
# Managing Vulnerable Frequent Service Users Northumberland

March 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 Northumberland 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 (6 & 20 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.

We understood that the concordat group would have existing information sharing protocols in place, sufficient for this process.

## Findings

At the first Accelerated Learning Event, 67 people were identified who themselves accounted for 2323 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 41 of the frequent service users were female (1505 contacts) and 26 male (818 contacts).

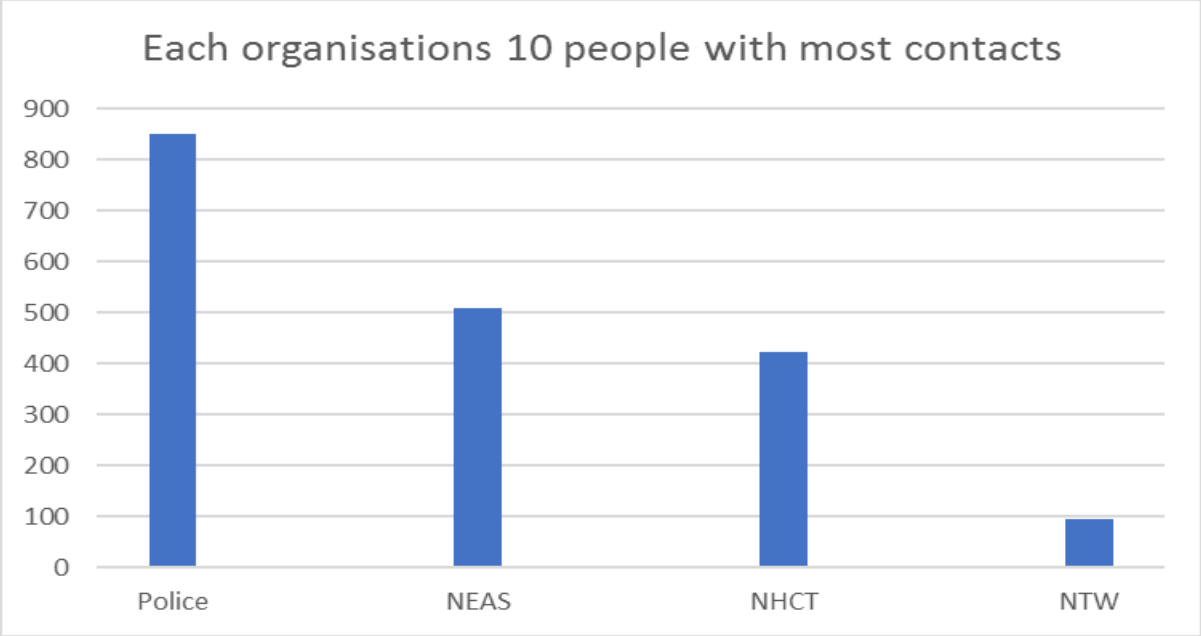
Figure 1 overleaf represents a breakdown of the frequent service users by organisation and the number of primary contacts with that organisation over a 12-month period. A small number of people (6) were primary contacts for Local Authority (AMHPS) and IAPT and no contact figures were recorded, they are therefore not included in the table below.

Figure 1

| Organisation/service | No. of frequent service users identified | Number of primary contacts |
|---|---|---|
| Police | 10 | 849 |
| Accident & Emergency | 24 | 762 |
| North East Ambulance Svc | 15 | 584 |
| MH Trust Psychiatric Liaison + Crisis Service | 12 | 117 |

More detailed analysis revealed that the 10 most frequent users of each organisation were responsible for 1874 of those contacts (see figure 2 below).

Figure 2




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 3 overleaf:

Figure 3

| Sub-group | Characteristics |
|---|---|
| Female | Late 30's - 60<br>Self-harm<br>Frequent contact with police, liaison, Initial Response Team (IRT) + liaison but not plugged in anywhere |
| Female | Late teens/early 20's<br>Self-harm<br>Frequent contact, vulnerable, open to MH (CYP AMH), referred to PD hub. MUS |
| Male | Self-harm<br>Alcohol/substance issues – open to substance misuse<br>Very high NEAS<br>High A&E (left before treatment)<br>Assessment by liaison but no engagement<br>Known to police |
| Male & Female | Lots of NEAS but assistance only<br>Not known to other services |
| Male | 30's – 50's<br>Significant MH issues, multiple presentations to A&E<br>Liaison, crisis services, current or previous use of MHA<br>Multiple services involved now and in past |

## 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 day 2, 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 described a group which were predominantly female, with ages ranging from late 30's – 60. This group was also characterised by high levels of contact with police and Initial Response Team (IRT) coupled with self-harming behaviour. Frequent contact with liaison services was also noted, however this group consistently failed to engage with mainstream services.

Discussion about current and future provision led to the development of recommendations and actions. Key points from the discussion are noted below:

Current provision

- NEAS provide transport/visit/treated on scene
- Street Triage: get involved where police are contacted, eg. Self-harm. Bizarre behaviour. Advice to police and others where clients are regularly engaged.
- High out of hours use
- Clients disengage early in the pathway
- NSECH: full work up – admit / discharge

Future provision

- Shared data
- Non-crisis services providing service that client values
- Proactive services at a lower level, eg. Support worker involvement
- ? Client responsibility: answerable for their actions where insight and capacity exists
- Assertive outreach team
- MDT planning
- Sharing plans
- Working closely together across organisations
- Information Governance protocol agreed across organisations
- Map what is available across organisations and services.

Recommendations

- Visit each other's organisations to understand what we provide
- Get high level agreement on sharing data about clients frequently using services
- Pilot MDT approach to frequent service users
- Look at triggers to set the planning process in place

Actions

- Kate (CCG) to arrange meeting re sharing organisations' information – frontline practitioners to attend and share knowledge
- Each organisation to nominate an individual to speak to their Information Governance team.

Sub-group 2

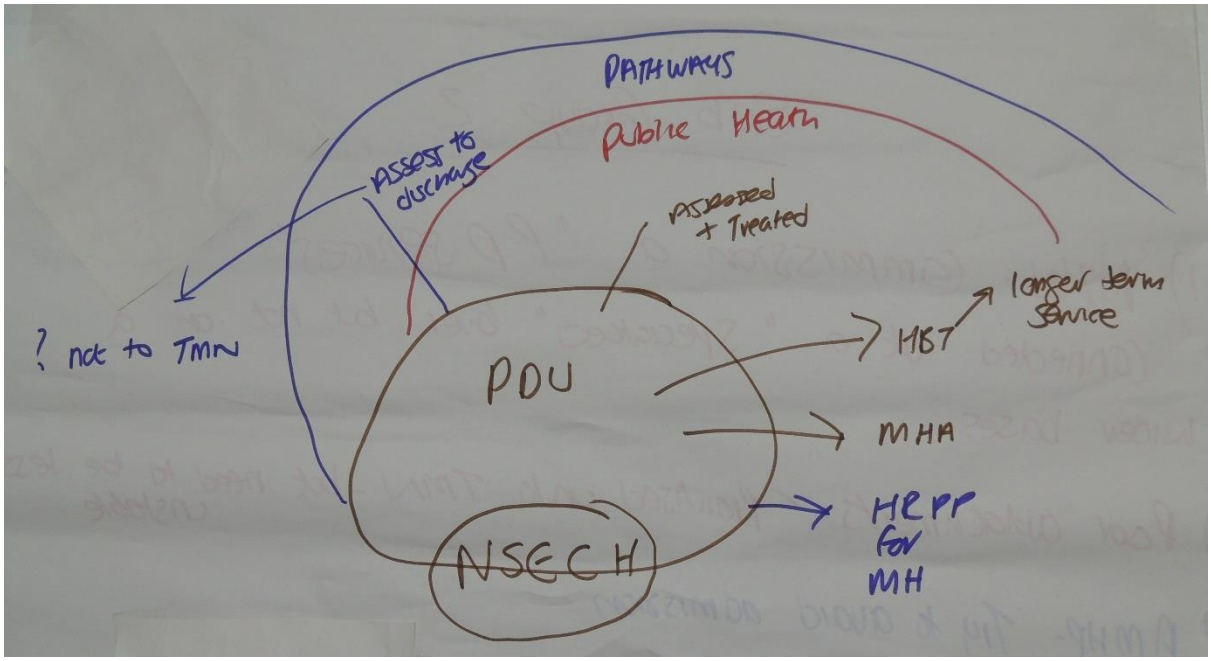
Sub-group 2 again were predominantly female, with ages from late teens to early 20's. Presentations included self-harm and a high level of medically unexplained symptoms, ie. presentations to A&E which were not self-harm and individually would not seem significant, however the number of contacts across a range of presenting problems and symptoms, coupled with self-harm, are suggested of higher level need. This group, who are regarded as vulnerable, may also be open to mental health services, children & young people's or adult mental health services, and may well have been referred to the personality disorder hub.

Current provision

- NTW commission PD services connected at a specialised level but not on a wider basis
- Poor attachments – prioritised into Talking Matters Northumberland – but need to be less unstable
- Approved MH Practitioner – try to avoid admission
- NEAS – presented with a 'critical issue' = admission. In Teesside flagged for consultant only
- Reactive service, ? early identifications
- Recovery arm of Talking Matters Northumberland

Future provision

The group attempted to visually represent a future service model:




Actions

- Understand each service's 'patient flows'
  - Arrange visits to critical hubs
  - Sub-group of crisis care concordat (data sharing)
  - Sub group of crisis care concordat (problem solving)

- Widen the membership of the crisis care concordat
- Involve public health, safer communities + care + voluntary sector
- Feed this into wider system transformation work
- Transport – look at widening of transport options

Sub-group 3

This sub-group was mainly male and represented a very high use of ambulance service, with a mixed presentation of self-harm/alcohol/substance misuse issues. Often known to police this group also had very high attendance at A&E, although frequently left before treatment, alongside frequent assessment by psychiatric liaison services but with no onward engagement.

Current provision

- Not assessed until sober
  - Street triage will see when intoxicated
  - Liaison will see
- Self-referral is required
- Is it a lifestyle choice?
- No finance for residential detox
- Legal highs = issues for NEAS/Police = increase in activity – what are long term effects – impact on health?
- Lots of service involvement – are they all communicating
- Alcohol – if don't engage, services won't work with individuals
- Personal health budgets? How will this impact on this group
- Need MDT input – need to share info
- Letters can be ineffectual for referrals – they make assumptions, ie can the patient read
- Engagement is difficult
- Residential detox was easier but no funding
- Council may have access to teams, health are unaware of
- A&E have a strategy meeting for frequent attenders

Recommendations

- Information Governance – each organisation take forward
- MDT regular monthly approach – ensure all organisations involved
  - Inform on service updates – are they being signposted correctly?
  - Involve patient in meetings/decision making = patient centred – patient sign-up
  - What does the person need
- Cost contacts

Sub-group 4

This sub-group was identified with very little gender differentiation and were characterised by frequent use of NEAS, but usually assistance only, and were not widely known to other services.

During discussion on the day it became clear that NEAS were working on this issue and had very recently established a frequent user group to consider the issues. This group highlighted the need for connectivity between the NEAS-led work and the other organisations represented within the crisis concordat.

It was therefore agreed not to discuss this group further at this event.

Sub-group 5

Sub-group 5 represented a group with complex presentation, generally male, 30's – 50's, characterised by long-term significant mental health issues. This correlated either with current or previous use of the Mental Health Act and was characterised by multiple presentations to A&E, psychiatric liaison and mental health crisis services. It was not uncommon for this group to have multiple services involved directly in care provision.

Current provision

- Crisis team
- Street triage
- Supported accommodation/Bernicia
- Hospital liaison
- CMHT – step up team
- AMHP – admission
- Ex-forces?
- Neuropsychiatry
- Less need for NEAS as more people involved
- Substance use?

Development

- Restore AOT?
- Monitor mental health post discharge from CMHT
- Share information to provide better response from allied services, engage with housing, employment
- Support carer/family network
- Use of CTOs
- Direct access for relapse if previously known
- Old fashioned CPN work/case load weighting/tool for assessing

Recommendations/Actions

- Share information across services – IG teams
- Red light re-referrals (past involvement of severe mental illness allowing short cut of referral process)
- Deep-dive – sub-group of Crisis Care Concordat to analyse this group – CCG to lead
- Develop tool to identify this group before discharge from services – NTW

## Summary

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

Sub groups 1 and 2 represent 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 could provide significant savings given a more proactive and co-ordinated response?

Sub group 3, a largely male cohort, also presented very frequently at A&E and have very high use of ambulance services. Although often seen by liaison, onward engagement was again very poor and this group also often left before treatment in A&E. This group was also characterised by substance and alcohol misuse with no obvious mechanism for engagement or treatment.

Again, the group felt that more connectivity between services and a planned response may be of benefit.

Sub group 4 represented those with very high use of ambulance services, though were not widely known to other services. Responses such as the Blackpool model were discussed to provide a proactive response to individuals and reduce call outs. Work has recently started on a group to consider these issues and we strongly recommend participation from the crisis concordat group to ensure connectivity across services.

Sub group 5 represented those with long term mental health issues, using multiple crisis services who were generally well known across services. Issues around access to 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 as well as the likely reduction in the use of crisis services this would bring.

**Appendix 1: Summary of Day 1 Data**

Managing Vulnerable Frequent Service Users: Northumberland case analysis

| Northumbria Police | North East Ambulance Service | Northumbria Healthcare NHS Trust | Northumberland Tyne & Wear NHS Trust | Local Authority Adult Social Care (AMHP) | Improving Access to Psychological Therapies |
|---|---|---|---|---|---|
| F1. 38 yrs, 350 contacts, ideas of being harassed | | | F1. CMHT Access services | | |
| F2. M1. 46+ contacts, Alcohol misuse | | | F2. M1. Liaison psychiatry | F2. M1. Safeguarding | |
| M1. 69yrs, 96+ contacts, ideas of being harassed | M1. | | | | |
| F3. 46 yrs, 15+ contacts, overdose + domestic violence | | F3. Overdose | F3. Drug & Alcohol | | |
| F4. Drug & Alcohol 37+ contacts, 48 yrs | | F4. Self-harm, liaison psychiatry | | | F4. Service declined |
| F5. 90 yrs, 25+ contacts, Loneliness | | | | | |
| F6. 24+ contacts, PD hub | | F6. 32+ contacts | F6. PD hub | F6. 7+ contacts | |
| F7. 65 yrs, Self-harm, street triage, PD. 80 contacts | | | F7. | | |
| F8. 61 yrs. Suicidal ideation. 35 contacts | | | F8. Liaison, 11 contacts, IRT | F8. | F8. Ref. to CMHT |
| F9. 55 yrs, ideas of being harassed, 141 contacts | | F9. A&E, 24+ contacts | F9. IRT, CMHT | F9. Blyth Star | |
| M2. | M2. 38 yrs, 111 + 999, 137 contacts | M2. 38yrs, A&E, self-harm, left before treatment | M2. Substance misuse | M2. | |

| | | | | | |
|---|---|---|---|---|---|
| M3. | M3. 56 yrs, 111 + 999, 81 contacts, self-harm | M3. LD, 28 contacts, medically unexplained symptoms | M3. LD, IRT, Liaison psychiatry | | |
| F10. | F10. 70 yrs, 111 + 999, 54 contacts, falls | | F10. OP CMHT | | |
| M4. | M4. 78 yrs, 111 + 999, 50 contacts, breathlessness | | | | |
| M5. Street triage | M5. 55 yrs, 111 + 999, 49 contacts, falls & MH | M5. Alcohol misuse, 36 contacts + detox admissions | M5. NRP, Liaison psychiatry | M5. Safeguarding | |
| M6. | M6. 49 yrs, falls, 30 contacts, assistance only required | | M6. Neuro rehab | | |
| M7. | M7. 70 yrs, falls, 29 contacts, assistance only required | | | | |
| F11. | F11. 59 yrs, mixed medical problems, 27 contacts | | | | |
| F12. | F12. 49 yrs, 111 + 999, 26 contacts, assistance only | | F12. CMHT | F.12 | |
| F13. | F13. 50 yrs, 25 contacts | F13. 29 contacts | | | |
| F14. | F14. 23 yrs, 22 contacts, fits | F14. 23 contacts, epilepsy | | | |
| F15. | F15. 80 yrs, 19 contacts, falls, assitance only | | F15. OP CMHT | | |
| M8. Drug & alcohol + offending | M8. 36 yrs, self-harm, suicidal ideation, drug & alcohol misuse, 17 contacts | | M8. NRP | M8. | |

| | | | | | |
|---|---|---|---|---|---|
| M9. S136 | M9. 48 yrs, self-harm, suicidal ideation, 13 contacts | M9. | M9. Liaison psychiatry | | |
| M10. Alcohol misuse | M10. 49 yrs, alcohol misuse + assaulted by others, 5 contacts | | | | |
| | | M11. 32 yrs, 45 contacts | | | |
| | F16. 91 yrs, Falls - assistance required, 11 contacts | | F16. OP | | |
| M12. | | M12. 29 yrs, 44 contacts, GI, A&E | M12. Drug & Alcohol | | |
| M13. Street triage | M13. | M13. 29 yrs, 35 contacts. Anxiety, MH | M13. Crisis, 13 refs | M13. | M13. Recovery & drop-in |
| | | F17. 28 yrs, 67 contacts, A&E | | | |
| F18. | | F18. 47 yrs, 55 contacts, GI+++ Alcohol misuse | | | |
| | | F19. 44 yrs, 32 contacts, self-harm | F19. CMHT + I0 A&E liaison contacts | | |
| F20. Street triage. | | F20.17 yrs, 27 contacts, self-harm, overdose | F20. CYPS + Transitional services, PD Hub | F20. | F20. CYPS |
| F21. Overdose | | F21. 25 yrs, 26 contacts, GI Abdominal pain | | | F21. Disengaged |
| F22. Domestic violence | | F22. 37yrs, 25 contacts, GI Abdominal pain | F22. Liaison psychiatry | | F22. DNA |
| M14. Domestic violence (perpetrator) | | M14. 43 yrs, 24 contacts, GI, overdose, abominal pain | | | |

| | | | | | |
|---|---|---|---|---|---|
| F23. | | F23. 17 yrs, 24 contacts | | | |
| | | M15. 33 yrs, 34 contacts, psychosis & self-harm | M15. Rehab + recovery svcs + psychology | M15. Community Treatment Order | |
| M16. Street triage | M16. Overdose | M16. 24 yrs, 23 contacts, psychosis & anxiety, overdose | M16. CMHT, liaison psychiatry ++++ | | M16. Recovery drop-in |
| F24. High risk. Domestic violence | | F24. 30 yrs, 22 contacts, domestic violence, overdose + alcohol misuse | F24. IRT, crisis only | F24. | F24. Not suitable |
| | | F25. 40 yrs, 22 contacts, left before treatment | | | |
| | | F26. 25 yrs, 21 contacts, ? Psychosis + collapse, overdose | F26. Calls to IRT + Liaison ++++ | | F26. PD, Bi-polar |
| | | M17. 26 yrs, 21 contacts, GI abdominal pain, overdose | M17. Overdose, Liaison psychiatry | | |
| | | M18. 68 yrs, 44 contacts | | | |
| | | M19. 20 yrs, 34 contacts | | | |
| | | F27. 30 yrs, 32 contacts, medically unexplained symptoms | | | F27. DNA |
| | | F28. 27 yrs, 29 contacts | F28. Neuro rehab | | |
| F29. | | F29. 47 yrs, 26 contacts, overdose | F29. CMHT | | |
| F30. | | F30. 75 yrs, 25 contacts | | | |
| | | F31. 35 yrs, 25 contacts | | | |

| | | | | | |
|---|---|---|---|---|---|
| M20. Self-harm | | | M20. 57 yrs, 10 contacts, PD, IRT+++ | M20. | |
| M21. Drug & Alcohol | | | M21. 26 yrs, Drug & alcohol, 8 contacts - liaison psychiatry | | M21. Ref x 2 - DNA |
| M22. Self-harm, substance misuse | | | M22. 37 yrs, CMHT, IRT++++, 8 contacts - liaison psychiatry | | M22. DNA |
| F32. Alcohol, overdose | F32. | F32. | F32. 48 yrs, CMHT, NRP, 6 contacts - liaison psychiatry | F32. Previous contacts until 2016 | F32. Step 4 DNA x 2 |
| F33. Self-harm | | | F33. 21 yrs, CMHT, EIP, PD Hub, Autism, LD - 9 contacts - liaison psychiatry | F33. Sec 2 | F33. |
| M23. Self-harm. MAPPA | M23. | | M23. 36 yrs, NRP, Crisis+++ - 6 contacts | | |
| F34. Street triage, NRP, Self-harm | | | F34. 33 yrs, NRP, CMHT, 8 contacts | | F34. |
| | | M24. Overdose | M24. 49 yrs, self-harm, overdose, NRP, 6 contacts | | M24. Not appropriate |
| F35. Street triage, alcohol | | | F35. 30 yrs, substance misuse, self-harm | | |
| F36. Street triage, domestic violence | | | F36. 31 yrs, IRT, Crisis Team 11 contacts, past PD hub | | |
| F37. Street triage, Self-harm, overdose | | | F37. 53 yrs, CMHT, crisis++, IRT, 15 contacts | | F37. |

| | | | | | |
|---|---|---|---|---|---|
| F38. | | | F38. 20 yrs, crisis++, IRT, 20 contacts | F38. Self-harm | |
| F39. | | | | F39. 60 yrs, self-harm, PD, alcohol misuse, enduring MH problems | |
| F40. Self-neglect | | | F40. CMHT, PD | F40. 53 yrs, self-neglect | |
| | | | M25. Asperger support, CMHT | M25. 43 yrs, alcohol | M25. Discharged, DNA |
| M26. Alcohol | | | M26. CMHT++++ | M26. 32yrs, alcohol, drugs, psychosis | |
| F41. | | | F41. | F41. 59 yrs, dementia, challenging behaviour | |

NRP = Northumberland Recovery Partnership
GI = Gastro-intestinal
IRT = Initial Response Team