Managing Vulnerable Frequent Service Users
Durham & Darlington

April 2017

Introduction and context

Commissioned by the Academic Health Science Network North East and North Cumbria (AHSN) and Northern England Clinical Networks, the North of England Mental Health Development Unit (NEMHDU) has carried out a project looking to refine and spread the learning and best practice from a programme originally commissioned within the Tees Crisis Concordat amongst the remaining crisis concordat areas in the North East and Cumbria.

Part of this original programme focused on identifying and analysing vulnerable people who are frequent service users; this work became known locally as the Cohort 30 work stream as each organisation worked with their 30 most frequent users of services.

The project involved senior representatives from each of the participating organisations working together as those people identified as vulnerable frequent service users were categorised into five distinct groups and a range of actions and recommendations were put in place for each group.

Focused both on reducing demand on A&E, Ambulance, police and mental health crisis services as well as providing more proactive planned interventions for vulnerable people, the project made recommendations which included developing a proactive well-being and intervention service to reduce demand on emergency services, and better co-ordinating the responses from different services to manage people with complex needs.

The crisis concordat groups taking part in the process received support from NEMHDU to understand the patterns of behaviour of the frequent service users in their area and develop potential responses to better support those people and reduce demand on your services.

This report represents an overview of the process and findings from the Durham & Darlington Crisis Care Concordat Group.

Process

On 24 January 2017, the crisis care concordat leads were all sent a letter of invitation from the Strategic Clinical Networks to take part in the process, in which they were asked to identify a senior/appropriate individual from each of the following organisations/services (other relevant group members may also be added by the concordat groups, i.e Street Triage) to attend the Accelerated Learning Event:

- Police
- A&E
- NEAS
- Psychiatric Liaison
- Mental Health Trust Crisis Service.

Each organisation was asked to review their data from the most recent 12-month period available and identify:

- Name and Date of Birth of the 30 individuals (maximum) most frequently using their service
- What service/s that individual is using/accessing
- How often they are presenting and any patterns of service use
- Primary reason for contact
- Outcomes associated with contact

The identified senior person from each organisation would bring their data set to the Accelerated Learning Event, which took place over 2 days (22 & 31 March 2017), where the group would:

a) cross reference the vulnerable frequent user lists across organisations
b) identify sub groups based on common characteristics
c) develop system improvement recommendations for each identified subgroup.

Based on past experience and information found in the crisis concordat action plan, we assumed that the concordat group would have existing information sharing protocols in place to support this process. The process was sent to all participating organisations alongside the latest information sharing policy guidance from the NHS.

Findings

At the first Accelerated Learning Event, 53 people were identified who themselves accounted for 2789 primary contacts with the services represented at the event. This figure represents only the primary/initial contact; where the person was registered or known to another agency those contacts were not counted in this figure. Clearly, this level of initial contact with crisis services puts a significant burden on the system.

Brief analysis shows that 35 of the frequent service users were female (2092 contacts) and 18 male (697 contacts).

There were 4 people identified via the AMHP data who were in receipt of 38 Mental Health Act Assessments over a two-year period.

Figure 1 overleaf represents a breakdown of the frequent service users by service and the number of primary contacts with that service over a 12-month period. NB. The police data was only for a ten-week period, from January 2017 to mid-March 2017.

Figure 1

Organisation/service	No. of frequent service users identified	Number of primary contacts
TEWV + Crisis team	11	2062
A&E Liaison	20	621
Police	13	106
Integrated teams	7	Not identified

A full anonymised summary of the data and information used on the day can be found in Appendix 1.

As the group worked through the available information and data, sub-groups, who shared similar characteristics, began to emerge from the discussions. These sub-groups are broadly defined in figure 2 below.

Figure 2

Sub-group	Characteristics
1	EUPD Younger females Alcohol ↑ Self-harm ↑ Increased police involvement/contacts Transient – significant trauma
2	Males with psychosis. Age 30 – 50's Entrenched drug use often known to Criminal Justice Service. *Long periods of in-patient admissions. Substance misuse ↑ Darlington – especially amphetamines/alcohol. Difference in what substance services an offer – across sites – provision. ↑ Aggression.
3	Older male – complex physical health presentations. Multiple presentations

Issues Raised

During the day 1 discussions a number of issues were noticed and raised by the participants, which are noted below:

- Lots of agencies involved but little co-ordination/sharing of information (across all sub groups)
- Build relationships
- Organisational flags – permission to have MDT staff on site
- Section 12 Doctor availability & secure bed

- Police list all but 1 from Durham
- Lack of dual diagnosis input
- Darlington list ? very high proportion of Darlington admissions
- TEWV lists all Durham
- What are the internal flags to review care, ie. no of MHA assessments, admissions, contacts
- 147 S136 to place of Safety in 2016
- 20 S136 to custody in 2016
- TEWV crisis service contacts via telephone are not collected as data if the person is not open to crisis services.

Discussion and Recommendations

Following identification of the sub-groups at the end of day 1, individuals were asked to return to their organisations and consider how they might offer services to each of the sub-groups in the future, based on the following principles:

- A more connected response
- A more proactive response

Which will

- Provide better outcomes for the individual
- Reduce demand on crisis services

Upon reconvening for the second event, participants were presented with the summary data and information collated in Appendix 1 and throughout this document. Following this, participants were asked to consider each of the sub-groups in turn, to develop recommendations and actions for service improvement. The following is a summary of those discussions.

Sub-group 1

Sub-group 1 represented a group of predominantly younger females who presented very frequently to urgent and emergency care services. These presentations usually featured increased alcohol use, increased self-harm and or transient/significant trauma. Presentation at service was often characterised by increased police involvement. Participants described this group as possibly fitting some of the diagnostic criteria for sub-groups of personality disorder.

Discussion highlighted the following additional queries and information:

- Does this description fit a cluster? Cluster 8?
- Do we wait for 15 attendances at A&E or start proactively at 8 or 9?
- How do we provide proactive, multi-agency meetings as people start to present?
- Sub-group not connected/referred to EUPD service
- Do we need a personality disorder service which works without diagnosis, definitive pathway with agreed flags?

- Has this group got historical contact with the system, ie. care, CAMHS? How do we transition well, ie. transition workers.
- Use Stoneham (Durham only) for floating support
- Let's look at young people and presentations
- EIP is health only team.

The participants made the following recommendations:

Recommendation 1

Extending/replicating the current integrated transition service model for LD for young people with mental health vulnerabilities.

Recommendation 2

Develop a business case for a personality disorder service for this group of presentations to minimise impact on urgent and emergency care and future presentations and individuals' mental health.

Recommendation 3

Develop a multi-disciplinary/multi-agency process (with agreed flags) to provide a co-ordinated response, ie MAPPA, MAREC model.

Recommendation 4

Repeat the process used for this project for young people with multiple presentations at urgent and emergency care services.

Sub-group 2

Sub-group 2 was described as predominantly male, aged between 30 and 50 years. Presentation was a combination of long-term mental health problems (extensively psychosis) coupled with entrenched substance misuse (in particular the use of amphetamines in Darlington). This sub-group was also often known to the criminal justice system and may present with increased levels of aggression.

Discussion highlighted the following additional information:

- No dual diagnosis worker in Darlington
- No dual diagnosis in-reach
- This group has social/housing needs

- In Darlington this group often end up in hospital
- This group would have had intensive support from an AOT in the past
- Most of this group are subject to CTO
- There needs to be an improved offer of intensive community support for this group, including accommodation
- Need to break the cycle of presentation for this group
- There is a difference in what substance services are on offer geographically

Participants made the following recommendations:

Recommendation 1

Explore a business case considering the development of a team utilising the principles of assertive outreach and the RADT model to proactively engage with this group.

Recommendation 2

Explore the provision of a dual diagnosis practitioner that works into both in-patient and community settings to provide a proactive dual diagnostic response.

Recommendation 3

Explore best practice from across the country for treatments and interventions for this group.

Recommendation 4

Engage in more detailed analysis of this group and develop cost analysis across the pathway.

Sub-group 3

Participants at the second event felt that sub-group 3, whilst representing a significant pressure on urgent and emergency care services, were more likely to present with complex physical health problems and were unlikely to come into contact with other mental health crisis services. The participants felt therefore that a focus on the first two sub-groups would be more beneficial.

Summary

It is clear from the discussion across the events that there are a small number of people using crisis services very frequently.

Sub group 1 represents a group, predominantly female, frequently presenting at A&E with multiple issues, including alcohol and self-harm, but who are not engaging well with mental health services. There was some connectivity between this group and local personality disorder services though this was not consistent. This group accounted for a large amount of resource and a more proactive and co-ordinated response could provide significant savings.

Sub group 2 represented those with long term mental health issues, using multiple crisis services who were generally well known across services. Issues around access to substance misuse services and the need to better understand this group were raised.

Across the sub groups the desire from clinicians to provide a more connected response was clear. The issue of multi organisation/disciplinary meetings to discuss vulnerable people was raised in each sub group. Systems such as MAPPA and MARAC were used to highlight that such discussions already take place, though with those people identified as vulnerable for different reasons.

The group raised the idea of an 'organisational flag' (i.e. a set number of attendances over a set time period) which would trigger such a meeting being agreed and establishing, or using existing, systems to allow that planned approach to providing care and intervention.

Clearly for this to happen would require organisational agreement, in particular around information governance, however the existence of similar processes and systems should provide a basis on which this could happen. Clearly there are vulnerable groups of people who share similar characteristics identified through this process who would benefit from such an approach.

Throughout the process participants demonstrated a shared willingness and desire to provide a more connected and proactive service for vulnerable frequent users of their services and we believe this would make a significant contribution to both the quality and safety of care received by the individual as well as a reduction in the inappropriate use of urgent and emergency care services.

Appendix 1: Summary of Day 1 Data

Managing Vulnerable Frequent Service Users: Durham & Darlington case analysis

Northumbria Police N.B. Stats only from Jan - early March 17	**TEWV + Crisis team**	**AMHP**	**Local Authority/TEWV EDT, MDT, ADT**	**A&E Liaison**	**Other organisations noted**
F1 76yrs 17c Anxiety, paraniod ideas			F1 MDT +++ input from Vol sector		
F2 36yrs 11c Anxiety, and social problems			F2 4c over 3months ADT ++		
F3 55yrs 10c Paranoid ideation and complaints		F3 3c	F3 ++++++		F3 referred to NTW
F4 66yrs 9c	F4 3c				
M1 65yrs 8c POP			M1 12 c		
M2 37yrs 7c Public disturbance ++	M2 3c		M2 ADT		
F5 27, 8c LD			F5 +++++ LD Team		Stoneham Housing
F6 36, 7c Domestic issues, alchol misuse			F6 ADT		
M3 86yrs 7c			M3 HHOP		
M4 33yrs 8c most Cs from Hosp and awol notices	M4	M4 x 2 MHA assessments	M4		
M5 38yrs 6c ?Psychosis +++ 999		M5	M5	M5	
F7 77yrs 4c calls from Hosp				F7	
F8 55yrs 4c calls from hosp	F8	f8	F8 LD	F8	

	M6			M6, 54yrs 64c Alcohol	M6 Substance misuse team
			F9 MHOP team	F9 83yrs 38c Physical health and social and LT MH issues	
				M6 91yrs 34c Treatment for eye drops??	
F10		F10		F10 40yrs 33c Self harm, substance misuse	
				M7 Cardiac problems + anxiety	
F11	F11 11 MHA ass	F11	F11	F11 23yrs 22c Self harm Alcohol misuse PD	
F12	F12 305 c	F12 8 MHA ass	f12 open to many teams ++++	F12 31yrs 21c self harm+++ EUPD	
		F13 11 MHA asses 1 MHA detention		F13 39yrs 20c OD Alcohol abuse	
F14. S136	F14. 246 contacts			F14. 23yrs, 19contacts, OD, alcohol & substance misuse	
F15. +++++				F15. 34yrs, 15 contacts, MH issues	
	M8.			M8. 21yrs, 45 contacts, MUPS, ?PTSD	
				F16. 33yrs, 42 contacts, OD, anxiety	
				F17. 35 yrs, 31 contacts, self-harm	

			F18.	F18. 62yrs, 50 contacts, suicidal ideation + attempts, physical health problems	
F19.				F19. 49yrs, 34 contacts, alcohol abuse, suicide attempts	
F20	F20		F20.	F20. 20yrs, 34 contacts, alcohol, self-harm, aggression	
				F21. 17yrs, 21 contacts	
				M9. 23yrs, 20 contacts	
				M10. 27yrs, 20 contacts	
				F22. 21yrs, 30 contacts, often leaves before treatment	
M11. +++	M11. +++ long stays		M11. 48yrs, +++ housing issues, drug & alcohol misuse		
M12.	M12. Section 2 + Section 3	M12.	M12. 40yrs, substance misuse		
	M13.		M13. 53yrs, long-term MH, substance misuse	M13.	
F23.			F23. 50yrs, significant long-term MH issues		
	M14. +++		M14. 48yrs, drug & alcohol abuse, long-term MH issues		

F24. Often rings from ward	F24.	F24.	F24. 36yrs, long-term MH condition, autism		
M15.	M15.	M15.	M15. 34yrs, long-term MH issues, substance misuse		
	F25. 41yrs, 278 contacts, bi-polar, PD		F25.		
	F26. 43yrs, 254 contacts, self-harm, substance misuse				
	F27. 26yrs, 244 contacts, PD, self-harm		F27		
	F28. 61yrs, 188 contacts, depression & anxiety			F28.	
	F29. 30yrs, 183 contacts, psychosis +++, use of crisis house				
	F30. 30yrs, 177 contacts	F30.		F30.	
	M16. 59yrs, 157 contacts, psychosis, long-term MH issues	M16. 4+ contacts			
	M17. 32yrs, 148 contacts, psychosis, paranoia, alcohol misuse		M17.		
	M18. 32yrs, 145 contacts, long-term MH, referral to recovery team		M18. ADT		

	F31. 40yrs, 141 contacts, alcohol abuse, OD, anorexia		F31.	F31.	
	F32. 40 yrs, 128 contacts, referral to recovery house		F32.		
F33.	F33.	F33. 30yrs, 11 MHA assessments	F33.	F33.	
F34. S136 x 2	F34.	F34. 30yrs, 8 MHA assessments			
F35. S136 x 4	F35.	F35. 30yrs		F35.	