NHS

Thames Valley Strategic Clinical Networks

Winter planning for Mental Health Exercise & Scenario Report

12th December 2018, Reading

Report: Winter planning exercise for Mental Health

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Background

Following September's Berkshire West A&E Delivery Board and discussion between executive colleagues across the BOB STP patch, it was felt that it would be useful to have a workshop focussed on mental health and those actions which can reduce or divert mental health attendances from A and E and support flow, communication and escalation through A and E to a more suitable setting; improving patient experience and contributing to rapid and safe discharge from acute settings.

In order to maximise the impact of the discussion it was agreed that following an overview of services from Berkshire Healthcare and Oxford Health, colleagues would sit in their specific systems, chaired by senior leads from those systems.

Aims

The half-day workshop aimed to review and test processes and identify actions which may support improvement. The opportunity for networking and making connections across organisations was also a key output to ensure that there is a focus on parity between acute, community and mental health provision across the wider system.

Attendees

Attendees to the workshop came from across Thames Valley with representatives from primary care, liaison services, acute trusts, mental health trusts, ambulance service, police, local authority, AMHPs, voluntary sector. Senior clinicians and managers were in attendance.

Resources (See attached Appendix 1)

The resources include communications re; staying mentally well this winter and using alternatives to A and E, copies of the OPEL action cards for mental health and London's top 10 tips for mental health discharge. Details of the Tees, Esk and Wear Valley CAMHS crisis team, Bradford Whole System approach, Humbercare safe haven are also included.

Questions

In order to enable a consistent approach, the same questions were posed for each scenario with different systems given different questions to focus on in each scenario.

1) Who is involved in this scenario and what is their role?
2) What is the journey/flow of the person presenting from the initial contact (whether it be at A and E/GP/police/999/111)?
3) What are the blocks which need addressing to improve patient experience and flow?
4) What is the risk management plan and what actions can mitigate risk?
5) Have we all the information to ensure smooth communication channels?
6) Do we know how to escalate?

Themes

The proposed actions relating to discussion of each scenario are described after the specific scenarios. Some common themes emerged:

Hotline to advice from psychiatrist/mental health professional

It was felt that the ability for a GP, social worker, police etc. to urgently contact a mental health professional for advice could prevent A and E attendances.

Are the right people involved?

Is there a role for a trusted assessor and are the right staff monitoring observations in the ED. Could staff from Mental Health Trust support while waiting for assessment?

Secure transport

Faster access to secure mental health transport could prevent delays and help people to get to more appropriate setting in a timely way

Environment

Could there be an alternative de-escalation facility for people in mental health crisis or could there be a more discreet place in A and E for assessment (particularly for CYP) to prevent people in crisis in AMU being in bed next to someone elderly and physically ill?

Processes

Are processes written up so all staff including locums have a consistent approach and expectations and the right contact details? Do organisations outside health understand escalation processes?

Crisis plans

Have multi-agency crisis plans been developed proactively (e.g. with LAC)

Availability of AMHPs and Section 12 doctors

Visibility of availability of AHMPs and S12 doctors could help prevent delays

Communication

Is there a clear way to update those involved in the care of the individual in the crisis as to what actions are being taken and what is awaited? (*E.g. in scenario 2 – CAMHs, acute trust, social worker as corporate parent, safeguarding, education, transport*)

Risky behaviour vs mental health issue

When a CYP is risk to themselves or to others and taken to A and E but not identified as having a mental health issue is there a clear pathway which all understand?

Acknowledgements

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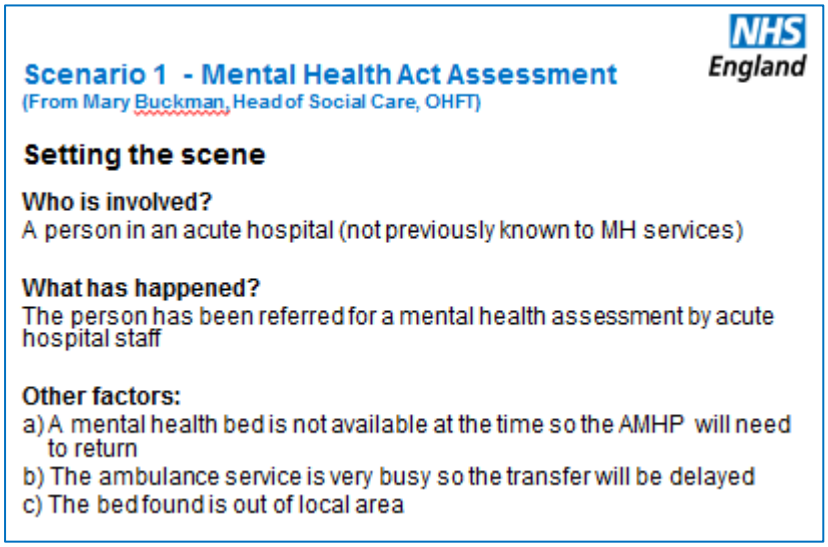
Scenario 1



Summary of Feedback

Who is involved in this scenario and what is their role?

- Patient/family/carer
- ED at Acute and staff
- Liaison services (PMS (Psychological Medicine Services at BHFT and Emergency Department Psychological Services and Oxford Psychological Medicine Service at OUH)
- Security services
- AMHP service to assess
- S12 doctor
- Not in A&E but also involved – community teams, consultant on call, night team or duty managers if OOH, teleconference in terms of request for bed

What is the journey/flow of the person presenting from the initial contact?

- Come into A&E (treated as adult in this scenario)
- Assessment - may remain in acute if no MH bed available (up to 3 days) and AMHP would need to come back and do another assessment (may need to use OPMS in a different way)
- Reviewed different pathways that could be used (have used PoS (Place of Safety) as capacity if know someone going to be discharged)
- Agreed transport services need to be more responsive

What are the blocks which need addressing to improve patient experience and flow?

- Chose OOH scenario as this is where biggest challenges (re access to AMHP and S12 doctors)
- Patient being held in unsuitable environment in ED
- Staff not having skills to manage patients
- Sometimes the assumption can be made that an individual is safe if in ED, however this presents a big challenge to staff
- Sometimes held in Observation bay however this presents a risk to other patients (e.g. may have frail elderly person next to them)
- Taking resources away from other people waiting for bed
- Challenge re; time delays and timing of resource/access to AMHP and Section 12 doctors – the example described that an AMHP may be available however waiting on a S12 doctor which may then hand over to emergency duty service for the individual to then hand over to the day team – question raised was whether further development could be given to a trusted assessor role?
- MH Delivery Board role – does it need more 'teeth' to manage these conversations and make difficult decisions – to consider?
- Described the need for GP access to be available earlier in a process to have conversation with

psychiatrist prior to direct admission to ED – to consider?
- Processes/bureaucracy – to be reviewed
- Where is a patient actually registered – e.g. patient may say registered in Reading so whole assessment undertaken but then find registered with a GP elsewhere - is there a way around this?

What is the risk management plan and what actions can mitigate risk?

- Correct "Holding place" – patient on a S136 should go to Prospect Park Hospital, however for others, ED is the inappropriate place. To consider - is there a bespoke option required for people who are neither on a S136 and may not be best seen in ED
- Alternatives to A&E? – looking at de-escalation before MHAA and avoiding detention
- Physical Health needs – consider innovations
- Is there a possibility of capacity from PPH/other Mental Health Trust to support person if need to stay in PMS?
- Look at AMU alternatives – moving out of busy area into somewhere more discreet
- Conveyance arrangements with private ambulance companies – to consider

Have we all the information to ensure smooth communication channels?

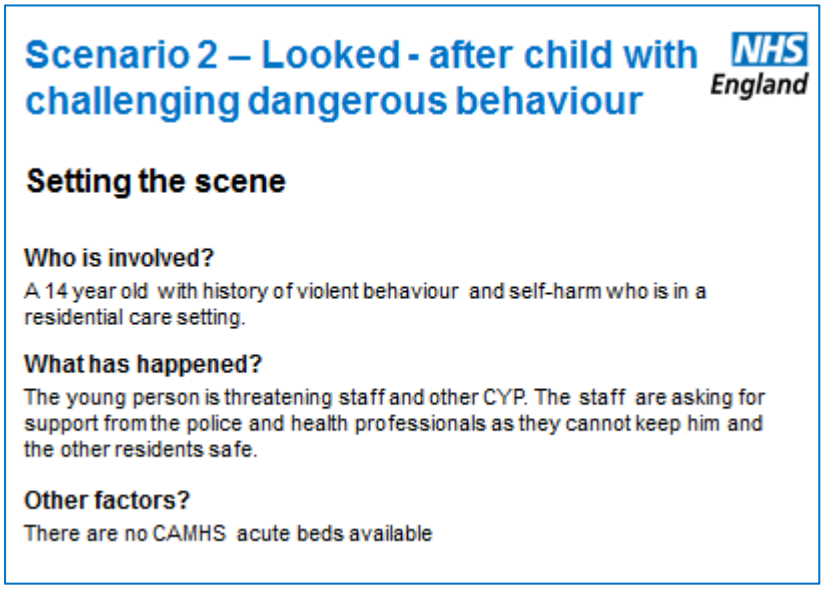
- Challenge for ED to know what is going on and who responsible for sorting out the next bit which sometimes leads to unnecessary escalation - maybe with AMHP or may be with a Trust to find a bed ; suggested feed into silver command within BHT to find a solution they can then feed into Execs to solve any anxieties, they also have good communications with CCGs
- Use twice daily conference calls to get shared understanding and overcome blocks and need to have feedback to BHT (if communicate effectively don't need to escalate)
- AMHPs statistics feeding back monthly into A&E delivery board now happens in Bucks (i.e. how many assessments, what were the delays etc.)

Do we know how to escalate? – This was not felt to be a concern

Potential actions to consider from discussion of Scenario 1

- **Look at AMHP and Section 12 doctor access and review delays and get learning from individual cases – is there possibility of easier way to understand availability?**
- **Is there scope for trusted assessor role?**
- **Look at patient transport service contracts to ensure effective and allows for on the day/emergency bookings – Hampshire have a secure ambulance service solely for mental health (further info from sonyamclean@nhs.net)**
- **Look at staff skills in ED around managing patients**
- **Alternatives to security services doing 1:1s, Observation monitoring – e.g. could be nursing, third sector worker?**
- **Look at environment – suitable places to hold patients waiting assessment and for assessment to be undertaken? Could there be an alternative to A&E?**
- **Review MH Delivery Board role in a scenario like this**
- **Look at possibility for GP to have access to have conversation with psychiatrist prior to direct admission to ED**
- **Is there a possibility of staff from mental health trust (in addition to liaison) supporting person while waiting for assessment?**
- **Is there a way to confirm where patient registered before assessment undertaken?**
- **Look at writing up process for mental health act assessments**
- **Consider how the delay, reason for delay and what happening is communicated to the acute Trust?**

Scenario 2



Who is involved in this scenario and what is their role?

- Young Person
- Social worker – corporate parent
- Staff in residential setting to give background
- School staff or, if excluded, virtual head teacher
- Looked After Children's nurse
- LD/Autism/Speech and Language difficulties?
- May be known to Youth Offender Service (assume not in this scenario)
- May have been seen by educational psychologist
- Safeguarding team needs to be informed – within LA or hospital safeguarding team – or CCG/GP safeguarding lead

What is the journey/flow of the person presenting from the initial contact?

- Initial concern that this individual does not go to A&E – not the right place for this CYP
- Time given for young person to tell story to a trusted person
- No evidence young person is mentally unwell in this scenario– may have history of trauma – may be exploited – challenging behaviour may not be directly linked to being mentally unwell
- Find out what child wants – ideally with a trusted person
- Avoid looking at CAMHS bed as no evidence of being mentally unwell (may just be behaviour challenges. Question was raised in the room, if a question of safety (as per scenario) who has responsibility of care?)
- Care Education Treatment Review type meeting to receive deeper detail of what is going on and what most appropriate for this young person - avoid police involvement
- How can system avoid an A&E presentation –is there an option for a have de-escalation facility (described model in Hull for CYP Safe Haven type service)
- In reality, the likelihood police would attend this scenario with S136 attend potentially into PoS or ED
- Challenge in this scenario would be that person would likely be in PoS or Acute Trust up to a couple of days later
- Police would ring SCAS – difficult to access expertise – may need to look at some of protocols – specifically communication and training with residential homes?
- Need to look at the rigidity of protocols to manage behaviour that may not be considered as mental health issue – shouldn't be immediately contacting emergency services – should know about alternatives (general sense was there could be a communication issue re; this, as colleagues agreed this case is not atypical?)

What are the blocks which need addressing to improve patient experience and flow?

- Need to decide whether this is a mental health issue or a children's services issue?
- Who is holding responsibility? Are we bringing the right people in?
- Who has responsibility if risk to themselves and others in residential setting?
- If MH issue – are we bringing in Specialised Commissioning or NHSE for Tier 4 services?
- Sharing knowledge and understanding – do corporate parents understand Mental Health Act and do MH staff understand Children's Act?

What is the risk management plan and what actions can mitigate risk?

- Can we provide additional support through CAMHS or children's services?
- Often children from Out of Area appear in care settings locally – how do we link back to original area? – is there regular review to prevent crisis?
- Moving in crisis plans to placements?
- Young person in PoS – legal framework

Have we all the information to ensure smooth communication channels?

- Generally felt is there enough information?
- Assume there is a multi-agency plan in place for this person with contact details – to test?
- CAMHS crisis team able to coordinate and offer support for residential home – perhaps emergency meeting

Do we know how to escalate?

Yes within own organisations – but would residential home know how to contact? – Action from workshop

Potential actions

- **Explore potential CYP de-escalation facility – crisis house for adolescents - could de-escalation happen in an acute setting perhaps with voluntary sector?**
- **Easy accessible hotline number to CAMHS for advice?**
- **Look at escalation processes across organisations outside of health?**
- **Look at protocol for managing child with risky behaviour where not mental health issue?**
- **Do residential care settings know how to escalate?**
- **Do we have multi agency crisis plans in place?**
- **Look at learning from the" Journey of the Child" work being undertaken across TV – what could be catalyst for change?**
- **Look at Hull experience – building a team around the CYP to de-escalate (see attached presentation)**
- **Is there a space within acute for safe place for CYP as may still go there? (this has been done at King's Hospital)**
- **CAMHS liaison service in ED?**

Scenario 3

Scenario 3 – Cross – organisation communication
(from Dan Knowles, CEO, Oxfordshire MIND)

Setting the scene

Who is involved?
3 service users with complex needs all known to the Adult Mental Health team who are regular attendees at the Safe Haven

What has happened?
The service users have held some off-site social events including alcohol use, all three service users were in crisis including suicidal ideation and self-harm. There was a concern from professionals regarding the peer relationships developing between the three.

Other factors:
This situation came to AMHT attention over a really busy weekend

Who is involved in this scenario and what is their role?
Service user
Other Service users at Safe Haven
Staff at Safe Haven

What is the journey/flow of the person presenting from the initial contact?
No clear journey – will depend; may go to PoS (Place of safety) or A&E depending on level of self-harm
Can appear quite minor issues with risk of rapid escalation
If individual service user is feeling unsafe, he/she may not be able to attend self-haven with peers so may need to go to ED

What are the blocks which need addressing to improve patient experience and flow?
Difficulties in joint decision making across 2 organisations – Safe havens open in evenings however the responsibility would sit with AMHT/CMHT during day

What is the risk management plan and what actions can mitigate risk?
More communication and awareness

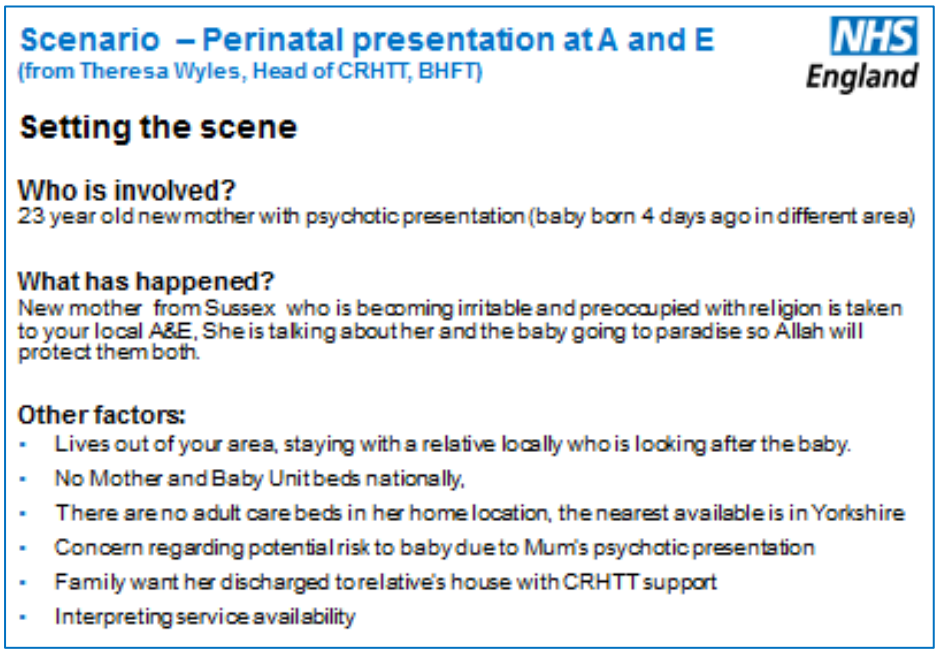
Have we all the info to ensure smooth communication channels?
Consider WhatsApp group for communication?
Need to raise awareness of these situations across teams?

Do we know how to escalate? – Not considered an issue

Potential Actions

- ***Consider Opportunity for AMHT and Safe Haven to meet and discuss risks in this type of scenario***
- ***Consider how everyone kept up to date and has same information about what happening (ED, Liaison, AMHT, Safe Haven)***

Two further scenarios were developed but not discussed at the workshop - individual systems may wish to consider these:



Scenario – Perinatal presentation at A and E

(from Theresa Wyles, Head of CRHTT, BHFT)

NHS England

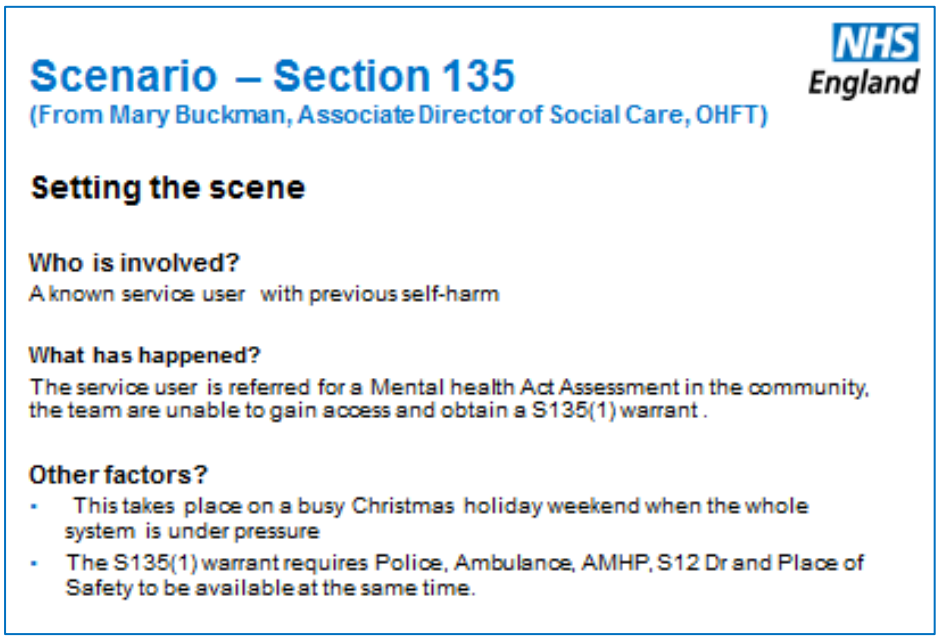
Setting the scene

Who is involved?
23 year old new mother with psychotic presentation (baby born 4 days ago in different area)

What has happened?
New mother from Sussex who is becoming irritable and preoccupied with religion is taken to your local A&E, She is talking about her and the baby going to paradise so Allah will protect them both.

Other factors:

- Lives out of your area, staying with a relative locally who is looking after the baby.
- No Mother and Baby Unit beds nationally,
- There are no adult care beds in her home location, the nearest available is in Yorkshire
- Concern regarding potential risk to baby due to Mum's psychotic presentation
- Family want her discharged to relative's house with CRHTT support
- Interpreting service availability



Scenario – Section 135

(From Mary Buckman, Associate Director of Social Care, OHFT)

NHS England

Setting the scene

Who is involved?
A known service user with previous self-harm

What has happened?
The service user is referred for a Mental health Act Assessment in the community, the team are unable to gain access and obtain a S135(1) warrant .

Other factors?

- This takes place on a busy Christmas holiday weekend when the whole system is under pressure
- The S135(1) warrant requires Police, Ambulance, AMHP, S12 Dr and Place of Safety to be available at the same time.

For more information please contact:

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