Mental Health Concordat – Coventry Position Statement:

	Concordat Outcome	What is recommended	Currently Available in Coventry	Current Gap in Coventry	Proposed Action
	Access to support before crisis point			`	
A1	Early intervention – protecting people whose circumstances make them vulnerable	Single point of access to a multi-disciplinary MH team	CWPT implemented a single point of access into their services in Coventry in April 2014.	• No gap but the new pathway was only implemented In Coventry in April 2014 so will need to keep it under review to ensure delivering expected outcomes. • Lack of awareness of single point of access from other agencies	• On going monitoring and review of the Single Point of Entry and re-designed MH referral and assessment pathway. • Improve access to single point of entry for emergency services
			• MH social workers are integrated into the IPU's within CWPT • Street Triage has a police officer and mental health practitioner in the car. This initiative has really improved partnership working for MH patients and its impact is far wider. It has increased mental health awareness, knowledge of policies, and understanding of alternative pathways • POD and Coventry Wellbeing Hub currently provides support to people with MH needs, (add pod	• Not as strong links between statutory, non statutory sector and primary care. • Lack of integration between social services and health in older adult MH services. • Review impact of dementia service • No needs assessment in Coventry	• Review current models and requirements for hubs across Coventry based on needs assessment findings. • Clarify role of each agency in the delivery of MH services and ensure that they are properly linked into the MH pathway. • Strengthen the role of the GP in the delivery of MH care within Coventry. • Scope opportunities with the development of well-being hubs ~~to work more in partnership delivering more holistic, person centred approaches.~~ • Increase information available on mental health, access to services and pathways to service e users and wider professionals
		Crisis and Home Treatment services	• Coventry has a Home treatment Team, and also an Assertive Outreach function and an	• No Specialist MH home care providers delivering a recovery	• To scope out service capacity gaps within

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			Early Intervention service within the IPU's all of which will provide support to people in their own homes.	approach within crisis. • Sufficient capacity within the HTT • Sufficient capacity within the AOT • Community rehabilitation service.	the Coventry needs assessment.
		Respite	• Limited dementia respite • Ad-hoc use of spare capacity within residential service vacancies	- No respite provision within Coventry. - Insufficient capacity within dementia respite provision with no easy access to provision for self funders.	• To scope out the wider health and social care impacts arising from access to respite provision.
		Peer support	• Peer support, Mental Health information and advice and social support • Befriending service • Stress and Anxiety management	• How these services link to the formal MH pathway. • People knowing what is available locally and how to access it. • Not maximising use of community assets in the delivery of MH care and support locally.	• Use the needs assessment to determine action plan in this area Small grants to grow numbers of people supported through local community activities.
		Access to liaison and diversion services for people with MH problems who have been arrested for a criminal offence	• Coventry has first wave national site for liaison and diversion. Services works with extended range of people including those at risk of offending. Service operates 7 days a week 0730-2000. • Service is supported by strategic programme board and operational management group. • Service has increased awareness of wider health and social needs of offenders	• Access to out of hours service	• Maintain strategic oversight of liaison and diversion programme • Continue to work with wider police teams to ensure those who are investigated or charged with criminal offence also receive service without need for detention in custody
	Urgent and emergency access to crisis care				
B1	People in crisis are vulnerable and must be kept safe, have their needs met appropriately and be helped to achieve recovery	The Concordat signatories believe responses to people in crisis should be the most community-based, closest to home, least restrictive option available, and should be the most appropriate to the particular needs of the individual.	Coventry has: • Single Point of Entry into secondary care services • AMHAT operating within UCHW • Home Treatment Team which includes AMHP provision • In patient MH assessment beds • Street Triage Service	• Insufficient capacity within MH acute assessment beds • Overstretched CRHT • A&E still used as a crisis service a – resulting in people getting stuck in an acute hospital • Adult MH respite beds/crisis house • Recurrent funding for street triage	• Keep number of inpatient assessment beds the same initially and scope future needs • Scope need for development of 7 day respite / crisis services for LD/MH

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			• Place of safety – both for adults and children and young people	• Out of hours services CAMHs / LD and adults after 5pm. • More intensive community support: - Mental Health urgent care centre - specialist MH domiciliary based care. • Use of 3rd sector providers	• Review of CWPT crisis service. • Develop options within SPE to identify and increase use of 3rd sector • Review the role of 3rd sector to support crisis. •
B2	Equal access	The Concordat supports the guidance produced by Mind on commissioning crisis care services for BME communities. It recommends that commissioners: • Consult and engage with BME groups early on when commissioning services – this may include the voluntary agencies that represent and support service users from BME communities • Make sure staff are delivering person-centred care that takes cultural differences and needs into account • Commission a range of care options that meet a diverse range of needs • Empower people from BME groups by providing appropriate information, access to advocacy services, and ensure that they are engaged in and have control over their care and treatment.	. • Coventry commissions third sector organisations to engage with hard to reach groups including black minority and ethnic groups across the borough of Solihull including the Carers Centre • Ashram employs Community Development workers whose remit is to target hard to reach groups including BME, Mental Health and drug and Alcohol Abuse. • All contracts and specifications require providers to ensure that their services reflect cultural differences to support and encourage access into their services. • The development of the web-portal and information and advice services running out of local neighbourhood hubs including libraries, will support the engagement of local communities and support the signposting of people to services and support that can address any issues they have in a timely manner. • Access to MH advocacy services • Access to interpreters	• Evidence base on supporting BME and LGBT communities with dementia and other MH needs and their carers is very limited nationally and locally. • Carers of BME communities with dementia feel reluctant to ask for help based on the stigma that is still attached to the condition. • Due to social hostility, stigma and discrimination faced by LGBT people, this may defer people from seeking help or accessing services because of further fear of discrimination.	• Identify gaps in research and data at a local and national level to better inform us on the MH needs of our diverse community within Coventry. • Build up data to look in greater detail at MH needs at a local level using clinical and demographic information. • Identify and adopt a number of approaches which have been successful elsewhere in the Country that will improve the take up of services amongst BME and LGBT communities. • Identify the specific needs of people with dementia and their carers arising from aspects of diversity, such as ethnicity, gender, religion and preferences about the delivery of personal care. • Develop an approach to better meet the language needs of

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					existing and future users and carers of MH services. • Potential for a register of staff and the languages that they speak. • Section 12 doctor app which is being developed will have profile of doctor which includes languages that they speak.
B3	Access and new models of working for children and young people.	• Children and young people with mental health problems should have access to mental health crisis care. • Patients under 18 who are admitted to hospital for mental health treatment should be in an environment suitable for their age. • Staff working with young people aged 16 – 18 in transition should have appropriate skills experience and resources; and should take account of the views of parents and other people close to the young person. • Robust partnership working between primary care for children & specialist CAMHS. • Partners such as schools and youth services should be involved in developing crisis strategies. • Children and young people should be kept informed about their care and treatment		Out of hours crisis service Crisis resolution and home treatment team for CAMHS	CAMHS redesign review. Implement recommendations from the WMQR.
B4	All staff should have the right skills and training to respond to mental health	• Staff whose role requires increased mental health	Police: Multi agency mental health training has been completed with officers. Coventry has a Mental	Police: New recruits will require training and officers on-going refreshers. There is	• CAMHs redesign

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	crises appropriately.	awareness should improve their response to people in mental health distress through training and clear line management advice and support. • Because individuals experiencing a mental health crisis often present with co-existing drug and alcohol problems, it is important that all staff are sufficiently aware of local mental health and substance misuse services and know how to engage these services appropriately. • Local shared training policies and approaches should describe and identify who needs to do what and how local systems fit together. Local agencies should all understand each other's roles in responding to mental health crises. • Each statutory agency should review its training arrangements on a regional basis and agree priority areas for joint training modules between NHS, social care and criminal justice organisations. Although it is desirable that representatives of different agencies be trained together, it is not essential. It is more important that the training ensures that staff, from all agencies, receive consistent messages about locally agreed roles and responsibilities.	Health lead, SPOC's within the Response Teams for the LPU who are knowledgeable in current practices and policies. A mandatory Ncalt package is also in place. CWPT has senior manager with specific responsibilities to liaise with local police and support training, application of policies and practice and identify issues with collaboration. WMAS: partnership agency training taking place. Concerns rose with University Paramedic curriculum as now limited MH training in degree course. This is being taken up by the Association of Ambulance Chief Executives who is insisting that minimum standards for MH awareness are taught. Voluntary Sector: Coventry and Warwickshire Mind ensures that workers have information on the appropriate agencies/referral systems for people in crisis (including drug and alcohol, and domestic/sexual abuse); and Advocates can support people to access the appropriate service. Coventry and Warwickshire Mind staff has training in dealing with people in distress/crisis.	no official trainer on LPU and therefore refreshers will be via Ncalt and cascade training.	programme to identify and scope requirements. • Each organisation to review training programme and agree where joint training should take place. Training should include mental health awareness, policies and legislation, access to services and pathways.
B5	People in crisis should expect an appropriate response and support when they need it.	• People in crisis referred to urgent secondary care service should be assessed face to face within 4 hours in a community location that suits them. • Service users and GPs access	• Single point of entry into secondary care services – people who have urgent needs are seen same day. • Home treatment Team – same day access • AMHAT 24/7 except Sunday / Monday night • Street Triage Service 1700-0200 7 days a week	• Out of hours crisis service for CAMHs / LD • Overstretched CRHT not currently delivering recommended timescales. • Recurrent funding for CRHT	• To assess crisis response service capacity as part of the urgent care re-designs. • Review need for crisis service to

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		to a 24 hour helpline • Crisis resolution and home treatment services available 7 days a week.	• Mental Health Matters help line 24 hour helpline. • Access to SPE to all 2ndry MH services • Timely response for AMHP's •		support CAMHS and people with and LD. • Develop integrated protocols.
B6	People in crisis in the community where police officers are the first point of contact should expect them to provide appropriate help. But the Police must be supported by health services, include MH services, ambulance services and emergency departments.	• NHS commissioners are required by the MH Act to commission health based places of safety. • Place of safety should be commissioned at a level that allows for 24/7 availability and that meets the needs of the local population. • Police officers should not have to consider using police custody as an alternative just because there is a lack of local MH provision, or unavailability at certain times of the day or night. • Police officers responding to people in MH crisis should expect a response from health and social care services within locally agreed timescales so that individuals receive the care that they need at the earliest opportunity	• Street Triage – current locally funded pilot – due to end December 2015. • Health based Place of safety • Place of safety available for children and young people • Local POS protocol developed and agreed with police, CWPT, UHCW, and WMAS.	• MH Urgent Care Centre- a more appropriate place to assess, treat/support people. • Identification of recurrent funding to secure street triage. • Capacity of PoS at peak times • Capacity of PoS to deal with individuals who are intoxicated and incapacitated but do not present an unmanageable risk to other patients or staff	• Increase access to support for police when considering detention under S136 • Increase awareness of alternative pathways to S136 for accessing urgent mental health care • Scope POS capacity to determine how often there is insufficient capacity to meet S136 requirements and identify contingency arrangement • Development of an urgent care centre. • Review 136/PoS policy to include: – police custody will only be used as Place of Safety in exceptional circumstances e.g. unmanageably high risk to other patients, staff – police custody should not be used for children and young people – If police custody used as PoS then this should be for

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					shortest time possible (maximum 24 hrs) and assessment under the Mental Health Act should be prioritised
B7	When people in crisis appear (to health or social care professionals or to the police) to need urgent assessment, the process should be prompt, efficiently organised and carried out with respect.	• Commissioners and providers should ensure that people who are in distress owing to their MH condition, and who are in need of formal assessment under the MH Act, receive a prompt response from S12 approved Doctors and AMHPs so that arrangements for their care, support and treatment are put in place in a timely way. • Timescales should reflect best practice set out in the RCoP guidance on commissioning services for S136 which states that AMHP's and S12 doctors should attend within 3 hours in al cases where there are no clinical grounds to delay assessment. • In the case of children and young people, the assessment should be made by a child and adolescent MH services consultant, or an AMHP with knowledge of this age group. • There should be no circumstances under which MH professionals will not carry out assessments because beds are unavailable • When deciding upon any course of action, all professional staff should act in accordance with the MH Act's principle of least restriction	• AMHP response times are good in Coventry • Improved conveyance policy • Street triage service (but only pilot with funding until December 2015	• Access to older adult consultants in and out of hours • CAMHs out of hours • Not sufficiently robust response to people in crisis living in care home services. • Too little use of persons own GP in the MH Act Assessment process. • Recurrent funding for street triage service.	• Scoping out the potential for a S12 Doctor Application for SMART Phones to ensure most appropriate and available Dr to undertake assessment. App developed by local consultant psychiatrist. • Development of a CAMHS and LD out of hours crisis response service as part of redesign • Training for GPs locally so more feel confident about providing medical input to the MHA Assessment process for their own patients.

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		and to ensure that services impose the least restriction on the person's liberty. Police forces should consider using unmarked cars to travel to a property to enforce a warrant under S135 of the Act.			
B8	People in crisis should expect that statutory services share essential 'need to know' information about their needs	All agencies including police or ambulance staff, have a duty to share essential 'need to know' information for the good of the patient, so that the professionals or service dealing with a crisis know what is needed for managing a crisis and any associated risks to the distressed person or others	• Health and Social Care have full access to the clinical records. • MH Social workers have full access to Epex and input all their daily case reporting onto Epex (the health system) • Police can now access the Epex system via the street triage team/Liaison and Diversion team 0730-0200. • AMHAT have access to Epex within UHCW.	• Access to CAMHS records by other partner agencies. • Councils do not have access to information from Epex, when responsibility transfers	• Review and agree arrangements/policy for information sharing. • Improve information sharing between agencies using agreed risk assessments particularly for those who regularly contact emergency services
B9	People in crisis who need to be supported in a health based place of safety will not be excluded	Irrespective of other factors (i.e. intoxication, previous history of violence, personality disorder) individuals suffering a MH crisis and urgently needing to be detained while waiting for a MH assessment should expect to be supported in a health based place of safety.	• Street triage • Local S136 policy • Access to a commissioned POS	• No recurrent funding identified for the continuation of the street triage pilot. • Sufficient capacity within acute inpatient assessment services to ensure smooth and timely flow of S136 people out of place of safety into inpatient provision where appropriate. • People in crisis can be excluded due to intoxication	• To address as part of the urgent care pathway service re-design • Review how often Health provided POS is full and alternative POS arrangements have to be sought. • prevent exclusion from PoS based solely on level of intoxication • Use of tests to determine level of intoxication as sole basis of restricting acceptance to PoS will be ceased •
B10	People in crisis who present in Emergency Departments should expect a safe place for their immediate care and effective liaison with MH services to ensure that they	• People experiencing MH crisis, who are exhibiting suicidal behaviour or who are self harming, are treated safely, appropriately and with respect by emergency department staff	• AMHAT operates 24hours at UHCW with the exception of Sunday and Monday night is commissioned to respond within 90 minutes to any MH issues identified within patients in A&E and to undertake a thorough MH assessment of the patient and agree appropriate next steps	• AMHAT does not operate overnight on Sunday and Monday • Current difficulties meeting the presenting inpatient needs within current local commissioned	• Check that Emergency Duty staff are aware of the NICE Quality Standard and Guidance for Self Harm.

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	get the right on-going support. Vicky to update – need to double check with AMHAT	• Clinical staff identifies MH problems in people presenting with a physical health problem and refer them to a GP or specialist help where necessary. • Clinical staff are equipped to identify and intervene with people who are at risk of suicide, through on-going training in accordance with the relevant NICE guidelines, statutory and legal requirements under MH legislation and communicate with other services so that people who are at risk are always actively followed up. • Emergency department staff should treat people who have self harmed in line with NICE guidance and work towards NICE Quality Standard for Self Harm. • Commissioners work with hospital providers to ensure that ED, police and ambulance services agree appropriate protocols and arrangements about the security responsibilities of the hospital and the safe operation of restraint procedures on NHS premises. ED's should have facilities to allow for rapid tranquilisation of people in MH crisis, if necessary, and clear protocols to safeguard the patient. This should be in accordance with NICE Guideline 25 Violence.	with the ED staff. • Part of the AMHAT function is to identify services that will best support and follow up the patient post discharge from the Emergency Department or following a period of admission. • AMHP's operate 24/7 and will respond within the agreed 3 hour target in most cases.	capacity. • Commissioned inpatient capacity not flowing as it should due to people not being able to be discharged as insufficient specialist community services that can provide the right level of intensive input. • Lack of available inpatient provision means that people admitted are acutely unwell, and such admissions will be longer. Again lack of specialist community support at the right level of service intensity to avert crises and support earlier discharge.	• Check current security and restraint protocols are in place within ED's • Scope the likely wider system benefits of more intensive specialist community MH services such as a MH urgent care centre, specialist home care/PA support readily available to avert crises.
B11	People in crisis who access the NHS via 999 system can expect their need to be met appropriately Vicky update.	• The provision of 24/7advice from MH professionals, either to or within the clinical support infrastructure in each 999 ambulance control room. This would assist with the initial	• The Street Triage service is a car which includes a police officer and a CPN. Street triage ensures that there is a robust initial assessment of MH patients who are potential S136 cases and will identify most appropriate support / treatment for the	• No recurrent funding yet identified to support Street Triage beyond the pilot phase.	• Identification of wider system savings achieved through street triage • Scope need for training to ambulance

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		assessment of MH patients and help ensure a timely and appropriate response. • Enhanced levels of training for ambulance staff on the management of MH patients. • Ambulance Trusts to work flexibly across boundaries by exercising judgements in individual cases to ensure that an individual's safety and treatment is not compromised.	individuals concerned. Ambulance and NHS 111 can access the service when they are requesting a police response. • National Ambulance Leads Group (supported by AACE Association of Ambulance Chief Executives) has a national policy mandating the emergency response for all s136 patients. • MH nurses now being utilised in WMAS ambulance emergency operations centre.		staff ~~and the police~~ to ensure that they know how best to approach and treat people with a MI, particularly those who are in crisis
B12	People in crisis who need routine transport between NHS facilities or from the community to an NHS facility, will be conveyed in a safe, appropriate and timely way.	Commissioners will need to make sure that the transfer arrangements put in place by MH Trusts and acute trusts provide appropriate timely transport. e.g. police vehicles should not be used to transfer patients units within a hospital	• Where secure and escorted patient transfer is required to a different hospital, services such as ERS are commissioned. This is currently on a spot basis. • WMAS Conveyance Policy supports transfer between NHS facilities and form community to NHS facility	• Capacity to transport in timely way	• Local multi-agency group to monitor any difficulties with conveyance and agree actions to reduce issues • Consider whether addition of paramedic in unmarked ambulance vehicle may achieve wider system savings to assist with conveyance of those needing multi agency support • Reduce use of police vehicles if police expedite conveyance without ambulance e.g. in urgent situation to manage risk
B13	People in crisis who are detained under S136 powers can expect that they will be conveyed by emergency transport from the community to a health based place of safety in a safe, timely and appropriate way.	• Where a police officer or an AMHP requests NHS transport for a person in MH crisis under their S135 and 136 powers for conveyance to a health based place of safety or an Emergency Department, the vehicle should arrive within the agreed response time. • Police vehicles should not be	• Conveyance policy agreed in support of S136 policy with WMAS	• Capacity and timely response of conveyance	• Consider whether addition of paramedic in unmarked ambulance vehicle may achieve wider system savings to assist with conveyance of those needing multi agency

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		used unless in exceptional circumstances, such as cases of extreme urgency, or where there is a risk of violence. Caged vehicles should not be used.			support • Reduce use of police vehicles if police expedite conveyance without ambulance e.g. in urgent situation to manage risk
	Quality of treatment and care when in crisis				
C1	People in crisis should expect local MH services to meet their needs appropriately at all times	Responses to MH crises should be on a par with responses to physical health crises. This means that health and social care services should be equipped to deal safely and responsively with emergencies that occur at all times of day and night, every day of the year. The dignity of any person in MH crisis should be respected and taken into account.	• AMHAT operates 24/7 within Heartlands and 8 until 8, 7 days a week within Solihull Hospital. The team comprises MH, substance misuse and older adult specialist staff and works closely with HEFT staff to improve the care of people accessing acute hospital services. • Coventry CRHT operates up until 9pm Social services provide access to an Emergency Duty Team out of hours. • AMHP's are available 24/7.	• Sufficient capacity within the CRHT for Coventry. • More appropriate environment within A&E/AMU for people with MH problems requiring physical health interventions. • Access to a MH urgent care centre where no on-going need for physical health intervention/treatment.	• Coventry need assessment will inform future actions • Link into the Acute Hospital Urgent Care re-design to ensure that it appropriately considers the needs of people with a MI. • Reviewing the RAID service and required specialisms across each site. • Ensure ambulances convey patients to the most appropriate service to get the support that they require.
C2	People in crisis should expect that the services and quality of care they receive are subject to systematic review, regulation and reporting.	• CQC already monitors and inspects services that provide a response to people experiencing a MH crisis including acute and MH hospitals, community based MH services, GP's and primary medical services etc. ***How these services respond to people experiencing a MH crisis will form part of the regulatory judgement that leads to a rating.*** • Service providers have a responsibility for monitoring the quality of their responses to people in crisis.	• CQC monitoring and inspection processes • Internal Trust monitoring and review of service quality. • Monthly Clinical Quality Review Group meetings between NHS providers and commissioners. • Real time patient/carer feedback stations available in MH facilities. • People in care homes have their services regularly inspected by Coventry monitoring officers.		• • To agree ways of obtaining service user feedback on nature of services provide to those in mental health crisis including those presenting to criminal justice system

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C3	When restraint has to be used in health and care services it is appropriate	• Staff properly trained in the restraint of patients • Adequate staffing levels • Clear restraint protocol including when police may be called to manage patient behaviour within a health or care setting. • Staff should be alert to the risk of any respiratory or cardiac distress and continue to monitor the patient's physical and psychological well-being.	• CWPT-staff access MAPA training • Staff are not trained in face down restraint but such restraint does sometimes happen and all such occasions are reported as incidents. • Coventry has increased the staffing levels on all inpatient wards in line with Francis Report recommendations. • Street triage provides a robust assessment of the person's needs by mental health professional hopefully reducing the number of incidents that become problematic requiring restraint. • Redesign of resources invested to support work around DOL's following Supreme Court Ruling.	• Sufficient advocacy capacity to support DOL's cases. • Lack of Paramedic within street triage	• To amend policy to ensure that ambulance is used to provide physical assessment after incident of restraint by police in community where mental health is a factor • To continue to review the numbers of times restraint is required and to look at whether there are particular patterns requiring further investigation i.e. particular ward etc. • To review whether there has been a reduction in restraint following increased staffing and fewer bed numbers on acute MH wards. • To review the impact that street triage has had on the use of restraint on patients in the community. • To look at opportunities for other providers to access the same training as Coventry staff to ensure a consistent approach to restraint across Coventry. • Review current impact of DoLs judgement on MH service
C4	Quality and treatment and care for children and young people in crisis.	• Standards for involving and informing children and young people • Access to an advocate	• Service working with West Midlands Quality Review Service on CAMHS Standards		• Include WMQRS standards as requirement in specification of new

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		• Principle of treatment at home, or close to home			service from April 2015.
	Recovery and staying well/preventing future crises				
A1	Early intervention.	• Care planning is a key element of prevention and recovery. Following a crisis NICE recommends that people using MH services who may be at risk are offered a crisis plan. • Transitions between secondary and primary care must be appropriately addressed. • Clear criteria for entry and discharge from acute care. • Fast track access back to specialist care for people who may need it in the future • Clear protocols for how people not eligible for the Care Programme Approach can access specialist health and social care when they need it. • Focus on the integration of care with comprehensive pathway of services organised around the patient. • Services must be able to meet the needs of individuals with co-existing MH and substance misuse problems. This needs to be an integrated approach across the range of health, social care and criminal justice agencies.	• Care plan for all service users which include agreed crisis plan. • Transitions protocol for CAMHs to AMHs transition clients. • Single point of entry established. • Fast track entry back into services agreed as part of the new MH pathway. • New pathways developed • Drug strategy out for consultation. • POD and Coventry Wellbeing Hub provides support to people Coventry in recovery • Specialist mental health supported accommodation and floating support available • Street triage will also focus on needs of those with substance misuse and mental health and those who are in regular contact with emergency services	• Knowledge about what is currently available in local areas that can support wider health and wellbeing needs. • Market resources. • Understanding the needs of the city. • Understanding education needs and impact.	• The development of the Coventry web-portal will help people navigate their way through the current complex system of care and support. • Ensure the Care Act requirements incorporate recovery and well-being. • Develop pathways in partnership with primary care. • Mapping providers and services onto the MH pathway, promoting a more integrated approach to the support of people with MH and co-morbid needs to ensure a more holistic and tailored approach to individuals.

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