NHS
Dorset
Clinical Commissioning Group

Mental Health Acute Care Pathway Review

Benchmarking Visit

Synopses

Updated September 2016

1. Introduction

1.1 This brief paper provides an overview of the locations and services that have been visited by members of the Clinical Commissioning Group and Dorset HealthCare University NHS Foundation Trust as part of the ACP Benchmarking activity.

1.2 The visits were arranged because nationally these areas were being flagged for their innovation and service redesigns and good practice in mental health. The sites were chosen because they were making service changes but also the areas were all been broadly comparable with Dorset in relation to the mix of conurbation and rurality and size of the population covered.

Table 1: Sunderland Synopsis

Location of Service Being Benchmarked	**Sunderland**
Date Visited	2 October 2014
Report Authors	EH and KFS
NHS Provider and Rating	Northumberland, Tyne and Wear
Scope of the visit	The visit was arranged because the Northumberland Tyne and Weir Trust has just reviewed MH services and care pathways. The visit encompassed meetings with: • Provider staff who deliver the CRHT and manage patients' entry into MH services • CRHT and triage staff • Clinicians and service managers who led the review and reconfiguration of services – we 'walked the wall' • Commissioners of MH services
Questions	**What is the size and demographic of the local population?** Northumberland Tyne and Weir has a population of 1.4 million and a mix of rural and urban areas. The area we visited in Sunderland had a population of 4.5 million with a mix of urban and rural areas. **What is the demand for services?** Figures based on data from Goldberg and Huxley (1992) would suggest for Northumberland the number of adults per year under 65 years expected to have a diagnosed mental illness would be approximately 20,000. An estimated 4,755 would be known to specialist mental health services, with nearly 1,200 admitted to psychiatric hospital per year. **What services are included in the Acute Care Pathway?** • PICU • In Patient treatment and assessment wards • CRHT • Triage • Psych liaison • Digital dictation • Access to all the other mental health provision in the pathway through the

single point of access

What does the Acute Care Pathway cost (total and by service)?

The budget for MH services across the Trust was £50 million but don't at this point have costs for Sunderland.
We are awaiting information about the budget and detail about how they funded any change.

Compliance with NICE and other Guidance on the delivery of MH Acute Care pathways?

In 2009 the trust received a very poor CQC report about the quality of the MH services and there was clear acknowledgement that services needed to change and the quality be improved. This report led to the full review of MH services and care pathways.

Service Review and redesign

The review of services was done in collaboration between the MH Trust and Commissioners.

There was full consultation and engagement and the changes that occurred happened because patients said what they wanted from MH services when there were in crisis.

The review highlighted key pressure points in the existing system that meant patients were delayed in terms of accessing the right service at the right time.

The review led to significant changes to the front end and access to services. The key change were:

- The creation of one access point to services, one phone number for the whole area with a fully staffed call management system. This avoided confusion and made access easy for everyone who needed to contact MH services.
- A fully staff triage services was put in place to deal with anyone calling in. The triage role is challenging because the staff team needs to be award of all services available, they need to be able to direct callers to the right service, they need to be able to assess so that people in crisis are picked up and that no one slips through the net. They also need to be able end calls skilfully
- The CRHT is based in the same office as the triage service so that there is continuity when needed.
- The CRHT is able to carry out planned and urgent work which gives clients choice about how they want to be supported.
- Crisis is defined by the patient and the services work with that to ensure that patients always feel that they have had opportunity to discuss their situation and plan their treatment and support or other options.
- Digital dictation was introduced to enable clinicians and practitioners to spend time with patients with an assurance that their assessments and care plans would be written up and be of good quality.
- The changes to the entry in to the MH system ensured that patients were directed to the right service at the right time and had choice and control over how they were supported.
- As part of the review the Trust and Commissioners reviewed all the services in the pathway and at each stage implemented changes that patients wanted for

	example patients wanted one initial assessment appointment rather than having one appointment to see psychiatrist, one to get blood tests done etc. The service changed the way they worked so that the patient has their assessment, goes off for their blood tests and return to talk through their care plan.
Thoughts and observations	Over all the service developments make a lot of sense and Dorset had wanted to take this approach to make access to services much easier for patients. Investing in the front end activity appeared to be crucial and this meant investing in more administration time and in the digital dictation service. Both ensure that clinician and practitioner time is given to patients rather than split doing patient and administrative tasks. There would possibly be a bed number challenge: the Tyne and Wear Trust has more MH beds per head of population which means that they can use in patient provision more readily and informally. The Trust reviewed the whole system and created a pathway making sure that patients know that they will be directed to the right service at the right time and there is a review process at every stage to ensure that the patients' treatment and care remains right for them. All services and service specs were reviewed to reflect change and development and described what each service provided.
Conclusions	The whole system review makes absolute sense and that the project should possible develop to incorporate pathway approach once someone has come in to contact with services

Table 2: Bradford Synopsis

Location of Service Being Benchmarked	**Bradford**
Date Visited	2 April 2015
Report Authors	EH
NHS Provider and Rating	Bradford and District
Scope of the visit	The visit was arranged because Bradford has just reviewed MH services and care pathways and implemented changes based on the model developed in Sunderland and adapted it for the Bradford context. The visit encompassed meetings with: • Provider staff who deliver the CRHT and manage patients' entry into MH services • CRHT and triage staff • Clinicians and service managers who led the review and reconfiguration of services • Commissioners of MH services • Staff from the consultancy company leading on work in the inpatient settings
Questions	**What is the size and demographic of the local population?** Bradford has a population of 660,000. The latest population figures produced by the Office for National Statistics (ONS) show that an estimated 526,400 people live in Bradford District.

What services are included in the Acute Care Pathway?

- First response service
- Home treatment
- Electronic diary management system
- PICU
- In patient services
- ICT for people with a personality disorder

What does the Acute Care Pathway cost (total and by service)?

Awaiting details from Bradford about costs and budget.

Compliance with NICE and other Guidance on the delivery of MH Acute Care pathways?

There were no compliance issues but there were pressures in the system that if left were unsustainable. For example there was high used of out of area bed provision.

Service Review and redesign

The review of services was a collaboration between MH Trust and Commissioners with an advantage of joint commissioning arrangements between health and local authority.

The review highlighted key pressure points in the existing system, particularly around the use of mental health beds e.g. Bradford's use of out of area beds. Patients had to travel when requiring a PICU bed. There was also significant pressure on the crisis services.

The review focussed on patients' experiences and this led to the development of the First Response Steering group

The review led to significant changes to the front end and access to services. The key change were:

- The Crisis and home treatment teams were split
- The creation of a single point of access to services, including one phone number for the whole area with a fully staffed call management system. This avoided confusion and made access easy for everyone who needed to contact MH services.
- A fully staffed triage services was put in place to deal with anyone calling in. The triage role is challenging because the staff team needs to be aware of all services available, they need to be able to direct callers to the right service, they need to be able to assess so that people in crisis are picked up and that no one slips through the net. They also need to be able end calls skilfully.
- In the triage services there was a decision to use tele coaches and fact finders and first responders to sign post and support people who called into the crisis service.
- The first responders are nurses who are able to carry out face to face or telephone assessments with a view to ensuring that the patient is accessing the right service to meet their need
- The Home Treatment Team (HTT) is based in the same office as the First Response service so that there is continuity of care when needed
- The HTT gate keeps all admissions to hospital and provides a step up, step down

	services that facilitate admissions and discharges. • The HTT is able to carry out planned and urgent work which gives clients choice about how they want to be supported. • Crisis is defined by the patient and the services work with that to ensure that patients always feel that they have had opportunity to discuss their situation and plan their treatment and support or other options. • Fact finders and tele coaches and first responders added to ensure that people accessing the service received the right i.e. the most beneficial in put at the right time • The review led to a reshaping of the CMHTs. These services became aligned to the GP Communities (equivalent to localities in Dorset CCG) • In patient services were reviewed by an independent company to look at treatment and processes on the ward with a view to ensuring the admission is the most beneficial for the patient
MH Provider Views	There were no additional funds to redevelop the services and so some investment was moved from inpatient services to develop the First Response Service.
Thoughts and observations	Over all the service developments made a lot of sense in the context of high demand and existing services being under some pressure which has a knock on effect on patients. Investing in the front end activity appeared to be crucial (echoed in the report about Sunderland) and this meant investing in more administration time and in fact finders and tele coaches. This approach enables the services to filter people in and out of the services dependent in the assessed and triaged needs but of primary benefit is the fact that people experiencing crisis of whatever type are listened to and filtered towards the most appropriate service to support them. The whole system approach was also necessary because of the impact of one service on another.
Conclusions	In some ways the Bradford service review and changes fit the Dorset context especially as the Clinical Service Review develops.

Table 3: Leeds survivor led crisis service synopsis

Location of Service Being Benchmarked	**Leeds**
Date Visited	20 November 2015 and 25 March 2016
Report Authors	KFS and EH
Third Sector Organisation	Leeds Survivor Led Crisis Service (LSLCS)
Scope of the visit	The Mental Health ACP Review has visited various services and looked at various models of care that will help to inform the modelling work in stage 3 of the project. The first visit to the LSLCS was organised by the Dorset Mental Health Forum and the second was a follow up visit to discuss some elements of the service in more depth. The Leeds services is a service user led crisis service that operates outside of statutory services but is signposted to by statutory services e.g. Crisis Home Treatment Teams and when necessary the service refers to statutory services if a client needs a different level of intervention.

	The service was set and delivered by people who have lived experience of mental illness. This is one of only a few services in the country that is delivered in this way and with the workforce challenges in Dorset it is important to consider other options that change the dynamic of the workforce. The benefits of diversifying the workforce are more clinical time and more choice for people who use services at the point of crisis and a real focus on people who are experts because of their experience of MH conditions and services.
Questions	**What is the size and demographic of the local population?** Leeds is city with approximately 800,000 people and is the second largest city in the UK. The west Yorkshire area has a population of approximately 1.8 Million. The area is diverse and although 85% of people consider themselves as white the ethnic mix consists of Black African and Afro Caribbean, Asian – Bangladeshi and India, Arab including people from Afghanistan and Iran and Iraq and a number of others who describe themselves as people of mixed race. **What is the demand for services?** • The services started in 1999 and was funded by social services and then received charitable status and currently has a mixed revenue • Modelled on services in California - Soteria Services which can be described as the 24 hour a day application of interpersonal phenomenological interventions by a nonprofessional staff, usually without neuroleptic drug treatment, in the context of a small, homelike, quiet, supportive, protective, and tolerant social environment. The core practice of interpersonal phenomenology focuses on the development of a nonintrusive, non-controlling but actively empathetic relationship with the psychotic person without having to do anything explicitly therapeutic or controlling. In shorthand, it can be characterized as “being with,” “standing by attentively,” • The service initially was based in one property and now has two properties a telephone crisis line and a bereavement service • It is now funded through a mix of charitable donation and money from the NHS and Leeds City Council • The service is open to people who say they are experiencing mental health crisis • People self-present/refer and if accepted can check into the house for social contact, space, de-escalation and one to one support as needed **What does the service cost?** The cost of the service is £740k per annum and is funded by the CCG and the Local Authority. The service cost benefit evaluation suggests that for every £1 invested in the service there is a social return on investment of £4-7. The full cost benefit analysis is based on a range of benefits and not just based on the cost of crisis intervention and bed day costs. **Service Building based services – Dial House and Touchstone House** The service is a charity and has a board of Trustees: 50% plus two have to be people who have lived experience of mental ill health. People who work or volunteer have to

have lived experience of mental illness but also need to have worked or experience of working in mental health services or business so that the staff team is experienced enough to develop the business model whilst not losing its core ethos.

Most people who work are also counsellors, mostly person centred but some other training backgrounds included. Ethos based on Rogererian principles that people innately make good decisions about themselves. Most of the counselling work is Integrative Counselling because dissociating is a very big part of their work.

The service has two properties one specifically targeting BME and LGBT and other marginalised groups. Touchstone House specialises in BME groups.

The staff team works across both sites because this enables the team to be skilled in all areas of the service provision.

Dial House in Leeds has no rent to pay because of the lease arrangement between NHS and the City Council.

The service is primarily funded through the NHS and charitable donation and operates five nights per week.

The service receives about 20 requests per night but can only take 15 per night. The service never turns down a request to first time callers and to callers that the service has not seen for a time.

Most of the work focusses on self-harm or suicidal ideation. Approximately 60-68% of people calling in to the services have experienced sexual abuse and have unresolved trauma which statutory services are not set up to manage. Approximately 60% of the people using the service are women but in the other service where BME groups are supported: they are also noting that men from the middle east are attending who have experience significant emotional and sexual trauma whilst prisoners is their place of origin

Approximately 30% calls are from people describing themselves as LGBT.

The service pays for taxis for people accessing the service which costs approximately £50k per year. This was a pragmatic response to keeping people safe. They looked at other ways of doing this e.g. buying a vehicle but the option they work now is the best fit.

The service has very little contact with statutory services but statutory services are the largest signposter to the service and over the years a level of trust has been developed.

The telephone support service

Helpline is available by phone and email and is going to be accessible to people who are deaf.

The serviced operates four nights per week between 6:00pm and 10:30pm and is delivered by one paid member of staff and a bank of volunteers between 1 and four volunteers per night. The peak time for calls at present is between 6pm-8pm. The demand is possibly linked to the times that most statutory services finish for the day. The service manages between 5-10 calls a night'

The service has a bank of approximately 40 volunteers and volunteers can get a reference after 6 months which enable people to move to paid employment

The helpline service is also available online and has an on line messenger service.

The service is clear about what is offered to that people don't have un realistic expectations of what can be given

Group work at the services

Group work at dial house was initially focussed on social isolation. The My Time group helped to reach out to certain groups that outreach wasn't helping.

Visitors can help out as much or little as possible - facilitator training is part of the service. All groups are facilitated by staff member who has often been a visitor and been promoted to a member of staff through training and support.

The groups see between 40 and 50 people per week and there are a range of supported groups covering a range of subjects but very much driven by what visitors say they need.

Meals can be cooked at the services and paid for by donation by the visitors or group attendees.

Staff support

Regular debrief sessions during shifts as well as a monthly session
Monthly reflective practice sessions
All staff receive regular and ongoing training

Service users views

A visitor told us that if she is declined for a visit there is the helpline and this gives her confidence.

They also told us that when visitors arrive they are offered:

- One to one support for up to 1 hour
- Social time
- Focus on enabling de-escalation
- A home away from home
- Calm and safe for a couple of hours where the attitude is completely different to statutory services
- Safe space where people are able to take control of themselves again
- Liaison with services but only if visitor wants this unless safeguarding is required
- Support at CPAs

We were told that most people who attend have been labelled with a personality disorder rather than being identified as someone experiencing unresolved trauma.

The service was really clear in their view about this and said that most people using the services were people with trauma in their history – their personalities are not disordered.

	One visitor told us about the on line support and that it provides online anonymity which means that they are able to state things that in a face to face session would be difficult - expressing on phone can cause the need to break confidentiality if it's taken in a certain way –anonymity is good. Other visitor comments are: • I work in supermarket but can feel alone despite speaking to people all day and calling in to the service really helps by letting me know I exist. • The service lets me be in the moment - it's not about 2 weeks earlier unlike the crisis team that always refers to history and not the current experience. • It doesn't matter what the staff members' lived experience is but you know that they have had an experience and that is important.
Thoughts and observations	Over all the service made a lot of sense in the context of high demand from and existing services being under some pressure because they are generally less good at providing support for people who have been diagnosed (or not) with trauma and personality related issues. The ethos of the service enabled people to resolve their own crisis as defined by them in a safe way that empowered rather than controlled. For statutory services this model may be a challenge because the approach to risk and the management thereof is much more controlled and controlling In terms of cost it seems to make good economic sense to invest in alternatives that work for people who otherwise would have to be intensively supported because of the risk factors. It also makes sense not to use clinicians' time if not absolutely necessary. Trust in the services has developed over time and this is important to consider if Dorset service users feel they would benefit from this type of service. There was heavy reliance on volunteers and although there are some benefits related to user expectations etc the risks are that the service could be unreliable and inconsistent and perhaps not robust enough at all times to meet the demand.
Conclusions	We were impressed with the service, the ethos and the real alternative to medical models of care with some caveats particularly related to the reliance on volunteer workforce.

Table 4: Aldershot Crisis Café Synopsis

Location of Service Being Benchmarked	**Aldershot**
Date Visited	20 November 2015 and 25 March 2016
Report Authors	KFS and EH
NHS and third sector organisations collaborating	NHS Crisis resolution Home Treatment Team and two third sector providers deliver the crisis service.
Scope of the visit	The crisis café in Aldershot was gathering a reputation for helping prevent people who experience serious mental illness from presenting to emergency departments when in

	crisis. Nationally it was being flagged as an example of good practice in mental health crisis management. Dorset is in a similar position in terms of a lot of people using emergency departments or being detained under sec 136 etc.
Questions	**What is the size and demographic of the local population?** Aldershot has a population size of approximately 200,000. **What is the demand for services?** The service was set up as a pilot to see whether this type of provision can support people experiencing mental health crisis and help them to reduce their need of more acute mental health care. **What does the service cost?** The service costs approximately £230,000 per annum. • The service is based in an information resource centre open which delivers different services in the day time • It utilises an already functioning site and brings mental health NHS clinicians together with two third sector organisations working in mental health, these organisations bring additional and non-clinical support from peer support e.g. people who have lived experience • The Crisis café opens in the evening 18:00-11:00pm and opens seven days a week • The service sees approximately 259 people per month and 48.6 use the service state that they use it instead of attending at an emergency department. • 62% of users stated that they used it for maintaining wellbeing. • People under the influence of drugs and/or alcohol are not allowed to use the service • Further testing is required to assess the impact on other MH services such as crisis response, OOH and inpatient usage to accurately reflect cost savings in this area • The café set up is staffed by peer support workers and the senior practitioner from the crisis team in Aldershot this mix enables people to have the least intrusive level of support but also enable people to access clinical support and intervention if needed for example the service has coordinated MH Act Assessments for customers when necessary
Thoughts and observations	Over all the service made a lot of sense in the context of high levels of crisis demand and existing services being under pressure. It makes sense to have an alternative to A&E for individuals but also for the police or ambulance crews when and emergency department is not necessary but often is a default position. The service provides space that enables people to manage or resolve their own crisis as defined by them in a safe way with a range of clinical and peer worker support interventions. In terms of cost it seems to make good economic sense to invest in alternatives enables people to manage their own crisis and logic suggests that this should have a long term benefit on acute service because people are being supported, in a way that suits them and it happens before crisis escalates.
Conclusions	We were impressed with the service, the ethos and the real alternative to help people to manage their own mental health challenges wherever possible.