A. Access to support before crisis
When I need urgent help to avert a crisis, I, and people close to me, know who to contact at any time, 24 hours a day, seven days a week. People take me seriously and trust my judgement when I say I am close to crisis, and I get fast access to people who help me get better.
A1 Early intervention – protecting people whose circumstances make them vulnerable
Please say how you will improve outcomes for people approaching crisis point. 24/7 crisis support is available for people experiencing a crisis in their mental health. This support comprises • 24/7 access to telephone support from mental health professionals • community based crisis support (9am -10pm) that is able to respond within 1 hour and is able to attend to people in setting of their choice – this is for people known and not known to services • 24/7 mental health liaison team (for adults) at local A&E • round the clock access to medical support including assess to OOH support via an on call rota • signposting to services by NHS 111 • care plans for everyone known to services include details about how to access services in the event of a crisis • web based information about how to access local crisis support services is widely available – key information points include the local MIND website, SPFT website, CCG and BHCC websites • awareness in primary care of what is available • availability of 24/7 crisis response home treatment team which provides supports in the community to enable them to remain at home when they are unwell. Where appropriate this team will facilitate admission to a bed • 27/7 access to telephone support from mental health professionals – CAMHS Consultant on call • CAMHS specific Urgent Help Service (CRHT) available until 8pm weekdays and 10am until 6pm weekends and bank holidays The Lighthouse service supports people with a diagnosis of personality disorder. Members of this service have access to: • A 7 days a week partnership service • Individualised Care Plans • Peer support workers Web-based support (IRIS)

IBIS Plans:
All adult patients identified as frequent attenders have updated information regarding needs and crisis support pathways uploaded onto IBIS.

All patients on CPA have an up to date Crisis Plan that they, their GP and other services/individuals (e.g. Carers) involved in their treatment and support are aware of that specifies individualised crisis/ risk management strategies and pathways, relevant contact numbers etc.

The early intervention psychosis service offers:

- Crisis Plans which are developed in collaboration with patients based upon work to help identify when they might be experiencing a deterioration in their mental health and detailing strategies which might be employed to help with this. Crisis plans also provide contact details for support when EIP staff are not available
- Risk assessments are undertaken at the point of entry into the service and are based upon referral information, discussions with the patient and where possible carers and family (see below). They are reviewed regularly and in response to changes in the levels and nature of risks. Risk assessments are used as a basis for Risk Management plans.
- Where the patient has given their permission (18+) carers and family members are involved in planning patient care, the identification and management of risks
- Where permission has not been given carers and family members can be supported through the provision of more general information regarding contact numbers in the event of a deterioration in the patient's mental health and by information regarding psychosis.
- All medical reviews are shared with the patient's GP
- Crisis plans, contingency plans and the overall care plan are reviewed regularly.

The city has an annual suicide prevention action plan. This is agreed by a multi-agency group, chaired by the Director of Public Health, and includes representatives from mental health secondary and primary care services, the Mental Health Liaison Team at A&E, CCG, voluntary sector, police, probation, ambulance and fire &rescue services, and Universities. The action plan for 2013-14 includes:

- identification of hotspots (on seafront and railways) and action to address this – signage, training, CCTV at stations;
- clinicians' meetings to identify learning from individual deaths by suicide, bringing together GP and mental health services staff;
- training for acute staff in A&E on self-harm, designed to raise awareness

and challenge stigma – audits show this has been effective;
- advice sent out to GP practices on debt, financial difficulty and mental illness;
- leaflets for the public, for the LBGT community developed and resources for those bereaved by suicide in development;
- training on suicide prevention, self-harm, mental health awareness for those working with a range of vulnerable groups, including BME, LGBT, those in contact with criminal justice system, high risk occupations, etc.
- Grassroots Suicide Prevention is working towards 'Suicide Safer City' status for Brighton & Hove; this includes training, tackling taboos about open discussion, and the development of Suicide Safer Organisations.

We have secured funding to develop crisis support for people with a learning disability. This service is still being scoped.

Have you considered:
- How to make people aware of who to contact in a crisis
- A combination of early intervention services that meet local need
- Joint crisis care planning
- The role of primary care
- Vulnerable groups, including BME communities, people with learning difficulties, people with physical health conditions, people with dementia and children and young people
- Suicide prevention

This checklist is based upon the 'I' statements made within the Concordat. It is intended as a prompt to help people working on local Declarations develop local action plans.

B. Urgent and emergency access to crisis care

If I need emergency help for my mental health, this is treated with as much urgency and respect as if it were a physical health emergency. If the problems cannot be resolved where I am, I am supported to travel safely, in suitable transport, to where the right help is available.

I am seen by a mental health professional quickly. If I have to wait, it is in a place where I feel safe. I then get the right service for my needs, quickly and easily.

Every effort is made to understand and communicate with me. Staff check any relevant information that services have about me and, as far as possible, they follow my wishes and any plan that I have voluntarily agreed to.

I feel safe and am treated kindly, with respect, and in accordance with my legal rights.

If I have to be held physically (restrained), this is done safely, supportively and lawfully, by people who understand I am ill and know what they are doing.

Those closest to me are informed about my whereabouts and anyone at school, college or work who needs to know is told that I am ill. I am able to see or talk to friends, family or other people who are important to me if I so wish. I am confident that timely arrangements are made to look after any people or animals that depend on me.

B1 People in crisis are vulnerable and must be kept safe, have their needs met appropriately and be helped to achieve recovery

Please say how you will ensure that people in mental health crisis will not be turned away but will be safe and find the support they need 24/7.

Face to face and telephone crisis support is available across the city 24/7.

People who present at or who are taken to the Royal Sussex County Hospital will be supported by the Mental Health Liaison Team (Adults). This team has access to a dedicated room where patients can be supported in a calm and safe environment.

The ambulance and police services is aware of the support options and is able to call though to services to service to establish whether community support can be provided or whether the patient needs to be taken to hospital.

Where practical community based crisis support can be provided to support patients outside of hospital settings.

The ambulance service has access to IBIS records for around 100 adult mental health patients, including many frequent callers which provide key information about a patient's needs. This information is intended to enable the ambulance crew to provide the most appropriate level of response.

Presentations to Ambulance Services / 999

- Emergency Operations Centres (EOC) and 111 have access to both mobilising an ambulance response, accessing crisis services and GP Out of Hours services
- By encouraging other health providers to use IBIS there will be greater knowledge of an individual's needs and both routine and crisis care plans
- NHS Pathways modules are in place to allow for the assessment of MH

crisis and both local and national variations are being produced to reflect the urgent response required

- SECAmb will always seek to convey patients to the most appropriate destination according to their health needs which may mean A+E or another destination subject to local agreements
- Control Centre Protocols for decision making / directed access to different options e.g. as above as alternatives to blue-light attendance
- Control Centre / Data-base with details of known mental health patients Conveyance to A&E if necessary / indicated.
- Where young people/children are frequent callers SPFT works with police to share relevant information about the care plan with consent

Have you taken account of:

- All agencies the person may turn to first
- Options that are community-based, close to home, least restrictive and appropriate to the individual

B2 Equal access

Please say how you will address equality of access and outcomes for people in mental health crisis, with particular reference to engagement with BME communities.

Written information about local crisis services is available in a variety of languages and formats

Translation and interpretation services are available for NHS services 24/7 at short notice

Equality and diversity training is a mandatory training requirement for all staff.

All services have an identified BME Lead who links into services to ensure service provision is culturally appropriate/ diverse. All services have undergone an EHIRA.

All ambulance policies and procedure are subject to EA process and cannot be approved without this process

B3 Access and new models of working for children and young people

Please say how you will ensure children and young people with mental health problems have access to crisis care.

Tier 3 of CAMHS offers community based crisis support for children and young people between 9am – 5pm , Monday to Friday . The T3 CAMHS Team has a dedicated daily Duty Clinician and Duty Psychiatrist who are able to respond to urgent and emergency referrals and offer support and assessment when required. T3 CAMHS provides a 4 hour response to urgent referrals where required and offers assessment and treatment advice to colleagues at the RACH including on site assessments when necessary.

Tier 4 – Acute services are provided in the form of inpatient, day, and crisis resolution and home treatment services. The Crisis resolution and home treatment (CRHT) is accessed via tier 3 services and emergency presentations in Accident and Emergency departments or in relation to the mental health act. The CRHT is the gateway to an inpatient mental health bed if this is required. This service is age appropriate and delivered in line with Quality Network for Inpatient CAMHS standards and currently has an outstanding rating.

The service has the following key features, (Every Child Matters, DH 2003), which provides a statement of both its values and its commitment to a comprehensive CAMHS provision based on assuring multi agency and multi-disciplinary working:

- Child and young person focussed
- Family friendly
- Have an ability to meet the most complex mental health needs of children and their families.
- Be part of a network of care for children and young people with severe, challenging and complex problems.
- Be able to provide intensive home treatment for 3-5 face to face contacts per week. Specialist consultation and advice to Tier 3 teams.
- Provision of initial assessment of referrals in order to detail goals prior to admission if required which will occur in close collaboration with locality Tier 3 services.
- Intensive home and community assessment and treatment for young people and children whose needs can be met whilst remaining at home. Without this service they would require admission into hospital.
- Facilitating prompt and timely discharge from the in-patient setting with follow up work when indicated.
- Contributing to the 24/7 face to face and on-call crisis assessment where acute interventions are determined to be necessary (provided in conjunction with the in-patient service), alongside working age services.

The primary purpose of the CAMHS CRHT is to provide an intensive home treatment service to children and young people who are presenting with acute

mental health needs or emotional disturbance to a degree where the levels of risk they pose indicate an inpatient admission may be necessary. This will enable young people where possible to be supported in remaining at home and reduce the need for an inpatient admission and ensure appropriate and a timely access to and discharge from the inpatient service.
In addition, the service will respond to mental health crises of children and young people out of normal office hours as well as undertaking a gate-keeping role for admission to the CAMHS Tier 4 Day & Inpatient Adolescent unit. The inpatient accommodation at Chalkhill is purpose built for the age group.

Teen to Adult Personal Advisors (TAPA) is a young person's mental health service (14-25 years) provided by SPFT in partnership with Sussex YMCA, Impact initiatives and Allsorts to meet the mental health needs of young people across the city who are `hard to reach`. They use an assertive outreach approach that is holistic and person-centred which means they will meet with, engage, advise and support young people wherever they feel most comfortable.

Have you addressed:

- Age-appropriate accommodation for under-18s
- Support for young people making transitions into adult services
- Involvement of parents
- Robust partnership working and communication between primary and secondary care agencies
- Involvement of schools and youth services
- Keeping children and young people informed about their care and treatment

B4 All staff should have the right skills and training to respond to mental health crises appropriately

Please say how staff will gain the knowledge, awareness and skills needed for multi-agency working in crisis response

All SPFT staff undergo Mandatory Training in respect of Clinical Risk Assessment and Management, Care Programme Approach and Safeguarding – which, in addition to core clinical assessment, escalation and care planning elements include guidance and support in respect of multi-agency pathways and partnership working.

All staff engage in regular clinical and managerial supervision, case load review sessions and multi-disciplinary clinical team meetings where specific patients, pathways, care plans and multi-agency working needs and arrangements are

discussed.

Specific pathways, referral and joint care planning arrangements/ protocols are in place between core adult mental health services and Substance Misuse and Secure and Forensic Services.

Grassroots is a local voluntary organisations that supports the prevention of suicide. It is commissioned to raise awareness about and provide training and education to frontline professionals about suicide and self-harm. Commissioners are also currently procuring mental health awareness training as well as training about mental wellbeing awareness and promotion.

Youth projects and organisations including Right Here and RUOK ? have carried out training in primary care to support clinicians to understand young people's needs.
In the ambulance service

- all University Qualified Paramedics have received education and experience in a Mental Health Setting
- There have been local initiatives to raise the awareness of MH in Ambulance Staff
- Paramedic Practitioners complete a module on Mental Health as part of their training programme
- Paramedic Practitioners also receive update training and a 1 day placement with a crisis team
- There is also the possibility of an e-learning package to be available for all staff via the Trust's e-learning website

In the Summer of 2014 Sussex Police revamped and updated the training for officers and staff, specifically the Communications lesson plan. This plan now focuses on mental ill-health. The session includes group work on how to identify signs and symptoms of mental ill-health and then develops into a group discussion on what officers / staff could do to adapt their communication style to assist them in dealing with the situation they are involved in. The session balances the need to make adjustments with their own personal safety and dealing with the circumstances that called for a police presence. A practical scenario has also been trailed and this is under review to ensure it adds value. This lesson plan now forms part of all Sussex Police programmes (Regular Officers, Specials, PCSOs, and

Police Staff).

In addition, Sussex Police call handlers now receive a bespoke training package on mental health and how to communicate with someone over the telephone that is in distress and seeking help and support.

Sussex Police works closely with our partner, Sussex Partnership NHS Foundation Trust as their staffs play a key role in training Police officers and staff. The Police, Courts, Liaison and Diversion practitioners deliver training to Custody officers and staff and Street Triage nurses working with uniformed officers in Eastbourne provide on-going support and advice to a wide range of officers and staff.

There is also the computer based training package from the National College of Policing "Responding to people with mental ill health or learning disabilities" and this is mandatory training for key groups of officers and staff.

There are also pockets of training being provided with local groups and organisations and Sussex Police is constantly striving to ensure we provide our staffs with the right training to be able to deliver an excellent service to the public in Sussex who have a mental illness, learning difficulty or vulnerability.

Have you addressed:

- Management advice and support
- Awareness of local mental health and substance misuse services and how to engage them
- Training arrangements across NHS, social care and criminal justice organisations
- Understanding of locally agreed roles and responsibilities

B5 People in crisis should expect an appropriate response and support when they need it

Please say how you will ensure a prompt, high quality response that works towards the Access to services statement in NICE's Quality standard 14 for service user experience in adult mental health

24/7 crisis support is available across the city – see response to A1 for details.

Specific response times details:
Community mental health crisis: 4 hour response time from initial referral/ contact by patient/ referrer.

A&E: 1 hour response time for urgent referrals to the Mental Health Liaison Team

(adults).

Mental Health Act Assessment/ AMHPs:4 hours to assess and 6 hours to complete assessment for both adults and children and young people

There are plans to increase the availability of OOH face to face support for patients under the secondary mental health services (moving to an extended community-based Duty/ Crisis Response service available until 10pm, 7 days a week).

There is access to telephone support 24 hours a day, 7 days a week via the BURs service (24/7), support by the provision of the Mental Healthline OOH.

T3 CAMHS provides a 4 hour response to urgent referrals where required and offers assessment and treatment advice to colleagues at the RACH including on site assessments when necessary.

Have you addressed:

- Time from referral to face-to-face assessment
- 24 hour helpline
- 24/7 availability of crisis resolution and home treatment teams
- Commissioning that allows for beds to be readily and locally available in response to urgent need
- Commissioning provision for under 18 year olds that ensures local provision for young people in urgent need
- Availability and use of crisis plans and advance statements

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, including mental health services, ambulance services, and Emergency Departments.

Please say what you will do to ensure sufficient NHS places of safety, reduce the inappropriate use of police custody suites as places of safety, and put in place a local protocol for the approach to be taken when a police officer uses powers under the Mental Health Act.

Section 136:

- There is an NHS purpose built S136 suite/ place of safety
- There are agreed operational protocols and pathways (including Authority to Exclude from NHS Place of Safety) and regular multi-agency (police, CCG, NHS/LA) meetings to review working arrangements and activity/ exceptions relating to use of S136 and police/ NHS place of safety facilities
- There is an AMHP and S12 medic on-call rota

- AMHP response times: 4 hrs to commence and 6 hrs to complete assessment
- Qualified nursing staff undertake mandatory Fitness to Detain training
- The mental health in-patient facility has a dedicated Unit Co-ordinator (24/7) who supports admissions and the operation of the NHS 136 Suite

Mental health is Police business but often the Police are the only agency who can provide a truly 24/7 response in a timely manner. If there were safe alternatives or services who could intervene at the time the person was having their crisis and in the location where the crisis occurs, Police would not have to use their powers of detention under s136 mental health Act 1983 as often.

Once someone is detained under s136 they must be removed to a place of safety. The Mental Health Codes of Practice have always stated that Police cells should only be used as a place of safety in exceptional circumstances.

Exceptional has never been defined but should really be held for those people who are so violent that they need to be physically restrained, and if released could seriously hurt themselves or others. There are inherent dangers with physically restraining someone in this situation for any period of time, especially when they are displaying signs of excited delirium or other medical conditions. Police officers cannot be expected to medically diagnose someone at the scene of an incident.

They should have immediate access to a medical professional with the option of taking the person to A&E for an emergency medical intervention if required. If there is no physical emergency but the person is violent then a Police cell is probably more appropriate. It should never be the case that someone is refused access to an alternative place of safety because it is closed due to lack of staff, because the person is displaying disturbed behaviour or they are intoxicated. This is not exceptional, this is the norm, and Police cells are then used as the default position and the regular backup to the NHS.

The mental health Codes of Practice state that a mental health assessment should begin within 4 hours of the person being ready to assess and completed within 6. This is usually not complied with as depending on time of day and day of week, it may not always be possible for an AMHP and Doctor to be available together. People detained in Police custody are not seen as a priority for an assessment; there are no fast track options to have people assessed. Statistics show that a child or young person detained under s136 will remain in the cell longer than an adult waiting for an assessment due to the shortage of specialists in this field.

Transfers between places of safety do occur but this is rare. It is incumbent on the Custody staff to keep contacting the hospital place of safety to see if there are

able to accept the detainee and at busy times in custody it is not always possible for the staff to keep calling. The hospital places of safety rarely if ever call custody to say they are free to take someone.

In each area there is a multiagency group who monitors the use of s136 within that locality; it looks at reasons for refusals and closures of the place of safety.

Have you addressed:

- Timescales for health and social care services to respond to police
- Police officer training
- What happens if a police cell is used – fast-tracking assessment or transfer, data recording, review and learning
- Ensuring any use of police stations is truly exceptional
- The needs of children and young people
- Healthcare staff taking responsibility
- Timeliness of assessments
- Understanding of roles and responsibilities and arrangements for escalation

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

Please say how you will ensure that people who need formal assessment under the Mental Health Act will receive a prompt response and that arrangements for their care, support and treatment are put in place in a timely way.

Protocols that have been developed and shared with all the relevant agencies that set out the arrangements for supporting people who need formal assessment under the Mental Health Act. These protocols include

- the arrangements for securing an approved mental health professional to carry out the assessment
- details about the role of the unit co-ordinator
- arrangements for emergency admission to beds
- arrangements for supporting people detained under S136 of the Mental Health Act

Access to local in-patient beds if required:

- Bed Management function: 24/7 support for in-patient facilities to support AMHPs and other professionals seeking access. OOH escalation process via on-call Manager and Director if required.
- Commissioners have agreed additional local overflow provision if required (Hove Priory).

Monthly joint police/NHS meetings review use of NHS and Police Places of Safety. Reviews include detailed analyses of the Authority to Exclude cases. Protocol recently reviewed and revised to support increased use of NHS Place of Safety. Staff recently updated re, communication and training in relation to Authority to Exclude.

T3 CAMHS provides a 4 hour response to urgent referrals where required and offers assessment and treatment advice to colleagues at the RACH including on site assessments when necessary.

Have you addressed:

- Best practice guidance on timescales for section 12 doctors and approved mental health professionals (AMHPs), i.e. within 3 hours
- Assessment of children and young people
- Bed availability and sufficient provision of AMHPs
- Least restriction and avoiding stigmatisation

B8 People in crisis should expect that statutory services share essential 'need to know' information about their needs

Please say how you will introduce appropriate data sharing about people's needs and circumstances

SPFT is committed to further increasing the use of IBIS records so that the ambulance service has access to key information regarding patients, particularly those who are frequent callers and attenders. These records include information about any advance statements, crisis plans, dependents, communication requirements and physical impairments.

Multi- disciplinary team meetings take place to share information about complex patients and to ensure that crisis plans are developed and shared.

SPFT have robust clinical governance and safeguarding polices and procedures in place. All patients have a level one risk assessment which will determine if escalation to a mutli-disciplinary level two assessment is required. In certain very complex cases, clinicians can call upon the Trustwide Clinical Risk Panel for review and input to the formulation and planning processes.

SPFT have a Lead Nurse for Safeguarding and a named doctor who can provide specialist advice and support into complex Safeguarding cases for adults and children.

Pan-Sussex information sharing protocols and procedures are in place to support sharing of essential information relating to risk management and Safeguarding issues.

S115 Crime and Disorder Act 1998 gives a Relevant Authority the power (not the duty) to share information in a wide range of circumstances, including the prevention and detection of crime, If there is a risk of harm to the person, or a risk of harm to others (including children). Information sharing should be proportionate and justified but it often needs to be exchanged fast time. Many medical practitioners are nervous about giving out information and will seek authority to do. This can cause unacceptable delays and before the information has been provided an irreversible decision has been made.
There needs to be clear and robust information sharing agreements in place that staff members can read and understand that cover emergency and slow time situations. In an emergency situation there needs to be a member of staff immediately available to take the request from the enquiring agency and respond.

The Police Courts Liaison and Diversion Service and the Street Triage Service have specific information sharing agreements between the relevant authorities involved in delivering the service. The ability for information to be shared in these instances has been invaluable and are at the foundations of both services.

Have you addressed:

- The range of information that may need to be shared including communications needs, physical impairments, crisis plans and advance statements, and any dependents.

B9 People in crisis who need to be supported in a health based place of safety will not be excluded

Please say how you will ensure that people are not excluded from health-based places of safety / Emergency Departments due to intoxication, history of violence or lack of appropriate provision for people with personality disorder

There are 2 places of safety in Brighton – Millview Hospital and Hollingbury police station. The only reasons that a person will be excluded from accessing the suite at Millview is if they being actively violent or threatening and in these cases individuals will be taken to police custody.

If the Unit Co-ordinator at Millview is seeking to exclude a detained person from the Suite and they are not currently violent or aggressive then they will need to demonstrate robust risk information to support their decision.

As referenced previously there is an agreed Authority to Exclude policy and protocol and exceptions are routinely reviewed in monthly joint police/NHS meetings. This policy is included in the on-call Manager's guidance to support Manager's involved in any escalations.

Unit Co-ordinators and qualified (Band 6) nursing staff all undertake Fitness to Detain training. Beyond issues of active violence/ aggression – if a patient has a suspected head injury or may have been the victim of a serious crime (requiring the immediate support of the FME) they will probably be unsuitable for the NHS Place of Safety.

The Lighthouse (previously outlined) provides additional community-based support for patients with PD (excluding Anti-social PD) with a view to reducing/ preventing crises emerging.

Have you addressed:

- Staff skills in screening, assessing, diagnosing and monitoring people who are intoxicated
- What circumstances may pose too high a risk
- Commissioning of services that can respond to the needs of people with personality disorder and prevent escalation into crisis, in line with NICE guidance

B10 People in crisis who present in Emergency Departments should expect a safe place for their immediate care and effective liaison with mental health services to ensure they get the right ongoing support

Please say how you will ensure that Emergency Departments provide a safe place for people in crisis and that people receive treatment that is on a par with standards for physical health, with adequate liaison psychiatry services in place, and a local forum for agreeing protocols and escalation issues.

A dedicated room is available to the mental health liaison team to support patients.

Clear protocols exist between A&E and the mental health liaison team for referral between services. Once a patient is deemed by A&E staff to be medically fit, onward referral to the MHLT can be progressed.

There are clear KPIs in relation to response times for the MHLT receiving urgent/priority referrals from A&E:

- *1 hour response*. The team is expected to be able to triage and assess a patient with an urgent need within an hour of the request being made or within an hour of the patient becoming medically fit.

- *4 hour response*. The team is expected to provide a 4 hour response, where the mental health problem is putting the patient's physical health, other patients of staff at immediate risk.

As referenced previously all MHLT staff are suitably qualified and skilled in assessing, care planning and liaising in relation to patient's presenting with mental health issues/ crises. All MHLT and CRHT staff undertake the ASSIST training in addition to Mandatory training requirements relating to assessing mental health presentations, risk assessment and management, MHA/MCA and PMVA.

If any form of restraint is required whilst a patient is attending A&E/RSCH – this duty rests with BSUH staff.

It is our intention to invest in children and young peoples crisi services as follows:

Crisis pathway and acute mental health liaison

There is some psychological support at The Royal Alex Children's Hospital (RACH) for children with long term conditions, but not for those who attend A&E and/ or are admitted in a crisis. There is a recognised need for mental health liaison with RACH but the exact model has yet to be defined and depends on the demand, need and acuity of children and young people. This would need to be for Sussex residents as well as Brighton and Hove as RACH take children and young people from a wide catchment area. The intention is to invest in 2015/16 in this service.

The aim of the service would be to:

- Improve the quality of care for those experiencing mental problems whilst they are being cared for at Royal Sussex County hospital (RSCH) and/ or Royal Alex Children's Hospital (RACH) and to integrate mental health care with physical health care;
- Enhance the skills of non-mental health professionals to better equip them to support patients with a mental health problem;
- Reduce emergency admissions and A&E attendances for children and young people with mental health problems by:
  providing a rapid access assessment and treatment for patients experiencing a crisis in their mental health
  securing onward referral to community mental health services where appropriate;
  providing telephone advice between 8pm and 8am;

- Provide in patient mental health care to patients when they have been admitted to both short stay wards as well as general hospital wards, where there is concern over their mental state; and
- Reduce the length of stay for patients following admission by planning for discharge as soon as a patient is admitted.

Have you addressed:

- Safe, appropriate and respectful treatment of people who are suicidal or self-harming
- Identification of mental health problems and referral
- Staff skills in connection with suicide risk, including NICE guidelines and legal requirements
- Emergency Department staff's adherence to the NICE quality standard on self-harm
- Ensuring that the use of restraint procedures is safe and that there is provision for the safe use of rapid tranquillisation in Emergency Departments – see NICE guidance on the management of disturbed behaviour and Positive and proactive care: reducing the need for restrictive interventions.

B11 People in crisis who access the NHS via the 999 system can expect their need to be met appropriately

Please say how the 999 system ensures an appropriate response.

There is 24/7 access to mental health advice and support for all professionals via the community and A&E BURs service.

MHLT offer student placements to ambulance, BSUH and other health and social care staff.

People calling 999 will be assessed by SECAmb via NHS Pathways, there are also Clinical Supervisors (Paramedics and Nurses) who can assist in complex calls and upgrade response as required.

In some areas staff and EOC can access Crisis teams direct and OOH services can be contacted directly by staff at scene and EOC

All 999 calls to the Police in Sussex are taken by experienced call handlers and Police officers. None of these call handlers are nurses or are employed to give advice regarding mental health or physical health. The call taker records all necessary information and depending on the nature and degree of risk will assign a Police response accordingly. Our call handlers will engage people in distress in a

conversation and do all they can over the telephone to keep that person safe. The only response we have is to send a Police officer and if it's obviously a physical injury/need then we will contact the ambulance service and ask them to attend.

The Police have no agreements with any other health teams or services to respond to incidents that have a clear mental health element to them. The Police have no access to GPs, and if they do, many GPs will not even tell the Police whether someone is registered with their practice. The officer will usually attend the incident knowing very little if anything about the person is distress but will ultimately do all they can to ensure the person's safety.

Have you considered:

- Mental health advice available to the 999 ambulance control room 24/7
- Enhanced training for ambulance staff
- Flexible working across ambulance trust boundaries.

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

Please say how you will ensure safe, appropriate and timely transport.

As per S6 MH Act – police do not convey patients who are detained/ require conveyance following decision to detain to in-patient units.

1. SECAmb currently only commissioned to provide S136 transport in Kent area, consequently in Brighton and Hove police vehicles are generally used to convey individuals to the place of safety
2. Commissioning of this activity is required
3. Currently the only vehicles available to transport in an emergency would be a Double Manned Ambulance
4. PTS vehicles may be used for routine or less acute presentations not requiring an emergency response

In line with the mental health Codes of Practice the Police service would rather people were conveyed by Ambulance in a timely manner and not conveyed by Police vehicles. In cases of exceptional violence when a Police vehicle would be the most appropriate method of transport a medical professional (paramedic) should travel with the detained person til they arrive at the place of safety or A&E.

Currently, once someone is detained under s136 mental health Act 1983 the only vehicles they are transported in, to the place of safety are Police vehicles. The vehicle could be a marked Police car, an unmarked Police car (street triage only)

or a marked caged Police van.

Following an assessment in the community if there are unacceptable delays in the ambulance service responding or the ambulance service are refusing to take the patient then they will be transported in a Police vehicle, unless the AMHP is prepared to arrange a private ambulance, which would be the preferred choice of the Police.

Have you made sure that:

- Police vehicles are not used to transfer patients between units within a hospital
- Caged vehicles are not routinely used.

B13 People in crisis who are detained under section 136 powers can expect that they will be conveyed by emergency transport from the community to health based place of safety in a safe, timely and appropriate way

Please say how you will ensure safe, appropriate and timely transport.
See above

Are you:

- Meeting response times and standards in the national ambulance service protocol
- Avoiding the use of police vehicles and caged vehicles.

C. Quality of treatment and care when in crisis

I am treated with respect and care at all times.

I get support and treatment from people who have the right skills and who focus on my recovery, in a setting which suits me and my needs. I see the same staff members as far as possible, and if I need another service this is arranged without unnecessary assessments. If I need longer term support this is arranged.

I have support to speak for myself and make decisions about my treatment and care. My rights are clearly explained to me and I am able to have an advocate of support from family and friends if I so wish. If I do not have capacity to make decisions about my treatment and care, any wishes or preferences I express will be respected and any advance statements or decisions that I have made are checked and respected. If my expressed wishes or previously agreed plan are not followed, the reasons for this are clearly explained to me.

C1 People in crisis should expect local mental health services to meet their needs appropriately at all times

Please say how you ensure that there is a safe response to crisis 24/7, on a par

with that for physical health emergencies.

Services that support people experiencing a crisis in their mental health do operate to standards that correspond to the standards expected in physical health care crisis management. Individuals requiring support in the community as well as in A&E can expected to be supported within 1 hour.

As with physical health the crisis services have performance measures which are monitored by commissioners.

All in-patient facilities including the NHS Place of Safety are SSA compliant. There is no use of CCTV in the NHS Place of Safety.

Does the service response provide for the dignity of the person in crisis?

C2 People in crisis should expect that the services and quality of care they receive are subject to systematic review, regulation and reporting

This is mainly a Care Quality Commission responsibility but please say how, as service providers, you will monitor the quality of your response to people in crisis.

The performance and quality of local services is reported on monthly to commissioners and monthly performance and quality meetings also take place

There are multi agency monthly meetings held in the localities of the s136 places of safety where any adverse issues can be raised.

All officers whether operation or in custody must document when they have used force on a person, this is internally monitored.

There are monthly meetings within Sussex Police to monitor the safety of all people detained in Police custody in line with the Guidance on the safer detention and handling of persons in Police custody. There are also standards set within the Police and Criminal Evidence Act 1984, Codes of Practice, which must be met.

Any complaints made about someone's care whilst in the "Care" of Sussex Police will be internally investigated in the first instance either by the appropriate Inspector or the Professional Standards Department. We are also regularly inspected by Her Majesty's Inspector of Constabularies, a member of whom is from the CQC. There is also scrutiny from the Independent Police Complaints Commission.

C3 When restraint has to be used in health and care services it is

appropriate

Please say what you are doing to implement the guidance Positive and proactive care and the Mental Health Act 1983 Code of Practice in relation to restraint.

SPFT have an annual PMVA Training Plan and have established a PPC Forum to review and revise current policy and operational protocols to align with recent guidance (PPC, April 2014).

SPFT have a Zoning Protocol to ensure that risk management and PMVA approaches are aligned to patient need and presentation.

Following a Safer Staffing review staffing levels are routinely monitored and issues can be escalated to on-call Managers OOHs to ensure safe staffing levels are adhered to at all times.

Local protocols are in place between SPFT and the police in relation to the management of violent/aggressive patients when accessing/ in-patient in NHS facilities.

Police should only be called to assist staff when they have effectively lost control of a violent patient. Police should not be called because there is not enough appropriately trained staff available to assist with the control and restraint of a patient. The Police intervention should be minimal and once control is regained the patient should be immediately handed back to the care of the nursing staff and the Police leave. Patients should be managed within the hospital and there should not be an expectation that Police will remove a patient into the cells because the hospital cannot safely manage their patient.

If nursing staff are trained, but unwilling to restrain a violent patient then it is not reasonable for the Police to be asked to do so.

Have you addressed:

- Staff training
- Staffing levels
- Protocols for if the police are called to manage patient behaviour, and ongoing mental health staff responsibility for the patient's health and safety.

C4 Quality and treatment and care for children and young people in crisis

Please say how you will ensure that the treatment and care of children and young people is appropriate to their needs, and that they are informed, involved and enabled to have a voice

SPFT CAMHS have operational protocols, policies and training in relation to Care Planning, Risk Assessment and Management and Crisis Plans – which include advanced directives and care plans where appropriate.

The voice of the children and young people is central to the planning and delivery of individualised plans of care. All children and young people are given the opportunity to meet with a CAMHS clinician alone. Gillett competency is always considered where appropriate.

Once assessed and treatment is indicated each child and young person has an allocated CAMHS Lead Professional who ensures that the service user and their family are fully informed, involved and have a voice in the collaborative treatment process.

CAMHS is actively encouraging of user involvement. The Brighton CAMHS team has allocated staff who take a specific interest in engaging young people in service development, design and delivery. The CAMHS Team has established good links with the local MIND young person's representative. Young people are involved in the recruitment and interview of CAMHS staff where appropriate with the support of MIND.

Service user participation is a standing agenda item on CAMHS Business Meeting Agenda's and Local Governance Forum Agenda's.

The TAPA Team is a discretely commissioned team of Teen to Adult personal advisors who engage with young people who are unable to engage with Tier 3 CAMHS. It is a A Young Persons Mental Health Service (14-25 year olds)

TAPA is a service provided by Sussex Partnership NHS Foundation Trust in partnership with the Children & Young Peoples Trust, Sussex Central YMCA, Impact Initiatives and Allsorts to meet the mental health needs of young people across the city who are 'hard to reach' by current mental health services or who themselves find current mental health services 'hard to reach'.
TAPA workers provide direct mental health work to young people and young adults and advice, consultation and training to professionals and young people. Supporting where appropriate access to mainstream mental health services

In addition there are a number of 3rd sector drop in centres across the city where young people can access information and support . These services can also sign post and refer young people to crisis support if appropriate.

Have you addressed:

- Age appropriateness of information and approaches to involvement

- Advocacy and support to make complaints
- Family contact
- Treatment close to home
- Key worker support
- Age appropriate environments

D. Recovery and staying well / preventing future crises

I am given information about, and referrals to, services that will support my process of recovery and help me to stay well.

I, and people close to me, have an opportunity to reflect on the crisis, and to find better ways to manage my mental health in the future, that take account of other support I may need, around substance misuse or housing for example. I am supported to develop a plan for how I wish to be treated if experience a crisis in the future and there is an agreed strategy for how this will be carried out.

I am offered an opportunity to feed back to services my views on my crisis experience, to help improve services for myself and others.

Please say what you will do to optimise recovery and prevention.

SPFT operational protocols, policies and training in relation to Care Planning, Risk Assessment and Management and Crisis Plans – which include advanced directives and care plans where appropriate.

There is a Long Term Service User policy and protocol in place to support the re-referral of patients back to specialist services if required following discharge.

All patients have a care plan and have information on how to access support and treatment in times of crisis. Care planning is undertaken in a person-centred manner in consultation with patients/ carers/ other professionals as required.

SPFT have worked with commissioners to establish and implement Dual Diagnosis Care Plans to support integrated working between mental health and substance misuse services working collaboratively with patients.

There are a range of mental health and criminal justices services/ initiatives supporting patients including a Mental Health Court Diversion Service and RMNs based in custody suites across the City.

Have you addressed:

- Crisis planning including advance statements – see NICE guidance on crisis planning

- Entry and discharge criteria including fast track access back to specialist care for people who may need it in future
- Protocols for people not eligible for the Care Programme Approach, for accessing specialist and social care
- Integrated, person-centred pathways
- Coordinated approaches for people with co-existing mental health and substance misuse problems, with service specifications that require a speedy crisis response
- Joined up support in criminal justice settings.