Agenda Item 7

Report to:	**East Sussex Health and Wellbeing Board**
Date:	**15 January 2015**
By:	**Director of Adult Social Care and Health**
Title of report:	**The Mental Health - Crisis Care Concordat**
Purpose of report:	**The East Sussex Declaration to implement standards set out in the national Crisis Care Concordat**

RECOMMENDATIONS

The Health and Wellbeing Board is recommended to:

1) **Note the background to signatories being invited to the East Sussex Declaration on the Crisis Care Concordat set out in Appendices 2 and 3; and**

2) **Authorise the Chair of the Health and Well-being Board to sign the Declaration set out in Appendix 1 for and on behalf of the Board.**

1. Background

1.1 The Health and Well-being Board is invited to formally support the East Sussex Declaration committing itself and partner agencies to work together to implement standards set out in the national Crisis Care Concordat for "improving outcomes for people experiencing mental health crisis."

1.2 The Declaration is included as Appendix 1 and is based on the national template provided for this purpose.

2. Supporting Information

2.1 A short introduction to the Crisis Care Concordat is provided in Attachment II, which also describes requirements and timescales for achieving red, amber or green status.

2.2 In summary, a Declaration signed by partner agencies is required by 15th December 2014 with specific Action Plans being added early in 2015.

2.3 Appendix 2 also describes the work that has taken place to date in East Sussex and across Sussex, making reference to an exercise mapping existing services and identifying gaps relating to Concordat standards, which is available as Appendix 3.

2.4 This work has led to the following being invited to become signatories to the Declaration:

Organisation	**Signatory**	**Obtained** (as @ 15th December)
Adult Social Care Services, ESCC	Keith Hinkley	Yes

EHS and H&R CCGs	Amanda Philpott	Yes
HWLH CCG	Wendy Carberry	Yes
SPFT	Colm Donaghy	Yes
Sussex Police	Giles York	Yes
Police & Crime Commissioner	Katy Bourne	Yes
Children's Services, ESCC	Stuart Gallimore	Yes
South East Coast Ambulance Service	Paul Sutton	Yes

3. Recommendations

3.1 The Health and Well-being Board is recommended to:

1) Note the background to signatories being invited to the East Sussex Declaration on the Crisis Care Concordat set out in Appendices 2 and 3

2) Authorise the Chair of the Health and Well-being Board to sign the Declaration set out in Appendix 1 for and on behalf of the Board.

KEITH HINKLEY
Director of Adult Social Care and Health

Crisis Care Concordat

Mental Health 3)

The East Sussex Declaration on improving outcomes for people experiencing mental health crisis – December 2014

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

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

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

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

We are responsible for delivering this commitment in East Sussex by putting in place, reviewing and regularly updating action plans.

This declaration supports 'parity of esteem' between physical and mental health care in the following ways:

- Through everyone agreeing a shared 'care pathway' to safely support, assess and manage anyone who asks any of our services in East Sussex for help in a crisis. This will result in the best outcomes for people with suspected serious mental illness, provide advice and support for their carers, and make sure that services work together safely and effectively.
- Through agencies working together to improve individuals' experience (professionals, people who use crisis care services, and carers) and reduce the likelihood of harm to the health and wellbeing of patients, carers and professionals.
- By making sure there is a safe and effective service with clear and agreed policies and procedures in place for people in crisis, and that organisations can access the service and refer people to it in the same way as they would for physical health and social care services.
- By all organisations who sign this declaration working together and accepting our responsibilities to reduce the likelihood of future harm to staff, carers, patients and service users or the wider community and to support people's recovery and wellbeing.

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

Appendix 2

What is the Crisis Care Concordat?

The Crisis Care Concordat was published in February 2014 with the aim of "Improving outcomes for people experiencing mental health crisis".

The National Concordat has an extensive range of signatories from representatives of partnership organisations such as Associations of Chief Officers of Ambulance and Police Services, Local Government and NHS Bodies such as the NHS Confederation, as well as Royal Colleges and Third Sector Organisations.

Each commits themselves to take action and to support the local delivery of more co-ordinated crisis care for people with mental health problems.

It makes clear that effective delivery will depend on local inter-agency agreements or 'Declarations' on what gaps exist in current services and their performance against standards / expectations for crisis care published in the Concordat.

Declarations are also to list what actions each agency commits to taking to address gaps and by when.

The standards are split in to 4 sections or organising principles covering:

- A - Access to support before crisis point
- B - Urgent and emergency access to crisis care
- C - Quality of treatment and care when in crisis
- D - Recovery and staying well / preventing future crises

It is also expected that governance arrangements will be in place through which agencies can be held to account for delivery against their commitments.

A web-site has been created to support the policy's implementation, with resources of various kinds available including a 'model' Declaration, and a map of England showing the current status of each area:

- Red – No Declaration
- Amber - Declaration without Action Plan
- Green – Declaration with Action Plan

What is required by the Concordat?

It is expected that all areas will have an agreed Declaration in place by the end of 2014, although it is not expected that action plans will be required by this date – DH representatives have recently advised their preference for these to be 'robust' rather than premature.

Signatories to local Declarations are expected to include all statutory health (NHS) and social care organisations (including for children), the police and ambulance services, and as extensive and appropriate a range of other local organisations as possible, such as 3rd sector and stakeholder representative groups.

It is expected that in order to progress towards Green status the process to be followed will involve:

- mapping of existing services against Concordat standards
- identification of gaps in existing services
- agreement and sign-off between partner organisations of mapping of existing services and identified gaps
- commitment from local partner organisations to address identified gaps within an agreed governance structure: "the Declaration" (Amber)
- agreement of actions to address the gaps with timescales: "the Declaration, with Action Plan" (Green)

3. What progress has been made to date?

Coastal West Sussex CCG as lead Commissioner with Sussex Partnership NHS Foundation Trust jointly convened a series of meetings in the second half of 2014, involving relevant partner organisations from across Sussex, to oversee and facilitate progress in the development of local Declarations.

A number of meetings have been held with key personnel from East Sussex organisations to progress the mapping of existing services against Concordat standards and to identify gaps. Other local organisations have input through the provision of written descriptions of current services and gaps.

A small Conference bringing together 3rd sector and stakeholder groups in East Sussex was also held which focused specifically on the Concordat, and invited additional comments on local services and their performance against Concordat standards.

This work led to several drafts of a document being completed and successively updated as input was harnessed from different partners, culminating in a detailed document "Towards Multi-Agency Actions Plans: Service & Process Mapping and Gap Analysis".

This document was circulated to all partner agencies at the same time that signatories to the Declaration were sought, with the aim of providing assurance that in signing up to a commitment to develop and implement action plans, work had already been well progressed on mapping existing services and identifying gaps to be addressed.

The principal gaps in services / standards in East Sussex are likely to concern:

- reducing s136 police custody detentions
- responsiveness to mental health presentations in A&E
- provision of discrete and safe areas for mentally disturbed patients in A&E
- more coherent and co-ordinated agency responses in particular to people who most frequently call on services in crisis eg. personality disordered
- specialist responses to crises from child and adolescent mental health services

A series of initiatives including some already being piloted such as street triage, and others included as targeted resilience fund bids, may be expected to reduce the use of police custody for s136 detentions, as well as improve A&E liaison and availability of mental health services to respond more generally to crisis.

Opportunities and Risks

The Concordat provides an opportunity to overcome a small but important number of long-standing problems arising from in particular a need for more effective inter-agency working, to ensure good quality care for patients with mental health problems

presenting to any of a range of health and social care services, as well as other statutory agencies.

On the other hand, much is being brought in to this 'initiative' with various policy aspirations, including aspects of 'parity of esteem' for mental health being 'badged' as Concordat-related.

There is a risk therefore that the Concordat becomes a panacea for all things, and is unable to deliver due to excessive and undue additional strains being placed upon what should be a clearly defined and focused piece of work.

In many respects mental health services in East Sussex perform well against Concordat standards for example in relation to prevention of crisis through well-being services, and access times which in many regards, already meet recently published targets and aspirations for these to have 'parity of esteem' with physical health services.

Governance Arrangements

Following a briefing being taken to and considered by the CCG's joint 'Area Management Team' meeting on 22nd October, it was agreed that progress on the East Sussex Crisis Care Concordat would be governed through arrangements in place for the Better Together Programme.

A 'Project Charter' related to the Concordat was subsequently approved by the 'Integrated Strategic Planning Group' (ISPG), which reports and is accountable to the Better Together Programme Board.

Appendix 3

East Sussex Crisis Care Concordat

Towards Multi-Agency Action Plans: Service & Process Mapping & Gap Analysis

1. Introduction and Approach

The approach taken to developing action plans for signatory agencies to the Crisis Care Declaration and Concordat in East Sussex, is to draw on high-level process maps and describe activities currently being undertaken by services provided by local agencies at each stage, and identify what gaps exist between these and best practice and national standards set out in the national Concordat.

The Process Mapping starts by assuming that people may present to any of the signatory agencies when in crisis, and each of these has then to decide what action to take next.

What is decided, and how suitable it is relative to best practice and outcomes, depends across agencies' upon:

- Staff skills and training – to deliver a response themselves or decide what action to take next
- Decision support – the availability of information, advice and guidance to help make the right decision
- Options available – what services there are available to provide a suitable response to the person in crisis

Each of these aspects is mapped to see how well agencies' perform now against Concordat standards, and to enable gaps to be identified. Where actions to address gaps are already agreed these are described.

The national Crisis Care Concordat describes services and standards required to achieve objectives in four areas:

A - Access to support before crisis
B – Urgent and emergency access to crisis care
C – Quality of treatment and care when in crisis
D – Recovery and staying well / preventing future crisis

The contributions made to achieving each of these objectives, are referenced in brackets (below), for each of the services provided and / or decisions being taken by organisations in response to people with mental health problems, including those in crisis (highlighted in red).

2. Persons in Mental Health Crisis

Somebody who considers they are at risk of or are experiencing a mental health crisis may consider seeking help from any of a range of services provided by different organisations.

The decision they make is likely to vary depending on whether theirs is a new experience or a long-standing problem, whether they are known to various services, and what experience they may have had previously when seeking help from specific services.

What services are available from the different organisations which people may approach for help, and how well they respond and / or work together to ensure help is provided will be described in detail in later.

However, firstly what support is available to help somebody make the right decision.

2.1 Decision Support - Telephone Help Line

There is a telephone help line available provided by Sussex Partnership NHS Trust across Sussex Monday to Friday 5pm until 9am and 24 hours over weekends and bank holidays.

It provides advice and guidance on what to do if a crisis is felt to be close, including directing access to options for presentation to services for face to face assessment, care and / or treatment. In summary it provides:

- a service to anyone concerned about their own mental health or that of relatives or friends
- encouragement to callers to make choices about the way their own mental health needs are met
- immediate support to people expressing distress
- part of the caller's total care package when they are known to Mental Health services by participating in case discussions and recording call details on care systems

It is promoted in Telephone Directories and on Trust and other health and social care associated web-sites, alongside other helpful contact numbers such as for the Samaritans and Saneline. Many third sector organisations also provide telephone access for information, advice, support and guidance.

Gap: The telephone helpline is limited in its capacity to take multiple calls, and there is some confusion over what it is intended to provide. In so far as it perceived to be for providing counselling and support as opposed to information and advice, people accessing this services this can find it engaged and / or time limited, leading to poor frustration and dissatisfaction.

There may also be other options such as 111 that could provide decision support to people who are at risk of or are experiencing a mental health crisis

3. General Practice

General Practice is often the most trusted source of help and guidance to which people turn when they are approaching or experiencing a crisis in their mental health, and it is estimated that one in four consultations involves a mental health problem.

The national Crisis Care Concordat has secured undertakings from the Royal College of General Practitioners to "support, develop and improve GPs knowledge of severe mental illness".

3.1 Training

GPs vary in their knowledge and skills in relation to assessing mental health problems, both in terms of severity and urgency, and it may be expected that there will be some variation in how presentations are interpreted and responses provided. Patients presenting to GPs in crisis will be directed or referred to services in accordance with the GPs assessment of severity and urgency of need.

3.2 Decision Support

Information on available services and guidance for their use is published on GP web-sites, and describes referral routes and criteria for accessing each of the services described below.

Primary Care Mental Health Workers (staff from 'Health in Mind') also provide information, advice and support to GPs when deciding on suitable actions for specific patients.

3.3 GP Options

3.3.1 Watchful Waiting (A)

GPs are experts at managing risk based on their detailed knowledge of patients on their practice lists, and will often offer advice with follow-up appointments to monitor whether problems deteriorate.

3.3.2 Direction to Well-being Centres (A, D)

Directed access to Well-being centres provided by Third Sector Organisations in every locality across East Sussex is available to GPs, who have also been provided with a Directory of these and all other directly accessible 'universal services', which include peer support.

3.3.3 Referral to 'Health in Mind' (A)

These primary care based mental health services provide an alternative to NHS Trust referral.

Information advice and support is provided to GPs and patients, as are assessments within 5 days or 4 weeks depending on urgency. Psychological therapies are also available within primary care at levels 2 and 3, within 4-6 weeks of referral.

The Health in Mind Web-site has links to self-help on-line and advice and guidance on how to manage mental health and what to do if crisis is close.

3.3.4 Referral to Assessment and Treatment Centres – ATCs (A)

These Centres provide the single access point of access for all routine / non-emergency referrals to specialist mental health services provided for adults by Sussex Partnership NHS Trust, providing response times to assessment of 4 weeks and to treatment of 13 weeks.

3.3.5 Referral to Crisis Resolution and Home Treatment Team – CRHTs (B, C)

CRHTs exercise control over or 'gate-keep' access to acute psychiatric services including in-patient beds. They also have exclusive rights to admit patients to a 7-bed Crisis House (in Hastings), the Sanctuary which is run by the Third Sector Organisation 'Turning Point' with active treatment input daily from CRHTs.

Unlike in other parts of Sussex, GPs in East Sussex have had direct access to Crisis Resolution and Home Treatment (CRHT) Teams for a number of years, through which they can request a 4 hour response for their patients, if they meet defined criteria for access.

GP out of hours services can also access CRHTs for checking patient details and risks / management plans for patients known to services and to aid decision making and recommended courses of action.

Collaborative conversations are held with referring GPs regarding clinical need and what is the best clinical course of action. This sometimes leads to advice to direct to A&E if there are limitations on clinical capacity at the time of the call, which has led to frustration and dissatisfaction.

Gap: There have been persistent concerns expressed by GPs that CRHTs do not always provide the response requested due to different interpretations of access criteria, and whether a sufficient response has to be via face to face contact.

As a primary purpose of CRHTs is to use their team's capacity to provide intensive home treatment to patients as an alternative to in-patient care, there are limitations on how much more flexibly they can apply access criteria to respond to GPs' patients, which has led to frustration and dissatisfaction, and directions to A&E.

On exploring these issues in more detail, it became apparent that providing GPs with only two response time options for referrals: either 4 hours from CRHTs, or 4 weeks from ATCs, resulted in non-emergency referrals being made to CRHTs which did not need to access within 4 hours, but could not wait 4 weeks.

Agreed Action: A new set of response time standards for GP referrals to SPFT is being piloted in East Sussex from October 2014:

- Emergency – 4 hours
- Urgent – 5 days
- Routine – 4 weeks

Levels of demand and responsiveness will be evaluated and subject to improvements in access and satisfaction arising, these new standards will be permanently adopted.

3.3.6 Direction to A&E (B, C)

Direction by GPs to A&E arises when CRHTs are unable to provide a timely face to face response due to other commitments such as the provision of home treatment to patients as an alternative to in-patient care.

Psychiatric Liaison Teams provided by SPFT have been in place at both Eastbourne DGH and the Conquest Hospital for adults and older people for many years, and these are available to A&E (as well as acute medical wards) for specialist consultations and assessments, and for making arrangements as necessary for admission or out-patient follow-up as appropriate.

Gap: Patients who are directed by GPs to A&E are likely to be anticipating or expecting to be treated like other patients who are generally seen within one hour and discharged (or admitted) within 4 hours. Standards for attendance by A&E Psychiatric Liaison staff are currently 2 hours, and performance data suggest that this is being met over 95% of the time.

Agreed Action: Investment in expanding psychiatric liaison services has been agreed for one year and new staff are being employed with the aim of improving the frequency with which response times are met for patients presenting in mental health crisis.

3.3.7 Referral to Adult Social Care - Mental Health Act Assessment (B, C)

Patients whom GPs (including GP out of hours services') consider may be a threat to themselves or to others, and require assessment and possible detention under the Mental Health, can contact Adult Social Care services 24/7 who will make arrangements for an Approved Mental Health Practitioner to attend.

4. Police

Responding to people experiencing mental health problems is considered by Sussex Police to be within the range of their responsibilities and officers will respond to emergency situations in the community 24 hours a day and 7 days per week. Police officers are not doctors, nurses or social workers and having responded to the crisis it is essential that services are immediately available to support the Police and take responsibility for the person

4.1 Training

Police officers are strong and effective communicators, who should be able to spot vulnerability but not necessarily a mental illness or condition.

In the summer of 2014 Sussex Police updated its training for officers and staff and specifically the communications lessons plan which now focuses on mental ill-health.

The session includes group work on how to identify signs and symptoms of mental ill-health and then develops into a group discussion on what officers / staff could do to adapt their communication style to assist them in dealing with the situation they are involved in.

The session balances the need to make adjustments with their own personal safety and dealing with the circumstances that initially called for a police presence. This lesson plan now forms part of all Sussex Police programmes for Regular Officers, Specials, PCSOs, and Police Staff.

In addition, Sussex Police call handlers now receive a bespoke training package on mental health and how to communicate with someone over the telephone who is in distress and seeking help and support.

Sussex Police works closely with Sussex Partnership NHS Foundation Trust since their staffs play a key role in training Police officers and staff. The Police, Courts, Liaison and Diversion practitioners deliver training to Custody officers and staff and

Street Triage nurses working with uniformed officers in Eastbourne provide ongoing support and advice to a wide range of officers and staff.

There is also the computer based training package from the National College of Policing "Responding to people with mental ill health or learning disabilities" and this is mandatory training for key groups of officers and staff.

There are also pockets of training being provided with local groups and organisations and Sussex Police is constantly striving to ensure we provide our staffs with the right training to be able to deliver an excellent service to the public in Sussex who have a mental illness, learning difficulty or vulnerability. This training is not designed to give officers expertise in mental health but to raise their awareness levels.

4.2 Decision Support

Officers have access to information held by the Police regarding previous arrests or detentions but no direct access to information about the person held by the NHS, social care or other statutory agencies, although such information could be crucial for the officer when deciding the most appropriate course of action.

Sussex police officers have powers to detain a person under s136 mental health Act 1983 for the purpose of taking them to a place of safety for an assessment by an Approved Mental Health Practitioner (AMHP) and section 12 Approved Doctor.

The Police can only use this power if the person appearing in crisis is in a place to which the public have access, there is a suspicion of mental illness and the person is in immediate need of care or control, and / or a danger to themselves or others.

An officer faced with someone in mental health crisis, who is unable to communicate effectively and may be threatening self-harm or suicide, is most likely to detain that person under s136, if there is no background information on the person available immediately.

This may not always be appropriate or necessary, and if information was available coupled with a professional medical/social opinion in the best interests of the person the decision and outcome could be different. Street triage is starting to make a difference to this – see 9.3.6.

Gap: the data on s136 detentions in 2013/14 indicates that 64% resulted in no admission to hospital, suggesting that use of s136 may not be the most appropriate way to respond to people in crisis, “many of whom are asking for help” according to the East Sussex AMHP Annual Report 2013/14 which also cites Guidance for Commissioners that recommends the police should be able to gain advice from mental health services prior to detaining a person.

People who are “asking for help” with their mental health crisis may turn to the Police as one of the only 24/7 agencies. Although conversions into hospital admission from s136 detentions remains low the vast majority of people detained are given community follow up from a variety of services. Police officers need support at the point of dealing with the crisis to engage the person with the most appropriate team for their needs and avoid an assessment under s136.

4.3 Police Options

4.3.1 S136 detention (B, C)

It should never be the case however that someone is refused access to a health-based place of safety due to insufficient staffing or because the person is displaying disturbed behaviour or they are intoxicated or the place of safety is full or they have a history of violence.

If there is no physical / medical emergency meriting conveyance to A&E but the person is exceptionally violent, then a police cell may be appropriate for use as a place of safety for somebody detained under s136.

Gap: Data for the year 2013/14 show that of 416 detentions under s136 of the MH Act in East Sussex 258 (62%) were detained in police custody. There were also 8 children under the age of 18 detained in police custody.

The high use of custody for detentions under s136 of the MH Act runs counter to the Code of Practice which states that custody should be used in only 'exceptional circumstances'.

From April 2015 it will also be a requirement that no person under the age of 18 is detained under s136 in custody as opposed to a health-based place of safety.

The target set in the Concordat is to see "the use of police cells as places of safety falling rapidly, dropping below 50% of the 2011/12 figure by 2014/15."

The Crisis Care Concordat (CCC) states that intoxication or a previous history of violence or aggression should not automatically indicate custody should be used, although it does also call for local definitions of 'exceptional circumstances' to be agreed and adopted, citing "seriously disturbed or aggressive behaviour".

Gap: The reasons for the high proportion of custody detentions in East Sussex include that 33% of those detained under s136 were exhibiting a degree of intoxication, although closure of health-based suites had also been a persistent issue (until 2014), and sufficient staffing levels remain a concern.

Gap: There is currently no locally agreed definition in place of the 'exceptional circumstances' in which police custody should be used for s136 detention.

Gap: There is currently no agreed protocol in place for ensuring that children under the age of 18 are never detained in custody under s136 and that in all instances a health-based place of safety will be made available instead.

Gap: The occupancy of health-based s136 suites at peak periods of demand and out of hours in particular, can also contribute to custody being used, which in turn is related to the time taken to commence and complete MH Act assessments by AMPS and s12 doctors. Attendance by specialist CAMHS clinicians has also been highlighted as a problem.

Transfers between places of safety do occur but these are rare. It is incumbent on the Custody staff to keep contacting the hospital place of safety to see if they are able to accept the detainee and at busy times in custody it is not always possible for staff to keep calling. Health-based places of safety rarely if ever call custody to say they are free to take someone.

Gap: The MH Act Code of Practice states that a mental health assessment should begin within 4 hours of the person being ready to assessed and completed within 6 hours. This is usually not complied with as depending on the time of day and day of the week, it may not always be possible for an AMHP and Doctor to be available together. People detained in police custody are not seen as a priority for an assessment.

Gap: More than 64% of s136 MH Act assessments commenced later than 4 hours after detention, and the average time for completion was 12.9 hours and 12.5 hours for health-based places of safety and custody suites respectively.

Gap: Although a proportion of delays in commencement and protracted periods for completion of MH Act assessments relate to the person being 'unfit' due to for example intoxication, other factors include demands on AMHP time to carry out community assessments (not in places of safety), and lack of immediately available s12 doctors.

It is evident that the numbers of people being detained under s136 is placing high levels of demand on the available capacity of services undertaking formal assessments under the MH Act to always be able to respond and complete these in as timely a way as would be desirable.

4.3.2 No further police action – with / without contact with GP / mental health services initiated (A, D)

In the absence of access to information, advice or support from GP / primary care services or mental health services, the police may determine that no further action is to be taken in relation to a person they believe may have a mental health problem but does not merit s136 detention. This may represent an opportunity missed for their mental health to be brought to the attention of services and for them to gain access to care and treatment which may help them and prevent a recurrence of crisis.

4.3.3 Arrested and detained in custody (A, D)

Qualified mental health professionals from 'Police Courts Liaison & Diversion Services' are located in custody suites across East Sussex, and provide specialist assessments of people arrested and detained in custody, whether they are known or unknown to local services.

Following assessment the practitioner will offer advice to the police and courts on what services and support is required by the detainee to address offending behaviours, look to divert the detainee away from the criminal justice process when appropriate, or to support the detainee to Court, where they can assist with possible options for disposal including referral for treatment.

5. Ambulance Services / 999

5.1 Training

All University Qualified Paramedics have received education and experience in a Mental Health Setting, and there have been local initiatives across the South East Coast to raise the awareness of mental health issues in Ambulance Staff

Paramedic Practitioners complete a module on Mental Health as part of their training programme, and also receive update training and placements with a mental health crisis team.

Gap: the possibility of an e-learning package to be available for all staff via Trust's e-learning websites would be beneficial.

5.2 Decision Support

'NHS Pathways' protocols are in place to allow call responders in Emergency Operations Centres to assess mental health presentations / crisis and both local and national variations can be developed to reflect the type and urgency of response that may be required as a result.

In addition to dispatching an ambulance, this may also include accessing GP out of hours services or other health service providers in accordance with established criteria and / or patient specific advance directives specified within IBIS (Intelligence Based Information System).

5.3 Ambulance Options

5.3.1 Close Call – no further ambulance action

'NHS Pathways' protocols may indicate calls have low or no priority and close the call without further action.

5.3.2 Close Call – contact made with GP Out of Hours (A, B)

'NHS Pathways' protocols may indicate calls should be re-directed to GP out of hours services.

5.3.3 Close Call – contact made as per IBIS (A, B)

By encouraging NHS mental health-care organisations to produce patient specific advance directives for uploading on to IBIS, ambulance services' responders will have greater knowledge of an individual's needs and both routine and crisis care plans to activate if and when contact is made.

This can potentially avoid controllers dispatching an ambulance inappropriately, or closing a call not only without dispatch but with no response whatever being offered or communication of the call being made to those services which may know the patient and be able to respond.

SECAmb will otherwise seek always to convey patients to the most appropriate destination according to their assessed health needs and / or available information, advice and guidance, including IBIS based advanced directives.

Responsibility for uploading information on to IBIS in relation to patients for whom there may be crisis care plans / advanced directives in place, or benefits in having these developed and shared with Ambulance services, resides with SPFT.

Gap: To date very few have been uploaded given that total adult caseloads for East Sussex patients is over 3,700 of whom approximately one third will be on CPA. This relatively small number of patients known to SPFT whose details are uploaded on IBIS might therefore be considered a 'gap'.

5.3.4 Frequent Caller – contacts made with GP / mental health services (A)

Frequent callers to ambulance services can be identified by call logging systems, and a policy is under development to identify what actions could be taken to reduce these frequent calls by facilitating access to appropriate primary or secondary care services for the persons concerned.

Gap: By agreeing how and when ambulance services could contact and access mental health services for people who call frequently but for whom an ambulance dispatch would be unnecessary or inappropriate, callers with mental health problems or recurrent crises could benefit from interventions they need which are otherwise unavailable by calling ambulance services.

5.3.5 Ambulance dispatched (B, C)

'NHS Pathways' protocols assign a low priority to police requests for attendance when a person is found in a public place to be mentally disturbed and consideration if being given to detention under s136 of the MH Act, and / or to requests from the police no convey a person detained to a place of safety. As a result police vehicles have to be used for the purposes of conveyance.

Gap: The Crisis Care Concordat makes clear that persons detained under s136 of the MH Act should not be conveyed to a place of safety in a police vehicle, but rather in an ambulance.

Agreed Action: Following a national decision by the Association of Ambulance Service Chief Executives, South East Coast Ambulance Services has agreed to adapt 'NHS Pathways' protocols to increase the priority to be accorded calls from the police in respect of s136 detentions, and committed from 1st January 2015 to attend within 60 minutes and convey persons as necessary to an appropriate place of safety.

Ambulances dispatched to other calls relating to mental health crisis are likely to be conveyed to A&E departments.

6. Accident and Emergency

6.1 Training

Front line A&E staff have excellent communication skills and the ability to identify high risk patients with and without medical needs, and can appropriately refer direct to mental health liaison services without the need for patients to be reviewed by an A&E clinician. They do not however have specialist training or skills related to mental health problems.

Gap: Formal training on mental health problems for A&E nursing staff and / or the appointment of dual qualified nurses would be beneficial, as would (conversely) mental health nurses being trained to complete basic first aid and medical observations training, to mitigate the need for some patients to be transferred from psychiatric in-patient beds to A&E.

Benefits anticipated by A&E department management include: knowledge sharing between specialities; team building; shared pathways development; enhanced patient care; reduced complaints; patient satisfaction.

6.2 Decision Support

As front-line staff within A&E departments are not trained as specialists in mental health issues, their principal support for decisions concerning these presenting problems is obtained from the Psychiatric Liaison Service, which is provide at both Eastbourne DGH and the Conquest Hospital by SPFT.

Patients presenting with mental health problems are triaged like others patients by an experienced nurse. If no medical health needs are identified they will refer adults directly to the psychiatric liaison team as appropriate.

If medical health needs are identified patients will be prioritised and seen by a clinical decision maker. Once an adult patient is deemed medically fit for mental health review they will be referred to psychiatric liaison team.

A brief audit of A&E practice at Eastbourne DGH by Dr Sally Doust found that only 40% of patients were seen by psychiatric liaison services within 4 hours. Other more extensive data from both East Sussex Acute Hospital sites would be helpful.

Patients referred to A&E for mental health review by other health care providers such as GPs, are often expecting to be seen immediately rather than within the response time standards provided by the psychiatric liaison team, which causes frustration, anxiety and sometimes aggressive behaviour.

In the context of the Emergency department aiming for patients with medical health needs to be seen by a doctor within an hour of arrival, adult patients with mental health needs waiting for the liaison team often voice their concern that they are forgotten.

The response time standard for A&E assessment by Psychiatric Liaison Services is 2 hours, but this is not always met, or at least the definitions for eligibility for referral, medical fitness or readiness for commencement of assessment, and hence from when the 2 hour response standard should operate, are not always agreed upon and / or reported commonly across service providers.

Gap: The audit by Dr Doust suggests that formal adoption by A&E staff of an evidence-based mental health triage tool would help them more appropriately identify and prioritise patients in to ‘care pathways’ for referral to Psychiatric and specify what would represents a suitably timely response for each. The audit also suggests for example that ‘delays’ in specialist mental health assessment can be due to ‘invalid’ views about clinical conditions prohibiting this going ahead.

Gap: Whilst it is acknowledged that work remains to be done between service providers working to meet the needs of patients with mental health needs including in crisis in A&E departments, there is agreement that relative to nationally recommended models of best-practice and capacity for Psychiatric Liaison Services, an increase in staff and provision of enhanced service would help improve response times and access to specialist mental health care when it is needed.

Agreed Action: System Resilience Funds of £330,000 has been agreed for 2015/16 to increase Liaison psychiatry provision in the Conquest and Eastbourne General Hospital Accident and Emergency departments.

The aim of specialist mental health assessment in A&E is to identify needs and to either directly provide, or direct access to services able to meet immediate needs or make arrangements for these to be met in an appropriate and timely way in the future.

The many people who present in mental health crisis in A&E who are not previously known to mental health services are thereby able to gain access to these, as necessary and appropriate to their assessed needs, often in preference to other sources of help and support such as from their GP or mainstream mental health services, (noting record of attendance at A&E are routinely copied to patients' GPs).

It is also known that there are people who are known to mental health services who frequently attend A&E in mental health crisis, and a small number who do so very frequently indeed, which suggests that mainstream mental health services could potentially be provided in a way which better and more appropriately meets their needs, and potentially reduces their A&E attendances.

Gap: It would be beneficial for planning purposes if the numbers and times of people attending A&E departments with mental health problems, being recorded and reported, included whether they were previously known to mental health services. This would enable those who frequently attend to be identified and provided with other service options, as well as to help understand why A&E appears for those attending, to be their preferred route to access mental health care.

6.3 A&E Options

6.3.1 Treated in A&E and discharged – further action by mental health services (B, C)

The audit by Dr Doust reports that 27% of patients seen by psychiatric liaison services were discharged from A&E with arrangements for mental health services' follow-up, whilst 18% are admitted to a psychiatric ward.

Patients with mental health problems are asked to wait within the common waiting room area if they do not require immediate treatment.

Patients with mental health problems will be assessed either in a cubicle within the Emergency department at Eastbourne DGH or in the psychiatric assessment room at the Conquest Hospital.

Gap: Local stakeholder groups frequently report how uncomfortable people attending A&E in mental health crisis feel about waiting in common areas, and being treated in surroundings which may not always promote their privacy and dignity.

6.3.2 Treated in A&E and admitted - further medical action (B, C)

Of patients seen by psychiatric liaison services 32% were admitted to medical assessment units often due to the need to treat medical conditions arising for example from self-harm.

6.3.3 Treated in A&E and discharged – no further action

Only 14% of patients seen by psychiatric liaison services were discharged with no follow-up.

7. Adult Social Care

Adult Social Care services for people with mental health problems consist of teams of qualified social workers who assess and manage access to services that meet needs, and the commissioning of services from in-house staff and from other external organisations.

Services range from day care and activities to residential and nursing home care. ASC is also responsible for organising and undertaking Mental Health Act assessments in the community through the provision of Approved Mental Health Practitioners being available 24 hours a day, 7 days a week.

7.1 Training

All Social Workers carrying out assessment and care management are qualified practitioners. Those carrying out AMHP duties are also specially trained and accredited, although since this involves a very demanding and intensive course, trainees have to be experienced, motivated and supported by their organisations.

Standards are set for commissioned services' providers to ensure their staff are suitably trained and able to safely and effectively deliver the specified services they are contracted to provide.

7.2 Decision Support

Direct access to Adult Social care in East Sussex is available via a free-call telephone number, staffed by trained operators who will make a provisional assessment of need and make arrangements for a professional assessment if indicated.

Qualified Social workers who specialise in mental health care will undertake an assessment and arrange a package of care appropriate to the individual's eligible needs, or offer a direct payment or personal care budget and access to support to help the individual make their own arrangements.

Social workers are co-located with and work closely in association with NHS Trust colleagues in Assessment and Treatment Centres, undertaking joint assessments and reviews of individuals' needs as necessary and appropriate, allocating health or social care professional care managers, and making arrangements for access to psychiatric services and / or social care services if eligible.

7.3 Adult Social Care Options

7.3.1 Universal Services (A,D)

Universal services commissioned by Adult Social care are available regardless of whether an individual has an 'eligible' need which the Council is statutorily obliged to meet. These services are often preventative and / or aimed at helping people who may have long-term mental health problems maintain their health and well-being.

In East Sussex these services include well-being centres providing opportunities for socialising and pursuing activities, community links workers who help people pursue their interests outside of the centres, and vocational support workers who help people to find work, whether through training, voluntary or paid employment.

These services have been successfully modernised over the last 3-5 years, having been transformed from previously very traditional day services based in buildings offering little in the way of meaningful and service-user led activities, or opportunities to gain develop greater independence, (rather than dependence).

They are now developing further and hosting in-reach from other organisations offering 'citizen's advice style services for example, as well as structured psychological therapies provided by Health in Mind.

Their vocational support services have also teamed up with Health in Mind, and are now one of only 5 pilot sites developing new ways of ensuring people with mental health problems gain and / or maintain employment.

7.3.2 Care Managed Services (D)

People whose assessed needs are determined as 'eligible' for being met by Councils as a statutory duty, have these needs provided for by qualified social workers and other arranging access to in-house or commissioned services, as necessary and appropriate. The speed with which access to services is put in place is related directly to the severity and urgency of assessed needs.

7.3.3 Mental Health Act Assessments (B, C)

The Annual Report on AMHP activities in 2013/14 states there were 1,445 MH Act assessments carried out, with the majority of referrals coming from police custody suites (24%) and in-patient places of safety (12%), suggesting s136 referrals are represent a very significant proportion of demand (c.36%). Community teams and in-patient units referred 23% and 13% of those provided a MH Act assessment, with the remaining 28% coming from a variety of sources.

Only 53% of MH Act assessments commenced within the set standard of 4 hours, and their average duration was 16.8 hours, with community based assessments taking on average around 20 hours. This compares with a standard of 72 hours.

Gap: commencement of MH Act assessments are exceeded standards of best practice in 2013/14, due to sickness and cross-cover from other rota'd staff giving rise to overall shortfalls in operational capacity.

Agreed Action: ESCC has committed to increasing AMHP capacity, in part by increasing numbers in training through a focus on timely support for suitable applications going forward to Brighton University. This already resulted in newly qualified AMHPs joining the East Sussex rota in 2014/15.

Timely access to local in-patient beds was also reported as proving "problematic for several periods" in 2013/14 resulting in long waits for admissions to beds out of area. This is recognised as a national problem arising from peaks in demand occurring sometimes simultaneously across Sussex, although overall bed occupancy across 2013/14 in East Sussex was within commissioned local capacity.

Gap: the local Trust and Adult Social care need to continue to prepare for and improve the deployment of contingency plans to respond quickly to peaks in demand for beds and prevent so far as possible delayed admissions taking place to unit out of area.

8. Child and Adolescent Mental Health Services (CAMHS)

8.1 Training

Training is provided by a Primary Mental Health Care Team to a wide range of staff working across services for children including school staff, school nurses and parent support advisors and Targeted Youth Support (TYS) staff.

Sussex Partnership Trust are providing provide an on-going programme of training for general paediatric ward staff as well as staff working in A&E in acute hospitals, to

enable them to better manage children and young people with challenging behaviours.

Gap: A recent CAMHS needs assessment identified the requirement for mental health training across all services, with more specialist training needed particularly in 'Tier 2' services in response to the increasing complexity of presenting behavioural and emotional needs, including in acute hospital / A&E departments.

Gap: At the same time acute hospital staff report there should be more responsive and timely support and involvement from CAMHS to enable them to manage Children and young people in acute general wards and A&E departments.

Gap: Occasionally children and young people presenting in an acute ward may need to be confined to a side room due to their behaviour, and capacity for this facility is sometimes limited meaning alternative approaches need to be considered and developed.

Gap: Joint training between social workers in children's services and specialist mental health services would help to ensure learning and resolution of problems arising where there is ambiguity over responsibility.

8.2 Decision Support

There are sources from which decision support can be gained from CAMHS by professionals such as GPs and other statutory service providers such as in A&E.

A CAMHS service directory is available on the GP information web-sites and the ESCC website. This describes a range of services available at variously specialist levels to help enable them to support children and young people with emotional and mental health issues. It is updated regularly

A CAMHS consultation line is open every day Monday-Friday from 12pm to 1pm for professionals to seek answers to any general enquiries, to discuss possible referrals or obtain general advice.

An on call CAMHS psychiatrist is available for telephone advice and guidance on week days between 5pm and 9am and on weekends & bank holidays 24 hours a day.

An Urgent Help Service provides out of hours advice, consultation and crisis intervention service by a team of staff able to respond when young people in mental health crisis present at A&E, on paediatric wards or in custody suites. It is available week days between 5pm and 8pm, and on weekends & bank holidays between 10 am and 6 pm.

Gaps: the availability of decision support is clearly limited to the hours it is available, and there is no dedicated specialist CAMHS psychiatric liaison service in acute hospital settings to help transition patients in to suitable and appropriate CAMHs services.

8.3 Services for Children

8.3.1 Primary Mental Health Worker Team (A, D)

In addition to the training referred to above, this team provides early mental health assessments and interventions in community settings such as schools, alongside information about other local services that are available to support the emotional well-being needs of children, young people and their families. It also provides an interface with higher 'tiers' of CAMHS and the wider children's workforce.

The current service is organised across the five east Sussex Districts and Boroughs with an emphasis on areas of greatest population density and highest deprivation and/or mental health need. The service model has been developed and refined over a number of years in response to identified need and changes in the provision of other universal and targeted services for children and young people in the County.

8.3.2 East Sussex County Council 'Tier 2' Services (A, D)

Targeted early help services are provided by the THRIVE programme which adopts a strategic transformation approach to Early Help that reduces children's safeguarding needs as well as the demand for high cost statutory social care services and referrals, child protection plans and looked after children (LAC).

Targeted Youth Support works one to one with young people in a range of settings to offer a continuum of support recognising escalating need. The service has clear pathways to specialist services and is co-located with statutory social care Youth Support Teams.

The Targeted Youth Support (TYS) service provides help to young people aged 11-19, working closely with secondary schools, academies and college. Key work assistance is offered to families with young people at risk of multiple problems including children and young people engaging in risky behaviours, substance misuse, and anti-social behaviours.

8.3.3 Children's Community Mental Health Teams (A, D)

There are three children's community mental health teams provided by SPFT in East Sussex providing specialist assessment and care management in response to routine referrals. They operate a duty system with a named clinician who is available 9-5 pm to offer advice and support as well as triaging referrals.

8.3.4 The Urgent Help Service (B, C)

This specialist SPFT services will a rapid 4 hour response to children and young people who meet the criteria for such urgency.

9. Third Sector Organisations

9.1 Training

Standards are set for commissioned services' providers to ensure their staff are suitably trained and able to safely and effectively deliver the specified services they are contracted to provide.

9.2 Decision Support

Where clients in receipt of services provided by the third sector, are thereby having their 'eligible' needs met and have allocated care managers, any issues or concerns arising about mental health or deterioration can be referred directly to their care manager.

However, as many of the third sector-provided services in East Sussex are aimed at prevention of deterioration and / or on-going support and maintenance of mental health and well-being, (including that of carers), and are not therefore always provided to meet 'eligible' need to people who may not necessarily therefore have allocated care managers, it is reported that it can be problematic to gain access to specialist services when crises become apparent to these providers' services.

Gap: protocols should be developed for information sharing between statutory and third sector organisations providing care and support to individuals who may have been known to and in receipt of statutory sector provided or commissioned care, as well as for those who might otherwise benefit from third sector organisations having direct access to specialist care and support, when people using their services present in crisis and / or appear to be experiencing deteriorating mental health.

Gap: similar protocols should be developed to potentially include 'advanced are directives' setting out options for when a carer may feel their cared-for person's mental health is deteriorating to crisis point, but are expressing reluctance to seek help which cannot be offered only on the basis of it being sought by the carer on their behalf.

9.3 Third Sector Services

9.3.1 Well-being Centres, Community Links Workers and Employment Support, including peer support / recovery college (A, D)

These are the universal services referred to above as commissioned by Adult Social Care (albeit jointly funded by the NHS), and can be accessed directly by anybody 'walking in' or otherwise making contact and asking for help.

Their availability is publicised through a widely distributed printed Directory, which is also available electronically on Council and NHS web-sites. It has been sent to all GP practices across east Sussex and followed up with presentations and GP visits for example to their local Well-being Centres.

Their aim is principally to promote good mental health and well-being and prevent deterioration and hence crisis point being reached also, as well as providing on-going care and support to people with long-standing mental health problems.

9.3.2 Supported Housing (D)

Third sector and independent providers of supported housing have an important stabilising effect on individuals with mental health problems by providing a safe and supportive home environment in which to re-establish their independence.

They are all commissioned on the basis that they should meet standards for promoting recovery, and meet the 'eligible' needs of people assessed and funded by ASC care managers for that purpose.

9.3.3 Residential Home 'Tiered Framework' (D)

Although operating with a different status and regulatory regime, residential care provided by the third sector and independent providers in East Sussex, are being encouraged to join the 'tiered framework' of approved organisations, able to deliver more pro-active rehabilitative care aimed at accelerating recovery and independence, attracting a higher payment for thereby meeting 'eligible' needs.

9.3.4 Crisis House (B, C)

This 7 bed house in a residential street in Hastings is run by the third-sector organisation 'Turning Point' and staffed 24 hours per day by trained staff.

In common with access to acute in-patient beds and home treatment episodes, access to these beds is gate-kept by the CRHTs. It provides them with an additional option for the accommodation of people in acute mental crisis, who would otherwise require hospital admission – those who could obtain home treatment but whose own home / family circumstances mean they cannot accommodate their receipt of this.

10. Sussex Partnership NHS Foundation Trust (SPFT)

As the principal local provider of specialist secondary mental health services, SPFT is the organisation to which patients in crisis will often need to find their way in order to receive clinical care and treatment, whichever organisation they might otherwise come in to first contact with.

The Trust is therefore obliged to operate flexibly and accommodate access to its services via multiple entry-points, and respond in accordance with the urgency and severity of presenting needs, people's physical location and ability or willingness to travel, and the time and day of the week they are contacted.

10.1 Training

The Trusts' medical, nursing and other staff are highly trained and qualified practitioners able to assess and treat mental health problems, and help people recover and maintain so far as possible, their mental health, well-being and independence.

As with any NHS provider of specialist services however, the capacity of SPFT is not infinite, and so what it can provide and for whom has to be decided on, albeit in collaboration with Commissioners (funders) of services, as well as by negotiation with other organisations who come in to contact with and have responsibilities in relation to people experiencing mental health problems.

10.2 Decision Support

In order to help ensure best use is made of SPFT's available resources, it is important that it provides information on what it's services are, who they are for, how they can be accessed, and what can be expected from them in terms for example of response times, care and treatment and on-going support.

SPFT has a web-site which sets out what services it provides and many other details about them, and as has been noted, runs a the telephone help which can be used by any caller to get information and advice about what to do if they are experiencing mental health problems, which may risk developing in to a crisis. Ways in which this service might be improved have been identified above.

The majority of referrals to SPFT come from GPs to whom people most often disclose concerns about their mental health, providing opportunities for these to be identified early and treated, potentially with input from primary care based services such as Health in Mind.

However, when specialist mental health services are needed, whether these require a routine, or urgent response, or indeed in an emergency, GPs report they remain unclear about precisely how to access SPFT services and what response they can expect.

Gap: GP web-based information systems would benefit from being brought up to date with the inclusion of more detailed information about when and how to access SPFT services.

Agreed Action: A new GP web-based information system 'DXS' is being populated with detailed information provided by SPFT about what services they provide, for who (referral criteria), how quickly they will respond, and what they need to know in order to ensure the person referred to them gets the best and most timely suitable response, care and treatment.

Descriptions of SPFT services were provided earlier (above) and in varying degrees of detail, and what follows here therefore concerns their capacity and responsiveness, and any gaps that may exist in these specific regards.

10.3 SPFT Options

10.3.1 Primary Care Mental Health Services – 'Health in Mind' (A)

Over 1,800 people entered treatment with primary care based psychological therapies in 2013/14, which represents 15% of the population estimated to experience anxiety and depression and be able to benefit from these interventions each year, and thereby meets the target for provision set by Government.

Of those completing treatment more than half were considered to have recovered using validated measures, again meeting the target level set by Government. Waiting times of 4 weeks are also being met for over 50% of referrals, thereby already meeting response time standards recently announced by Government as being required by 2015.

10.3.2 Assessment and Treatment Services (A,D)

These services provide routine and urgent assessments largely in response to GP referrals, although direct access is also available.

Over 95% of referrals to Assessment and Treatment Centres (ATCs) were assessed within 4 weeks and commenced treatment within 13 weeks, thereby representing significant progress towards access to mental health services being accorded parity of esteem with other NHS services.

Over 8,500 new referrals of adults are being made to ATCs each year, and there are nearly 4,000 adults on active caseloads at any one time.

10.3.3 Crisis Resolution and Home Treatment Teams (B, C)

There are on average around 50 referrals per month made by GPs to CRHTs for an assessment within 4 hours, although around one third of these are not considered by CRHTs to meet their criteria for emergency contact. Of those who are considered to meet criteria 100% are seen and / or responded to within 4 hours.

Gap: It has been acknowledged above that there are different sometimes different interpretations made and that work remains to be done in this area, including introducing and evaluating the new 5-day 'urgent' response time standard for access to ATCs.

In the mean-time there is also local agreement that in order for services to be more responsive to crises in the community, an increase in CRHT staff would enable them to provide an enhanced service (outside of the narrow national definition of CRHTs' role), and improve response times and access to specialist mental health care when it is most needed.

Agreed Action: System Resilience Funds of £541,000 have been agreed for 2015/16 to increase capacity and provide a responsive community-based assessment service between 9am and 9.30 pm 7 days per week.

10.3.4 A & E Liaison (B, C)

Approximately 2,000 referrals per annum are reported by SPFT as being made by A&E staff to their Psychiatric Liaison services across both acute hospital sites in East Sussex.

Gap: The Trust reports response time standards of 2 hours for A&E assessment by Psychiatric Liaison Services are nearly always met, although it has also been acknowledged above definitions for eligibility for referral, medical fitness or readiness for commencement of assessment, are not always agreed upon and / or reported commonly across service providers.

Agreed Action: As noted above, System Resilience Funds of £330,000 has been agreed for 2015/16 to increase Liaison psychiatry provision in the Conquest and Eastbourne General Hospital Accident and Emergency departments.

10.3.5 Acute Care / Mental Health Act Detention (B, C)

Around 800 admissions of adults take place to acute in-patient beds each year in East Sussex, with a further 1,200 home treatment episodes being provided by CRHTs either as an alternative to admission or to facilitate earlier discharge. Average (mean) lengths of stay are around 3 weeks across East Sussex, but vary between areas ranging from averages of 2 weeks to 4 weeks.

Gap: It has been acknowledged above that timely access to local in-patient beds has sometimes been problematic due to peaks in demand occurring sometimes simultaneously across Sussex, meaning that the local Trust and Adult Social care will need to continue to prepare for and improve the deployment of contingency plans to respond quickly to peaks in demand for beds and prevent so far as possible delayed admissions taking place to unit out of area.

There are also a relatively small number of people who have very frequent acute admissions associated with their diagnosis of personality disorder, as well as high levels of community services' contacts.

Gap: There are no local services in East Sussex specifically designed to meet the needs of people with personality disorders, who are very high users not only of SPFT services but also A&E and potentially other organisations' services too.

Agreed Action: SPFT have been incentivised throughout 2013/14 (via a 'CQUIN'), to develop proposals for introducing new services for people with personality disorders, by diverting funds from their current use across the health care system

10.3.6 Street Triage / Health-based s136 Suites (B, C)

Gap: The significant pressures being placed on services by the numbers of people detained in East Sussex under s136 of the Mental Health Act have been acknowledged above, along with some of the consequences – inappropriate detentions in police custody and delays in commencement and completion of assessments.

These observations suggest that an overall reduction in rates of s136 detention would have a beneficial impact, which has already begun to be seen since the introduction of street triage in Eastbourne in October 2013, as one of nine nationally funded one-year pilots.

Street Triage involves a dedicated police officer with vehicle being accompanied by a qualified mental health professional to attend incidences in the community where officers re considering using their powers under s136 of the MH Act.
The presence of an expert in mental health issues with access to information from local services provides decision-support to officers and thereby enables other options than detention to be considered.

A projected pro-rata reduction of 61% has been seen in the use of the Eastbourne custody compared to 2011/12, based on data from the first quarter of 2014/15, due in large part to an overall reduction in s136 detentions.

Agreed Action: System Resilience Funds of £350,000 has been agreed to continue street increase for Eastbourne in to 2014/15 and 2015/16, and to extend it to also cover the rest of East Sussex also in to 2015/16. Formal evaluation will be undertaken to determine its effects and case for longer-term investment.

Whilst an overall reduction in s136 numbers reduces pressures across the system and impacts positively on numbers being detained in police custody, it has been acknowledged that there remains work to be done to agree a definition of the 'exceptional circumstances' in which police custody should be used as a place of safety, operating between the police and health-based s136 suites.

Statistics for 2013/14 show that suites located at both Eastbourne DGH and the Conquest Hospital were 'closed' and unavailable for admissions on only very few occasions, which is important given that staffing issues had in the past led to these suites being unavailable more often.

Whilst recognising that it is possible that during peak periods of demand each of these one-person capacity suites might be occupied when somebody else might need conveyance for assessment, (and actions to reduce commencement and completion times will help reduce this), it is also evident from the statistics that this does not explain the frequency with which police custody continues to be used as a place of safety.

Gap: Alongside work to agree an operational definition of the 'exceptional circumstances' in which police custody should be used, a review is required of

whether and why people are being excluded due to the degree of their disturbed behaviour and / or level of intoxication and / or history of aggression or violence. This is likely to need to focus on staff's ability to clinically assess and manage risk associated with these presentations.