Yorkshire and the Humber Urgent & Emergency Community Mental Health Network Launch 15.09.17

Q&A Summary

1. **Are you planning some qualitative research to provide CRT staff narrative in interpretation of your data?**

Bryn Lloyd-Evans: Yes. There will be two phases. The first relates to thoughts regarding the crisis teams and the second to those who received service improvement support, who will be asked what worked well and what could be better. This will accompany the research.

People like the personalised support better than the on-line package.

2. **Is your team willing to support any local areas that want to rate their services / undertake a review of their services against the fidelity tool? For example, an STP area.**

Bryn Lloyd-Evans: Yes definitely. The website is available and the team would be able to talk through the resources available. Unfortunately there are limited resources to undertake a review, but support could be available to the process.

3. **Why don't NHS England prescribe the way that funding should be spent rather than putting it into baselines?**
4. **Is this presentation made to CCGs and Commissioners who are expected to divert funding into mental health services?**
5. **Why didn't NHS England ringfence the £69m extra allocation for CRHTs? There has been no additional investment in the Humber area (East Riding & Hull).**

Bobby Pratap: Ring-fencing is not the way that the health service works any more. The CCGs have responsibility for the spend. NHS England is trying to establish data regarding where teams should be spending the funding and data regarding spend and up-lifts. The aim is to make spend public and transparent but at present the data is not currently fully available.

There is further funding for Liaison Mental Health in 2019 and there is a case under consideration as to whether this should be opened up to cover wider pathways. A view from the group as to whether this would be supported would be helpful.

Adrian Elsworth: There are challenges as at the moment the decision is made for the whole and not for the part. Could this be reconsidered?

Bobby Pratap: Unlocking money for crisis teams would be difficult but it may be possible to re-profile some other money. Increased assurance is required alongside improved data. Pressure will continue on the system to ensure that standards are met. The survey may be re-run to assist with this.

6. Re: Eliminating out of area acute placements. What is the NHS England view regarding use of a neighbouring Trust's PICU if the organisation does not have such a facility, e.g. if it is too small?

Ruth Davies: PICU is more difficult as not all providers have one so it is a grey area. Continuity of care needs to be considered. For example, if the PICU is close then it may not impact on the quality of care. But NHS England are aware of issues with the commissioning of PICUs and it is necessary to test whether these are adequately commissioned. This is a big issue in some areas.

7. Re: Out of Area Placements. Are there statistics regarding how many beds per area versus how many out of area beds are used? For example, if beds are less in one area, are there more OAPs?

Ruth Davies: No work has been undertaken nationally, but this could be considered locally. Some areas have eliminated OAPs and reduced the bed base. However, it is important not to simplify and suggest that this could be done everywhere. There is a very delicate balance and the whole system needs to be considered. In the future NHS England may look at this issue more to understand bed numbers nationally.

Bobby Pratap: NHS England is just beginning to obtain some data in this area. More beds are rarely going to be the answer.

Chris Dixon: In Bradford there has been a reduction in beds but this should be looked at alongside the whole system. Access and availability of support in crisis is what reduces the need for admissions.

Mark Vaughan: It is important to look at the number of incidents as increased pressure may be put on community services resulting in unwarranted outcomes. It can be a high risk strategy bringing people back from out of area.

8. Do you pool health and local authority budgets in Bradford? What have been the challenges associated with this?

Mark Trewin: The challenge has been that there are not pooled budgets! However, there is a joint commissioner. An issue for the local authority is that the Care Trust saved whilst the Local Authority became overspent. This was because no one went out of area and there was a high spend on tiny residential placements, but the outcome for service users are better. From a Local Authority perspective this is an expensive option. Some places have one Trust and seven Local Authorities so this can be hard to achieve. More integration between the Department of Health, Department for Communities & Local Government and NHS England would be helpful.

9. What is NHS England's vision for Older Adult Crisis Services? Are Older Adult Services going to be given the same prioritisation as adult crisis teams?

Bobby Pratap: The guidance is for adults and older adults. Access to crisis services by older adults is an inequality. The guidance does not address this fully but it does need to be addressed. It is clear that dementia should not preclude a crisis response. Léa Renoux-Wood has just joined the team to lead on older adults, prior to this there has not been a dedicated member in the team.

Ruth Davies: There has not been a big enough focus on this area and this is being addressed. All guidance highlights inequality. The guidance has been developed in conjunction with the National Collaborating Centre for Mental Health and specific guidance on addressing inequalities will accompany the release.

10. How does the Leeds Survivor Led Crisis Service balance access and risk?

Fiona Venner: Following a presentation to service users the first question is always 'what can we do to get a service like this?', however following a presentation to health professionals the first question always relates to risk! The team are very skilled at assessing risk, although standard assessment tools are used as these have not been found to be fit for purpose. The service can be more accessible because it is not statutory. There is not the power to section, so there is a moral duty rather than a statutory duty. This often means that people are more willing to talk, and people want to be in the service rather than being required to be.

Visitors behave well, although there are high expectations of visitors. It has been that case that people have control and are treated with compassion and therefore there is nothing to provoke them.

The team do ring and ask advice of statutory services regarding the crisis clinical risk.

The service has been open for 18 years and there has never had a violent incident where a staff member was attacked, although there have been a couple of attacks on the building. There have been no death or serious incidents, although there have been a couple of near misses.

There is a proven approach to risk and a good track record.

11. Regarding skilled workforce: What is your approach in Bradford around training?

Mark Trewin: There are a number of elements – police, voluntary sector, local authority, health – and training may be approached differently in each area. There has been a lot of training with the police as often the police are the first contact for someone in crisis. There has also been training undertaken with peer support workers.

It is important to look after the whole workforce.

In Social Care there has been work across the whole service, considering "what are we aiming for?" It is not just about bed and not always best to utilise residential care.

Training and consideration is given to rights and capacity. It is important that there is appropriate decision making, and it is not just about assessing risk.

Chris Dixon: The First Response team have undertaken a range of training, including Advanced Nurse Practitioner training and risk assessment training, along with ASSIST training. This has been particularly important for call handlers.