Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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| **TITLE:** | Crisis service improvements; integration of the North Durham and South Durham & Darlington Crisis Teams into one service across the Durham & Darlington locality and proposal to close the Crisis and Recovery House |
| **REPORT OF:** | Levi Buckley, Director of Operations |
| **REPORT FOR:** | Consideration and Decision |

## Executive Summary:


The purpose of this paper is to outline the next stage of crisis service improvement plans, specifically to describe the integration of crisis services across County Durham and Darlington to improve patient experience and allow more efficient and effective use of resources. Currently there are two separate teams (North Durham and South Durham and Darlington) and there is variance across staffing and ways of working. The paper also outlines the stakeholder engagement undertaken to review the useage and function of the crisis and recovery house in Shildon and recommends that it is closed permanently with resource released to increase capacity to deliver home based treatment.

A three-day Improvement Event was held in September 2018. Attendees were asked to consider the following topics: access to the crisis service; location of bases and how this will work; how the teams should look; assessment and intensive home treatment; key skills of the team and team members; attitudes, culture and values; co-production with service users, carers and families. This paper summarises the outputs from this event and consequent detailed proposals that have been developed to support our transformation of crisis services. These proposals have been supported by TEWV Executive Management Team and the Tees, Durham and Darlington MH & LD Partnership.

At the same time TEWV with commissioners has reviewed the usage and function of the Crisis and Recovery House in Shildon and completed an engagement exercise with stakeholders across County Durham and Darlington in June/July 2018. This identified that a bed based service was not a high priority and attendees identified a' safe space' particulary out of hours as well as more flexible and increased home based treatment as things which would help them if/when the experience a mental health crisis. Further workshops have taken place to develop further the function of a safe space/haven and Commissioners have secured funding via the NHS 10 year Long Term Plan to develop this further. The paper outlines the engagement event process and feedback, reviews the use and effectiveness of the crisis house and recommends that it is closed permanently with resource used to increase capacity to deliver home based treatment.

Savings made from the closure of the Crisis & Recovery House will be re-invested into the Crisis Service to enhance the offer of Intensive Home Treatment (IHT) that the team is currently able to provide. The clinical leadership structure of the team has also been reviewed. There will be 1.0 WTE consultant and 0.8 WTE senior psychologist post for the new Crisis Service, working across the locality. This is in addition to the current clinical leadership provided primarily by advanced practitioners. IHT will be undertaken by both qualified clinicians and support workers.

The model for the new crisis service is a 'hub and spoke' model with a hub based centrally within the locality and two spokes in the North and South of the locality. Crisis clinicians will be responsible for managing calls directed to them by triage workers for clinical decisions and/or further advice. A crisis clinician will act in a Duty Supervisor/Shift Coordinator capacity. There will be a single contact number that will enable all calls to reach the central hub, with a queue system in place for times of peak demand. Standard work will be in place to support Triage workers to manage incoming calls safely and efficiently. Triage workers will have

constant access to a comprehensive and up-to-date Directory of Services so that callers can be accurately signposted.

The single crisis service was implemented in Quarter 1 2019/20 and although currently the teams are still separate there is increasingly more generic support across the 2 areas including input from Advanced Practitioners and Team Managers who now work into both teams. The hub will be established at Auckland Park Hospital from October 2019.

The 3-day improvement event was attended by stakeholders, service users and carer representatives to ensure that the action plan was truly co-produced and all recommendations are in line with the Commissioner led crisis review and discussion at the Crisis Concordat.

**Recommendations:**

The Overview and Scrutiny Committee is asked to note the outcome of the work undertaken so far and the integration of crisis services across Durham and Darlington

The Overview and Scrutiny Committee is asked to support the single service approach and the implementation of the revised model in Quarter 1 2019/2020 and establishment of a hub at Auckland Park Hospital in October 2019.

The Overview and Scrutiny Committee is asked to note the work to date to engage with stakeholders to consider the function and use of the crisis house and is asked to consider if any further consultation is required prior to seeking support to permanently close the Crisis and Recovery House.

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| **MEETING OF:** | County Durham Overview and Scrutiny Committee |
| **DATE:** | |
| **TITLE:** | Crisis service improvements; integration of the North Durham and South Durham & Darlington Crisis Teams into one service across the Durham & Darlington locality and proposal to close the Crisis and Recovery House |

## 1. INTRODUCTION & PURPOSE:

1.1. The purpose of this paper is to inform the Overview and Scrutiny Committee of the improvemennts across crisis services and describes the integration of crisis services across County Durham and Darlington. Bringing the two crisis teams together and having one standard way of working; patients across the locality receiving a consistent approach and service irrespective of where in the locality they live. The changes will also support effective and efficient use of resource and increase resilience and flexibility of service provision. The paper also seeks support for the permanent closure of the crisis and recovery house in Shildon which will allow increased capacity to deliver home based treatment. Investment to develop safe haven(s) has been secured via the NHS Long term plan to progress this element of provision.

1.2. A three-day Improvement Event was held in September 2018 and was attended by a range of clinical and corporate staff, and involved service user and governor representation. The Trust-wide Urgent Care Pathways Lead also attended the event and is supportive of the proposals and how it links with the trust-wide models work on crisis. This paper summarises the output, further work and considerations that came out of this event.

1.3. Following support by TEWV EMT and Commissioners ( via the Tees, Durham and Darlington MH & LD Partnership), the single service was implemented in Q1 2019 with a hub to be established at Auckland Park Hospital ( APH) in October 2019.

## 2. BACKGROUND INFORMATION AND CONTEXT:

2.1. There are currently two separate crisis teams covering the North Durham and South Durham and Darlington areas. However, there are significant variances across the teams in terms of staffing levels and ways of working.

2.2 The Adult Crisis Service works on a 24/7 basis to undertake comprehensive triage assessment of individuals who are currently experiencing a mental health crisis, with the aim of preventing their admission to hospital. Where the individual is admitted to inpatient services, the crisis team works with them to support leave and recovery-based discharge, and enable productive bed flow. The crisis service is also responsible for providing intensive home treatment and facilitating S136 assessments outside of street triage working hours.

The Street Triage Team (STT) works in partnership with Durham Constabulary to provide mental health advice and guidance to assist the Police in joint decision making process around managing risk. The team provides support around mental health legislation as well as offering telephone triage and face-to-face triages to those who come into contact with Police where there is concern for their mental health. Core working hours for STT are between 14.00 and 00.00 hours, 7 days a week.

2.3 The North Durham team is based at Lanchester Road Hospital, Durham and the South Durham and Darlington team is based at West Park Hospital, Darlington. Each team currently comprises a Team Manager, Advanced Practitioner, crisis clinicians and support workers with variance in terms of substantive medical input and admin support between teams..

2.4 There have, however, continued to be significant differences identified in the functioning of the two teams and their ways of working, including the criteria used to refer the patient into inpatient services.

2.5 Staff, patients and stakeholders, through the workshop in September, have therefore proposed that the current crisis service be integrated to form one team and to provide a more standardised approach. This approach has been supported by members of the local Crisis Concordat.

2.6 This work is intrinsically linked to discussions about the future of the Crisis & Recovery House in Shildon. The crisis and recovery house in Shildon is a nine bedroomed house, registered with the CQC to provide social care. Feedback from people who have spent time in the crisis house is very positive. However, the service is only being used by a very small number of people. In 2017 there were only 88 admissions to the crisis house (with an average length of stay of 11 days) and, on average, less than half the beds were being used at any one time. During the same period over 1300 people received intensive home based treatment in their own home (over 7700 visits).

In 2018 there were 28 admissions to the house - with 1412 people receiving intensive home based treatment ( over 7098 visits). The table below details the occupancy by Durham residents.

| Month | % Occupancy (all admissions) | % bed days used by Durham residents |
|---|---|---|
| January - June 2018 | 0% | 0 |
| July 2018 | 6.45% | 61% (11 bed days) |
| August 2018 | 43.01% | 72% (86 bed days) |
| September 2018 | 36.67% | 68% (67 bed days) |
| October 2018 | 14.7% | 83% (34 bed days) |
| November 2018 | 14.4% | 44% (17 bed days) |
| December 2018 | 1.79% | 100% ( 5 bed days) |

On average, a bed in the crisis and recovery house costs the Trust £478 per day to run. In comparison, it costs us on average £380 per day for an inpatient bed in one of our assessment treatment wards and £324 for one of the beds in our rehabilitation units

2.7 There are a number of factors which explain why we have seen a reduction in the use of the crisis house. The way we provide mental health services is changing and there is a greater range of support available for people when they are experiencing a crisis such as:

- a liaison service (working closely with colleagues in Darlington Memorial Hospital and University Hospital of North Durham to support people with mental health problems). This service is available 24 hours a day, seven days a week
- a street triage service - the team provide support for people with mental ill health who come into contact with the police

We know that people get better more quickly if they have increased support at home. We also know that the length of time people need to spend in hospital can be reduced if we offer intensive home treatment in their own home

## 3. KEY ISSUES:

### 3.1 New Service Model

The model for the new crisis service is a 'hub and spoke' model with a hub basedat APH. ) and two spokes in the North and South of the locality (Lanchester Road Hospital and West Park Hospital).

### 3.2 Staffing of the Hub

Triage workers in the Hub will be predominantly support worker/health care assistants who are appropriately trained to safely provide initial support to individuals presenting in crisis. There will be three triage workers working 8am-8pm and two working 8pm-8am, 7 days a week which is the same level of resource as currently available in the Recovery House. From 9am-5pm the Hub will also be staffed by administration staff and one administration apprentice.

Admin staff will provide support and assistance to triage workers and will also undertake additional activities such and producing discharge letters, liaising with GPs etc. It has also been suggested that admin staff are able to directly book assessment/triage appointments into the crisis team diaries. The administration team will have a joint central email account.

There will be at least two crisis clinicians based at the hub for the whole day time shift and at least one crisis clinician based there at night. These staff will be responsible for supervising and supporting the triage workers and triaging calls directed to them by triage workers for clinical decisions and/or further advice. The crisis clinician will act in a Duty Supervisor/Shift Coordinator capacity.

### 3.3 Calls to the Hub – Access to the Crisis Service

There will be a single contact number for D&D crisis services that will enable all calls to reach this central hub. Particularly for times of peak demand, there will be a queue system employed on all calls which would let the caller know their position in the queue of calls to give them some idea of how long they will be waiting before their call is answered. While they are waiting, callers will hear a recorded message providing advice and guidance e.g. Samaritans telephone number, advice to call care coordinator if known to services and their call is during office hours, etc.

There will be no answerphone option available on this phone line as there have previously been. Serious Incidents identified after delays in crisis teams responding to patient's answerphone messages. This would ensure that patients always receive a timely response from the service, as current feedback indicates that they can sometimes be difficult to get in touch with. The proposal is that there will be increased staffing resources in the hub, especially to manage times of known peak demand, across the 24 hour period to respond in a more timely basis and with less interruption.

Standard work will be in place to ensure consistency.

Based on evidence from the commissioner crisis review, it is very likely that a percentage of callers coming through to the hub will require signposting to other, more appropriate services outside of the crisis teams, i.e. across the wider crisis pathway; for example, third sector providers, wellbeing services, social welfare provision e.g. housing services/resources, financial advice, employment advice, local food bank/fuel services as well as signposting to other local resources such as Aspire, Waddington Street, St. Margaret's, ARCH Recovery College, etc. To support this, work is ongoing through the crisis concordat to develop a centralised directory of services for the crisis pathway as a whole that can be used to support all agencies and ensure individuals access the right care for their needs.

### 3.4 Leadership Team

The team will be led by a Service Manager who will be responsible for the locality Crisis Team and the Street Triage Service, ensuring close alignment between the two elements of specialist crisis support. There will be 2 Team Managers and 2 Advanced Practitioners working with the Service Manager. With additional leadership capacity, the intention is that the Team Managers will be able to deliver direct clinical work for 20% of their role. Resource has been identified to implement 2 Peer Workers within the team.

### 3.5 Assessment and Intensive Home Treatment Teams

Savings made from the closure of the Crisis & Recovery House would be re-invested into the Crisis Service to enhance the offer of Intensive Home Treatment that the team is currently able to provide. Specifically the level of support worker resource would be increased to the level in the crisis and recovery house (three workers 12 hours per day 7 days per week and two workers 12 hours per night 7 nights per week There would be 1.0 WTE consultant post for locality. The service would also have input from a 0.8 WTE psychologist. The provision of dedicated psychology input will mean the IHT service meets the requirements of RCP, and would also provide enhanced capacity for specialist supervision within the team. Intensive home treatment would be undertaken by both qualified clinicians and support workers.

### 3.6 Culture, attitudes and values and the integration of the two Teams

It is important that the two teams work together to build trust in each other. During the event, the teams highlighted the need for transparency and for open and honest conversations at all times. Staff also acknowledged that they need to be willing to change, and agreed to voice any concerns that they have. Work continues to be undertaken on the attitudes and cultures within the teams to improve the image of the service and the way that it is perceived currently by service users, carers and families, as well as to improve interagency working.

### 3.7 Co-Production

The 3-day workshop was attended by service users and carer representatives to ensure that the action plan was truly co-produced. The Trust ladder of engagement was used and it is felt that this piece of work has achieved the 'Involve' level (People have an active role in influencing options and outcome but the final decision remains within the organisation), with some elements of the 'Collaborate' level (People working together with clear roles and responsibilities and direct involvement in decision making and action).

Suggestions and plans for future involvement to ensure that the model continues to involve people with lived experience through mobilisation, implementation and monitoring/evaluation include:

- Undertake periodic phone consultation exercise with ten recent users of each Crisis team to gain insights into perceptions of the team
- Establish Focus Groups of Service Users to gain better perspective of how the teams can work together to ensure their service users, their carers and families are getting what they want out of their experiences with the service.
- Establish a Service User/Carer Group that can be consulted regularly, including Recovery Experts.
- Undertake further work to look at how Peer Support/Peer Workers (including potentially paid Peer Support) can be best utilised by the service, in line with the Trust-wide Recovery approach and to ensure maximum benefit for service users and carers.
- Involve and integrate service users/experts by experience into the co-delivery of training to the new team

3.8 **Crisis House Engagement**

As part of the review of the crisis and recovery house an engagement exercise was undertaken during May and June 2018. This included 5 engagement events; 1 in Darlington and 4 in County Durham, along with a dedicated session with the crisis house staff. A briefing detailing the engagement events was sent to stakeholders which included all service user groups, the voluntary sector, local authorities (including overview and scrutiny committees), MPs, all TEWV members and governors. Commissioners were requested to share the briefing with their engagement leads to ensure it was sent to established forums across the locality. The events were promoted widely via TEWV core brief, e-bulletin, TEWV website and using social media. (Briefing attached in Appendix 1). The Darlington event was part of a wider locality engagement to share information and good practice across a range of partners.

The format of the engagement events followed a 'world café' style to encourage group discussion with options for attendees to make individual comments privately to staff or via the TEWV email address. A short presentation was also given providing information on the crisis house provision, usage, cost and feedback from patients and regulators. Stakeholders were asked their views on the following 4 questions:

*Intensive home treatment*

1. What support would you find helpful when experiencing a crisis? (and what isn't helpful?)
2. Where should this support be provided (e.g. at home, crisis house or somewhere else)?
3. Who are the best people to provide this support?
   i) What clinical skills should they have?
   ii) What personal attributes should they have?

*The crisis and recovery house (the building)*

4. Do you think the current service is the best use of this building and why? Could we make better use of the building and, if so, do you have any suggestions for an alternative use?

There were 32 attendees at the 5 events including TEWV crisis service staff, governors, Darlington LA Adult social care, N Durham CCG, service users, Darlington Health Watch, Durham LA staff, Rethink, Darlington Samaritans and Durham Police. The full list of attendees is attached as appendix 2. Feedback and comments from the engagement events and the dedicated session with the crisis house staff were reviewed by the crisis leadership teams and Commissioner staff from the 3 CCGs.

Using the comments and feedback, the following conclusions and proposals were developed by TEWV and CCG staff:

- **Service model**: a desire was clearly identified for the development of a safe haven / safe space which will be available and out of hours OOH. Whilst the criteria would need careful definition there is a need for this to be centrally based and accessible to all. Feedback during workshop discussions highlighted that the current model is not sufficiently inclusive for all, due to the admission criteria and the necessity for direct management of access via the CRHTs. It may be that this could be developed into something that is peer-led

- **Bed based crisis and recovery house**: this was not identified as a high priority for those attending engagement. However the skills and local knowledge of the staff within the Crisis and Recovery House (such as skilled signposting, engagement skills, empathy) need to be retained within the CRHTs to enable the provision of Intensive Home Treatment (IHT) in a more flexible and responsive way in peoples own homes. Equally, there may be an option for a different bed based model that is peer led.

- **Carers:** the need to develop and provide support to carers was highlighted. Whilst this may not need to be led by TEWV there was a strong view that the needs of the carer are essential to meet when supporting a person in a mental health crisis.

- **Use of current building**: Whilst it is accepted that for those able to access the current service their experience is positive, it was highlighted through the workshops that the provision of IHT should not be reliant on a 'bed base'. Feedback highlighted that the location for the provision of this service did not meet the needs of the majority.

Overall, the findings from the pre engagement exercise suggest we need to consider whether a bed based crisis and recovery house is the most appropriate use of resources to meet patient need.

**3.9** Work to scope possible Safe Haven Models following commissioner discussions has also commenced and a summary of this work is attached at appendix 3. Alongside this, discussions have been continuing with the Crisis Concordat and Commissioners (linked to the concurrent Commissioner review of the wider Crisis pathway) about wider service developments that need to be taken forward with the wider health economy and community. Investment has been identified as part of bids for NHS Long Term Plan priorities to further develop the safe haven work. And although this is in its early stages the proposals support the principle of a range of availability across the geography of the Locality which addresses the concerns of a single provision of the Crisis and Recovery House across the County Durham and Darlington geography

## 4. CONCLUSION:

TEWV continues to develop its crisis services to meet the needs of people in County Durham and Darlington, as part of the wider crisis model development which is led by the crisis concordat. The aim is to develop a single crisis team for County Durham and Darlington, offering a standard approach whilst maintaining the flexibility to meet individual needs and changing demand. The hub will be based at Auckland Park Hospital from October 2019.

The feedback from the engagement exercise undertaken in June/July 2018 in relation to the function and use of the crisis and recovery house demonstrated that people who were experiencing a mental health crisis preferred to be supported at home whenever possible.

Staff who previously worked in the crisis house work will continue to provide much needed skills and additional capacity within the crisis team. This will increase the level of intensive support that can be provided to patients. We anticipate being able to support people who would previously have spent time in the crisis and recovery house at home.

Investment has been secured via the NHS Long Term plan to further develop safe haven(s) across County Durham and Darlington with work to commence from October 2019.

## 5. RECOMMENDATIONS:

The Overview and Scrutiny Committee is asked to note the outcome of the work undertaken so far and the integration of crisis services across Durham and Darlington.

The Overview and Scrutiny Committee is asked to support the single service approach and the implementation of the revised model in Quarter 1 2019/2020 and establishment of a hub at Auckland Park Hospital in October 2019.

The Overview and Scrutiny Committee is is asked to note the work to date to engage with stakeholders to consider the function and use of the crisis house and is asked to consider if any further consultation is required prior to seeking support to permanently close the Crisis and Recovery House.

**Levi Buckley, Director of Operations, Durham and Darlington**
**August 2019**

## Appendix 1 – crisis house engagement briefing documents

role and future of the crisis and recover

Crisis and recovery house in D&D.pdf

## Appendix 2 - crisis house engagement list of attendees

crisis house engagement Attende

## Appendix 3 – safe haven model

Appendix 4 - Safe Haven Design summa