This discussion

What are the current challenges for people in crisis in 2014

What is the model we are aiming for in line with Crisis concordat and Urgent and emergency care review

What metrics do we have to measure the baseline and progress

Where are the outstanding examples of routine good practice, innovation and transformation in every crisis response agency across England

What can we, as leaders, do to make progress

What help do you need?
### Baseline: What is the current problem with mental health crisis services in England in 2014

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Implication</th>
</tr>
</thead>
<tbody>
<tr>
<td>If I have a physical health crisis I ring 999 or 111 and get expert help</td>
<td>If I am in mental health crisis, I don’t know what number to ring or where I should go to get help</td>
</tr>
<tr>
<td>I may end up in any of 14 different places to get help in crisis including police cells, transport police, duty systems in mental health and acute care, A/E, home care.</td>
<td>If I have a physical health crisis and I go to my GP or A/E, staff are trained to manage me well</td>
</tr>
<tr>
<td>I may be brought to a police cell for a mental health assessment rather than a hospital.</td>
<td>If I go to my GP or A/E in a mental health crisis, I have a 1:3 chance of being assessed and treated in line with NICE basic standards</td>
</tr>
<tr>
<td>I have just a 45% chance of being seen by a trained mental health liaison team in A/E so I am more likely to be admitted to a bed in a hospital or care home.</td>
<td>If I go to A/E I have only a 45% chance or being assessed by staff trained to do mental health assessments</td>
</tr>
<tr>
<td>If I am seen by a crisis home treatment team they are so busy that they can give me and my family less support than I need.</td>
<td>I am more likely to keep having to come back to A/E in crisis when I don’t get a trained response and am more likely to go on to commit suicide</td>
</tr>
<tr>
<td>If I need admission to a mental health bed in a crisis, I may have to travel hundreds of miles.</td>
<td>If I am from a BAME community my crisis is likely to be responded to by police, not healthcare</td>
</tr>
</tbody>
</table>
Using technology to transform care
Liaison Services – “I statements” for professionals now

How new technologies can help

- **Admission/Attendance**
  - Information about attendance or admission is not automatically sent to mental health trusts systems

- **Referral**
  - I can only receive information by fax or over the phone and then have to transcribe this into an electronic record system

- **Assessment**
  - I have to write duplicate entries in the medical records, often still paper based, and the mental health records system
  - There is no place for a collaborative shared care plan between the medical team, mental health team and the patient/their carers

- **Care Planning**
  - I cannot use technology based interventions and monitoring routinely in care planning

- **Investigations**
  - I have to rely on colleagues in acute trusts to access pathology results otherwise I have to call the pathology lab and receive the results manually over the phone
  - I have to rely on paper systems to transfer results of investigations between acute settings and mental health outpatient and community clinics

- **Treatments**
  - I can only use technology in a limited way to keep patients up-to-date with follow-up arrangements
  - I cannot routinely contributed to an integrated discharge summary that is electronically distributed.

- **Discharge**
  - Information about attendance or admission is not automatically sent to mental health trusts systems
Crisis care & the NHSE Mandate

The Mandate for 2014-15 establishes specific objectives for the NHS to improve mental health crisis.

The government expects:

- NHS England to make rapid progress, working with clinical commissioning groups (CCGs) and other commissioners, to help deliver on our shared goal to have crisis services that, for an individual, are at all times as accessible, responsive and high quality as other health emergency services.

- NHS England to ensure there are adequate liaison psychiatry services in Emergency Departments.

- Every community to have plans to ensure no one in crisis will be turned away, based on the principles set out in this Concordat.
What is the transformational MH crisis care model we have agreed in line with Crisis Concordat & the Urgent & Emergency Care review

Our agreed NHSE consensus approach is to:
1. **Tackle causes & Prevent** actions:
   - **Identify the causes of MH crises & prevent**
   - **Work with public health, Health & Wellbeing Boards, CCGs, transport systems, police, housing etc. to prevent**

2. **Single coordinated access number & system**
   - **single access No. & all agency system ? 111:**

3. **Tele triage and tele health well triaind**
   - **which reduced face to face need by 40%**

4. **Crisis Home treatment teams with fidelity**
   - **reduce admissions and LOS by 50%**

5. **Liaison mental health teams**
   - **in A/E & acute trusts reduce admissions to acute beds and care homes by 50%**

6. **3rd sector Crisis houses & day care for PD** as alternatives to beds

7. **Adequate acute beds when needed**

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1. CCGs & HWWBs tackle causes
2. Single number access ? 111
3. Trained tele triage & tele health
4. 24/7 Crisis Home Treatment Teams
5. 24/7 Liaison mental health teams in A/E & acute trusts all ages
6. Alternatives to Hospital beds e.g. day treatments and crisis houses
7. Adequate acute beds if needed
Tackling causes

Employment
Family friendly, productive practices,
Creating wealth
Can every large, medium & small employer be a positive employer? What can GPs and CCGs do?

Schools:
4 Rs: reading, writing, `arithmetic & Resilience
Building resilience, addressing dyslexia
Training school nurses & form tutors
Engaging school governors

College students: & Adult education
Building resilience &
Physical & mental health literacy in future leaders

Transport hub related :
Preventing isolation in older people
Reducing avoidable suicides and
Reducing detentions

Fire chiefs
70% of avoidable fires, domestic accidents, & RTAs

Police commissioners
Commissioning parenting
Safer neighborhoods
Alcohol
What metrics do we have to measure the baseline and progress

Where are outstanding examples of innovation, transformation in commissioning & provision in every agency across England

What can we, as leaders, do to make progress

What help do you need
The myths we are busting in England with the power of user voice, the intelligence network

- **Mental health just happens or not! You can’t learn it!**
  - No, it’s **NOT**. Like physical, academic or creative achievement, it can be taught & learnt.

- **Mental health is a long term condition**
  - No, it’s **NOT**! It’s so often in England an **untreated acute condition**

- **Mental health is all too complex & scary!**
  - No it’s **NOT**! It’s the people we all know with depression/anxiety, eating disorders, perinatal depression, OCD, alcohol, psychosis episodes etc.

- **Mental health has no evidence based treatments**
  - No it’s **NOT**! We have over 100 NICE guidelines, HTAs, Quality standards etc
  - We have highly powerful, robust, cost effective treatments **if given early**
  - The neurobiology & science & economics are not understood

- **Mental health has no data to help commission locally appropriate services**
  - We now have the Mental health intelligence network like cancer or CVD
  - [http://fingertips.phe.org.uk/profile-group/mental-health/profile/severe-mental-illness/data](http://fingertips.phe.org.uk/profile-group/mental-health/profile/severe-mental-illness/data)
  - We have robust economic cost evaluations for every single mental health condition
# 1. Baseline information for your CCG and LA

The basic baseline information needed immediately for every CCG. LA, SCN area team, region, national

<table>
<thead>
<tr>
<th>CCG area contextual factors</th>
<th>City/urban/rural/ deprivation quartile</th>
<th>Hot spots for suicide / crisis events/ transport hubs</th>
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</thead>
<tbody>
<tr>
<td><strong>Governance</strong></td>
<td>• Is there a MH section of the system resilience board</td>
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<td></td>
<td>• Is MH present in the urgent care networks</td>
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<td></td>
<td>• Is the crisis concordat multi agency programme established</td>
<td></td>
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<tr>
<td><strong>Agreed standards &amp; response times</strong></td>
<td>• Have you agreed your local standards</td>
<td></td>
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<td></td>
<td>• Have you agreed the waiting times in line with national best practice</td>
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<tr>
<td><strong>Single number to ring</strong></td>
<td>Yes/No</td>
<td></td>
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<tr>
<td><strong>Primary care crisis response</strong></td>
<td>In and out of hours</td>
<td></td>
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<tr>
<td><strong>111 Directory of services up to date</strong></td>
<td>Yes/No</td>
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<td></td>
<td>Yes/No</td>
<td></td>
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<tr>
<td><strong>Tele triage and tele health service</strong></td>
<td>Yes/NO</td>
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<td></td>
<td>• Is your triage service multi agency ie includes social care, out of hours GPs, housing etc</td>
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<td></td>
<td>• Do u have street triage with police project</td>
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<td></td>
<td>• Do u have ambulance hub based triage</td>
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<td></td>
<td>• Do u have transport hub based triage</td>
<td></td>
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<td></td>
<td>• Do u have fire services based service</td>
<td></td>
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<tr>
<td></td>
<td>• Do you have police station crisis and diversion service</td>
<td></td>
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<tr>
<td><strong>Crisis home rx team</strong></td>
<td>• Is the team commissioned in oien with predicted need</td>
<td></td>
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<td></td>
<td>• Is the team operating to fidelity best practice model</td>
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<td></td>
<td>• Rate of CRHT gate-keeping (DK)/ Number of admissions to acute wards that were gate kept by the Crisis Resolution Home Treatment team (IQ)</td>
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<td></td>
<td>• Home treatment episodes ie NO people and No episodes</td>
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<td></td>
<td>• Trends in last 2 years re activity</td>
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<td></td>
<td>• What is the team’s RCPsych peer accreditation</td>
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<td></td>
<td>• HTA network standard</td>
<td></td>
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<td></td>
<td>• Skillmix of the team</td>
<td></td>
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<tr>
<td></td>
<td>• Training level of the team</td>
<td></td>
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<tr>
<td><strong>Liaison MH</strong></td>
<td>• Is the team Core, Core Plus, enhanced, comprehensive</td>
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<td></td>
<td>• Was the person a 4 hour breach</td>
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<td></td>
<td>• What is the team’s RCPsych peer accreditation PLAN network standard</td>
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<tr>
<td><strong>Crisis houses</strong></td>
<td>Do you have crisis houses</td>
<td></td>
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<tr>
<td><strong>Day treatment services</strong></td>
<td>Yes/No</td>
<td></td>
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<tr>
<td><strong>Beds of all types</strong></td>
<td>How many of each bed type do you have</td>
<td></td>
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<td></td>
<td>• Acute beds</td>
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Alternatives to Hospital beds e.g. day treatments and crisis houses

24/7 Liaison mental health teams in A/E & acute trusts all ages

24/7 Crisis Home Treatment Teams

Trained tele triage & tele health

Single number access? 111

CCGs & HWWBs tackle causes
111 workstreams: steering group has started

1. **Leadership:** Who is the 111 lead local to you

2. **Governance arrangements** for national & local planning

3. **Directory of Services:** user groups being organized to agree a specification of MH local services for DOS

4. **Crisis Assessment for MH:** What is the current assessment for people in mental health crisis in every agency & can it be amended to add a mandatory Suicide risk assessment which reduced suicide

5. **Information sharing** protocols

6. **Good practice examples of 111 MH:** what can we learn e.g. Isle of Wight BTP pilots, street triage pilots

7. **Training:** in mental health awareness do 111 staff need

8. **MH Pilots** to place mental health trained staff in 111:
Direct access & tele triage and tele health

Evidence of best Value for commissioners & progress

Tele triage by skilled trained staff person centered and economic benefits:

- access rates and times, especially in rural areas
- Provides care to a person in their home
- Is easier in rural areas
- Reduces the need for face to face contact by 30-40% if there is a well kept up to date Directory of Services
- Enables reengineering of estate
- Is more eco friendly reducing carbon footprint through travel
- If access is faster, patient is at an earlier stage in problem, so staff skillmix can be very cost effective

Exemplar Case examples:

- NTW has band 4 tele triage staff sitting alongside band 6 tele health trained staff
- NWL is applying NTW methodology to a federation of 8 CCSs in NWL

Research

International fast review of tele triage and tele health for MH

- York Centre doing a NIHR/ DH/NCD commissioned brief review
- Wales did a more phased training programme in tele health / visit Australia where it is more advanced
- Ask DH suicide strategy programme to find the best brief suicide reduction assessment tool
<table>
<thead>
<tr>
<th>Baseline Key facts summary</th>
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</thead>
<tbody>
<tr>
<td>• CHTTs are the backbone MH form of A/E rapid response 24/7 if commissioned &amp; provided well</td>
</tr>
<tr>
<td>• There are clear standards and ‘fidelity’ criteria for optimal safe, effective care and commissioning value &amp; an accreditation network &amp; 3 day training programmes to upskill</td>
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<tr>
<td>• The challenge is that commissioning and provision is in line with evidence base in just 45%</td>
</tr>
<tr>
<td>• CHTTs need to be included in the 7 day standards MH</td>
</tr>
<tr>
<td>• Crisis demand is rising and services are under pressure: timely action to be taken, as we do with A/E demand &amp; other winter pressures</td>
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<tr>
<td>• Stratification is critical</td>
</tr>
<tr>
<td>• Identification of the causes and prevention is critical</td>
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</table>
A/E: What are the most common clinical reasons for mental health crisis in A/E

Mental health hospital presentations

1. Dementia
2. Self harm
3. Alcohol dependence
4. Psychosis relapse
5. PTSD related

1. Raid Liaison Models in A/E
2. Liaison & health psychology services in wards & LTC clinics
3. Liaison mental health field force
4. Liaison services for older people reaching out to larger health centres
Mental health demand on A/E all ages

- Mental health service users are high users of A/E
- They account for >40% of 4 hour breaches
- Just 41% of A/Es have commissioned safe effective liaison MH services
- There are excellent standards set by NHSE SW SCN/Rcpsych liaison MH faculty and an accreditation stds network
- A tariff is being developed
- An excellent Outcome KPI set has been developed
- LSE/ Centre for MH have provided robust economic analysis of savings of 50% and decreases in admission to acute beds and care homes beds of 40-50% if the Raid model is commissioned
- Liaison services must include a skill mix team to provide care for dementia, alcohol, relapse psychosis, self harm and suicide, CYP
- Liaison services also target acute out patient clinics

The economic challenge is all about reengineering and modeling the money ..........
WE know what works to provide safe, effective care for patients
We know it’s a spend to save programme that’s needed
We just need to be clever enough to make that happen!!
We need £400 million to get all A/E & acutes with a liaison team & there would be a £200 million saving within 18 months ( see case study )
- http://www.hsj.co.uk/resource-centre/best-practice/qipp-resources/liaison-psychiatry-canbridge-the-gap/5051771.article#.U_B9gEtQ9yE
Liaison mental health teams for acute trusts: 2014/2020:

<table>
<thead>
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<tbody>
<tr>
<td>• Liaison MH teams are highly evidence based clinical and cost effective</td>
</tr>
<tr>
<td>• 45% of A/E s and acute trusts now have a Liaison service</td>
</tr>
<tr>
<td>• There are clear standards and ‘fidelity’ criteria for optimal safe, effective care and commissioning value &amp; an accreditation network</td>
</tr>
<tr>
<td>• Liaison teams also reduce by 50% outpatient attendances to pain, bariatric, IBS, neurology, COPD, CVS clinics &amp; reduce LOS &amp; can outreach to primary care</td>
</tr>
<tr>
<td>• CCG case studies now show reengineered spend from hospital to Primary care at scale areas e.g. Swindon, Oxford, Sunderland, Hackney</td>
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<tr>
<td>• The new historical access standards announced last week will start the journey to put MH crisis on a par with physical health response</td>
</tr>
<tr>
<td>• Winter pressures, better care funds, personalization, new housing supports can be accessed</td>
</tr>
</tbody>
</table>
An effective pathway to improve crisis care responses

Support before crisis point
- Access to support before crisis point
  - Tele triage and tele health
  - Early Intervention Services
    - Suicide prevention
  - Personalised care budget
  - Helplines
    - Peer Support
    - Help at Home
  - Supported Housing
    - Adult placement
- Urgent and emergency access to crisis care
  - ‘Parity’ between responses to physical or Mental Health emergencies
  - Single point of access to specialist mental health services 24/7
  - Crisis Home Treatment team
  - Crisis and respite house
  - Hospital Admission
    - See Effective Bed Management Pathway
- Quality of treatment and care when in crisis
  - Physical assessment and treatment
  - Mental state assessment
  - Safe, competent treatment at home wherever possible
  - Timely ambulance transport to appropriate NHS Facility
  - Access to Liaison & Diversion from police custody or Court
- Recovery and staying well / preventing future crises
  - Crisis Plan (NICE)
  - Self management and family involved crisis plan
  - All utilities working, food in house, debts and benefits sorted
  - Transition to GP led care (with ‘fast track’ access back)
- Getting a life back
  - Care and treatment (inc MHA, MCA, CPA)
Using the digital revolution to advantage
Liaison Services – “I statements” for professionals in 5 years

Admission/Attendance
- My team are able to receive timely alerts through an integrated system that enable us to respond quick and triage our work more effectively
- I can write one entry in one record system and it is shared with other linked records systems, or there is one record systems across trusts
- I have access to pathology systems within the electronic patient record for mental health service. I can order investigations online and remotely
- Information about physical health investigations is shared with primary care and community services electronically

Referral
- I can receive referral electronically that integrate into the electronic records system reducing duplication of work

Assessment

Care Planning
- Care plans are shared in real time across systems and can be updated and accessed by all involved (including patients)
- I can recommend technology-enabled care that integrates well with other IT systems – e.g Apps or remote sessions using videocalling

Investigations
- Discharge plans (eg. appointment times) are routine shared and updated through an electronic system. Notifications are sent about changes to staff who will see the patient

Treatments

Discharge
- I can contribute to an electronically integrated discharge summary