West of Dorset recovery house

Aims

» To provide an alternative to acute psychiatric inpatient admission, which allows care and support to be delivered in a safe environment that promotes recovery.

Rationale

The service was opened in April 2013, as part of a reconfiguration of mental health acute care services, in which hospital bed numbers were reduced and home treatment provision increased.

Development

The service was commissioned by Dorset CCG, who developed the service specification in collaboration with Rethink Mental Illness and the Crisis and Home Treatment Team (CHTT) provided by Dorset HealthCare NHS Foundation Trust. CHTT offer a stay at the recovery house to people whose needs can be safely and effectively met there and who would otherwise require hospital admission.

Care plans are developed and delivered in partnership by the recovery house team and CHTT. The staff establishment consists of a Services Manager (half-time), Shift Lead and 5.7 Mental Health Recovery Workers. Daytime shifts comprise at least two staff and two sleep-in overnight. The annual cost is £327,777, including building costs. Existing resources were aligned to support the service e.g. the Services Manager also leads Rethink community services; a Rethink Carers' worker is linked to the house.

Challenges

» Convincing stakeholders that the house provided a viable alternative to hospital admission
» Developing effective shared protocols with a recently expanded CHTT
» Maintaining sufficient referrals to achieve target occupancy level of 95 per cent
» Building positive relationships with local residents

Benefits and outcomes

» Increased choice
» Avoidance of hospital admission
» Positive experience of mental health services, "treated as a person, not like a patient."
» Recovery aided by the calm, homely environment
» More opportunities to maintain daily living skills, community involvement and employment
» Partnership between health and third sector providers generates different perspectives on delivery of care and service development
» Reduced stigma/institutionalization
» Improved access to acute mental health care for people living in remote rural areas

Tips for commissioners

A good relationship between operational managers of the recovery house and CHTT is key. Specifying a maximum stay of two weeks maintains access and promotes good care planning. Allowing service-users to transfer from hospital widens access; specifying that this can only occur within 72 hours of hospital admission helps maintain the recovery house as an alternative to hospital stays, rather than a continuation.

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26. HPFT: Host families scheme

Aims

» The Host Families scheme from Hertfordshire Partnership NHS University Foundation Trust (HPFT) is an alternative to hospital admission or follows on from inpatient care and aims to offer intensive intervention and support to service users in a crisis, building on strengths and assisting the service user to manage the crisis at home whenever possible.

Rationale

The scheme is an integral part of the Crisis Assessment and Treatment Team (CATT) providing a supportive, therapeutic alternative to inpatient care. Host families are recruited to offer a supportive family environment to mental health service users.

Development

As part of the development of the scheme the HPFT staff visited a Host Family Scheme in Lille, France and gained their support in developing the Hertfordshire model. A particularly important aspect of the Lille scheme involves closely 'matching' the service user with a host family. HPFT adopted a similar process which means the CATT, informed by a recovery-oriented approach, looks at the service user's strengths and interests as well as needs and issues. For example, if the service user enjoys gardening it may be beneficial to place them with a host interested in gardening. A key part of developing the model included establishing a steering group with service users and carer representation and voluntary sector involvement.

The scheme is managed and supported by CATTs throughout Hertfordshire. It offers 24 hours, 7 days a week individualised support to people aged 18 and over and aims to assist the service user and relevant carers to learn from the crisis and endeavour to reduce the service users vulnerability to crisis and maximise their resilience and recovery. The host family are expected to support a recovery model of work and receive ongoing appropriate training and support to do this. CATT actively involve service users who have stayed with host families in planning service development and providing feedback about their experiences of the service to ensure continuous improvement. There are currently 11 host families and 61 people have been placed with a host family; placements that have prevented hospital admission or supported early discharge.

Challenges

The concept of supporting people who are acutely unwell in a family home raised some concerns therefore the team have worked with Hertfordshire County Council to put in place a robust safeguarding process.

Collect measurable qualitative and quantitative data from the start to demonstrate quality and impact of Host Families scheme as a true alternative to inpatient care.

Benefits and outcomes

» Raise awareness and understanding of mental health issues in local communities; promote social inclusion and reduce stigma
» Reduce pressure on acute inpatient care services
» Offers people an alternative environment in which to receive treatment in; less medical, more social
» HSJ award – Innovation in mental health 2012
» Evidence of good clinical outcomes

Tips for commissioners

Offer host family as a choice at point of assessment when an individual's needs are increasing and they enter the acute pathway.

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27. Redbridge home treatment team

Aims

» To provide a genuine focus on the provision of multi-disciplinary acute home treatment as an alternative to admission through the introduction of an integrated care pathway model
» To allow inpatient wards to better focus care on clients whose risk profile requires admission

Rationale

In 2008 in response to the social inclusion agenda and the desire to improve acute care, North East London Foundation Trust embarked on the redesign of trust wide mental health acute services for working age and older people. This involved the progressive introduction of a new model of integrated care pathway working to the four London boroughs served by the trust, adapted to the needs and resources in each area. This way of working has led to less demand for acute inpatient treatment; it has therefore been possible to divert resources to home treatment teams and towards improving the quality of care.

Development

Redbridge home treatment team is a 24-hour acute service working with people experiencing acute episodes of mental illness including people with learning difficulties, personality disorders where the risk profile indicates this is required and substance misuse problems (where this is not the primary presenting problem).

The team is multi-disciplinary, including social care staff, psychologists and occupational therapists. All referrals to acute services are initially assessed by a mental health practitioner - referring teams are guaranteed an immediate telephone response and physical assessment when needed within two hours.

The home treatment team have a 100 per cent gate-keeping role to their wards and are also 100 per cent involved in inpatients discharge: arranging same-day home visits for service users discharged from hospital and daily follow-up until the end of the acute phase. The team work with acute wards on a daily basis to progress discharges and identify outstanding practical issues: the co-location of the team with the wards at one central base facilitates this integrated way of working. Redbridge actively involve service users and their families in their treatment and seek feedback.

Challenges

It is important to ensure all care pathway teams, including access and liaison psychiatry at A&E are working to the same model and with sufficient resources.

Benefits and outcomes

» Increased treatment at home - promotion of social inclusion, reduction in social isolation
» Enhanced patient involvement in the delivery of care and service user and carer engagement
» Reduced risk of long-term adverse effects caused by multiple or long admissions
» Progressive reduction in acute bed usage and bed base
» Improved financial efficiency of ongoing service delivery

Tips for commissioners

Ensure sufficient investment in home treatment teams in order to allow them to safely deliver home treatment as an alternative to admission, alongside increased investment in remaining wards to allow them to work with the more efficient model.

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28. South Tyneside crisis resolution and home treatment team

Aims

» To provide intensive home based treatment to people in mental health crisis as an alternative to hospital admission.

Development

Northumberland Tyne and Wear NHS Foundation Trust provides a crisis resolution and home treatment team (CRHT) with the capacity to visit service users up to three times daily, providing a range of psychological and physical interventions including support and psycho-education for carers and families. The team works extensively with the inpatient units; gatekeeping 100 per cent of admissions and also providing early discharge planning.

The team provide a 24 hour mobile workforce inclusive of nurses, doctors and support workers; access to specialist clinical advice is available by accessing scaffolding and augmenting services to ensure that all the clinical needs of the patients referred to the service are met. The introduction of the use of mobile solutions has improved performance in record keeping and also reduced time spent completing documentation. The team have access to laptops and also digital dictation services with the ability to dictate, using an app on their mobile phone, and send to a transcription service, which inputs into the patient record.

Access to the Team is via the South of Tyne initial response service which provides 24 hour telephone access for all referrers who require urgent support from mental health services.

A nurse initially completes a telephone triage, the outcome of which may require a face to face triage or a crisis assessment provided by the CRHT. This triage model supports clinical staff to work in the community and provides a central hub for all referrals.

Benefits and outcomes

» Frequent hospital admissions for some service users are neither helpful nor provide any therapeutic benefit. Through the use of MDT meetings and working collaboratively with service users we have been able to provide robust packages of care working within a recovery based model
» The introduction of “mobile solutions” has reduced clinicians administrative workload; providing a more timely response to referrals and allowing the clinical staff to focus more on clinical interventions
» The use of the initial response service to manage telephone referrals provides a central point of access; this means the team are only contacted if a face to face response is required and avoids disruption to clinical care
» Maintaining an individual’s care in the community, reducing the adverse effects of hospital admission
» A significant reduction in hospital admissions and bed usage and improved financial efficiency

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29. What makes a good crisis plan?

Aims

» To co-produce what is considered to be an exemplar crisis plan and good practice standards for the crisis planning process

Rationale

Quality statement nine of the NICE guidance on service user experience in adult mental health service (2011) states that people using mental health services who may be at risk of crisis are offered a crisis plan. NICE (2011) define a crisis plan as a future statement of preferences and practical arrangements. It may therefore be considered as an advance statement. In summary, there are three main types of advance statements developed by people with mental health conditions and these are generally known as psychiatric advance directives. In 2013/14, one of the Trust's CQUIN targets is to review the crisis plans of people on Care Plan Approach and implement a programme to improve the quality of crisis planning. The first outcome for this CQUIN has been to co-produce what is considered to be an exemplar crisis plan and good practice standards for the crisis planning process.

Development

A three-stage process was used:

» Stage one reviewed the research literature.
» Stage two a workshop took place bringing together the expertise of service users, carers, friends, families and professionals to identify what makes a good crisis plan.
» Stage three involved the undertaking of a Delphi exercise to identify areas of consensus.

Challenges

The challenge is to move from this process into the day-to-day reality of collaboratively developing crisis plans in our routine practice but more importantly, the accessing and honouring of the plans when a person is in crisis.

Benefits and outcomes

Through the literature review and the workshop a total of 94 statements were generated for what makes a good crisis plan. 78/94 statements reached positive consensus within the Delphi exercise. The 16 statements which reached 'no positive or negative consensus' were analysed further to understand if there were differences between service users, carers, friends, families and mental health professionals. There were no differences for 10 statements with all respondents being clustered in the centre of the scale. However, for 6 statements, respondents did differ in their responses. In particular, 10 per cent of service users and 25 per cent of carers and families in comparison with 49 per cent of mental health professionals disagreed or strongly disagreed with the statement that crisis plans will not work because services will not honour them. The 3 stage process for co-producing an exemplar crisis plan and good practice standards appears to have worked well.

Anecdotal feedback from participants has been very encouraging about the trust working in this way and involving a wide range of people to coproduce this work on crisis plans. The Delphi exercise has enabled service users, carers, friends, families and mental health professionals to freely express their opinions without undue social pressures to conform from others in the group but also enabled a greater number of people to be part of the process of co-producing a solution to crisis plans. The issue of trust came up strongly in the workshop and continued throughout the Delphi exercise.

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30. Ways to wellness: social prescribing for people with LTCs

Aims

» To improve the quality of life of people with long term conditions (LTCs) through access to social prescribing and reducing costs to commissioners. The objective is to develop a sustainable and economically viable model of social prescribing for people with LTCs in order to bring about long term behaviour change, increased social wellbeing and social networks. Ways to Wellness will offer social prescribing to 5,000 patients per year.

Rationale

GPs in West Newcastle have had a longstanding interest in using social prescribing as a way of responding meaningfully to people with long term conditions and mental ill health, especially in terms of recognising the impact of co-morbidity, and addressing the wider determinants of a patient's wellbeing such as social isolation.

Development

The Ways to Wellness model incorporates learning from a series of social prescribing commissioning initiatives that have been tested locally over the years[1]. This includes early pilots in practice based commissioning, and a People Powered Health project[2]. This work tested the role of 'link workers' which formed a key part of the model.

Link workers provide focused support to help patients identify and access community activities and where necessary specialist advice to help improve their wellbeing. A recent project has looked closely at maximising the effectiveness of the social prescribing offer and the link worker role for people whose needs include mental health problems[3].

Ways to Wellness Ltd will hold a contract with Newcastle West CCG, whereby the CCG agrees to pay for the provision of social prescribing services to their patients if Ways to Wellness can evidence achievement of performance measures that demonstrate value to patients and a reduction in the use of NHS resources. This will be a Social Impact Bond type model. The main funding has been £130,000 of development funding which came from the Social Enterprise and Investment Fund and the CCG have just submitted their Stage 2 application to the Big Lottery Commissioning Better Outcomes and the Social Outcomes Fund to secure funding to help CCG to pay for financial benefits (such as reduced GP visits) that fall outside of the CCG's budget. Preliminary projections estimate that £2.75 million to £3 million of social investment.

Challenges

» Practice engagement - ways of informing and changing GP behaviour
» Public and patient engagement - ways of informing and changing patient expectations
» Having access to good quality information about what resources, services and groups are available
» Reduced capacity in community, health and social care resources due to public spending cuts
» Finding a set of comprehensive metrics simple enough to base contracts on and trigger payments.

Benefits and outcomes

» Improvements in patient self-management and in patient's health compared with predictions
» Reduction in secondary care usage leading to net savings because of reduced NHS usage
» Reduced visits to GPs
» Reduced reliance on prescription drugs for some conditions (such as those for depression)

Tips for commissioners

As an evolving project, there has been a culmination of several years of experimentation and investment in social prescribing - there isn't a quick commissioning fix. Building trust and relationships to establish confidence to do things differently is key. The recent Ways to Wellness procurement prospectus for link worker provider host organisations and the open and consultative way in which it was put together and the fact that it has a values base are very good learning point for commissioners.

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1 *Thanks for the Petunias, A guide to developing and commissioning non traditional providers to support the self management of people with long term conditions*, NHS, 2011, www.diabetes.org.uk/upload/Professionals/Yearper cent20ofper cent20Care/thanks-for-the-petunias.pdf
2 www.nesta.org.uk/project/people-powered-health
3 Social Prescribing for Mental Health - and Integrated Approach (Draft report) http://movingforwardnewcastle.co.uk/

31. The Sandwell Esteem Team

Aims

» The aim of the Esteem Team is to support people with mild- moderate mental health conditions and complex social needs at an early stage to prevent deterioration and admission to secondary care services. It aims to empower patients to take control of their own lives by offering guided therapies and tools for self-help.

Rationale

Patients can feel left unsupported if a care intervention is not successful. Complex referral pathways can mean that patients get 'lost'. In standard practice patients can access a certain number of therapy sessions and have to seek a new referral from their GP once these end or if their condition has not improved.

Development

The hub is mainly funded by the Sandwell and West Birmingham CCG. The cost for the Esteem Team in 2012/13 was £490,349. In 2013/14, the budget was £569,674. The team is part of the Sandwell Integrated Primary Care Mental Health and Wellbeing Service (the Sandwell Wellbeing Hub). It is a holistic primary and community care-based approach to improving social, mental and physical health and wellbeing.

The team receives referrals from secondary, primary and community care organisations as well as social care and probation services. Patients can also self-refer. Link workers are navigators, typically having a social worker background and/or experience with mental health conditions. Link workers form close relationships with patients, visiting patients at home and accompanying them to appointments.

Challenges

In the absence of formal referral criteria, many services would refer inappropriate cases to the team, which led to duplication and increased the team's workload. The team would also receive referrals of people with acute suicide risks. The team helps in these cases by alerting the appropriate services, but at the expense of prolonging distress for the patients and creating additional work.

Benefits and outcomes

A statistical analysis carried out showed significant levels of improvement on a clinical and a wellbeing scoring tool (the Core 10 and Warwick-Edinburgh Mental Wellbeing Scale -WEMWBS). There was also a reduction in the percentage of patients with a diagnosis of clinical depression.

Tips for commissioners

» Review processes and interventions on an ongoing basis. Early intervention and reaction to problems ensured continuity of service for patients during the restructure of the team
» Co-production and involving patients and service users in service design.
» Skill mix and staff roles
» Staff have experience of mental health conditions; therefore understand the patient's issues.
» Awareness-raising and relationship-building
» The team relies strongly on relationships with other services, particularly those in the voluntary sector, to offer patients access to a range of services and support groups.
» Holistic care tailored to patients needs using a stepped care approach
» The team tailors care packages to the specific need of patients.

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32. Manashanthy: CBT for Tamil people in south west London

Aims

» The aims of this project were to identify needs in the Tamil community, raise awareness of existing IAPT services and offer interventions to meet their needs.

Rationale

The group was developed as part of the Improving Access to Psychological Therapies (IAPT) initiative in Wandsworth and Merton. A mission statement of IAPT is to improve access to psychological therapies for 'hard to reach' communities: actively working with a potentially excluded group to minimise this and offer better service. The Tamil community was identified as one such marginalised community in south west London, and the Manashanthy group (mind-peace) has been developed.

Development

Tamil speaking cognitive behaviourial therapy (CBT) therapists were employed and trained to provide workshops at the Wimbledon Shree Ganapathy temple to the Tamil community, as well as via other local temples and churches. Additional support came from a community development worker increasing awareness of the work with local GPs. The workshops covered IAPT services in general, stepped care approach, how to access IAPT services, basics of CBT, mindfulness, basics of PTSD and available support. The temple offered rooms for clinical work this was an ideal setting as the Tamil people were comfortable and familiar with the Temple as a place of safety. The first group ran in October 2010. Since then there has been a process of learning and adapting for example changing the number of sessions offered and tailoring the treatment model used to incorporate eastern healing methods and mindfulness.

Challenges

There were number of challenges in developing the Manashanthy Group: developing partnerships with community organisations and developing culturally appropriate services took time and required flexibility; overcoming stigma; equipping therapists to work with people who have been tortured to manage their own distress and reactions; clients would "drop out" or "disappear" because they had been sent back home or moved to a different place, this disturbed the group dynamics; a community setting means working in a non-clinical environment which increases the risk and health and safety issues.

Benefits and outcomes

» A culturally adapted CBT model has been established
» Good clinical outcomes
» The service is working with a number of partner organisations, including Asylum Welcome, Freedom from torture, Food Bank Project, Tamil Welfare Organisation and Tamil English Teachers
» Promoting the service with GPs, CMHTs and traumatic stress services

Tips for commissioners

» Community engagement is strengthened by training staff from local communities to deliver interventions
» Co-production with communities ensures interventions that are tailored to the local needs
» Key performance indicators need to be flexible to enable innovative working

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About the Strategic Clinical Networks

The London Strategic Clinical Networks bring stakeholders -- providers, commissioners and patients -- together to create alignment around programmes of transformational work that will improve care.

The networks play a key role in the new commissioning system by providing clinical advice and leadership to support local decision making. Working across the boundaries of commissioning and provision, they provide a vehicle for improvement where a single organisation, team or solution could not.

Established in 2013, the networks serve in key areas of major healthcare challenge where a whole system, integrated approach is required: Cardiovascular (including cardiac, stroke, renal and diabetes); Maternity and Children's Services; and Mental Health, Dementia and Neuroscience.

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MH-UC-CS-102014-rev1