Trust Innovation

Northumberland, Tyne and Wear NHS Foundation Trust

Healthier Lancashire & South Cumbria

Lancashire Urgent Mental Health Pathway Review Final Report and Recommendations

May 2019

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Scope of this Review:

The Mental Health system in Lancashire has experienced a rising tide of demand and operational pressures over the last year. A Risk Summit of system leaders and regulators took place in April 2018 to discuss these issues, and an initial Mental Health Improvement Plan was agreed.

Commissioners provided additional resources to support the Improvement Plan, and the Leaders of the Integrated Care System (ICS) agreed to support a peer review of the Urgent Care Pathway in Lancashire, led by Northumberland, Tyne and Wear NHS Foundation Trust.

The objectives of this review are noted to be as follows:

- To review Urgent Mental Health pathways and service delivery across the Lancashire system
- To consider the opinions of those who use Urgent Mental Health services, those who care for them, and those who work in these services
- To triangulate those opinions with a variety of data and information sources
- To consider at a high level only how wider service delivery in 'less urgent' services may impact on 'urgent'
- To provide recommendations to the system as a whole and to individual organisations on how service delivery may be improved

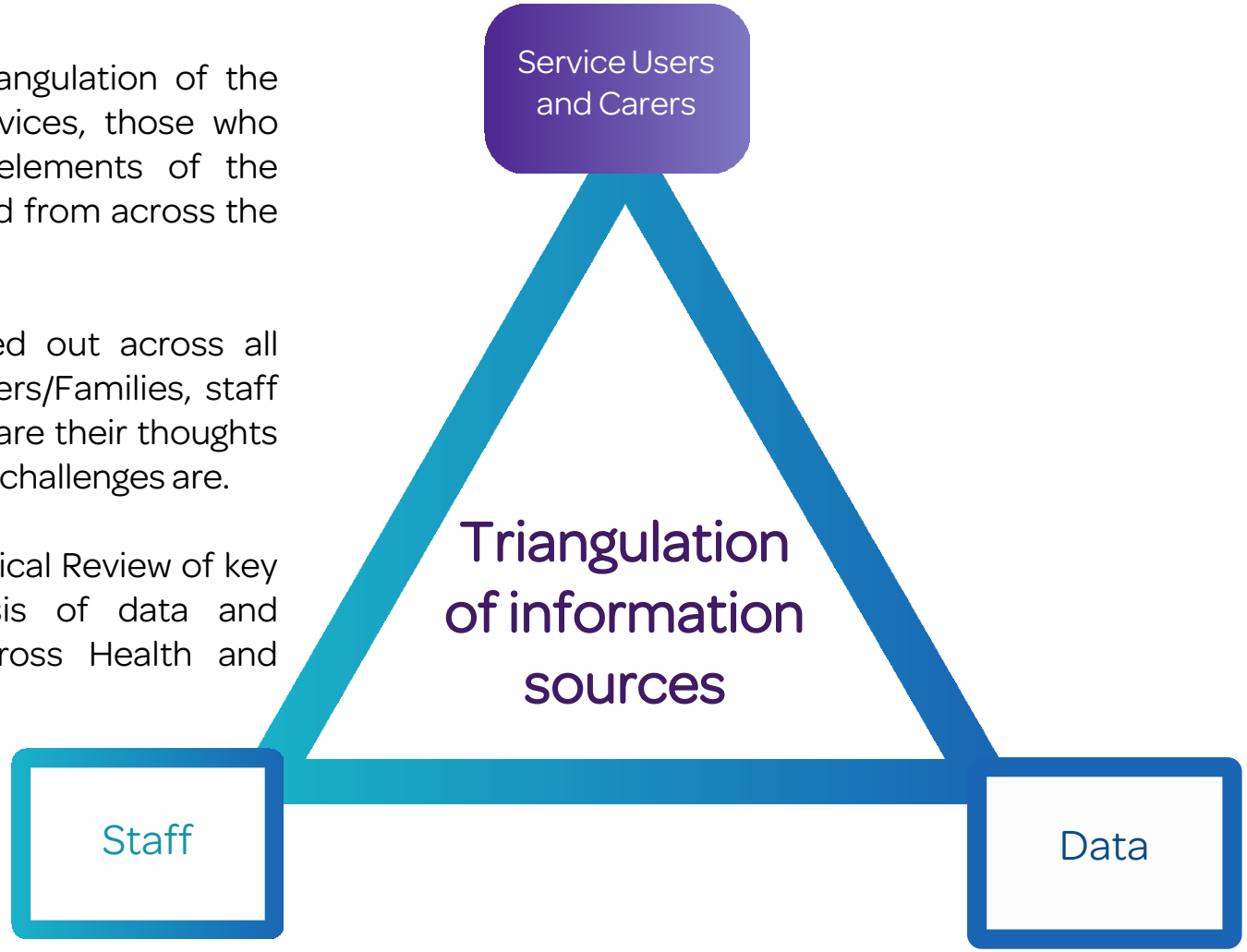
System Leaders are aware that the Mental Health system in Lancashire is continuing to experience serious operational problems. Demand pressures remain high, many Service Users are experiencing long and distressing waits to be seen, and there are significant public and professional concerns about the resilience of the system.

The review approach...

this document presents the triangulation of the opinions of those who use services, those who support them, alongside key elements of the comprehensive data set analysed from across the system as a whole.

17 Listening Events were carried out across all localities, for Service Users, Carers/Families, staff and partners including GPs to share their thoughts on what works well and where the challenges are.

This was in parallel to a Peer Clinical Review of key services in LCFT, and analysis of data and information gathered from across Health and Social Care providers.



In reviewing the Urgent Care Mental Health Pathway across Lancashire, this report will consider the following elements in turn:

- *National context*
- *Demographics, prevalence, providers and commissioning*
- *Emergency Departments and Services, and Mental Health Decision Units*
- *Police involvement in Mental Health and use of MHA Section 136*
- *Urgent Mental Health services*
- *Inpatient wards*
- *Community non-urgent services, in Health and Social Care*
- *Culture and Relationships across the system*

Each section is summarised, and finally drawn together in a set of recommendations - the response to those recommendations by the ICS System Leadership concludes this report.

National context and drivers:

Just less than 2 million people per year use Secondary Mental Health services - a figure that has grown steadily since the introduction by the Blair Government of the *National Service Framework for Mental Health* (1999). And, whilst inpatient demand has remained broadly the same over that time, the number of NHS beds available has reduced, with the resultant demand for community services and alternative providers.

Many of the same issues articulated in the 1999 NSF are observable across the system today. Excess demand for support, notably when in a Mental Health crisis, alongside increased rates of self-harm and suicidality, have impacted across the public sector over the last decade in particular. Emergency services and Emergency Departments have, in some parts of the country, inappropriately become a default pathway to manage people in mental health distress and crisis.

The launch of the *Crisis Care Concordat* in 2014, signed across Whitehall and national partner agencies, recognised that Mental Health crises have a whole system impact, and thus an effective response requires a whole system solution. This requires action to: prevent crises before they've begun, as far as possible; ensure joined up approaches to the initial response to crises across agencies; and to provide a range of high quality, accessible options for intervention and treatment, which where possible avoid inpatient admission.

National context and drivers, contd.:

The *NHS Long Term Plan* (2019) builds on the *Five Year Forward View* (2014), and focusses attention on improving Mental Health services further:

- Increased investment locally and nationally
- Earlier support in a person's journey, with Improved Access to Psychological Therapies (IAPT) and more holistic models of community Mental Health support: place-based, multi-disciplinary service delivery that is easy to access and responsive
- 24/7 community-based crisis response services, offering intensive home treatment as an alternative to admission, via a single point of access system that is open to everyone and incorporates links to NHS 111
- A move towards Mental Health Liaison services fulfilling the 'CORE 24' model in all Acute Hospitals
- More alternatives to attending Emergency Departments (ED) and to admission when in crisis
- Improved training for Ambulance staff in Mental Health crisis support
- Purposeful, patient-oriented and recovery-focussed inpatient care when needed, in therapeutic environments, with a national average length of stay of 32 days expected, and an end to acute out of area placements

Demographics:

Lancashire and South Cumbria has a population of 1.74m GP registered patients, with a mix of rural and urban areas:

CCG	Population (Mid-2015)	Area (km^2, 2015)	Rural/Urban Divide (% split)	Mental Health weighted Population (from NHS England)
NHS Fylde & Wyre CCG	167,894	266	16/84	140,263
NHS Blackpool CCG	139,578	35	0/100	203,717
NHS West Lancashire CCG	112,742	347	39/61	102,470
NHS Chorley and South Ribble CCG	172,533	236	19/81	142,852
NHS Greater Preston CCG	202,843	383	10/90	192,921
NHS East Lancashire CCG	374,223	913	13/87	390,991
NHS Blackburn with Darwen CCG	146,846	137	4/96	183,274
NHS Lancashire North CCG	161,456	759	38/62	303,077 (as the combined Morecambe Bay CCG)
NHS Cumbria CCG	504,502	6,905	53/47	

Prevalence:

- Lancashire is above the national England average for socio-economic deprivation, with four areas in the 2015 English Indices of deprivation's top 20 most deprived local authority districts in England (Burnley, Blackburn, Blackpool and Pendle)
- The link between deprivation and Mental Health is well established nationally and is considered below:

Percentage of GP registered population with Psychosis, Non-Psychosis and Organic conditions/illness (from Public Health England):

Upper Quartile
Above Median

	Threshold (Upper Quartile of National Mean)	NHS Lancashire North CCG	NHS Cumbria CCG	NHS Fylde & Wyre CCG	NHS Blackpool CCG	NHS West Lancashire CCG	NHS Chorley and South Ribble CCG	NHS Greater Preston CCG	NHS East Lancashire CCG	NHS Blackburn with Darwen CCG
Organic	0.90%	0.99%	0.98%	1.21%	0.99%	0.95%	0.79%	0.71%	0.79%	0.64%
Non-Psychosis	9.36%	10.79%	9.61%	10.78%	13.54%	9.26%	11.01%	10.45%	8.54%	9.55%
Psychosis	0.92%	0.92%	0.96%	1.00%	1.44%	0.78%	0.85%	0.98%	1.06%	1.21%

From the data above, we can see that the 3 core categories of Mental Health problems show greater than national average prevalence in the majority of Lancashire localities.

While there appears to be a pattern between levels of deprivation (next slide) and the presentation of Psychotic illness shown here, this does not appear to be the case for data on Non-Psychotic (depression, anxiety, etc.) or Organic conditions (such as dementia).

Data from Public Health England 'Fingertips' Dashboard system:

Locality	Socio-economic deprivation score (2015) NB higher scores indicate greater deprivation	Severe Mental Illness Recorded Prevalence: % of GP practice register, all ages, 2017/18	Long Term MH Problems (GP survey, % of respondents, 18+, 2016/17)	Contact with MH or LD services, rate per 1000 patients on GP practice list, 18+ (2014/15)
England	21.8	0.94%	5.7%	38.7
Blackpool	42.0	1.54%	8.7%	40.6
Blackburn with Darwen	34.2	1.26%	5.9%	53.2
Lancashire	East Lancs: 28.1 Preston 27.4 West Lancs: 20.0 Chorley & S. Ribble: 17.5	1.02%	6.0%	52.6
Cumbria	Barrow-in-Furness: 31.4 South Lakeland: 12.2	1.02%	5.7%	43.3

Health economy partners which exist across Lancashire and South Cumbria (L&SC – not all part of this review):

- 8 CCGs and 5 Integrated Care Partnerships
- 4 Local Authorities
- 2 Police Constabularies and 1 Ambulance Provider
- Lancashire Care NHS Foundation Trust is the main provider of secondary care Mental Health services across Lancashire and South Cumbria (the Trust also delivers secure services, Children and Young People's Mental Health Services (CYPS) and physical health community services in parts of Lancashire)
- Cumbria Partnership NHS Foundation Trust – provides secondary care Mental Health services in South Cumbria
- Blackpool Teaching Hospitals NHS Foundation Trust – provides CYPS services in the Fylde Coast, and the Single Point of Access for referrals to LCFT
- East Lancashire Hospitals NHS Trust – provides CYPS services in Pennine Lancashire
- Mersey Care Foundation Trust – provides Mental Health Liaison services at Southport A&E, (although outside L&SC receives significant numbers of West Lancashire residents)
- Independent Sector – there are a number of Independent Sector Mental Health units in L&SC providing acute and rehabilitation services often commissioning on a spot-purchase basis
- Voluntary Sector – integration into Mental Health services is described as limited in Lancashire and South Cumbria, however the sector is particularly active in IAPT (Lancashire Women's Centre) and Dementia services (Alzheimer's Society), and increasingly in Crisis services (Richmond Fellowship, Calico)

Commissioning spend – data from NHS England's Five Year Forward View Dashboard:

CCG (with population)	CCG spend on MH in 2017/18 as % of CCG base allocation	MH actual spend 2017/18 (in brackets, planned spend in 18/19)	Crisis Resolution and Home Treatment Teams Actual Spend 2017/18	A&E and Ward Liaison MH Actual Spend 2017/18	Total estimated spend per head of population on Crisis, Home Treatment & Liaison services
NHS Fylde & Wyre CCG (168K)	13.5%	£30.7m (£33.9m)	£910K	£87K	£5.94
NHS Blackpool CCG (134K)	12.9%	£36m (£37.1m)	£1.3m	£407K	£12.23
NHS West Lancashire CCG (133K)	13.1%	£20m (£19.9m)	£924K	£167K	£9.68
NHS Chorley and South Ribble CCG (173K)	12.2%	£29.7m (£31.2m)	£1.6m	£416K	£11.68
NHS Greater Preston CCG (203K)	12.4%	£33.9m (£35.3m)	£2.3m	£369K	£13.16
NHS East Lancashire CCG (375K)	12.2%	£68.2m (£69.5m)	£2.8m	£339K	£8.39
NHS Blackburn with Darwen CCG (147K)	13%	£29.7m (£30.7m)	£1.3m	£362K	£11.32
NHS Morecambe Bay CCG (303K)	13.9%	£71m (£72.2m)	£1.4m	£220K	£10.03

From the data above, we can see that spend on Mental Health services, and specifically on crisis and liaison pathways, is significantly variable across this system, with an average of £9.11 per head of population. While commissioning is complex and in part driven nationally, proportional spend of base allocation on Mental Health here is lower than some areas with comparable deprivation and prevalence of Mental Ill Health, such as Birmingham (16.2% spend and a deprivation score of 37.8), Sunderland CCG, (15.1% spend and a deprivation score of 29.7), and in Central London (20.1% spend, and a deprivation score of 27.7).

Through the Review process, Commissioners across this region have noted concern over value for money returned on funding given to LCFT – agreement with providers on whether there is sufficient capacity in the system to meet population need, and whether that resource is being used effectively and efficiently by all will be a key part of moving this system forward.

Review of Service Delivery:

The following sections of this report examine the Urgent Care Mental Health pathway as followed by Service Users within the Lancashire elements of the system (as per the agreed scope of this review):

- *Emergency Departments and Services, and Mental Health Decision Units*
- *Police involvement in Mental Health and use of MHA Section 136*
- *Urgent Mental Health services*
- *Inpatient wards*
- *Community non-urgent services, in Health and Social Care*

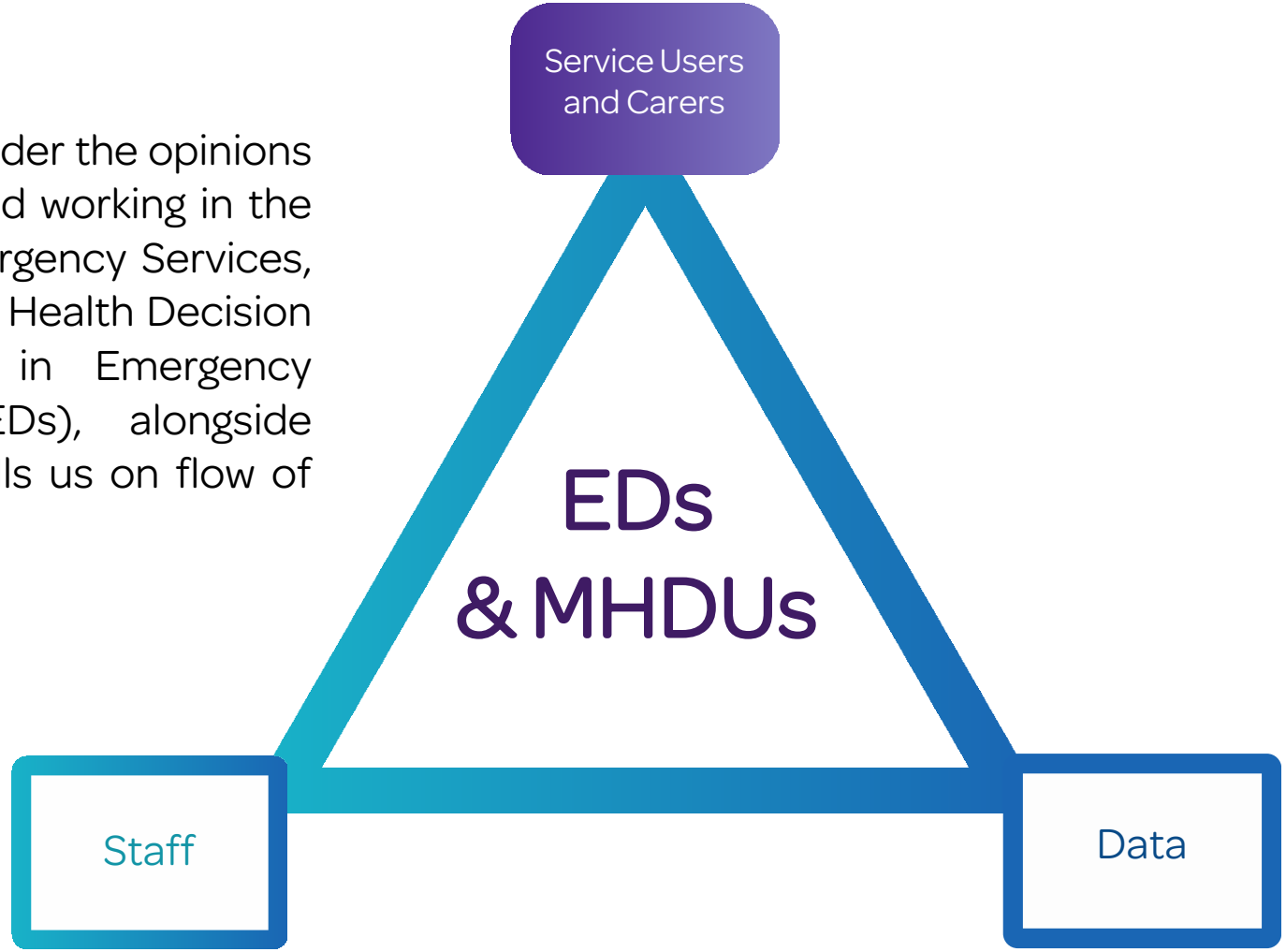
Listening Numbers:

Where opinions are included, these were gathered at Listening Events held, and in meetings with individuals and small groups, where attendance was as follows:

- *Service Users and Carers – 100 attendees*
- *Staff/professionals from across the system – 105 attendees*
- *GPs – 50 attendees*
- *Plus many individual discussions with Commissioners and Senior Leaders from all Providers and the wider Health and Social Care system*

Review Section 1:

Here we will consider the opinions of those using and working in the front line of Emergency Services, and in the Mental Health Decision Units (MHDUs) in Emergency Departments (EDs), alongside what the data tells us on flow of patients



What are Service Users and Carers saying about Emergency Departments and Services, and about Mental Health Decision Units?

- *ED is not an appropriate place for most Service Users but is the only place to go as Crisis Services are not responsive, and there is a lack of response or support from Emergency Services (also not seen as appropriate in most cases)*
- *Don't always receive compassion, respect or a quick response from ED staff – variable in how staff deal with Mental Health Service Users, need to ensure all are trained in MH and Learning Disabilities enough to be supportive and helpful*
- *Long waits in inappropriate circumstances such as sitting in A&E or in a MHDU - left waiting on a trolley in the corridor for 10 hours, overnight waits for Liaison Team to come and assess*
- *ED security staff are obtrusive and inappropriate at times*
- *Poor links between Mental Health and Physical Health services*

What are staff saying about Emergency Departments and Services, and about Mental Health Decision Units?

- *ED is often the only choice, as there are no comprehensive 24/7 Crisis/Home Treatment Teams, and Liaison staffing to ED is very limited*
- *Should not have to take Service Users to ED because S136 Suites are full - Section 136s often expire after 24 hours without review or plan; Police spend a long time in ED 'supervising' patients waiting for services*
- *Poor relationships between LCFT and Acute Hospitals – pressures, lack of understanding of each other's roles, lack of communication, records not joined up = too much blame*
- *Significant delays in accessing AMHPs and Section 12 doctors at times*
- *Too many people spending too much time in MHDUs waiting for Crisis Team or a bed*
- *Voluntary Sector Leaders described their services as the "poor relation", with some seen as being reluctant to make referrals to VCS options, keeping individuals in MHDU settings for many days when alternatives are available*
- *Very limited MH support offered to younger people puts Emergency Services and ED staff in a difficult position*
- *Liaison staff noted that they spend up to 60% of their time doing admin tasks, with documentation increasing significantly, and that admin support and streamlined recording systems would be of great benefit to them*
- *In feeding back to the LCFT's Quality Improvement team, staff from across the MHDUs noted that they face challenges with staffing, with Medical availability, and in supporting those with Emotionally Unstable Personality Disorder (EUPD) in the Units, and would welcome clarity on pathways and expectations. Data provided indicated that the MHDUs were felt to be appropriate environments for the referred patients in 69% of cases at Arkwright in Preston, 83% at Towneley in Blackburn and 94% at Blackpool MHDU*

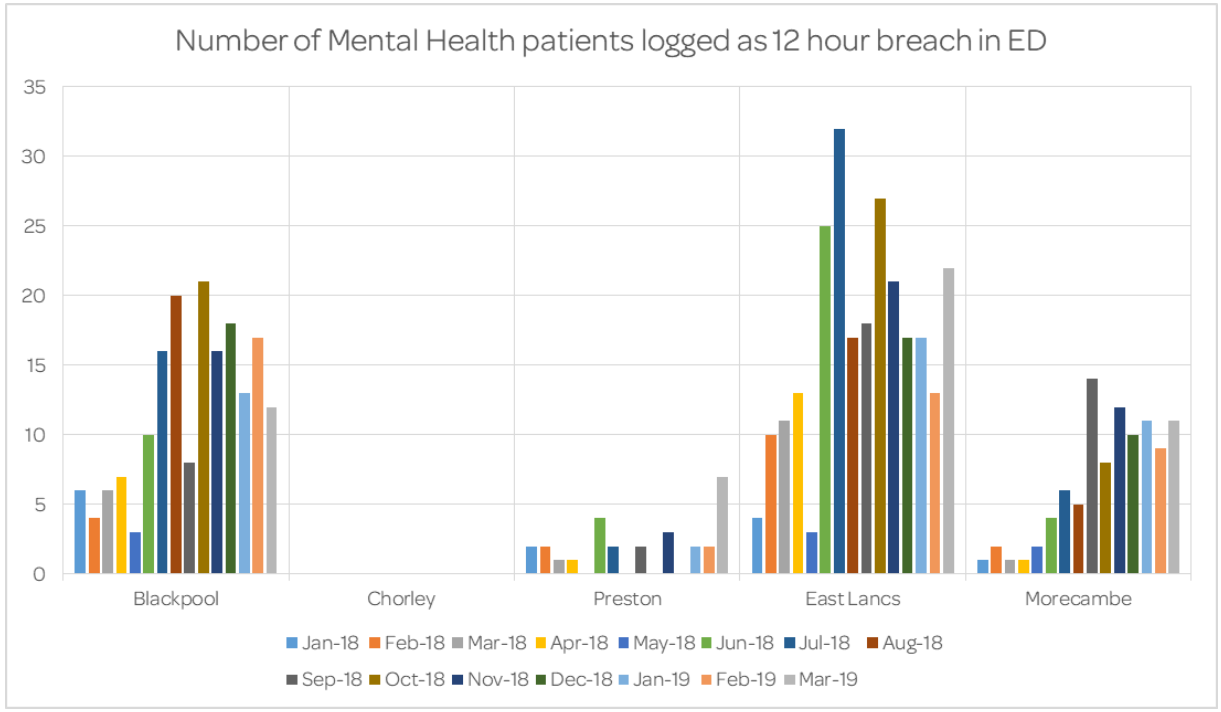
What did the Peer Review visit to the Royal Preston Hospital Mental Health Decision Unit (Arkwright) tell us?

- *This MHDU is staffed 24 hours with both a Nurse and staff from the Richmond Fellowship - accepts mixed sex referrals*
- *The length of stay for Service Users in the MHDU is meant to be limited to 23 hours, however some of those present had been there for 5 days. It was noted that, during their stay on the unit, Service Users can access support for benefits and housing and can leave the unit at any time on leave and return there whilst waiting for an inpatient bed*
- *In a similar way to the Section 136 suites which were also visited by the Peer Review Team, Service Users can be restricted in terms of movement following a best interest assessment. This would depend upon the risk to self and/or others and the Service User's capacity, but is without any legal framework*
- *The Service Users that were on the MHDU following an initial assessment were all awaiting admission to an inpatient bed, but had not had any further assessments to ascertain whether this admission was still appropriate after the significant delays. It was the view of the visiting clinical team that the MHDU is becoming a holding area for Service Users waiting for often many days for inpatient admission*

What does the data on Emergency Department (ED) flow tell us?

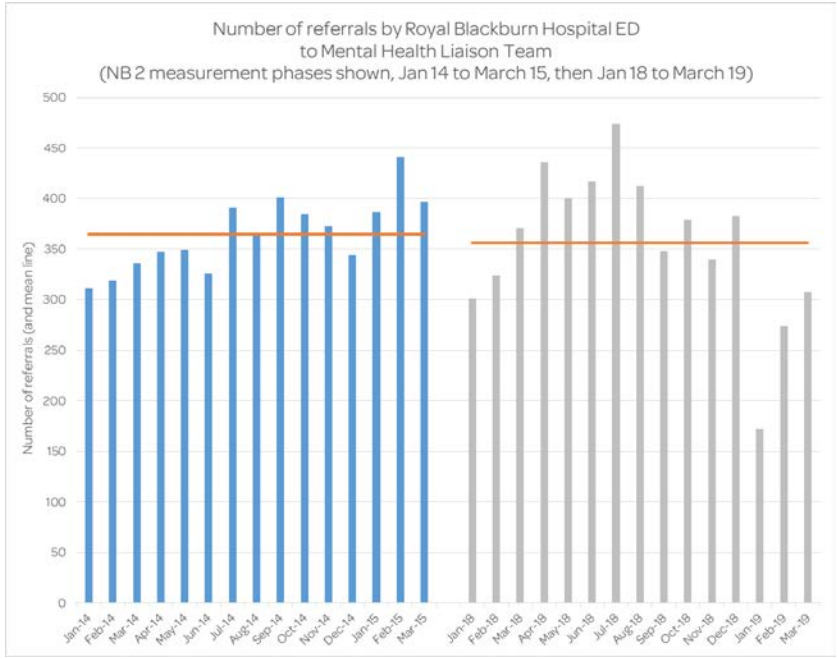
We can see that the number of patients waiting more than 12 hours in ED to be seen by Liaison is highest in East Lancs, with significant numbers also being noted in Blackpool and Morecambe.

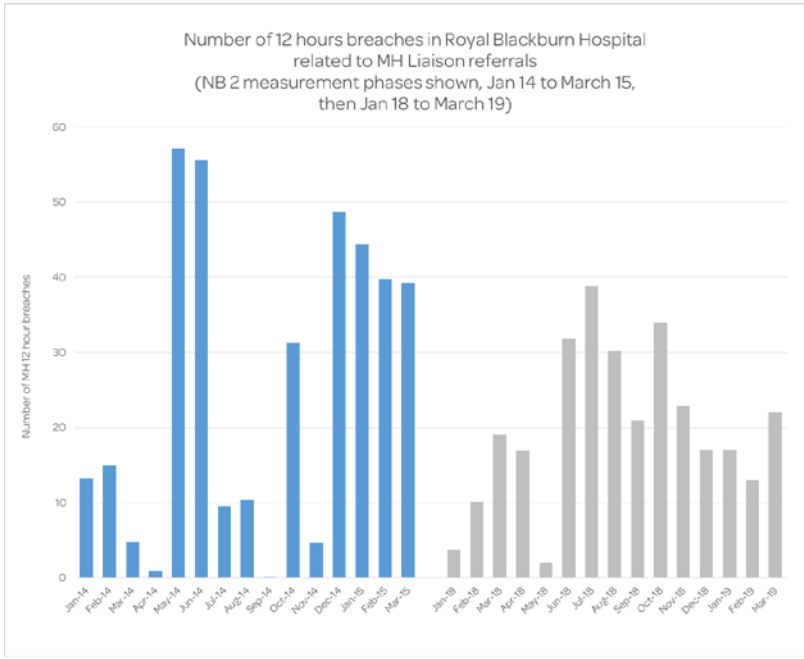
While breaches appeared to be reducing over the winter months in general, numbers recently increased in March again in East Lancs - in that same month, the conversion rate from referrals made to patients being seen by Liaison in East Lancs was only 59%. This is explored further on the following page.



What does the data on Emergency Department (ED) flow in East Lancs tell us?

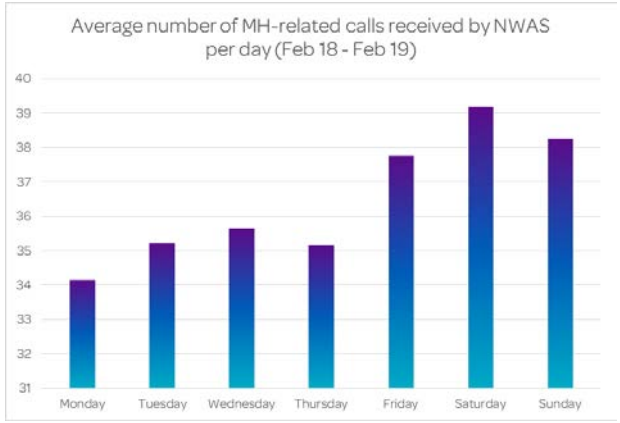
While footfall into Blackburn's Emergency Department doubled from 2015 (8900) to 2018 (17,700), referral rates from ED to their Psychiatric Liaison team are reasonably static, with a potential recent downturn which should be monitored. We can see below right that the number of 12 hour breaches related to Liaison referrals here is significantly less now than in previous years, but that they are happening more consistently.



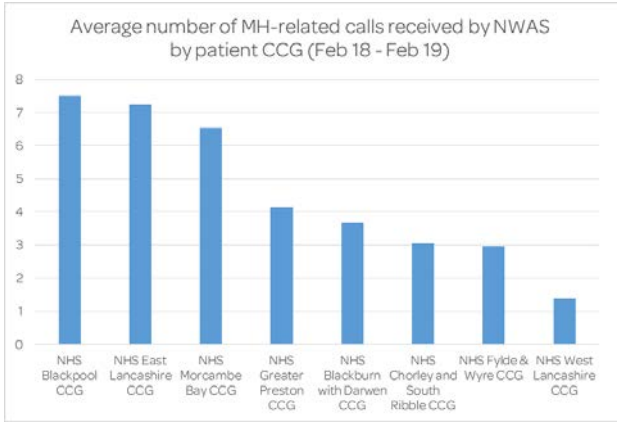


What does the data from North West Ambulance Service (NWAS) tell us?

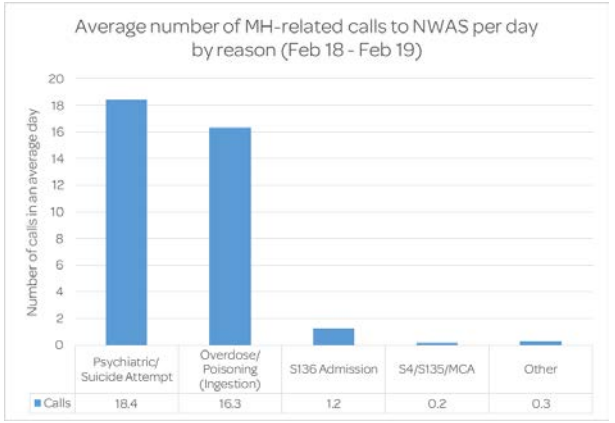
NWAS receives an average of 37 calls per day in Lancashire which they attribute to Mental Health issues (1% of total volume), with demand rising towards the end of the week



Blackpool generates the highest demand on NWAS, which is in line with the significant prevalence in this area



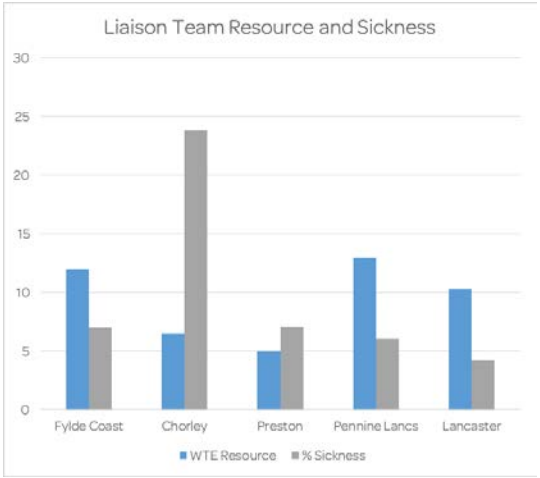
Most calls relate to suicidal ideation and/or overdose, with an average of 1.2 calls per day relating to S136 transport across Lancashire. Triage processes were not explored in this exercise but would warrant consideration



Data published in The Guardian in 2017 by the then Labour MP Luciana Berger revealed a marked increase nationally of 23% in the number of people Ambulance Services responded to in a Mental Health crisis: from 140,137 in 2015/16 to 172,799 in 2016/17, resulting in over 200,000 hours support (up 32% between years)

What does the data on Adult Liaison Teams in EDs tell us?

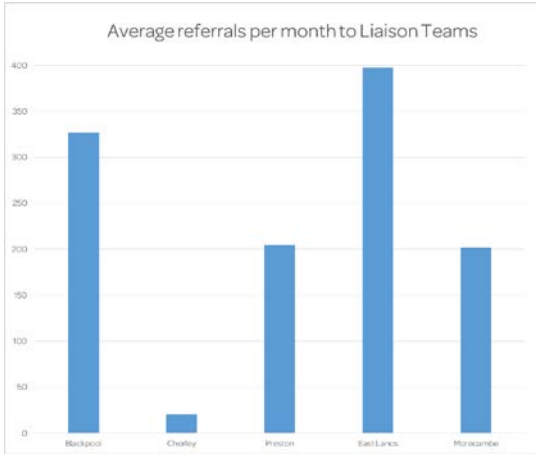
Staffing capacity in these Liaison teams may hinder their ability to provide support 24/7 to ED as well as support to Inpatient wards, and is compounded by sickness rates in some areas



Chorley is an outlier in terms of demand, felt to be due to the transition from having an ED to having an Urgent Care Centre

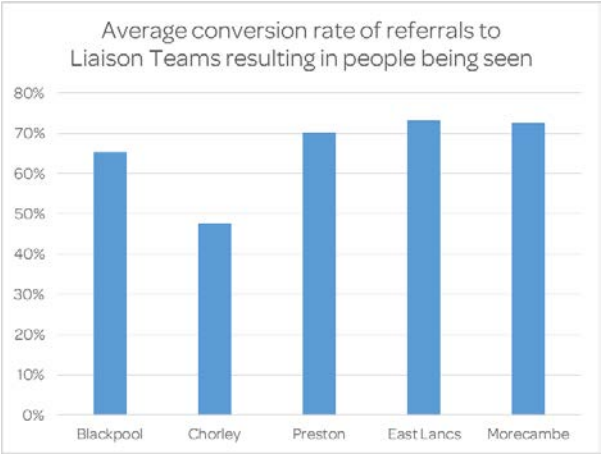
Resource levels in the chart to the left do not correspond to demand shown below

(NB service naming conventions in data sources vary)



With the exception of Chorley (43%), the majority of referrals to Liaison Teams come from Emergency Departments (77%) and not inpatient wards

LCFT data indicates that the overall conversion from referral received to being seen face to face is lower than might be expected, at 62% on average – this warrants further exploration



What does the data from the MHDUs tell us?

With low daily referral rates and an average length of stay longer than the recommended 23 hours, the significant challenge faced in MHDUs is their internal capacity and flow, which links to flow in the wider system. Staff recorded this data in spreadsheets, with their headings noted in quotes below, and reference given to low completion rates of relevant documentation.

MHDU data (April-Dec 18)	Daily Referral Rate	% of referred patients who are 'open to services'	Median Length of Stay in MHDU (expected is <23hrs)	Maximum Length of Stay in MHDU	% outcomes (relating to largest onward referrals, admissions or discharged to GP)	% who have a 'Safety Plan'	% who have a 'Support Plan'
Arkwright (6 Chairs, Preston)	1.3	65%	2.3 days	15 days	34% to Crisis Team 24% to Crisis House 11% admitted (gaps in data regarding discharge to GP)	24%	22%
Blackpool (4 Chairs)	0.5	67%	1.3 days	21 days	39% to Crisis Team 28% to Crisis House 15% admitted 15% to GP	23%	24%
Towneley (6 Chairs, Blackburn)	1.8	69%	2.1 days	12 days	32% to GP 22% to Crisis House 18% to Crisis Team 14% admitted	21%	24%

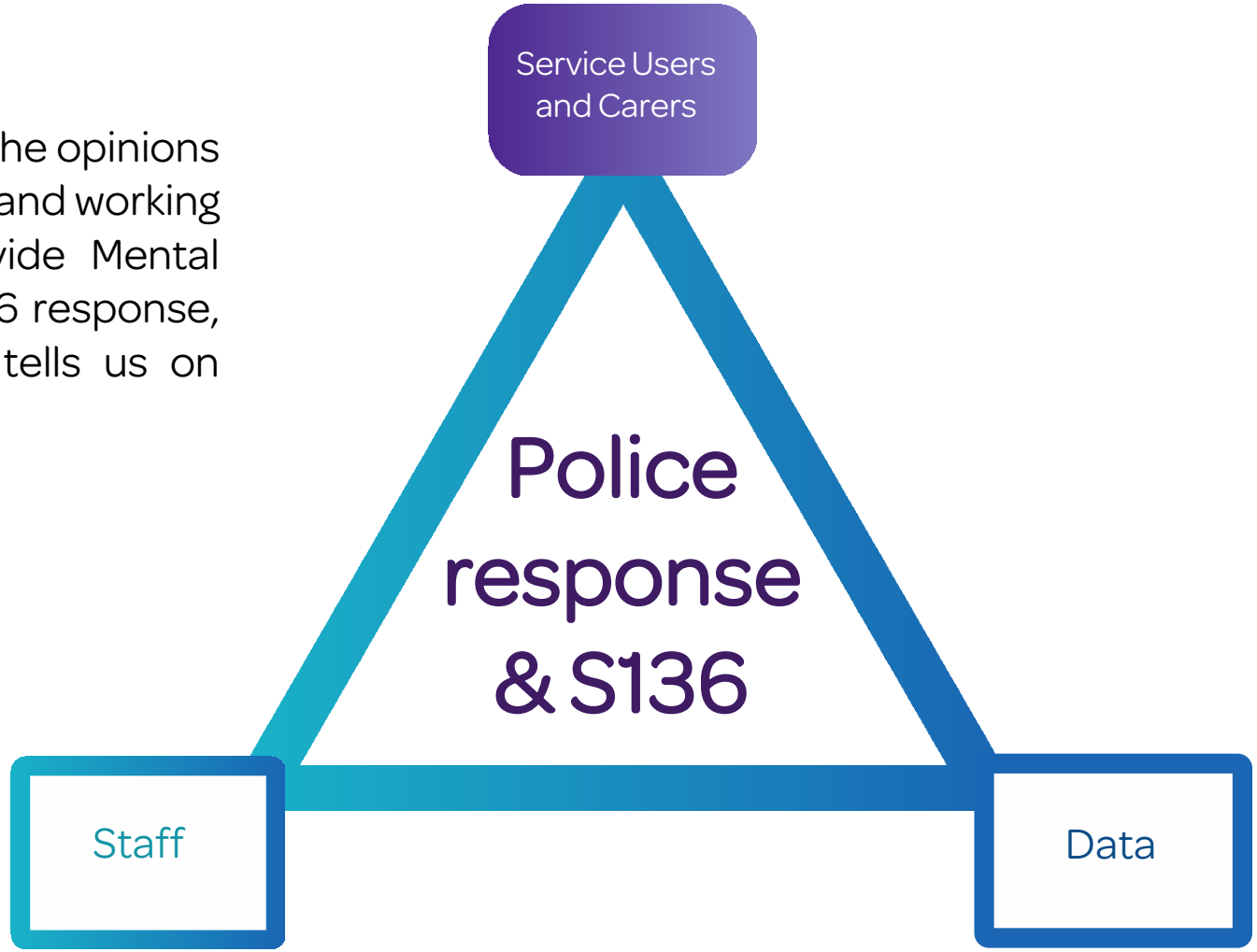
Triangulation of Opinions and Data on Emergency Departments, Liaison and Ambulance Services and MHDUs:

We can see, from a comparison of the data with the opinions of those using and working in services, that:

- *There is little alternative to attendance at the Emergency Departments, for adults and younger people, and little compassion is perceived*
- *Staffing is limited in Liaison Teams and capacity struggles to meet demand - use of clinical time in these services is often inappropriately focussed, with observation highlighting significant opportunities to reduce waste around referral handling and administrative tasks. Relationships between LCFT and Acute Trusts are strained*
- *There are MDT working challenges described, with limited medical input which may be linked to legal challenges around detention in MHDUs*
- *10% of patients referred to Liaison teams wait over 12 hours to be seen, something which is becoming a more regular event in the ED departments at Blackburn, Blackpool and Morecambe. The low conversion of referral to Face to Face contact in Liaison teams warrants further exploration at depth*
- *While Ambulance services staff report significant challenges with Mental Health support calls, NWAS takes 1.3 million calls in a year, of which 1% are attributed to Mental Health issues – with 37 of these calls in an average day in Lancashire CCGs, 1.2 calls result in S136 transportation being provided by the Ambulance service. The impact of their involvement in the 'Psynergy' Street Triage Pilot is to be determined*
- *MHDU challenges result from poor flow, not excessive demand, with limited onward options and long stays*

Review Section 2:

Here we will consider the opinions of those experiencing and working in services that provide Mental Health Act Section 136 response, alongside what data tells us on flow of patients



What are Service Users and Carers saying about Police response and S136?

- *'Sectioning' has been used as a threat by a range of professionals across the system including Police*
- *Shouldn't have to call the Police in a crisis, very little alternative available*
- *We can see that the Police are stretched, and while their response can be helpful and supportive, a greater degree of compassion and understanding of what's needed would be welcomed – individual Service Users are quoted as saying that Police Officers are "sometimes too heavy-handed"*
- *When attending to crisis at home, limited compassion, respect and engagement has been experienced from the Crisis team, from Ambulance and Police staff, for the Service User and their family*

What are staff from across the system saying about Police response and S136?

- *Police are not always respectful of the individual, their understanding and how they should be involved in their care and support planning – threats used in some instances*
- *Service Users shouldn't have to be picked up by the Police just to get help - the system is criminalising people with Mental Health problems and that is wrong – less detentions needed; Police shouldn't have to take people to ED and 'guard' them because S136 suites are full – support people sooner in community services*
- *Section 136s regularly expire after 24 hours without review or plan - people get stuck in S136 suites for days*
- *'Street Triage'–type functions would improve and reduce Police interactions with Service Users; rapid response is needed to reduce admissions, S136, etc.*
- *Inconsistent and inaccurate communication between staff/providers creates risk which Police then get pulled into*
- *Need safe places to go that aren't ED; need a plan for those with substance/alcohol problems too*
- *In research carried out by the University of Central Lancashire, Police Call Takers were noted to offer guidance and signposting around Social Care issues to many callers, with those in the early hours of the morning more likely to relate to suicidality and S136 responses*
- *Criminal Justice Liaison and Diversion staff in LCFT are felt to be supportive to Police colleagues with good relationships, but report that on average only 20% of their time is spent Face to Face with Service Users, with significant administrative tasks to undertake*

What did the Peer Review visit to the Harbour S136 Suite tell us?

- *The suite was in use at the time of visit and so it was not appropriate to access. Staff described the suite as having a lounge area, a bedroom and a seclusion suite. This is the only Section 136 Suite within LCFT which is staffed 24/7*
- *It was identified that it was common practice that the Service User would remain in the suite until an inpatient bed had been allocated. At this point, the Approved Mental Health Professional (AMHP) would then make the application for an appropriate section of the Mental Health Act. This often results in long periods of time (in many cases, several days at least) when the Act is not in place leading to the Service User not having the safeguards which the Mental Health Act provides in place, i.e. access to an Independent Mental Health Advocate (IMHA), right to a Tribunal, etc.*
- *For Service Users who are assessed as having capacity to make decisions this is not an issue, but for those Service Users who are deemed at risk to themselves or others or lacking capacity, a Best Interest Assessment is used for each shift in order to restrict their movement, support administration of medication and the use of seclusion when appropriate*
- *It was unclear if this assessment is part of the Mental Capacity Act, and staff were aware that this approach is not supported by any legal framework. They stated that there was an escalation process for when this happens, however noted that this is "the norm and not the rare occasion". Both the Bed Manager and Matron confirmed that this position is acknowledged and supported by senior leaders within the Trust*

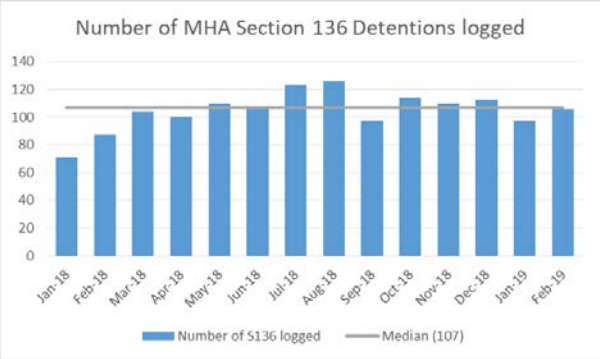
What does the data on S136 usage tell us?

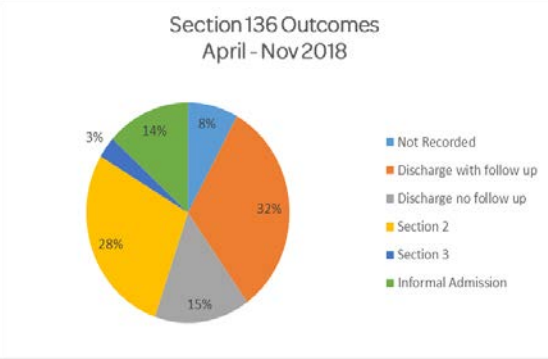
While the number of S136 detentions has risen significantly over recent years, we can see from the chart below that it has become stable at an average of 107 per month (3.5 per day) – the 'Psynergy' Street Triage Pilot is not Trustwide and so little impact has been seen on the overall totals yet. Of these detained individuals, over 90% were known to LCFT services in the past 3 years

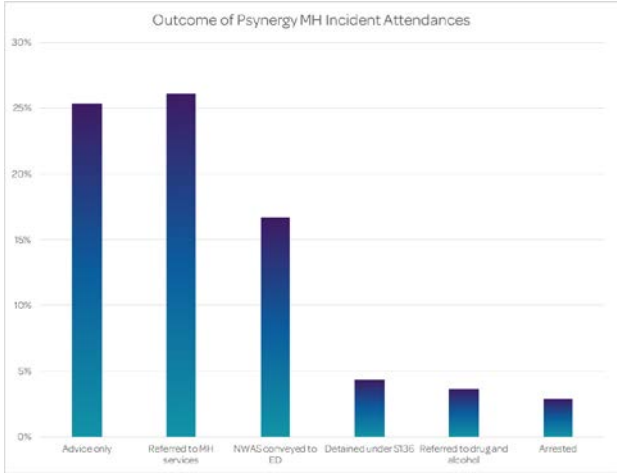
Approximately 31% of S136 cases were formally admitted to a bed, and of those discharged, 2/3 were followed up.

Examples were given of S136 detention without follow up include a number of individuals actively attempting suicide

The 'Psynergy' Pilot has been running in Blackpool since 1/12/18, with an average of 4 incidents per day logged. ¼ of those only required advice, and a further ¼ were referred to MH services. 60% of incidents required the presence of a MH Nurse, with 40% requiring Ambulance support (including transport), and 40% requiring Police support/intervention – a 44% decrease in total Police activity around S136 was seen in the first 45 days







The Chief Constable of Lancashire has been quoted in saying that, in 2017/18, 20,000 Officer response hours, or 29% of **all** response time, was spent on Mental Health crisis calls

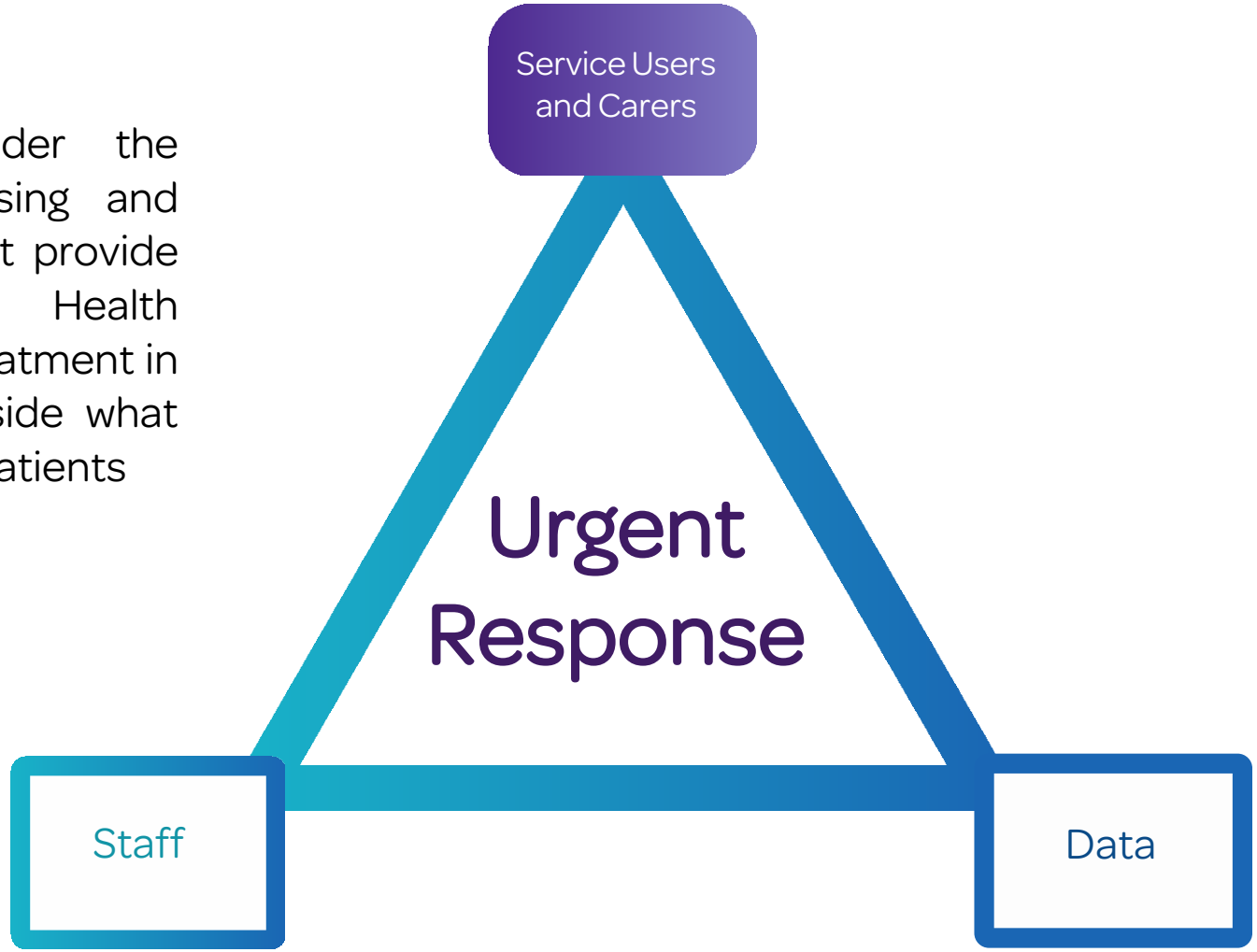
Triangulation of Opinions and Data on Police response to Mental Ill Health and use of Section 136:

We can see, from a comparison of the data and the opinions of those using and working in services, that:

- *More compassion and respect is needed for Service Users and families from staff across the whole system – Service Users can see Police staff are stretched in their tasks, and not always appropriately used – individuals shouldn't need Police attendance to get help from Mental Health services*
- *Inaccurate and inconsistent communications across the system create risk for everyone*
- *Of the 107 detentions per month, 31% are formally admitted; of those discharged, 1/3 receive no follow up – examples are noted of S136 detention without follow up including a number of individuals actively attempting suicide*
- *S136 detentions regularly expire without review, and individuals remain in those suites for many days waiting for a bed – legalities around this have been brought into question*
- *The 'Psynergy' Pilot with Police, Ambulance and Nursing staff is beginning to show positive results, and further analysis of impact and Service User feedback would be helpful before expansion is considered*

Review Section 3:

Here we will consider the opinions of those using and working in services that provide crisis/urgent Mental Health response and home treatment in the community, alongside what data tells us on flow of patients



What are Service Users and Carers saying about Urgent Mental Health Response?

- *Lack of available, skilled Crisis support in your own home when your needs are urgent - unresponsive, messages not answered, long waits, several weeks in some cases*
- *Postcode lottery*
- *Crisis treatment described as being "told to have tea and a bath", nothing more productive, limited compassion, engagement*
- *'Sectioning' has been used as a threat by a range of professionals across the system*
- *There is no service for 16-18 year olds*
- *Carers views/needs not explored or supported*
- *There is a need for a phone number which is always answered by staff who are respectful, compassionate and skilled, and who can respond to the needs of Service Users and families. Need more proactive support for families, including children*

What are staff saying about urgent Mental Health support?

- *Lack of 24/7 crisis response has a significant impact on the care and support that can be delivered across the system - need to improve the response and the Home Treatment delivered to those in crisis, and ensure there are enough staff to do the job well*
- *Advice Line response is limited for professionals - GPs would like to access clinical expertise quickly to discuss referrals and issues*
- *Too many differences of opinion, Service Users bounced between services, postcode lottery*
- *Interventions are too late, and are not holistic – too reactive; lack of psychological interventions available*
- *Resources and skill mix should match demand - more focus on care and support, and less on paperwork: staff in Home Treatment Teams (HTTs) reported spending an average of 25% of their time face to face with Service Users, which is echoed by system data*
- *Systems are falling down, and IT equipment is slow and old - need enough Admin staff doing the right tasks with the right skills so Clinical staff can work effectively*
- *GPs described the definition of 'urgent' as what the service can provide at that time, not what it means for the individual and what response they need*
- *Need a full 24/7 response to need, one access point, one team that Service Users and Carers can contact directly – no wrong door, more listening to Carers, rapid response when the Service User is in crisis – comprehensive Home Based Treatment options*

What are staff saying about urgent Mental Health support in Blackpool?

- *Blackpool is unique in that it operates a partnership access model, where referrals for urgent response are handled by the Single Point of Access operated by Blackpool Teaching Hospitals, while the Crisis Team is part of LCFT. SPA operates Monday to Friday, 9-5, and beyond these hours has an answerphone which directs callers to ring the Crisis Team*
- *Referrals are only accepted from professionals, which limits these to operational hours*
- *Following triage in SPA by clinicians, crisis referrals passed to LCFT are held for what is now a twice daily meeting, where all are discussed and re-triaged by an MDT before a decision is made on whether the person is to be seen or not – this appointment is taking place within 24 hours if agreed. 'Rejected' referrals from the afternoon MDT may be passed back to SPA close to the end of their operational hours, leaving those SPA staff to make alternate plans at short notice for Service Users whose GP or other professional has requested urgent support*
- *Service Users describe not getting an answer when they ring the Crisis Team directly, the inability to self-refer in crisis, and little home support*
- *Carers describe minimal support, even less so in a crisis*
- *Staff in Listening Events described contacting the Crisis Team as difficult, and note that the Community Mental Health Teams (CMHTs) feel like it absorbs some of Crisis Team's work; staff and GPs also described the SPA as a 'barrier' to accessing services rather than a help*
- *Senior leadership in the system is considering a review of the approach in this locality*

What did the Peer Review visit to the Blackpool, Fylde and Wyre (LCFT) Crisis Team tell us?

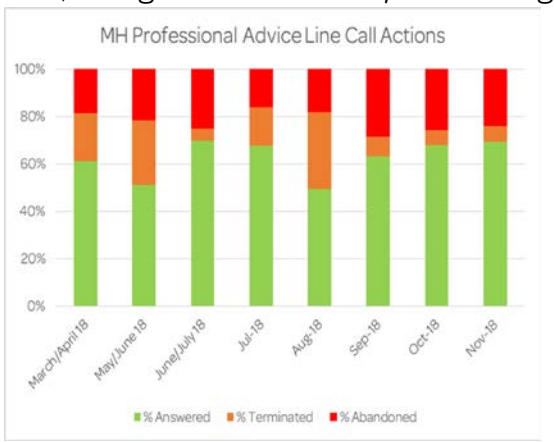
- *Noted that the team still has vacant posts although has recruited some new starters*
- *The team has released a staff member to take up a Street Triage role (from January 2019)*
- *Telephone triage takes place 24/7*
- *All cases are received from SPA triage are re-triaged at a twice daily MDT and once a referral has been through that process, a Face to Face appointment is arranged within 24 hours*
- *Following assessment, an MDT discussion is again held at those twice daily meetings to decide if home treatment is to be offered, or signposting elsewhere*
- *Home treatment generally lasts up to 6 weeks, with some people seen daily or more than that, others every other day or weekly*
- *The team does not play an active role in facilitating discharge from Inpatient wards, but does carry out follow up appointments on discharge*
- *The team are the 'gatekeepers' of all admission to beds, but noted that this is not a Face to Face role in most cases; they describe not being informed or involved in all admission assessments or S136*

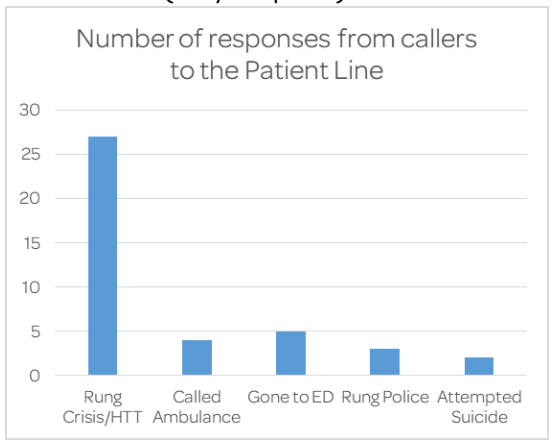
What does the data on calls to Mental Health response lines tell us?

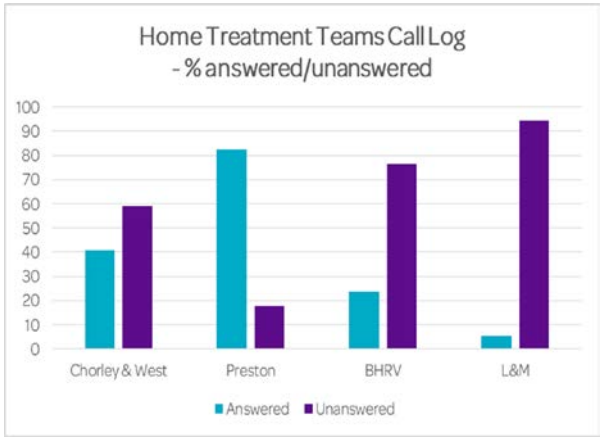
Significant challenges exist across the system is gaining a response to a telephone request for help or support, whether you are a professional, a Service User or Carer - of those Service Users asked what the alternative would have been if they hadn't rung the Patient Line, most replied that they would have rung the Home Treatment Team, but data indicates struggles to get a response in ¾ of teams (chart shows May-Oct 18).

A small number of callers surveyed noted that attempting suicide may have been their alternative to calling.

In relation to whole Trust data supplied by LCFT, the number of completed suicides per quarter from Q2 2017/18 onwards ranging from 10 to 14, falling to 3 in Q1 of 2018/19 but rising again to 11 in Q2 (July-Sept 18)



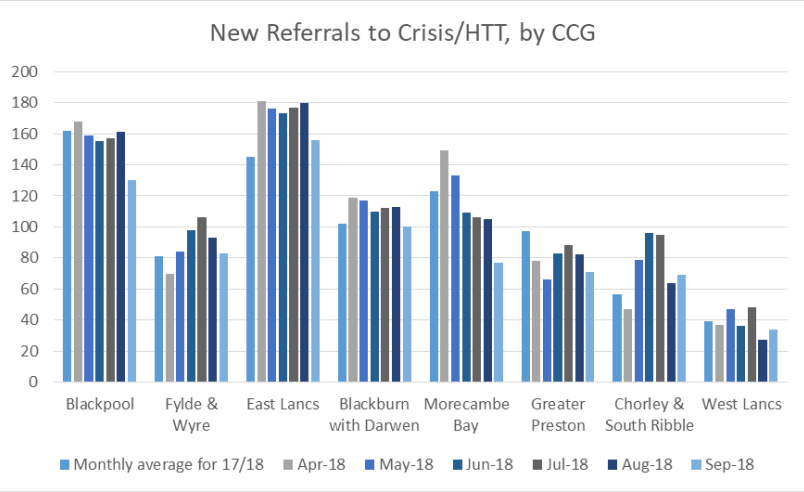




NB MHPAL Calls 'abandoned' are those where 'the caller hung up before the phone was answered'; 'terminated' are 'when there is not a practitioner logged onto the telephony system'

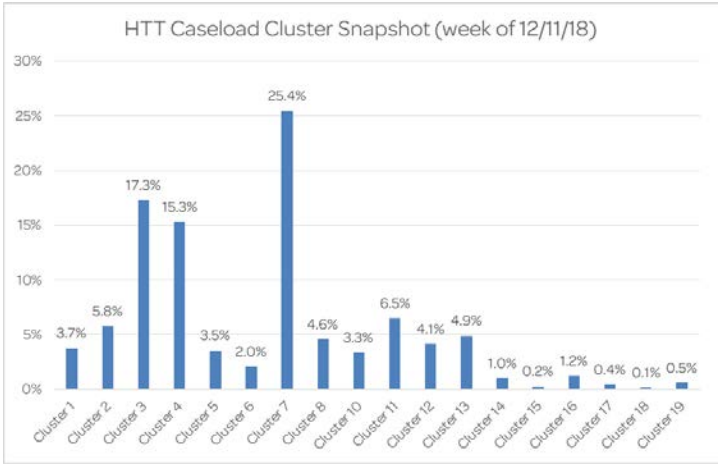
What does the data on urgent Mental Health response teams tell us?

Referral demand on Crisis/HTTs varies significantly by CCG, and does not correspond entirely to prevalence data previously shown, or indeed with staffing levels in these teams



In taking a snapshot of the Clusters of patients across the HTTs, we can see that, while the highest numbers of patients are Cluster 7 (enduring Non-Psychotic Disorders, high disability), there are significant numbers of Cluster 3 and 4 patients (where Primary and Secondary Care CMHT services usually interface). One may expect more Cluster 8 (Personality Disorder) and Clusters 14-17 (Psychosis, high need) patients to be seen in Crisis Services. It is noteworthy that an audit of a sample of records showed 22% of patients were not Clustered, and more exploration is warranted.

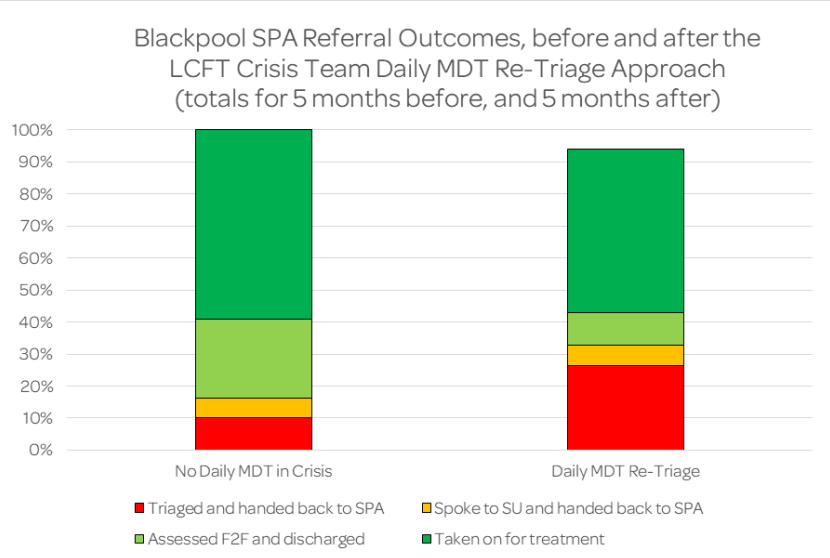
Analysis of the 'Health of the Nation Outcome Scores' (HoNoS) within the Clustering snapshot also indicates low levels of patients scored 'moderate' or 'severe' on at least one HoNoS question – this again indicates more lower levels of need in this patient group than may be expected. From the notes audit, pathways of treatment were not always clear and did not always match the Cluster assigned.

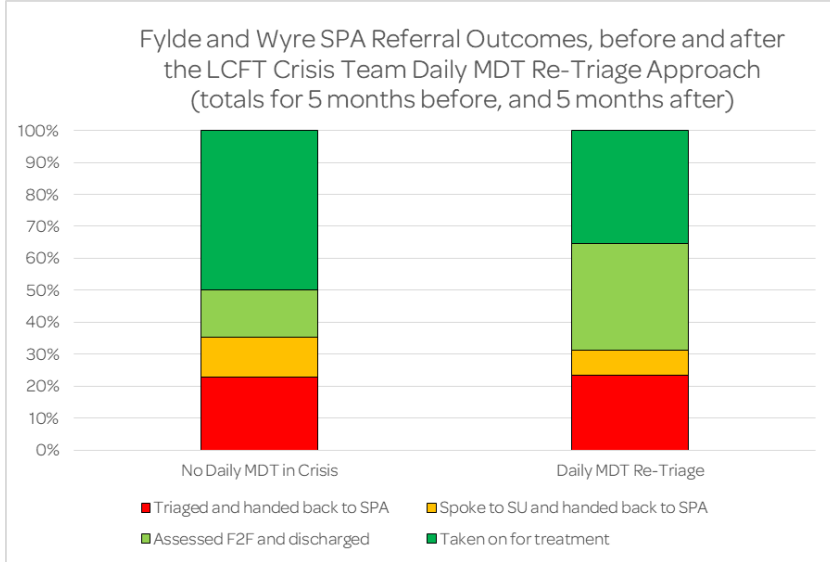


What does the data on urgent Mental Health response in Blackpool tell us?

Following issues raised around referral triage quality in Blackpool Teaching Hospitals SPA, LCFT's Crisis Team introduced a re-triage step into their pathway in October 2018, with a now twice daily full MDT which discusses all referrals that SPA have triaged and sent to them.

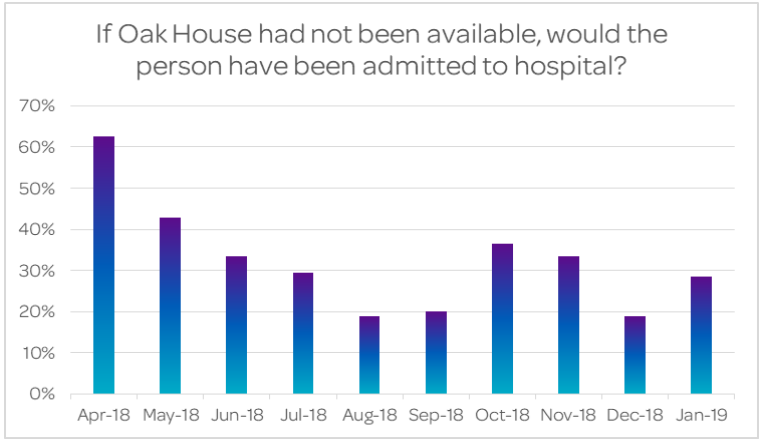
The outcomes of this re-triage step can be seen below, with many more referrals being handed back to SPA than before in Blackpool, compared to F&W who are now assessing more individuals then discharging without treatment. Senior leaders from across the provider organisations are keen to explore this interface in more depth, to minimise 'hand-offs' between providers and delays for Service Users





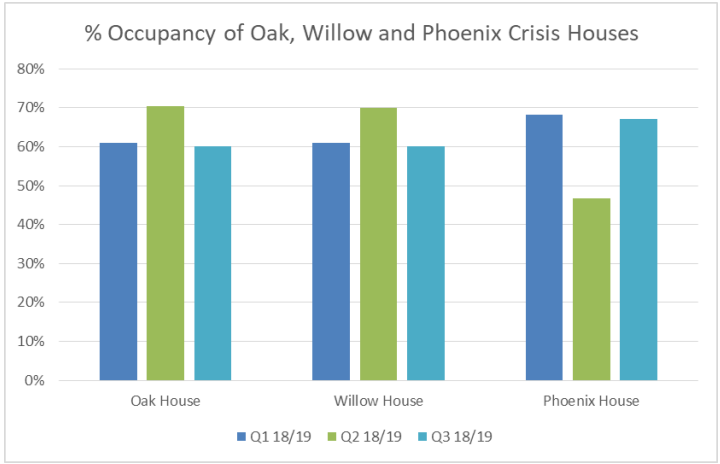
What does the data on Crisis Houses tell us?

Oak House, East Lancs x 5 beds is operated by Richmond Fellowship – staff recorded their judgement on whether the individual would have been admitted in the absence of this alternative



While Oak House and Willow House in East Lancs and the Phoenix service (4 beds in Blackpool) are valued, there does appear to be significant capacity to take more referrals when we consider occupancy levels shown below (NB data on Phoenix shown below is slightly skewed by additional respite bed provision (+ 2 beds) which can be used in crisis if required).

Local Authority Commissioners of Phoenix also note the presence of Gloucester Avenue in Blackpool, a respite facility which has moved from serving the needs of older adults who have been in long term hospital placements, to younger individuals with drug and alcohol issues – a common theme in Blackpool which correlates with prevalence data, and challenges around substance misuse pathway delivery noted



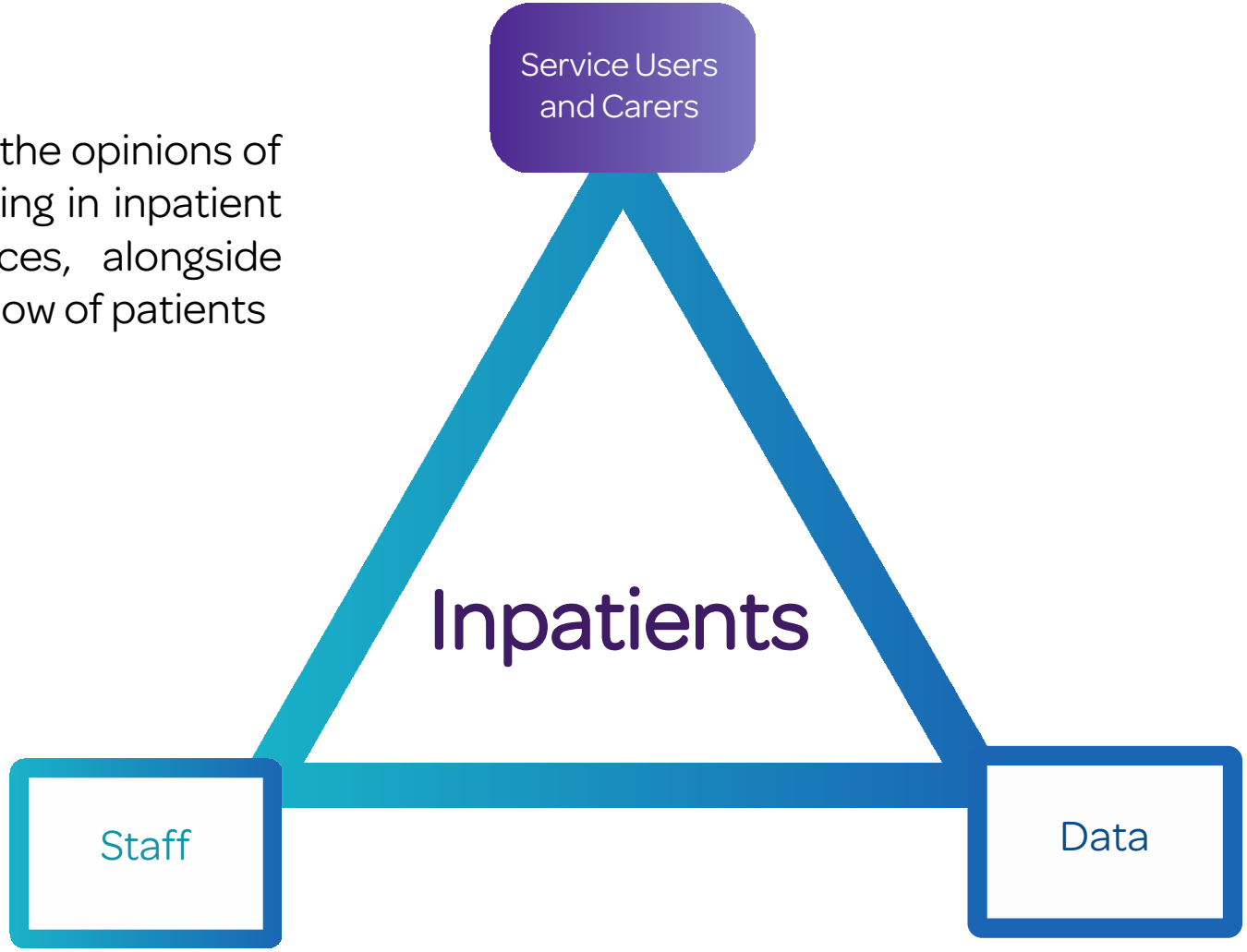
Triangulation of Opinions and Data on Urgent Mental Health response services:

We can see, from a comparison of the data and the opinions of those using and working in services, that:

- *There is a lack of crisis support and home treatment pathways delivered at home, for adults and younger people, with many individuals feeling they have no choice but to attend Emergency Departments or ring 999 for support*
- *Suicide rates average at 4 per month*
- *Clinical time spent face to face with individuals averages at 25% of available staffing*
- *Carer needs are not explored or supported proactively, and even less in a crisis*
- *Telephone responsiveness is poor, with answerphones and high proportions of calls made by Service Users, Carers and professionals requesting help going unanswered*
- *Blackpool's Single Point of Access interface with the Crisis Team warrants further exploration, as additional steps and delays have been built into the system because of differences in opinion over referrals. The Crisis Team holds referrals for several hours before MDT discussion and has a 24 hour response target in which to see patients face to face*
- *Evidence does not support the caseloads of these services being focussed on those with the most significant need*
- *Crisis Houses in the region have bed capacity averaging at 38% but patients are often held in MHDUs or S136 suites while waiting for admission – there are limitations in when Crisis Houses will accept admissions, due to staffing levels at night*
- *Crisis Teams are not at the forefront of admission 'gate-keeping' and do not actively facilitate discharge from wards*

Review Section 4:

Here we will consider the opinions of those using and working in inpatient Mental Health services, alongside what data tells us on flow of patients



What are Service Users and Carers saying about inpatient Mental Health services?

- *Long waiting times for beds means we become more unwell while we wait, often looked after at home by family without any support to them, or stuck in ED or MHDUs*
- *Carers views/needs not supported on wards*
- *Too much variation in quality of inpatient wards, staffing levels and their skills, assessment is OK but limited treatment or activity, very little rehab offered – we don't feel safe on many of the wards; some wards are open dormitory, some shared rooms, so very little ability to sleep or recover*
- *Challenges in trying to stay local to family when admitted, as beds are rare and family support is important to recovery*
- *When admitted, had rights explained at a time when they were not well enough to understand and discuss, and these were not repeated when they were well enough to understand; Panel meetings held without preparing the individual, or inviting Carer or Care-Coordinator – walked into the room expecting one individual and it was full of unknown people*
- *Staff on some wards spend too much time sitting in the offices so patients have to look after each other, whereas other wards do get it right in helping you to feel safe and supported, checking on you discreetly*
- *Why are all wards not consistently good and learning from each other?*

What did the staff say about inpatient services?

- *Closed beds at the same time as reducing community services. Services are hospital-based and not community-delivered as they should be. Service Users should be given a bed when needed, and not 'admitted to a chair' for several weeks*
- *The system is running a 'musical beds' and not a proper treatment service; discharge is resource-driven not clinical, beds are not used to help the right Service Users*
- *Those with personality issues are being medicalised and put in wards which is not appropriate*
- *Inpatient wards wait until they have discharged the patient then ask GPs to make referrals for treatment – why could they not do this?*
- *Consultants dividing their time between inpatients and community means there is less time for them to spend quality time with either – mixed medical model across localities with differing results*
- *Lack of Occupational Therapists and activities on wards*
- *There is a need for appropriate, high quality inpatient wards with the right staff and skill mix, and better step up/down and rehab options; Physical Health should be as important on Mental Health wards, but is not; more step up/down and rehab services are needed – why no rehab beds?*

What did the Peer Review visit to the Bed Management Hub tell us?

- *The Clinical Practitioner within the Bed Management team prioritises the location of beds based on clinical risk - it was stated by the team that Senior Leadership have advised that when Service Users in ED are breaching their waiting targets, those Service Users are the main priority for MHDU allocation and/or bed allocation, even if risks are lower*
- *During the visit, 22 Service Users were awaiting beds, 19 male and 3 female Service Users - 70% of these Service Users had a diagnosis of EUPD, whilst only 30% were suffering from a psychotic illness. Staff expressed views that, as there is currently no tangible Personality Disorder (PD) pathway, and the view that Medics are risk averse in relation to home treatment for these individuals, many Service Users with EUPD are admitted to hospital. LCFT, supported by AQUA, are working to develop this pathway*
- *Some Service Users had been waiting for a bed in S136 suites for 5 days and in MHDUs for 8 days at the time of the visit, some utilising leave on a daily basis*
- *54 Service Users were in out of area beds. It was identified that there were 5 vacant posts for discharge facilitators which reduces support to the flow of Service Users within the inpatient wards*
- *Staff noted that it is common practice in MHA assessments that medical recommendations were completed but the AMHP application would not be made until a bed was available/allocated. The Service User would wait in the Section 136 Suite or the MHDU and a best interest assessment would be used to restrict a Service User if appropriate. In many cases, the medical recommendation would then expire and further assessment would need to be completed whilst the Service User continues to wait for the bed.*

What did the Peer Review visit to inpatient Mental Health services in LCFT (Edisford & Ribble) tell us?

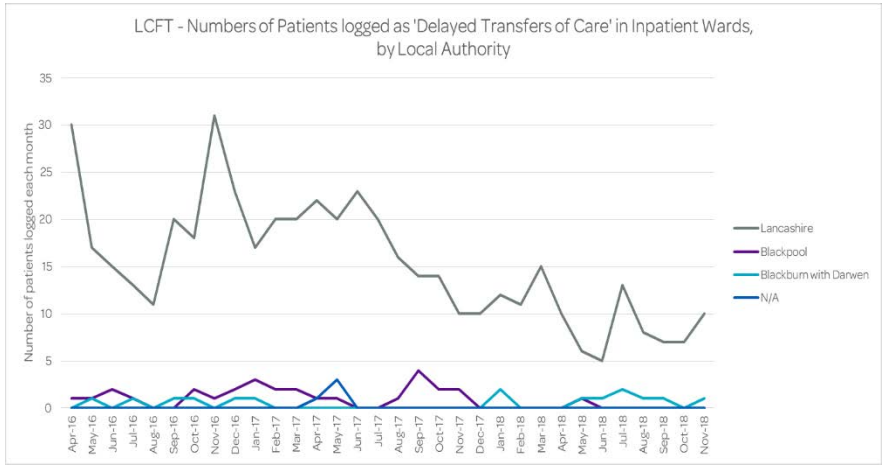
- *80% of Service Users admitted to these Assessment Wards at the time of the visit had a diagnosis of EUPD. For these Service Users, the ward described trying to work on a 3-5 day admission for assessment, but that it is often 7-14 days before being discharged or transferred to the treatment ward (assuming beds are available)*
- *It was noted that, with a cover system in place, Consultants do not attend the wards at weekends to review Service Users and so there is generally no movement of Service Users; staff described inconsistent medical support due to recruitment and retention issues*
- *A common practice described across all of the wards is not to offer overnight leave to informal or detained Service Users, even to support the testing of Service User progress. Day leave was actively used but not overnight as the bed would be allocated to another Service User*
- *The male assessment ward (Ribble) was in need of refurbishment, in part due to a recent incident with a Service User*
- *The female assessment ward (Edisford) has recently moved and appeared clean, spacious and newly furnished. It not have a seclusion room so the Service User must be escorted out of the ward, down two flights of stairs, out of the building and across a public walkway to the next building - staff described loss of dignity, and in the past, police have had to be called to facilitate the movement of the Service User*
- *When requesting information about length of stay, Cluster breakdown, number of admissions/discharges, etc. this was not readily available for discussion. There did not appear to be a criteria for admissions to the wards, or a clearly documented plan of what the admission expected to deliver for the Service Users, which can only hinder the flow through the inpatient service and wider system*

What does the data on inpatient flow tell us?

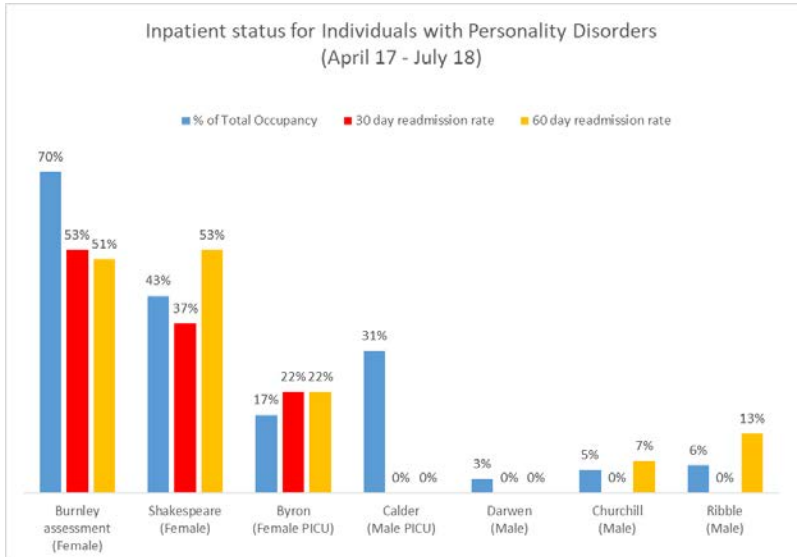
Average length of stay is around 40 days on many LCFT wards (less in out of area placements), with significant challenges faced around discharge.

As shown below, the largest numbers of 'delayed' individuals have been within Lancashire Local Authority, most of those being attributed to placement/housing need, and with a significant reduction in numbers waiting in recent years.

Fragmentation of pathways across Lancashire as a whole is notable, with no rehab beds, and limited Learning Disability and Substance Misuse options in the system.



Admissions of those with Personality Disorders is common across several of the LCFT wards, and for female patients on Burnley and Shakespeare wards, readmission rates within 30 and 60 days exceed 50%



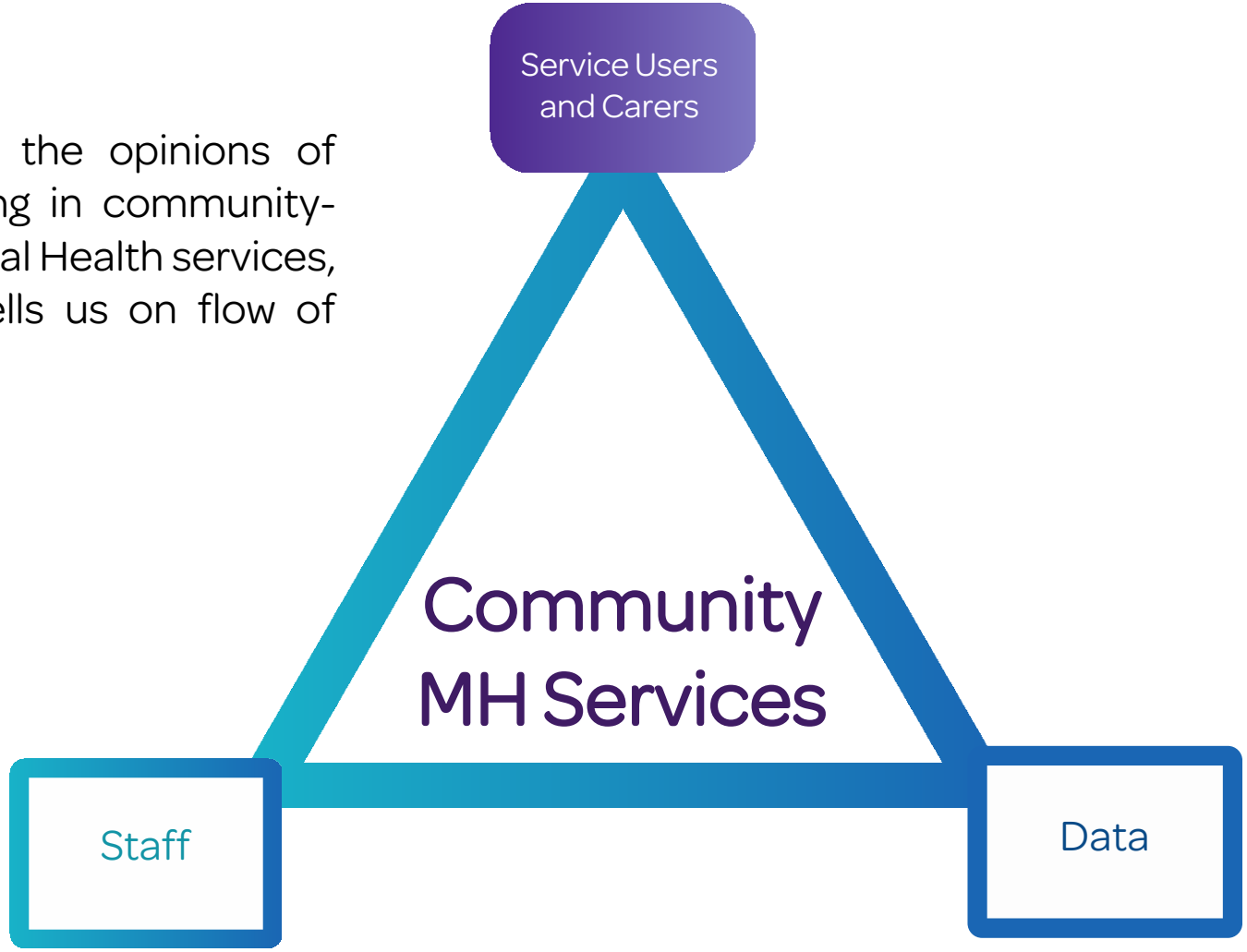
Triangulation of Opinions and Data on Inpatient Services:

We can see, from a comparison of the data and the opinions of those using and working in services, that:

- *'Sectioning' is described as a threat which is used across the system*
- *Long waiting times for beds means individuals are often supported at home by family and friends, who receive little support, and so when the person is admitted they are often more unwell. Added distress arises when the AMHP Assessment process is repeated after medical recommendations lapse without the bed being available*
- *Prioritisation of admissions is felt to relate to organisational pressures rather than clinical need/risk*
- *Medical input into inpatient services is mixed, and reviews are only available Monday to Friday which limits flow*
- *Service Users describe significant differences in quality and approach across inpatient wards – some have open dormitories and shared rooms which they feel hinders recovery, added to variation in staff available time – safety was raised as an issue on wards by many individuals*
- *The admission of individuals with Personality Disorders is a significant challenge for the system, with over 50% readmitted within 30 or 60 days in some areas – medicalisation of these individuals is felt to be an issue, and LCFT is working with others to develop an improved pathway in response to this*
- *When visited, inpatient areas could not easily articulate their criteria, purpose or performance – support in defining their remit within wider pathways would be of significant benefit, alongside standardisation of quality of care and environment*

Review Section 5:

Here we will consider the opinions of those using and working in community-based, non-urgent Mental Health services, alongside what data tells us on flow of patients



What are Service Users and Carers saying about community-based, non-urgent Mental Health services? (p1)

- *This is an 'Urgent Mental Health' review but community teams (Health and Social Care) should be the focus, before we get into crisis – you don't seem to have enough staff with the right skills and attitudes in community teams; long waiting times for community Mental Health teams*
- *There is no service for young people between 16 and 18 – why not? This is crucial!*
- *Links between Mental Health and Physical Health are very limited in general, and GPs have to do battle to get support for us, and to join up the pieces*
- *Psychiatry input is not delivering anything useful, and MDT communication and planning of treatment is poor, doesn't take into account the individual's wishes – it's arranged around the service. Very little psychological therapy/treatment available – private is the only option, as your waiting lists are several years. We have been told we have 'life-long problems', but there is too much medication, and not enough consideration of new approaches to treatment and recovery*
- *There is a significant gap between Mental Health and Substance Misuse services – told you can only be one or the other at once, but we are asking for support with both to aid recovery*
- *Carers views/needs not explored or supported – all services could do better with Carers and families, be far more proactive and save themselves time and effort in the long run*

What are Service Users and Carers saying about community-based, non-urgent Mental Health services? (p2)

- *Issues with consistency of engagement and support by Care Coordinators, who share their own work pressures with the individual, are not consistent in communication, or proactive in dealing with escalating needs. No input during admissions, no continuity of care. Examples given of caring, person-centred Support Workers who were supporting recovery but these were withdrawn.*
- *Autism service delivery and wider professionals' understanding of the challenges which individuals face is very limited*
- *Learning Disabilities services are very limited, and not felt to be supportive of families – those with both a Learning Disability and Mental Health issues do not have their Mental Health treated*
- *Inconsistent information on what services you can access – you get different answers to the same question. Better communications needed on what is available and where – false advertising about how helpful Mental Health services are should stop – sort out the services before telling people to use them*
- *We want respect, compassion and to be listened to – help us to help ourselves; we want our families and Carers to be respected, listened to, and proactively supported; we want to be able to self-refer/drop in for help, and get a quick and skilled response; we would like honesty and clear expectations of what is available and where.*
- *Remove the postcode lottery and improve services across the board - we want better community, crisis and inpatient services, for people of all ages and abilities – less waiting, better treatment, more psychological support. Care Coordinators should be proactive, and should challenge the failings in the system on behalf of their patients*

What are staff saying about community-based, non-urgent, Mental Health services? (p1)

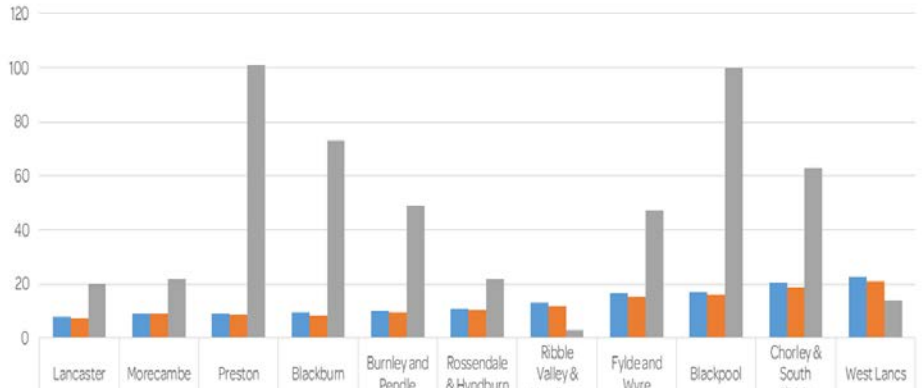
- *Pockets of good practice, good leadership and good relationships were described in every Listening session, but no consistency across the system*
- *Every conversation noted challenges in the culture, attitudes and relationships across the system, from Board to floor, with strong references to a blame culture in the system, a lack of transparency felt between parties, and a disconnect between senior leadership and shop floor service delivery challenges across the system; staff also noted stigma and racism from staff to Service Users from different cultures and felt that providers should tackle their staff on this*
- *Pressure to improve performance targets was felt to override good quality care and support in some cases, perceived too much focus on risk management, too much blame, too many differences of opinion, within an organisation and between organisations - Service Users get bounced around or lost between*
- *Pressure of litigation and fear of the Coroner's Court felt to lead to defensive practice, too much command and control; decisions on how services are delivered do not include clinical opinion; Significant medical caseloads so their time is limited; disputes over prescribing responsibilities take up too much time and need resolution – too many delays in initiating and changing medications*
- *Too much variation across the region – lack of clear pathways, not enough community-delivery, not enough staff with the right skills in key roles, including how to support those with the most complex problems; not enough social function support, not enough joint working between Health, Social Services and VCS; not holistic including physical health and psychological therapies*

What are staff saying about community-based, non-urgent, Mental Health services? (p2)

- *Some GPs noted: a gap in their understanding of MH conditions and limited options in a 10 minute appointment; limited services between Primary and Secondary Care, referrals often returned; some noted that they have LCFT staff as their patients and wellbeing/morale is low. High risk Service Users who are not engaging with services are discharged straight back to the GP – what do you expect us to do? The root causes of individual issues are not explored in enough depth at assessment - Service Users are caught in the 'crossfire' while we bounce repeated referrals back and forth. Lack of communication from providers to GPs on the care and support being given to their Service Users – we often don't know our Service User is receiving support until they are discharged and problems are passed back to us to support*
- *Younger people shouldn't fall through the gap that exists between CAMHS and Adult services*
- *Not enough support to Carers and families in all areas*
- *GPs don't feel informed on how Learning Disability services work and what is available; not enough support for those with Autism or ADHD – schools should be able to refer directly*
- *Substance misuse pathway is 'not fit for purpose'*
- *Corporate support in many organisations was described as the 'tail wagging the dog', and not focussed on enabling clinical and admin staff to achieve high quality service delivery. This was felt to be both within organisations and in links with Commissioning and wider governance structures*
- *Levels of admin support vary significantly, clinicians are doing admin's work, too many systems and processes, needs efficiency - IT systems don't talk to each other, equipment is old and slow*

What does the data on LCFT community-based, non-urgent Mental Health services tell us? (p1)

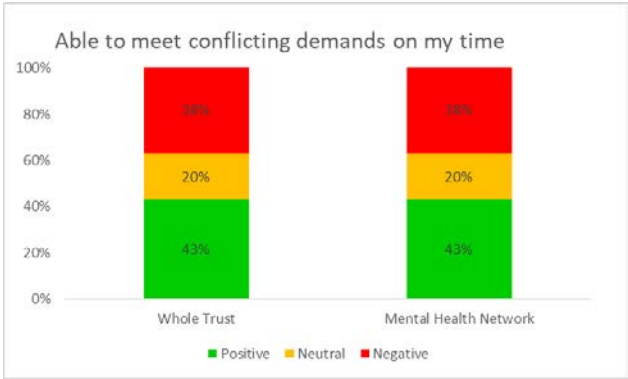
Chart to illustrate the increasing scale of resource in teams aligned to referrals for adults, compared to the average monthly referral rates from data supplied (April-Nov 18, with clear outliers excluded from the average)



	Lancaster	Morecambe	Preston	Blackburn	Burnley and Pendle	Rossendale & Hyndburn	Ribble Valley & Hyndburn	Fylde and Wyre	Blackpool	Chorley & South Ribble	West Lancs
WTE for 25-65s	7.64	9	9	9.49	9.89	10.7	13.19	16.39	17.13	20.29	22.8
WTE adj. for av. sickness	7.4	8.9	8.9	8.3	9.6	10.3	11.8	15.4	16.1	18.5	20.8
Av. referrals 18-65 yrs	20	22	101	73	49	22	3	47	100	63	14

Referral rates (demand) were generally static over 2018, and do not correspond directly to staffing levels shown on the left.

Staff comments on the challenges of meeting demand and the stress that creates are borne out by these charts, and echoed in the recent LCFT Staff Survey results (example below)

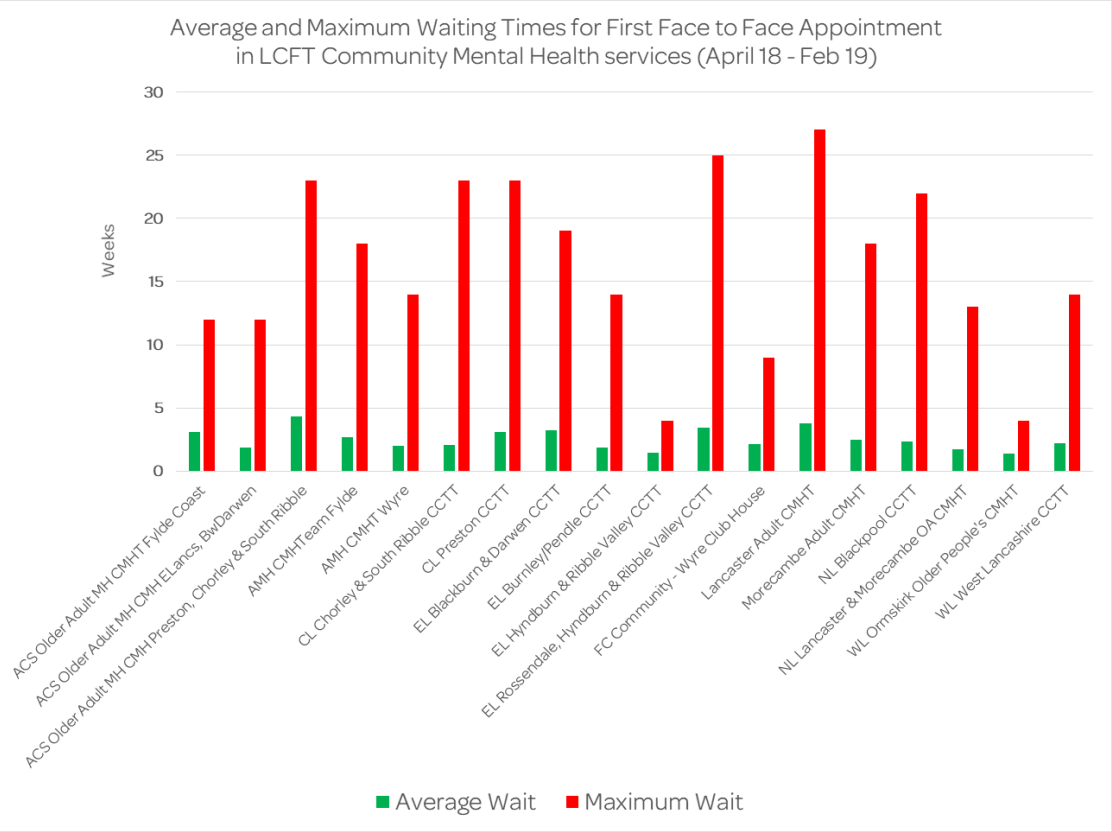


What does the data on LCFT community-based, non-urgent Mental Health services tell us? (p2)

While LCFT services do maintain average waiting times for first appointments at 4 weeks or less, there are individuals whose wait is much longer – this supports the views of many Service Users, Carers and of staff working in the system

Data on the balance between referrals and discharges was not available but data cleansing may allow further exploration to inform discussions on barriers to flow in the system

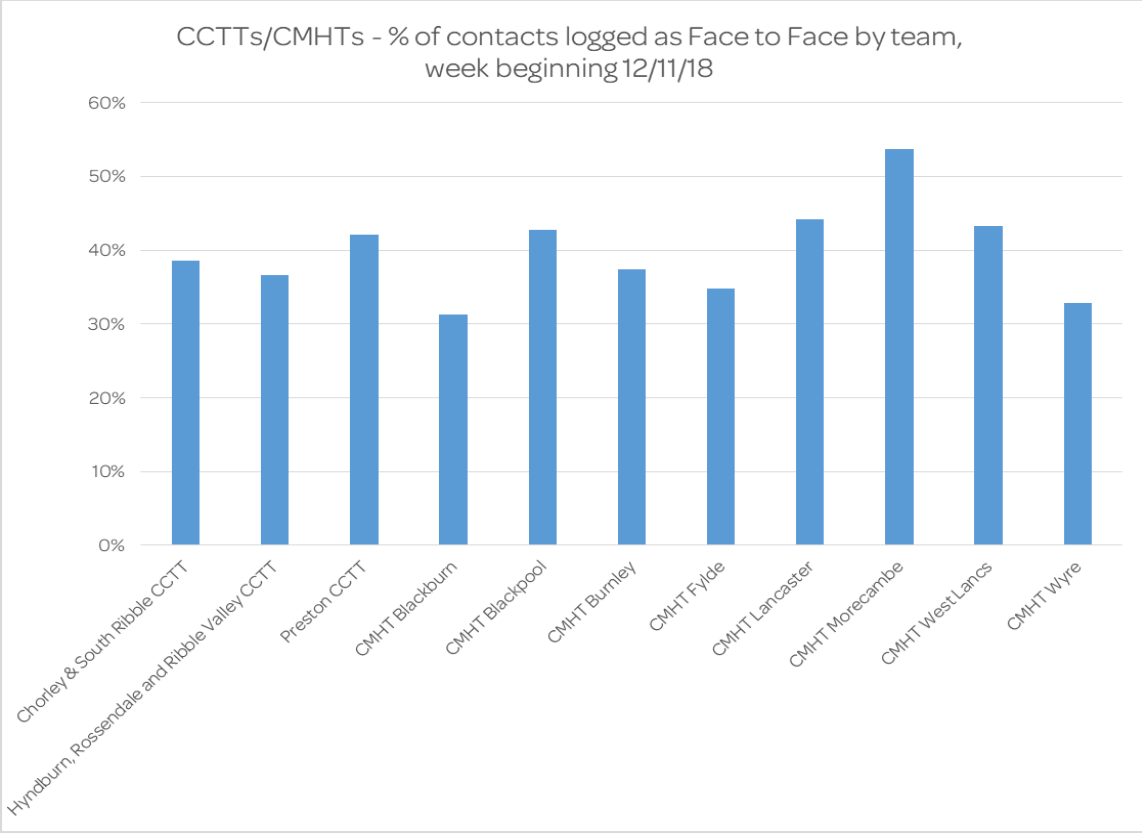
Data on the wait for treatment to begin after assessment is complete was also not available, but again is described by Service Users, Carers and staff as significant in many cases



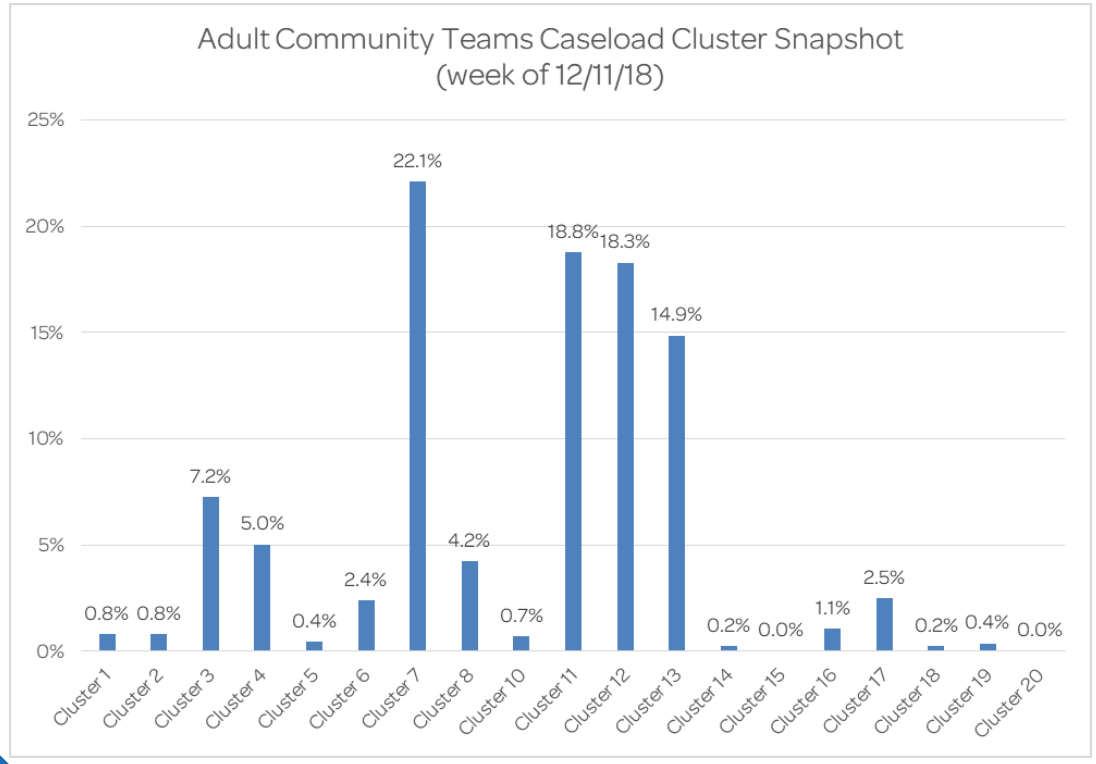
What does the data on LCFT community-based, non-urgent Mental Health services tell us? (p3)

Challenges were faced in extracting caseloads of individual clinicians within LCFT community teams from systems, with data cleansing underway – estimates range between 20 and 60 cases per clinician, and warrant further exploration to support staff in managing appropriate levels of workload, linked to Cluster and presenting need

The proportion of the week logged as being in face to face contact with patients is higher in CMHTs/CCTTs (30-40%) than in HTTs (25%) – one might reasonably expect a full-time CPN/Care Coordinator to spend no more than 50% of an average week in patient-attributable activities (face to face and indirect)



What does the data on LCFT community-based, non-urgent Mental Health services tell us? (p4)



In taking a snapshot of the Clusters of patients seen in a across the adult community teams, one may expect more Clusters 5 & 6 (very severe non-psychotic disorders) and Cluster 8 (Personality Disorder) patients in a Secondary Mental Health service.

In Blackpool, an overlap of service delivery is described between the LCFT CMHT and the Blackpool Teaching Hospitals 'Primary and Intermediate Mental Health Team', who both deliver treatment to patients in Clusters 1-8 – confusion over their service criteria is described and thresholds is described.

Analysis of the HoNoS scores of the individuals in this chart also indicates only 50% of patients scored 'moderate' or 'severe' need on at least one HoNoS question, leaving 50% with lower levels of need than might be expected in a Secondary Care service.

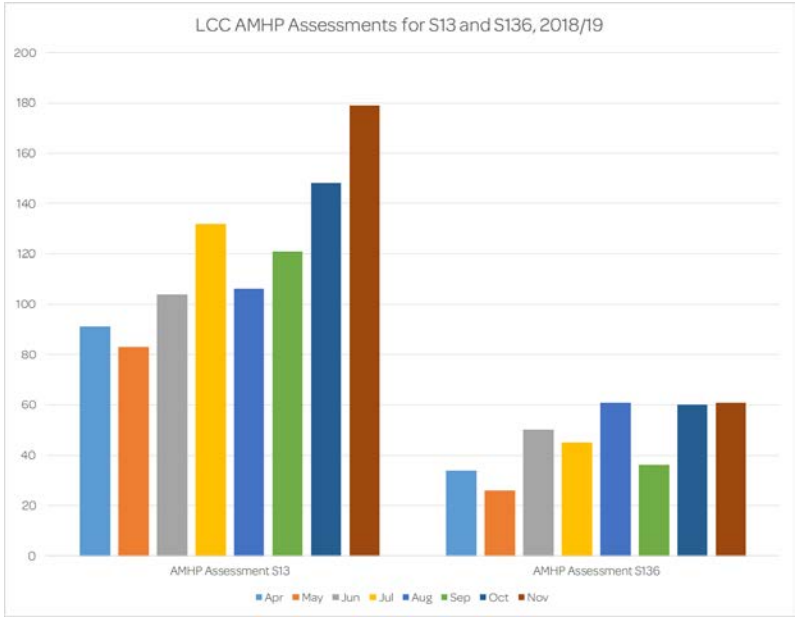
As with HTTs, Cluster score and clinical pathway were not always found to match up or be well-evidenced in the sample of patient notes audited.

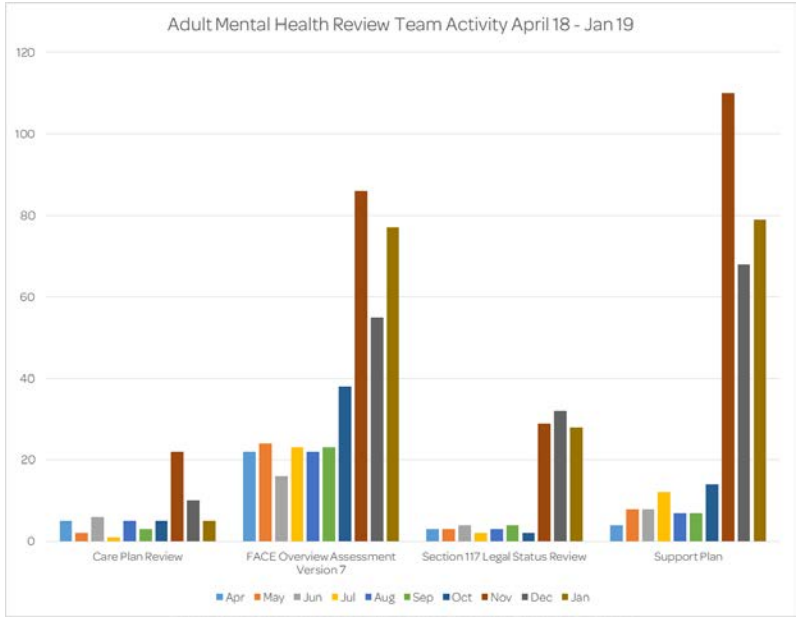
What is Lancashire Local Authority's current state? (p1)

- *The Local Authority and LCFT have recently gone through a process of reviewing their approach to integration, with concerns raised over the reduction in Care Act work which Social Workers in integrated teams were able to carry out – Service Users, Carers and staff all described concerns over a potential loss of integration during the timescale of this review, and it was not always clear that their perceptions matched the reality being described by senior leaders. The authors understand that a position has been agreed where front line Health and Social Care staff will continue to work together, but where Social Work staff and line management will re-focus their attention on statutory duties and on their specific skill set and remit*
- *Demand data provided shows an increase in referrals across 2018 (see overleaf) and an increase in the amount of Social Work activity captured in recent months, following the discussions between providers and repositioning of focus*
- *A snapshot of data from a week in November showed a decrease in waiting time in S136 suites (2.4 days) and ED (9.6 hours) for a bed, but an increased wait at home of an average of 5 days; this decrease in S136 and ED waiting times is not supported by the wider data sets provided*
- *As noted by the other Local Authorities in the area, the need for AMHPs to reassess individuals because of delays in finding a bed is described as significant, with hundreds of double assessments carried out in the past year*

What is Lancashire Local Authority's current state? (p2)

Activity data analysed by LCC shows increases across the board in recent months, felt to be in part due to an increasing referral rate (40% increase from Q2 to Q3 in 2018/19) but more related to increased focus on statutory remit and responsibilities in an integrated system – further analysis of this at depth would be warranted, to understand demand and capacity within these services





What is Blackpool Local Authority's current state?

- *Social Work staff are integrated into the Primary and Intermediate MH Team operated by Blackpool Teaching Hospitals*
- *Adult Social Work has grown in the last 5 years, and includes 7 qualified AMHPs, with others in Older Adults and Learning Disabilities – together they provide the daytime rota of 3 AMHPs on shift at once, something which can be increased from within the planned service in times of additional demand for statutory work (causing the postponement of planned work) – all AMHPs have planned caseloads in additional to these more urgent demands*
- *Resource has grown in response to increased demand, increased travel time, and the requirements of the Care Act work – caseloads were described as being 25-30; further data on demand and capacity was not available for analysis*
- *The Local Authority also commissions the Phoenix Crisis Service and Gloucester Avenue rehab service (described earlier)*
- *Very positive results were returned from a Leadership Survey in 2018 – over 90% of staff noted that the quality of leadership is good, that it is innovative and 'delivers on promises' in a collaborative way; minor comments were noted around visibility of senior leaders, a wish for improved communications and more training*
- *In a recent 'Health Check' exercise with staff, they again reported good work life balance, team work and support from leaders with workload and development needs; staff said they are given feedback on both compliments and complaints to improve practice*

What is Blackburn with Darwen Local Authority's current state? (written information only provided)

- *2 AMHPs on the rota during office hours and 1 at night – additional capacity is drawn in from qualified CMHT Social Work staff, often postponing planned work*
- *Social Worker recruitment and training challenges are faced*
- *Full integration with LCFT remains in place in BwD but is currently under review, to ensure focus on Care Act duties as noted by other Local Authorities – they remain optimistic about continued integration if issues can be resolved; BwD services have realigned to neighbourhood models sooner than other areas, but also note significant challenges with rising demand on community-based services, including that from individuals moving into the area*
- *AMHPs in CMHTs can expect to spend at least one day per week on MHA work, whilst carrying a caseload of 30-34 complex cases – referrals are triaged by the START duty hub (outside the CMHT); current systems do not allow the capture of contact activity/demand accurately – being addressed in 2019*
- *There are 2 AMHP/Social Workers in the BwD Home Treatment Team, plus 2 Support Time and Recovery Workers – day to day work is primarily with urgent cases but no particular focus on Social Care interventions*
- *Pressure around availability of beds has resulted in 2 distinct AMHP interventions – initial assessment having to be repeated when a bed becomes available, so the demand on AMHP time for an admission doubles, in addition to the extra support the person needs while waiting for the bed – further distress in Service Users left waiting was noted*
- *CMHTs in BwD have pressures in Band 6 Nursing, with significant vacancies – pressures around MHDUs have become a high priority and are not easy for staff to balance against planned caseload needs – organisational assurance is felt to distort front line practice*
- *Concerns are raised around lack of services in appropriate settings for younger people and for those from different ethnic backgrounds – outreach support in urgent cases should be better understood*

Triangulation of Opinions and Data on community-based, non-urgent services:

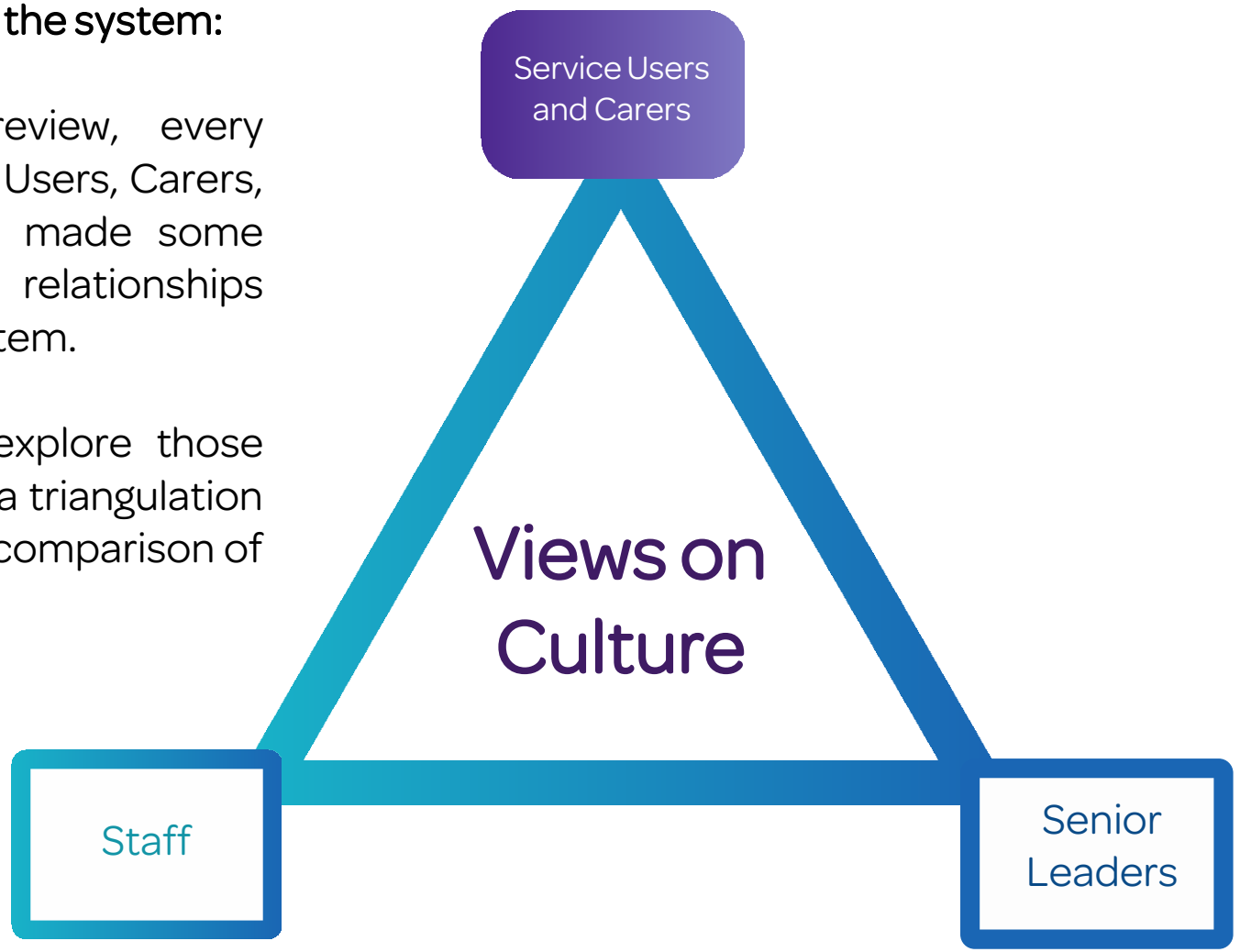
We can see, from a comparison of the data and the opinions of those using and working in services, that:

- *Pockets of good practice were described by staff in all agencies and areas, with challenges around consistency and the 'postcode lottery'*
- *Every conversation with staff and leaders made reference to culture and relationship challenges between organisations, which impact staff and how they support Service Users and Carers day by day*
- *How the available capacity is used to meet demand would warrant further exploration at depth in all Health and Social Care providers before any service improvements are implemented, with opportunities noted to remove waste and increase quality of service delivery across the entire system*
- *Service Users, Carers and staff at all levels across the system have asked that the plan going forward includes a comprehensive review of community services and pathways in Health, Social Care and Voluntary Sectors, to ensure focus on earlier support before crisis point is reached, in a holistic and multi-disciplinary/multi-agency approach, and with clarity on who provides what in each areas*
- *They describe the need for improved pathways for all – Younger People, those with substance misuse challenges, those with Autism and/or a Learning Disability, as well as Adults and Older People – that these pathways should be holistic and delivered in partnership between Health, Social Care and Voluntary Sector with Commissioning that supports such an approach*

Culture and Values across the system:

In carrying out this review, every conversation with Service Users, Carers, staff and senior leaders made some reference to challenging relationships and culture across the system.

In this section, we will explore those perceptions further – not a triangulation with data as before, but a comparison of view points...



What are Service Users and Carers saying about Culture and Relationships across the system?

- *We can see the strains between your services, particularly between LCFT and Social Services, and your staff describe this to us – this doesn't help us*
- *The lack of communication between LCFT and Local Authorities both ways means we don't get holistic, recovery-focussed assessment or support. The potential separation of staff worries us - make sure people aren't left waiting*
- *Health and Social Services could have much better links with charities and groups, as the benefits to Service Users and carers are not taken up, and we go to these things anyway but information is not shared*
- *Improve communication and work together for us across the region, Health, Social Services, GPs, Emergency Services and Voluntary/Charitable groups*

What are staff saying about Culture and Relationships across the system?

- *Significant issues were raised around the relationships between LCFT and Local Authorities, and the impact this is having on the care of Service Users and their Carers; inconsistent and inaccurate communication between staff, and fragmented relationships create risk - information is not shared between Health, Social Care and the VCS – some services described as 'secretive'*
- *Services were felt to be more reactive to one another than proactive with each other*
- *Service Users were noted to be feeding back to VCS staff that they feel the system is fragmented and power-based, rather than recovery-focussed*
- *Staff want autonomy and respect between professions of all kinds - lack of clarity on who provides what, with what skills, and the significant role that the VCS plays in this system - all were keen that the VCS be acknowledged for the support they offer to individuals, and that these organisations become more equal partners in the system going forward*
- *Discussions about 'co-production' approaches and true involvement of Service Users, Carers and supporters in service planning across the system often come to nothing*

What are Senior Leaders saying about Culture and Relationships across the system?

- *Significant issues were raised by those in a position to observe the relationships between the leadership of LCFT and others across the system, each person observing others in turn – what was apparent to the authors of the Review is that some appear to take pleasure in each other's challenges, and that blame is a default position in some*
- *LCFT and Local Authority leaders were clear in discussion that they each need to improve their service delivery within their own organisations, as well as their relationships with one another*
- *Voluntary, Community and Faith Sector (VCFS) leaders described their services being viewed as the 'poor relation', with little acknowledgement of the role they play, and their willingness to become a more integral part of the system*
- *Widespread acknowledgement of the need to build on relationships between Commissioners and providers of all kinds, based on honesty and transparency, and the need to be able to openly challenge to one another in a positive way. It was apparent in discussion that some have questioned the Mental Health expertise of some Commissioner colleagues in this, which has not aided relationships. All expressed the need for a shared vision and strategy for the system, and shared ownership to deliver it, to give assurance to each other on quality and value for money*
- *A collective leadership approach was raised by many as the way forward - CCGs and providers working together to share skills and knowledge for the benefit of Service Users and Carers*
- *Every conversation included a call for a system-wide strategy and more integrated working to improve flow and quality of service delivery, with Health, Social Care and VCFS providers working collaboratively, in a system created based on a shared values and evidence-base, and not perceptions. Work being done on 'neighbourhood' models was felt by many to be a positive way forward, to rebuild relationships and focus care and support as close to the Service User and their family as possible*

Triangulation of Opinions and Data on Culture and Relationships:

We can see, from a comparison of the opinions of those using and working in services, that:

- *Significant cultural challenges exist at a senior level in the system, between providers, and between them and Commissioners, which creates a direct impact on front line service delivery*
- *Some senior leaders have challenged the Mental Health knowledge of some Commissioning colleagues, with a direct impact on their relationships and approach to one another*
- *Staff on the front line are acutely aware of all of this, and share these challenges with Service Users and Carers – the system does not feel contained*
- *The authors note that some senior leaders appear to take pleasure in each other's challenges, and that moving these relationships forward in a positive way will take significant time, leadership and commitment on all sides*

Review Recommendations

The following section outlines recommendations for the system as a whole, its Commissioners and key Provider groups within.

While many of these recommendations draw upon the need to improve on some significant challenges within the system and within each provider element of that, there are many positives to reflect upon:

- A willingness by senior leadership to hear the views of Service Users and Carers, and to act upon these
- A willingness to also hear from staff of all kinds, and to encourage openness and honesty about the challenges faced
- Many pockets of good practice described across all Providers and Commissioners which can be built upon, spread and shared beyond organisational boundaries
- The strong desire of staff across the front line to deliver better services

The recommendations which follow have been drawn from the triangulation of opinions of Service Users, Carers and staff with data, and with the Review Team's independent view of services and the system's approach to their delivery. It is noteworthy that the open door approach of LCFT to this review has leant itself to gathering a richer picture of their services compared to others, and so the recommendations section may appear more detailed in their regard for this reason only.

Review Recommendations

ICS Leadership recommendations:

1. To lead the development of a whole system strategy to significantly improve Mental Health service delivery, culture and relationships between organisations, at a neighbourhood, ICP and ICS level
2. In that:
    a. to review the parity and balance of funding, demand and capacity across the system, and ensure consistent delivery of the highest quality services is achieved, while ensuring value for money is delivered – consideration of other models nationally and internationally to be given
    b. to actively support providers in their efforts to improve the delivery of care and support services, within the framework of an ICS-level strategy for Mental Health which spans from Primary Care to crisis and suicide prevention
    c. to engage more robustly with community and voluntary sector organisations across Lancashire to gain more understanding in what this sector could offer the system, and how that might be commissioned
    d. to facilitate the testing of new approaches within a framework which minimises the impact on 'business as usual', maximises the sharing of information for the benefit of Service Users and Carers, and promotes learning
    e. to ensure this work is seamless with parallel transformation programmes in CAMHS and Learning Disabilities services

Review Recommendations

CCG and Local Authority Commissioner recommendations:

3. To review, and where needed to increase, the capability and expertise around Mental Health within those staff that commission services - working together with providers, learning from one another, and exploring together what good looks like from other organisations both nationally and internationally
4. To review the parity and balance of funding, demand and capacity in commissioned services across the system, in reference to other examples nationally
5. To ensure funding supports local delivery of comprehensive, holistic Urgent Care pathways which should be developed in partnership with providers, be based on in-depth analysis and capacity planning, and with transparency over outcomes and value for money received in return
    a. from that, to create a standardised approach to commissioning and funding across Lancashire, directly linked to an in-depth understanding of prevalence and evidence-base around service delivery options nationally and internationally , and with clear outcome measurement built in
    b. to also consider the limitations of key pathways in the wider system at depth (e.g. CMHTs, Rehab, Learning Disabilities, Substance Misuse) and support significant improvements of those, creating a seamless system of care and support
    c. to engage more robustly with community and voluntary sector organisations across Lancashire to gain more understanding in what this sector could offer the system, and where opportunities to increase value for money exist

Review Recommendations

LCFT Recommendations:

6. As a matter of urgency, the Trust to review all practices/services which may deprive people of their liberty, and ensure all practice is covered by an appropriate legal framework and supportive policy documents
7. Facilitation of a Quality Improvement programme to review the drivers for demand and understand the capacity in all LCFT community and inpatient Mental Health services and pathways, and the transitions between those, at great depth
    a. in this, build understanding of where 'waste' can be removed from the system, so clinical resource and skills across the Trust can be focussed on the creation of a new system for the highest quality assessment, evidence-based care and treatment in all pathways, delivered in a timely manner. This design approach to be fully co-produced with operational staff, Service Users and Carers, and partners
    b. review the approach to accessing Mental Health services, so that Service Users and Carers can be empowered to take ownership of their care and treatment
    c. within system redesign, review the accuracy of clinical record-keeping and the value added to Service User care
    d. ensure an outcomes-focussed approach to service delivery, and in measurement and assurance of such

Review Recommendations

LCFT Recommendations contd.:

8. Further develop and support front-line staff in caring for Service Users with Emotionally Unstable Personality Disorders and Borderline Personality Disorders, building upon the current work to improve the clinical pathway
9. Review the training delivered to all clinical staff around supporting patients in positive risk-taking, and in delivery of therapeutic interventions to prevent escalation of crisis across all pathways
10. Review the Trust's approach to live status bed management (including MHDUs and Crisis House beds), gate-keeping and decision-making around admissions, and in the provision of robust alternatives to admission
    a. in this, significant attention should be paid to the creation of comprehensive and effective evidence-based pathways of community-delivered care and treatment, and support to families and Carers, which can be stepped up or down around times of crisis in a timely manner to minimise the need for admission
11. Consider embedding a constructive evaluation and challenge process for informal admission requests, best interest assessments and restrictive practice
12. Use of overnight leave and effective leave planning could be assertively introduced to support the return of individuals to community care, thus moving away from restrictive practice and reliance on inpatient beds

Review Recommendations

LCFT Recommendations contd.:

13. Further exploration of the leadership models being used within inpatient environments, to establish a clear leadership team who share responsibility for the performance of the wards
14. A review of the inpatient services as a whole is recommended, to ensure demand is met locally in an improved system where community-based care delivery is the first choice
    a. consider the use of "Red to Green" or similar purposeful admission initiatives in reviewing and planning the person's hospital stay on a daily basis, reducing the time they spend there, and support them to leave as soon as they're well enough
    b. consider the reinstatement of Mental Health Rehabilitation beds and pathways, providing specialist assessment, treatment and support to stabilise the person's symptoms and help them gain/regain the skills and confidence to live successfully in the community
    c. consider the value of having a Clinical Practitioner to review and repatriate Out of Area Service Users, while considering the impact on in-Trust services
15. Consider developing the role of a Police Liaison Officer, working with Police colleagues to review practices and skill base, and how their staff are supported with their own Mental Health - being proactive, reflective and encouraging learning to enhance the service for those in contact with the Police and in receipt of Mental Health services

Review Recommendations

Social Care Recommendations:

16. Build on the approach to refocus and further enhance the skills and competencies of Social Workers and AMHPs, while maintaining the integration approach with Health and Social Care in a well-defined and well-led system in all areas
17. Continue to actively focus on supporting the discharge of long stay inpatients, linked to a review of pathways of support for those of all ages and needs, and including improved holistic and integrated care for those with substance misuse challenges
18. Facilitation of a Quality Improvement programme to review the drivers for demand and to understand capacity in all Social Work/AMHP teams, and the transitions between those and Health/VCS, at great depth
    a. in this, build understanding of where 'waste' can be removed from the Social Care system so professional resource and skills can be focussed on designing and delivering a new system for the highest quality of service delivery, in collaboration with partners
    b. To ensure a focus on prevention wherever possible, with a cohesive strategy for Public Health and early intervention across Lancashire

Review Recommendations

Acute Sector Recommendations:

19. To work collaboratively with Mental Health colleagues to build skills and improve culture in front-line staff in relation to Mental Health – their own and for the benefit of the people they serve
20. To continue to provide support and challenge to Mental Health and Social Care providers in the creation of an improved system of care and treatment across Primary and Secondary Care service settings
21. To work collaboratively to create novel service delivery options focussed on the best and most efficient delivery of care and support for individuals and their families/Carers, across all urgent and non-urgent Mental Health and Physical Health pathways
22. To actively participate in Quality Improvement programmes of work in MHDU and Place of Safety environments, and in how Liaison staff work collaboratively into Acute pathways across general hospitals and beyond

Police and Ambulance Service Recommendations:

23. *To work collaboratively with Health and Social Care colleagues to build skills, expertise and improve culture in front-line Police and Ambulance staff in relation to Mental Health – their own and for the benefit of the people they serve*
24. *To expand the work which has restarted on 'Street Triage' and consider successful models from around the country – in this to actively triangulate the impact on ED attendance and inpatient admissions*

Review Recommendations

Voluntary and Charitable Sector Recommendations:

25. To work collaboratively with Commissioners and larger providers in the delivery of new and improved, holistic service models
26. To facilitate Quality Improvement programmes of work in all commissioned services they provide, to maximise effectiveness, efficiency, and to support the wider system in delivery of care which is value for money and as close to the Service User and Carer as possible
    a. in that, where they are providers of MHDU, Crisis House services and similar, to improve upon the efficiency of referral handling, assessment and flow within those services, working in partnership with Health and Social Care providers to ensure effectiveness within the pathway

ICS System Response to Recommendations

Leaders across the ICS system were asked to consider these recommendations and to take a strategic approach to translating them into actions which are timely, measurable and sustainable. It is the view of the authors that there is a significant willingness to work together across the system for the benefit of Service Users and Carers, from Board to floor.

Healthier Lancashire & South Cumbria

Urgent Care Pathway Review – Partner Responses

21st May 2019

ICS Leadership

- Work has already begun between commissioners and providers to develop a whole system strategy for Mental Health. This will be informed by the outcomes of this review
- One of the ICS identified priorities is “To strengthen the mental health and resilience of people and communities” this commits us to continue working in partnership at neighbourhood, ICP and ICS levels
- As an ICS, we will support Lancashire Care Foundation Trust, commissioners, local authorities and community/voluntary organisations to agree clear actions arising from this review.
- The ICS Mental Health Oversight Group will oversee the system response and ensure local partnerships (ICPs) demonstrate the impact of agreed changes on delivery of frontline services which are effective and joined-up in order to meet peoples needs.

Health and Social Care Commissioning

- As ICS partners, we will review the skills, competencies and experience required to effectively commission mental health services and implement a development Programme where identified.
- We will be transparent on spend across all commissioning organisations and understand how this links to demand and capacity.
- We will agree what looks and feels good for the people of Lancashire and South Cumbria including developing an outcomes framework we can all sign up to.
- We will understand in greater detail what other areas (National / International) invest in as part of the Adult Mental Health pathway and understand how transferrable that might be to LSC.
- We will collaborate with all stakeholders (including Service Users, Carers and VCFS) on and deliver a Mental Health strategy for LSC linked to the points above which enables a seamless system of care and support.
- We will work to understand how and against what areas we can better align budgets to ensure we reduce duplication and maximise the value of the limited resources we all have available – this will include working collaboratively to align budgets of other partners such as district councils and bodies such as Department of Work and Pension and Criminal Justice System.

LCFT Urgent Actions: Crisis Pathway

Theme	Action	Due
Strengthen Clinical Pathways in adult services (Pennine & Blackpool, Fylde and Wyre)	• Implement new leadership posts across liaison / MHDU/Crisis / HTT • Review & strengthen crisis / HTT operating model, including bringing teams together in Pennine Lancashire and ensuring robust 24/7 operating	Complete 30.07.19
A&E Liaison	• Increase staffing in line with MHIS and change staffing capacity to meet demand patterns • Relocate liaison team to A&E in Blackburn	31.08.19
S136/Place of safety	• Implement a substantive dedicated staffing model	Complete
MHDU	• Review clinical acceptance criteria • Develop operational SOP for function of MHDU	Complete 31.05.19
Crisis Houses	• Review acceptance criteria including time of day for admission	30.06.19
Frequent attenders	• Establish a Frequent Attenders clinical team	30.06.19
Joint Working with Acute Trusts	• Develop SOP for admission thresholds for acute sector including service users requiring detoxification and stable older adults	30.06.19

LCFT Urgent Actions: Bed Management

Theme	Action	Due
Short-term bed capacity	• Ensure 50/50 risk share of excess OAPs with CCGs is within LCFT contract	31.05.19
	• Commission adult rehabilitation & LD beds	30.06.19
	• Confirm with NHSI Priory beds are not defined as OAPs	31.05.19
	• Review early identification & management of OAP capacity	30.06.19
Assessment wards	• Review length of stay to bring down to 72 hours	31.07.19
	• Strengthen clinical leadership	31.07.19
Delayed discharges	• Implement red to green enabling appropriate discharge planning	31.07.19

LCFT Urgent Actions: System Redesign

Theme	Action	Due
Clinical Pathways	• Develop system-wide Mental Health Risk Register • Review primary and secondary care interfaces	31.05.19 31.05.19
Street Triage	• Evaluate Blackpool pilot and develop a plan to roll out across Lancashire	30.06.19

LCFT Urgent Actions: Community Teams

Theme	Action	Due
CMHT	• Support investment in CMHT staffing	31.08.19

LCFT Urgent Actions: Substance Misuse

Theme	Action	Due
Substance Misuse	• Map current provision and develop gap analysis	31.05.19

Longer Term

- Strategic partnership with LCFT & NTW and improvement programme agreed
- Partnership approach with service users, staff, commissioners and partners
- Immediate priority - redesigning the adult acute pathways across Pennine Lancashire and Blackpool, Fylde & Wyre
- Care pathway redesign across all mental health and learning disability services

Mental Health Investment Standard

- Ensure appropriate funding is secured in line with the national MHIS for A&E liaison, MHDU, Crisis/HTT and CMHT

Mental Health Act

- Reset current clinical practices regarding legal framework

Clinical Pathway Redesign

- Develop QI transformation programme in partnership with NTW, Service Users, commissioners and other partners
- Review drivers of demand and associated capacity
- Improve efficiency & productivity/reduce waste
- Develop evidenced based pathways, mapping current and future states and plans to address service gaps and co-produced with SUs – to include EUPD pathway

Service Users Co-Production & Involvement in Care

- Review the service model for access to MH services
- Enhance SU involvement in their own care plan
- **Co-produce Pathway Redesigns with service users**

Clinical risk-taking

- Adopt ‘home first’ approach
- Optimise SU leave planning
- Reduce restrictive practices

Beds Management

- Implement short and medium term automated live bed management tool
- Review bed gatekeeping function

Inpatient Services

- Enhance IP leadership to ensure clarity of criteria, purpose and performance of wards
- Review bed capacity against geographical requirements and bed distribution
- Develop business cases for Adult Rehab and LD assessment and identify capital source

Partnerships

- Work collectively to develop whole system ICS strategy for mental health
- Review role of Police Liaison Officer and develop and implement SOP with Police to ensure appropriate detentions
- Enhance working relationships with Service Users, Carers and Voluntary sector
- Strengthen partnership working with AMHPs and Social Workers
- Analyse data driving increase in demand for MH services
- Collaborate with Acute sector to train A&E staff in MH pathways, develop appropriate pathways for admission to acute beds, ensure appropriate environment for liaison staff to work with MH patients in A&E

Social Care

- We recognise the need for clarity of roles and contribution of the social care workforce who provide a distinctive contribution in partnership with NHS funded mental health services. This will require an integrated approach whilst focusing on the social aspects of people's lives.
- We will work collaboratively across the four local authorities to provide a consistent approach across the ICS, with recognition that each ICP will have specific needs.
- We will continue to support recruitment, retention and professional development of a social care workforce and will keep the skill mix under review to ensure resources are deployed in the most efficient and effective way for the benefit of service users.

Social Care

- All Local Authority Social Work teams are committed to contributing to and achieving joint outcomes for the ICS/ICP. Supporting discharge of long stay patients fits within these priorities.
- We will work with system partners to review pathways and ensure fully integrated and collaborative approach. Working to strengths and best using skills to optimise efficiency and outcomes with an emphasis on Home First & Community being the preferred pathway.
- We will work collaboratively on an approach to managing mental health in connection to substance misuse pathways including the joining up of resources upstream where required.
- We will implement a quality improvement programme to review the drivers of demand to under the capacity and demand in Social Care **w**orkforce. This will include identifying system efficiencies and refocusing on prevention.

Social Care

- We will use management tools such as LEAN to understand end to end services, map existing and where required redesign services to achieve better outcomes. This will be undertaken collaboratively.
- A focus on prevention will be built into the ICS MH strategy, which will include an informed and consistent framework. We will work in partnership with the VCFS sector to target resources to outcomes with real measure and grip on commissioning.

Acute Sector

- The CEOs of the Acute Provider Trusts endorse and support the report, and agree to work actively in partnership to respond to the issues raised including in participating in quality improvement programmes.
- We agree to work in collaboration with LCFT to build skills in our frontline staff that are specific to mental health. This will support their own resilience and benefit patients and their families.
- We agree to work in collaboration with LCFT to improve the A&E environment for mental health patients, including the availability of appropriate ligature safe assessment / therapeutic rooms and dedicated work space for MH staff to be based within the department.
- We will continue to provide robust challenge as partners in the ICS to areas of concern, these include:
  - Changes to Substance Misuse Services and their significant impact on acute pathways with an increase in alcohol related admissions and liver disease.
  - Working with LCFT and Commissioner to ensure that Liaison teams provider an effective 7 day service.
  - The high impact from MH patient breaches across the whole ICS system
  - The commissioning and decommissioning of third sector partners across the pathways that are specific to meet ICS and ICP requirements.

Police and Ambulance Service

- Lancashire Constabulary (and NWAS) accept and support the recommendations contained within the NTW report. We recognise the need to work collaboratively to improve the delivery of mental health services to the people of Lancashire.
- In order to support this improvement we agree to deliver improved mental health training to our frontline staff, in order that they may better understand patients with whom they come into contact, and the pathways available to improve their health via appropriate treatment options.
- We will work with partners including LCFT and third sector providers to ensure that the skills developed are appropriate and relevant to the situations faced by our frontline staff, and enable them to deliver effective mental health first aid, whilst ensuring they support patients into the most appropriate longer-term treatment options.

Police and Ambulance Service

- We will work in partnership with LCFT to ensure that the most appropriate methods of delivering immediate crisis response are in place throughout Lancashire, providing safeguarding and clinical support to those in most urgent need.
- This will be delivered in a model that ensures the most appropriate resources are deployed and in a position to provide safeguarding and informed clinical assessments. This will minimise the impact on patients, and maximise the opportunities to deliver effective treatment.
- Supporting this development changes will be made to our delivery models in communities alongside improvements to communication processes. This will ensure that patients suffering crisis or about to, are able to access appropriate resources at the earliest opportunity.

Voluntary, Community and Faith Sector

- We will offer a flexible and unique contribution around providing and delivering consistent person-centred service delivery models involving all partners / commissioners in harnessing this approach.
- We will work productively in a purposeful, cooperative way with commissioners and larger providers to align and deliver holistic expertise within the sector.
- We will contribute to the inception of innovative and diverse ways of working with patients/customers to further gain better and efficient outcomes.
- Our focus will be prioritising the review and quality / effectiveness of all delivery programmes with particular emphasis placed on outcomes and improved service patient/customer experience.
- We will place key focus on service entry and effective flow, to further contribute to seamless and responsive service delivery pathways.

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