

Agenda item 9

DERBYSHIRE HEALTH AND WELLBEING BOARD

7 January 2017

Report of Chief Executive, Healthwatch

**EXPERIENCES OF USING HEALTH AND SOCIAL CARE SERVICES
BEFORE, DURING AND AFTER MENTAL HEALTH CRISIS**

1. Purpose of the report

This report provides a summary of Healthwatch Derbyshire's (HWD) report on 'Experiences of using Health and Social Care Services, before during and after Mental Health Crisis'.

2. Information and analysis

The mental health crisis report considers the experiences of people before, during and after a mental health crisis, and was developed following discussion at Healthwatch's Intelligence, Insight and Action Committee, who regularly appraise and assess comments and experience received by the organisation. The committee recommended this engagement priority due to a number of comments relating to experiences before, during and after mental health crisis.

Research methodology

The engagement activity and research was conducted between May and July 2016 through a series of focus groups which took place across the County. Healthwatch used The Mental Health Crisis Concordat in Derbyshire as the framework for the engagement activity. The key principles from the concordat were captured on a prompt sheet for Engagement Officers to use, and refer to, when talking to participants. The Mental Health Crisis Concordat Delivery Group have been receptive to the work of Healthwatch Derbyshire as the independent insight is valuable, and have pledged to use the findings in this report to inform their 2017 action plan.

Summary of findings

The research identified several positive themes and these are:

- Telephone support lines appear to be valued and provide support for some participants.

- Support groups appear to be valued and provide support for some participants.
- The speed and quality of response made by police on most, but not all occasions.
- The value and difference made by easy contact systems and positive relationships with community psychiatric nurses (CPNs).
- Consistently positive feedback regarding Trevayler House.

In addition, some negative themes emerged, including:

- Focusline number is regularly engaged.
- Being passed around between services pre-crisis, and a lack of coordination. No sense of ownership from professionals to deal with the emerging situation.
- Access to, availability of and continuity with CPNs.
- Lack of consistency in dealing with and responding to mental health crisis in General Practice.
- Waits/delays in being seen in Accident and Emergency (A&E).
- Knowing where to go and what to do when needing support and action pre and post crisis.
- Police ability to identify and respond to potential overdoses.
- Lack of identification and recognition of the mental health needs that an individual has, or perceives that they have.
- Police did not always explain restraint, when used.
- Occasional use of prison cells for people in mental health crisis.
- Distress caused by supervised toileting/showering in secure units.
- No relationship with named nurse in secure units, so of limited/no value.
- Lack of activities in secure units.
- Lack of awareness of physical health needs when in secure units.
- Lack of time with staff when in secure units.
- Little awareness of or value placed on advocacy.
- Self-harm risks in rooms at The Priory.

Recommendations within the report

Building from the positive and negative feedback, the report identified a number of recommendations which include:

1. Provide clear information for patients, friends, family and carers about where to go, and what to do in a developing crisis situation.
2. Work to develop coordination of, and show real ownership of developing crisis situations.
3. Address access issues to Focusline.
4. Maximise access to, availability of and continuity with Community Psychiatric Nurses.
5. Support General Practice to deal with and respond to mental health crisis.

6. Work to improve patient experience in Accident and Emergency departments.
7. Address the Police's ability to identify and respond to potential overdoses.
8. The Police should explain restraint when used.
9. Address and seek to minimise use of police cells for people in mental health crisis.
10. Consider the distress caused by supervised toileting/showering in secure units, and consider alternative solutions.
11. Develop the role and purpose of name nurse in secure units.
12. Consider the provision of appropriate activities in secure units.
13. Consider how physical health needs are accommodated by secure units.
14. Raise awareness of advocacy and its purpose.
15. Consider and take any necessary action required to address reported self-harm risks in rooms at The Priory.

3. Response to report

An overview of responses to the report from Health and Wellbeing Board members is attached in Annex 1.

A copy of the full report can be accessed online at:

<http://www.healthwatchderbyshire.co.uk/wp-content/uploads/2016/12/V5-Mental-Health-Crisis-Report-13122016-HH.pdf>

4. Links with the Health and Wellbeing Strategy

The Health and Wellbeing Strategy states that one of its principle values is that services will be planned and delivered in partnership. As acknowledged in the strategy patients, service users and members of the public are a key part of this partnership and their views and experiences need to be taken into account in the design and delivery of services, and in responding to local healthcare challenges. This is particularly important in light of the changes that will take place over the next five years as a result of the five year forward view, which will be taken forward by the development of the Sustainability Transformation Plan.

RECOMMENDATIONS

The Health and Wellbeing Board is asked to:

1. Consider the content of the report on experiences of mental health crisis.
2. Reflect on their own performance standards and service delivery in respect of what patients and service users have been telling Healthwatch.

3. Promote the content of the report where appropriate, amongst their networks.

Karen Ritchie
Chief Executive, Healthwatch

Annex 1: Action responses from health partners in Derbyshire

Responses (Full responses can be found in the report, this summary focuses on actions pledged):

Chesterfield Royal NHS Foundation Trust

- The Liaison Team have been providing regular teaching sessions for the ED staff and are rolling out this training to staff on EMU and CDU. These sessions have become more formalised for recognition and continued educational needs.
- We are looking to increase our remit in Liaison Team meetings to include representation from Acute Medicine, Care of the Elderly/Frailty Unit, Gastroenterology, Critical Care and Surgery as well as amalgamating the Trust Substance Misuse Steering Group agenda to these regular meetings. This follows on from the 16 month service evaluation of the Liaison Team by the North Derbyshire and Hardwick CCGs.
- 6 e-learning packages have been developed by the Liaison Team on a range of mental health priorities identified by the Trust. The next stage is to make them widely available to staff by uploading onto the Trust's e-learning platform.
- We will ensure that support and training from the Liaison Team is promoted with staff in the Emergency Department and across the Trust, to raise awareness of this valuable resource.
- As part of our CQUIN (Commissioning for Quality and Innovation) work for 2017/18, we will be focusing on improving services for people with mental health needs who present to the Emergency Department; this particularly refers to high impact users (those who attend ED 10 or more times a year).
- The Urgent Care Village project proposal includes an assessment area to support people with mental health needs when waiting in the Emergency Department; however, there is no firm date for this at present.
- We will implement rolling health messages on Emergency Department TV screens and bespoke materials to hand out to patients, to provide information on mental health support. This will be included in the Emotional Support ambition of our Quality Strategy.
- We will undertake a period of focused patient feedback, looking at experiences of mental health patients in our Emergency Department.

Response from Derby Teaching Hospitals NHS Foundation Trust

We are planning to employ a Registered Mental Nurse in our ED and Medical Assessment areas to assist with caring for patients and staff support. We are fully committed to increasing the knowledge and skills of staff on caring for patients with mental health needs through general training and also through this level of one to one support and mentorship.

We are also currently exploring with the Mental Health Trust how we can involve patients in co-designing our services.

The Trust is very aware of the long waits in the Emergency Department (ED) for some patients who require specialist mental health assessment and access to a specialist mental health facility. We are working closely with our Partners and Commissioners to improve this.

Joint response from the Clinical Commissioning Groups in Derbyshire

The Clinical Commissioning Groups (CCGs) welcome this report. It is very timely as we are due to refresh the concordat action plan. We have invited Healthwatch to our meeting of the concordat in order to continue to provide challenge to our systems of emergency care. The report recommendations will be incorporated into our Concordat action plan. The report demonstrates that progress has been made but we also have a long way to go. For example, the use of police cells to detain people who have committed no offence but have a mental health problem has dropped substantially. In the last 8 months we have had no one taken to a police station on a section 136 –the police holding power. We work closely with the police and have a team based out of office hours in the Police Control Room providing advice and access to mental health support. We are pleased to see such good reports of people using the Richmond Fellowship Crisis House service. Trevayler, which is a service we commission and is integrated with the crisis and home treatment teams of Derbyshire Health care Trust. As a health and social care community we have just released our Derbyshire Joined Up Care Plans (sometimes referred to as STP). These include a number of areas specifically designed to address the issues that people have reported to Healthwatch Derbyshire.

We intend to develop increased support to primary care as we recognise that this is where most people go for help initially.

We are reviewing help lines (recognising the difficulties in accessing Focus line) and want to increase mental health support to the 111 service so there is one place people can turn to and get access to the right advice and if needed help. We are trialling Focus line staff being based some of the time at 111 to see if this helps with access. We have created an advice and assessment hub out of hours which can take calls from 111 and from ambulance crews and the police. So care can be more joined up and purposeful.

We have plans for an alternative safe place – so people can get help there rather than going to the Emergency Department. This builds on our investment in the Emergency Department of the liaison teams who already see people 24 hours seven days a week. We have expanded the services in the south at Derby Royal Hospital to include a response for young people and we intend to do the same in the north of the county for Chesterfield Royal.

We are intending to increase the hours of operation of the community teams so they are more accessible and can respond locally.

We note that there are frustrations of having changes of staff and of waiting for care coordination. We have invested in increased staffing in 2016 but we recognise recruitment has been a significant challenge and remains so for the foreseeable future. In future having less teams working separately from each other, as they do now, will help in providing more of a personal service based on people's localities. It will make it more likely if a crisis develops people will be seen by someone in a team who knows them and their circumstances.

We have plans to develop community resilience, self-help and other ways of preventing crisis occurring and enabling people to manage in their communities. This will include better information and sign posting on where to get help.

People have had some negative experiences as inpatients with different providers. We will raise these issues in our contract arrangements with them. We support the need for clarity of named nurse roles, provision of activity and physical health care.

We have a suicide prevention strategy with DHcFT which includes ligature removal and will take up issues of concern on environmental risks with independent sector providers.

The advocacy service in the county has just been retendered by the County Council and we anticipate greater clarity and focus on the use of advocacy in 2017.

The report provides valuable feedback on people's experiences in using a wide variety of services. We will raise these wider issues with all the providers we commission.

We have noted recommendations 1 and 2 the need for people to be provided with clear information on what to do in a crisis and for there to be coordination a sense of ownership of developing crisis services. This goes to the heart of the concordat declaration and as a system we have agreed to keep the concordat meetings going a further year to ensure we continue to make progress in a joined up way.

Response from Derbyshire Health United

From 14/11/2016, within the NHS 111 and Out of Hours services we are piloting a new service for our 18+ Mental Health patients in Derbyshire. This is called on the electronic Directory of Services (DoS):-

MH -Derbyshire Focusline (North)

MH -Derbyshire Focusline (South)

This service is for Patients and Carers of those experiencing Mental Health difficulties. Helpline workers can provide emotional support in a crisis situation and are able to signpost callers to other services.

Staff must try to warm transfer the call to the on duty Focusline worker by calling the designated internal extension before selecting the Dos profile.

At the moment if the line is engaged or not answered within 30seconds the Health Advisor will select another service. However, after Christmas we are enabling them to have a queue so patients will not get the engaged tone if accessing via NHS 111 rather than dialling Focusline direct.

This service is available: 1700-0100 7 days a week

We have obtained NHSE Workforce funding to employ our own Mental Health Nurse within the NHS 111 Clinician workforce over the winter period

Response from Derbyshire Healthcare NHS Foundation Trust

Recommendation	What we are doing	What we will do
Provide clear information for patients, friends, family and carers about where to go, and what to do in a developing crisis situation	<p>The DHCFT website provides details on how to access support in a crisis http://www.derbyshirehealthcareft.nhs.uk/getting-help/mental-health-crisis/</p> <p>In addition, people who receive our services have a care plan, and may have a crisis contingency plan, a safety plan and a staying well plan – these plans help the person and any carers/family to recognise early warning signs when a person may be coming unwell, and provide details of how to contact a range of services and resources that may be helpful in an emerging crisis</p>	<p>We will develop more detailed crisis contingency plans so that people know exactly what to do in an emerging crisis from our Trust and the community offers.</p> <p>In addition we will revisit the section of the 'My Care' leaflet and revise it based upon your feedback.</p> <p>We will continue to work in partnership with people, families and carers in the development of advance statements (plans that tell us how people would like care to be delivered when they are in a crisis or acutely unwell), staying well plans and safety plans so that people feel more informed about how and when to get help from the right people at the right time</p> <p>As part of the Derbyshire Sustainability and Transformation Plan (STP) we will work with partner agencies to increase the presence of mental health specialism within primary care, so that people have more rapid access to advice and the right help in an emerging crisis.</p> <p>If you are agreeable, we would ask for your assistance in writing an article in your newsletter and having some information on your website on where and what you can do to access help in a crisis, we would like to co-design this with service receivers and our commissioners to really listen to your feedback and try and improve.</p>
Work to develop coordination of, and show real ownership of developing crisis situations	We are holding workshops in our inpatient units to increase our focus on developing staying well plans with people who receive our services	<p>We will increase the presence of mental health specialism through our link working within primary care</p> <p>We will review how well the new Mental Health Advice and Assessment Hub (MHAH) service is working to inform future service development– this service aims to help people who may</p>

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		<p>otherwise attend A&E in a mental health crisis</p> <p>We will improve the interface and mechanisms between our community and urgent care services so that people do not have to contact more than one service in an emerging crisis</p> <p>Through our STP plans, we will work in partnership with other agencies, to make sure that responses are better co-ordinated and we will share information proactively, with consent.</p>
Address access issues to Focus line	We feedback any access issues to our partners in the Crisis Concordat	We will continue to provide feedback to inform future service provision
Maximise access to, availability of and continuity with CPNs	We have increasing pressure in our community services, which we received a partial settlement for in our contracting round in 2016. We are embarking on a programme of work to try and improve capacity and flow in our community services, however this is with the knowledge that referrals to the service have increased significantly over the last year. We have set in our strategy we would like to work in partnership with our commissioners to improve our community offer to deliver on the aspirations of our trust strategy to deliver a weekend and 7 day per week community offer in addition to community services.	We will continue to work internally and externally to our organisation to find system changes, internal innovations and develop ideas to reform and adapt our services to try and meet this objective.
Support General Practice to deal with and respond to mental health crisis	We are meeting regularly with GP surgeries and working with our GP colleagues through GP Quest events, to provide advice, support and education to GP's in terms of managing crisis situations. The Crisis Resolution Home Treatment Teams (CRHT) offer a consultation/liaison response to support GPs in responding to crises.	<p>The new care model within the Derbyshire STP will have better links between mental health specialists and GPs, with more integrated models of working so that people can get the right advice when they need it.</p> <p>We are developing a plan with Public Health in Derbyshire, to deliver Suicide Awareness and Response training to General Practice and Primary Care</p>
Work to improve patient experience in Accident and Emergency	Our mental health liaison teams meet their target of assessment taking place within one hour of referral from the A&E triage staff	We will review how well the MHAH is working to inform future service commissioning and development
Address Police ability	Mental health professionals work alongside the police, providing	We will review how well the MHAH is working to inform future

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to identify and respond to potential overdoses	support and education to officers working with people who may take or may have taken overdoses	service commissioning and development
Police to explain restraint when used	Our mental health professionals will continue to support police officers through education around working with people who have mental health problems	We will review how well the MHAH is working to inform future service commissioning and development
Address and seek to minimise use of police cells for people in mental health crisis	Mental health professionals work alongside the police, and offer support and education to officers working with people who may have mental health problems, ensuring that they are directed to the right environment for their mental health needs to be assessed	Together with the police, we will review how well the MHAH is working to inform future service commissioning and development
Consider distress caused by supervised toileting/showering in inpatient units, and consider alternative solutions	<p>We aim to provide care in the least restrictive environment. At times, in order to maintain a person's safety, we may need to provide care that can be intrusive, including the provision of one-to-one care in our inpatient units – this is sometimes known as 'observations'. To limit the impact this care has on a person's privacy and dignity:</p> <ul style="list-style-type: none"> • An 'observation' level care plan is developed with the person • The care plan is reviewed with the person regularly in order to reduce any restrictions as soon as it is safe to do so • The person is offered access to advocacy • The person is cared for on a gender specific ward 	<p>We will promote the use of advance statements for people who use our inpatient services and may require one-to-one care, so that we can include their preferences in care plans and minimise distress</p> <p>We will make sure that our observation care plans meet required standards through audit processes.</p> <p>We will share your report and feedback with our quality teams and ask them to reflect upon this valuable feedback and how our care is experienced.</p>

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Develop role/purpose of named nurse in inpatient units	<p>All people using our inpatient units are allocated a named nurse, however, recent audit work carried has highlighted some variance in practice.</p> <p>Work is being carried out across the inpatient units to clarify the expectations of the role of named nurse with nursing staff</p>	<p>By March 2017, the named nurse role will be explicit within</p> <ul style="list-style-type: none"> • Job descriptions • The nurse preceptorship program • Management supervision <p>And will be measured through regular audit of both clinical records and what people tell us about their experiences of care</p>
Consider provision of appropriate activities in inpatient units	<p>There is a wide variety of activities and resources available to people who spend time in our inpatient facilities. These can be accessed directly from the ward, for example, recreational activity, art materials, and quiet areas. The Hubs in the Hartington Unit in Chesterfield, the Radbourne Unit in Derby and the OT Department at Kingsway have a range of activities which have been designed to meet the needs of individuals or groups, through structured therapeutic intervention</p> <p>In addition to this we have community links to wider support networks and resources which people can access prior to and following the time they spend within our inpatient facilities</p>	<p>We will ask the people who receive our inpatient services, what additional activities they would like to receive, and develop a plan to respond to your helpful feedback that we need to reflect upon our care offers</p>
Consider how physical health needs are accommodated by inpatient units	<p>Routine screening and assessment of physical healthcare needs is carried out for all people using our inpatient services</p> <p>We work in partnership with specialists in supporting people with specific physical healthcare needs while they are an inpatient</p>	<p>Pieces of work are underway across all of our inpatient facilities to improve physical health care monitoring and physical health promotion. This is a wide ranging piece of work looking at diet, sleep, exercise, access to outside space and relaxation, as well as the monitoring of physical health, for example diabetes care, asthma care and venous thromboembolism assessment.</p>
Appropriate awareness raising of advocacy and its	<p>The named nurse makes people aware of how to access Advocacy Services in both of our inpatient units. The Hartington Unit holds weekly advocacy sessions, and a peer</p>	<p>The Radbourne Unit will meet with the Advocacy Service to identify ways in which the service could be better promoted for inpatients.</p>

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purpose	volunteer runs a 'your service, your say' resource in the Hub.	The named nurse role is being clarified as detailed earlier in this report and will include responsibilities relating to advocacy. We have included advocacy posts and how to access advocacy in our booklets. We will in addition add this to our website and provide this information to Healthwatch for your newsletter and website so we can reach as many individuals as possible
Consider and take any necessary action required to address reported self-harm risks in rooms at The Priory	<p>We respond to service receivers' feedback in relation to the experience of care from external providers</p> <p>We work closely with commissioners in the evaluation of standards of other providers</p>	We will continue to listen and respond to our service receivers' experiences of other care providers and maintain open communication channels with providers and commissioners



Mental Health Crisis Report

Experiences of health and social care
services before, during and after Mental
Health Crisis



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1. Acknowledgement

Healthwatch Derbyshire would like to thank the many groups and services who supported and cooperated with this engagement activity and the participants who gave up their time to talk to us about their experiences.

2. Disclaimer

The comments outlined in this report should be taken in the context that they are not representative of all patients, family, friends and carers who have experienced mental health crisis, but nevertheless offer a useful insight. They are the genuine thoughts, feelings and issues that patients, family, friends and carers have conveyed to Healthwatch Derbyshire. The data should be used in conjunction with, and to compliment, other sources of data that are available.

3. Background

Healthwatch Derbyshire is an independent voice for the people of Derbyshire. We are here to listen to the experiences of Derbyshire residents and give them a stronger say in how local health and social care services are provided.

Healthwatch Derbyshire was set up in April 2013 as a result of the Health and Social Care Act 2012, and is part of a network of 148 local Healthwatch organisations covering every local authority across England. The Healthwatch network is supported in its work by Healthwatch England who build a national picture of the issues that matter most to health and social care users and will ensure that this evidence is used to influence those who plan and run services at a national level.

We listen to what people have to say about their experiences of using health and social care services and feed this information through to those responsible for providing the services. We also ensure services are held to account for how they use this feedback to influence the way services are designed and run.

3.1 What is mental health crisis?

According to the organisation Mind, mental health crisis is when you feel your mental health is at breaking point. For example, you might be experiencing:

- suicidal feelings or self-harming behaviour
- extreme anxiety or panic attacks
- psychotic episodes (such as delusions, hallucinations, paranoia or hearing voices)
- hypomania or mania
- other behaviour that feels out of control, and is likely to endanger yourself or others.

<http://mind.org.uk/information-support/guides-to-support-and-services/crisis-services/#.V87JfvkrJD8>

3.2 The Mental Health Crisis Care Concordat

The Mental Health Crisis Care Concordat is a national agreement between services and agencies involved in the care and support of people in crisis. It sets out how organisations will work together better to make sure that people get the help they need when they are having a mental health crisis.

In February 2014, 22 national bodies involved in health, policing, social care, housing, local government and the third sector came together and signed the Crisis Care Concordat. Since then five more bodies have signed the concordat, making a total of 27 national signatories.

The concordat focuses on four main areas:

- **Access to support before crisis point** - making sure people with mental health problems can get help 24 hours a day and that when they ask for help, they are taken seriously
- **Urgent and emergency access to crisis care** - making sure that a mental health crisis is treated with the same urgency as a physical health emergency
- **Quality of treatment and care when in crisis** - making sure that people are treated with dignity and respect, in a therapeutic environment
- **Recovery and staying well** - preventing future crises by making sure people are referred to appropriate services.

Although the Crisis Care Concordat focuses on the responses to acute mental health crises, it also includes a section on prevention and intervention.

<http://www.crisiscareconcordat.org.uk/about/>

In Derby and Derbyshire, the concordat has been put into action through a variety of agencies who have signed up to a declaration statement and action plan for delivery.

The declaration statement says that:

‘We, as partner organisations in Derby and Derbyshire, will work together to put in place the principles of the national concordat to improve the system of care and support so that people in crisis because of a mental health condition are kept safe. We will help them to find the help they need – whatever the circumstances – from whichever of our services they turn to first.’

There is also an action plan giving more detail about how the principals set out in the declaration statement will be delivered.

For more information, go to <http://www.crisiscareconcordat.org.uk/areas/derbyshire>

4. Rationale for the report

In order to enable a diverse range of people to share their views and concerns about their local health and social care services, Healthwatch Derbyshire aim to pay specific attention to those who may otherwise struggle to be heard.

For this reason during May - July 2016 we agreed to focus our engagement activity on the experience that people in Derbyshire had when accessing health and social care services before, during and after mental health crisis.

The topic was selected by the Intelligence, Insight and Action Committee of Healthwatch Derbyshire, who regularly appraise all the comments and experiences received by the organisation. The committee recommended this engagement priority due to a number of comments relating to experiences before, during and after mental health crisis.

The Mental Health Crisis Concordat in Derbyshire became the framework for the engagement activity carried out by Healthwatch Derbyshire. The key principles from the concordat were captured on a prompt sheet for Engagement Officers to use, and refer to, when talking to participants, and so hearing how their experiences before, during and after mental health crisis compared to the key principles in the concordat. The Mental Health Crisis Concordat Delivery Group have been receptive to the work of Healthwatch Derbyshire and the insight that this independent source of patient feedback can offer, and have pledged to use the findings in this report to inform their 2017 action plan.

5. How we conducted the engagement activity

In order to collect consistent information which followed the principles set out in the concordat, a series of questions were developed to provide a framework for discussions with individuals. Healthwatch Derbyshire has attended meetings of the Mental Health Crisis Concordat Delivery Group. The group received the draft prompt sheet and were given the opportunity to contribute to the prompts, and make any suggestions for improvement. These questions can be found in Appendix 1.

The primary focus of these questions was collecting experiences of accessing health and social care services before, during and after mental health crisis within the previous 12 months, and capturing sufficient detail to ensure that this feedback would be useful to service providers.

In order to safeguard and consider the welfare of participants and staff, it was decided to ensure peer support for all participants and staff at all times during this work.

Engagement was conducted in small focus groups with a minimum of two staff members and two participants present at each. Staff were encouraged to have a short debrief session together, as required, after focus groups. Additionally, a whole team review session was held at the end of the project to ensure that any lessons were learnt to apply to future engagement priorities.

A number of considerations should be made when reading the findings. These include:

- Not all participants were able to respond to all questions. This is because some questions were not applicable depending on the types of service used and the experience recounted
- Some of the experiences recounted may have happened more than 12 months before the engagement occurred
- Some participants struggled to fully recall elements of their experience. This may be due to their mental state at the time of the experience happening and, in the

case of some participants, the apparent effect of medication at the time of participating in the focus group

- The participants that engaged in our focus groups were all accessing some type of mental health support group. This means that we did not involve any participants who had chosen not to access support after their experience.

Focus groups took part across Derbyshire with a total of 40 responses collected, 20 from the north of the county, and 20 from the south.

6. Summary of findings

There are several positive themes that have emerged from the findings, these relate to:

- Telephone support lines appear to be valued and provide support for some participants
- Support groups appear to be valued and provide support for some participants
- The speed and quality of response made by police on most, but not all occasions
- The value and difference made by easy contact systems and positive relationships with community psychiatric nurses (CPNs)
- Consistently positive feedback regarding Trevayler House

Negative themes that emerged included:

- Focusline number is regularly engaged
- Being passed around between services pre-crisis, and a lack of coordination. No sense of ownership from professionals to deal with the emerging situation
- Access to, availability of and continuity with CPNs
- Lack of consistency in dealing with and responding to mental health crisis in General Practice
- Waits/delays in being seen in Accident and Emergency (A&E)
- Knowing where to go and what to do when needing support and action pre and post crisis
- Police ability to identify and respond to potential overdoses
- Lack of identification and recognition of the mental health needs that an individual has, or perceives that they have
- Police did not always explain restraint when used
- Occasional use of prison cells for people in mental health crisis
- Distress caused by supervised toileting/showering in acute inpatient units
- No relationship with named nurse in acute inpatient units, so of limited/no value
- Lack of activities in acute inpatient units
- Lack of awareness of physical health needs when in acute inpatient units
- Lack of time with staff when in acute inpatient units
- Little awareness of or value placed on advocacy
- Self-harm risks in rooms at The Priory

7. Findings

A total of 40 participants took part in focus groups, 20 in North Derbyshire and 20 in South Derbyshire. A total of 19 participants were male, 21 were female.

Regarding age range, a total of 37 responses were collected:

Age range	Number of participants	% of total
16-24	5	12.5%
25-34	3	7.5%
35-44	10	25%
45-54	11	27.5%
55-64	7	17.5%
65+	1	2.5%
Unknown	3	7.5%

Participants were involved in small focus groups and were asked a series of questions in line with the prompt sheet. As mentioned previously, not all participants were able to answer all questions. Responses given were as follows:

BEFORE CRISIS POINT

Question - Did you have access to support 24 hours a day?

Participants described the support that they have, and when this is available. Some participants are unaware of who to go to for support, whilst others talk about who they have contact with for support, and their availability.

North Derbyshire - Negative

- “No, there was nothing in the way of access to support, despite depression and self-harming, plus taking an overdose of various tablets - heart, sleeping and ADHD tablets.”
- “No, I was only getting support from P3 in Chesterfield for one hour per week.” (This broke down and participant is currently homeless).
- “Only through my CPN.”
- “No, only the workers at Rhubarb Farm.”
- “I wouldn't know who to ring.”
- “Went to GP as I wasn't coping but didn't tell GP the full truth. I felt that although I didn't tell the truth my GP should have understood, knowing some of my history. I had a breakdown and suicidal thoughts.”

North Derbyshire - Positive

- “Yes, in terms of knowing that I could ring Call Derbyshire or go to A&E.”
- “The CPN did give me crisis team number. I was also given some numbers from my GP.”
- “Yes, via my GP, who was very good and wanted to get me into the crisis team. I hit crisis several times due to acute anxiety, depression, flash backs, nightmares, historical abuse and Asperger’s. I took to alcohol. The crisis team would not accept me because of the support I required. They said I needed re-assurance and ‘next steps’ and they said that was not what they were there for. This was after I had overdosed.”

North Derbyshire - Mixed

- “I had a brilliant CPN who went out of their way to help me. I had their mobile number which I could ring day or night. They have now retired and I am gutted. I now have a new CPN from Corbar View but I no longer have a mobile number. I have to ring Corbar View and they get a message to them, but what happens if they are off for a few days?”
- “Not really. The crisis team was called out by the hospital on the second time I hit crisis.” (The patient had history of extreme overdoses, taking multiple tablets). “The first time I slashed my wrists. The crisis team did come out that evening but to get them I was ringing from 8.30am and they arrived at 5.30pm. They were an amazing team, they spoke to me like a human being. They questioned me about my self-harming and overdoses. They were nice and calm and took control. The second occasion when on home release, when I was not drinking and not self-harming; I rang my GP for help but got no response. I was told I would have to wait four to five hours for a call back even though I said, ‘I need help, I will self-harm.’”

South Derbyshire - Negative

- “Not really in Derbyshire - the support is quite low level.”
- “No, never get help at weekends so I just speak to my mum.”
- “I have no help with my mental health whatsoever.”
- “No, I have had a lack of support for the past six months.”
- “No, I just had a social worker.”
- “No.” (In recent months struggling to cope with everyday life has been physically self-harming as well as abusing alcohol and needing constant personal attention so they could be prevented from taking their own life). “It seems that there is no mental health care for individuals with such severe difficulties in any of the seven days of the week.”
- “No, only limited support through GP.”
- Not 24 hour support, “Once you put weight back on the support stops.” (Does now have a support worker from Derbyshire Eating Disorders).
- No and has been on the waiting list for an Asperger’s diagnosis for two years - involved with the community mental health team but only has one appointment every six months.”

- No, only has a CPN and can only ring during the day, “I have no support through the night.”
- No, began to struggle and went to see their GP who referred to Talking Mental Health for Cognitive Behavioural Therapy (CBT). When they went to one of the CBT sessions they said, “I was having a really bad day and was feeling very suicidal and the therapist referred me to the crisis team.”
- No access to 24 hour support. Lives alone and can only contact CPN within working hours and said, “Most of the time they are in meetings.”
- Had a CPN who hasn't been seen for a while. Made contact prior to crisis to ask for help as was not feeling well and arranged to meet them for the following week, but took an overdose in the meantime.

South Derbyshire - Positive

- “Yes, I was living at Chilwell House and was having key worker sessions which increased from one hour a week, to two hours a week, to one hour a day. They could see I was getting worse.”
- “Yes, the staff from Chilwell House pushed for me to get admitted.”

Question - When you asked for help, were you taken seriously?

Although there are some positive accounts given by participants when they asked for help, the majority of participants indicated that they had not been taken seriously and expressed some dissatisfaction with the course of action taken by the health professional that they visited.

North Derbyshire - Negative

- “Not really. I felt as though I was passed around.”
- “No, only through CPN.”
- “No, no help was provided by the GP. I was told I was depressed and there was ‘nothing we can do’. I was put on Amitriptyline.”
- “No, even though I explained I had suicidal thoughts.”
- “No, my GP just sees my physical health but doesn't understand mental health.”
- “No, the GP is ‘old school’. I only get ten minute appointment and I have tried to explain things but feel I am not listened to. The GP just ‘dishes out pills’. I am on Diazepam, Codeine and anti-inflammatories for pain. The GP constantly tells me my problems are down to alcohol and old age.”
- “Not really. Felt I should have had counselling. Doctor mentioned Samaritans and possible men's counselling, which I could have self-referred to but never went.”
- “My GP sent me for CBT but it just wasn't useful. I keep self-analysing which was doing me no good.”

North Derbyshire - Positive

- “Yes, my CPN was so supportive. I tried to jump off a bridge”

North Derbyshire - Mixed

- “Yes, my GP was really good. However, sometimes I see different doctors at the practice and I do sometimes think they turn to the crisis team for help because of their lack of confidence with mental health issues. I understand that the crisis team rang the Gloss Project after my referral from the GP and said, ‘The GP is a weak link as they have not got the experience’ so they rejected my referral, saying, ‘Our services are not for you. All you need is re-assurance that is not what we are here for.’”

South Derbyshire - Negative

- “I never seem to come under the criteria even though I have anxiety, severe depression and borderline schizophrenia.”
- “No, I have a history of severe depression. I went to see my psychiatrist in April because I knew I needed help and when I arrived I was left waiting to be later told the appointment was cancelled. I told the receptionist that I needed to speak to someone urgently and the receptionist said she would book an urgent appointment and gave me the date mid-May, which felt too long to wait. I got worse as a result of this as I had been building myself up for the visit and to resolve some issues and speak to my psychiatrist.”
- Participant explained they have called 999 numerous times with chest pains and has been admitted to both Chesterfield Royal Hospital and Royal Derby Hospital. However, due to the relationship with alcohol and being drunk when admitted, the hospital have only ever treated/helped the physical side and not addressed their mental health issues.
- “Not at first.” Participant has been asking for help for years from the GP and felt like the GP did not understand, “My doctors have just let me slip through the net.” Participant explained that the GP thought that the anxiety/depression was due to life circumstance and not because of their mental health. A few days before being referred, participant went to see the GP because was feeling suicidal and they just gave tablets, “The way I was treated on Friday was appalling, I was hanging onto life by the skin of my teeth.” Over the weekend the participant was getting support from a friend. However participant began to get worse so the friend went back to the doctors and sat in on the appointment with the doctor. The doctor then referred participant to the crisis team. “When I go to the doctors on my own I can't say what I need to. Why did the doctors give out tablets that could be used for an overdose? It was only because friends were with me and supporting me that I did not take them.”
- “No, I do not feel like I was taken seriously by my GP. I was just told to go and speak to Derbyshire Eating Disorders, they see me as a liability. They do not have the skill or time to help me.”
- Participant has had numerous bad experiences with the crisis team so tries to avoid them at all costs. Some years ago, participant was in the Hartington Unit and then discharged themselves. The crisis team were trying to get hold of them but they had gone to stay with family to stay safe, but because this was just outside Derbyshire the crisis team would not come and see participant, saying, “That is not our area.” They had to arrange to drive to a road in Derbyshire and they agreed to meet them in their car. Another time the participant rang the crisis team and was told, “Sorry, but we do not have time it is 16:50.” Over the years the participant has had comments like, “Go and have a lie down and a cup of tea and then you will feel better.” The participant feels this is completely wrong and unprofessional.

The participant no longer asks for help from the crisis team, they just drive to a bridge and wait for the police to arrive to take them to hospital. This gives a sense of control. The police know who the participant is and they talk them down and then they are taken to hospital.

- “I have been getting worse and feel that I have not been listened to for a long time. I have wanted a CPN for over two years.”

South Derbyshire - Positive

- “Yes, some staff members did - the ones who knew me better could see I was getting really poorly.”

South Derbyshire - Mixed

- “Yes, once I got the help I was taken seriously. It was an overdose not a suicide attempt; it was a cry for help.” (Participant tried to access support prior to crisis from Talking Mental Health, but this was not taken seriously and was told they needed a period of stability, non-suicidal thoughts/actions before they could access their support).

Question - Were you provided with telephone numbers to ring in the event of a mental health crisis?

There was a mixed response to this question, with some participants responding that they were not given, and do not have numbers to ring in crisis. Many participants responded by saying who they had been told to ring, or would ring in a crisis situation.

North Derbyshire - Negative

- “No” x seven participants.
- “No, in fact the crisis team won't give out their numbers.”

North Derbyshire - Positive

- “Yes” x one participant.
- “Yes, via my CPN.”
- “Yes, call 111.”
- “My GP had given me a leaflet with crisis team details on.”
- “I am aware of the crisis team.”
- “CPN did give me crisis team number. I was also given some numbers from my GP.”

North Derbyshire - Mixed

Note: these responses have been categorised as ‘Mixed’ because participants answered ‘no’, but went on to suggest one or more place they would go or call.

- “No, only through CPN.”
- “No, only my GP's number, and I would also ring my daughter.”
- “No, only the workers at Rhubarb Farm.”

- “No, although I did access CAMHS for one appointment but they did nothing. I was discharged after one session.”

South Derbyshire - Negative

- “No” x five participants.
- “No, but I wish I did. If I wanted to speak to someone but no staff members were on shift that I could relate to. I felt very isolated and that’s when I went downhill.”
- “No, this would have been good to have though. It would have been nice to speak to someone different.”

South Derbyshire - Positive

- “Yes” x one participant.

South Derbyshire - Mixed

Note: these responses have been categorised as ‘mixed’ because participants answered ‘no’, but went on to suggest one or more place they would go or call.

- “No.” Participant explained they had gained various numbers through own research - had contacted Talking Mental Health but they asked too many questions. Also found out through research the Focusline number. Participant was able to contact them and was pleased that there was someone who could be rung after 5pm. Participant found them supportive, “They were good when I needed them.”
- “No.” Has number for CPN but feels as though is not taken seriously by CPN.
- No, but has heard of numbers such as the Samaritans but cannot ring and talk to strangers.
- No, but has the number for Focusline, “But every time I rang it was always engaged. “This is over a long period of time, about six months, and tried many times to call.”
- “Yes, I had numbers but whenever I rang them I felt like it was being passed around and nobody was actually helping me.”
- “No.” But in previous times that they had been involved with the crisis team (during the last eight months) they have provided them with numbers that they still have.
- “Only the number for a support worker which is office hours only.”
- “Yes, the Samaritans but they were too nice and they can’t give practical advice, just comfort.”
- “I was only provided with the number for St James House and Focusline.” Participant explained that they have never used Focusline because they cannot speak to people and really open up unless they know them.”
- “Yes, Focusline and Samaritans.” Participant has used both in the past but it seemed Focusline was always busy, “*All operators are helping others at the moment please try again later.*”

- “Yes, but when I or others have called, they were slow to react. When a health worker did come round nothing came of it.”

Question - Were you told if the numbers provided were staffed 24 hours a day?

The majority of participants were not aware if the numbers/contacts they had were staffed 24 hours per day. A few participants were aware, or weren't sure.

North Derbyshire responses

- “Yes” x three participants
- “No” x 14 participants
- Not known/unclear x three participants.

South Derbyshire responses

- “Yes” x five participants
- “No” x 12 participants
- Not known/unclear x three participants.

Question - Were you provided with alternative support if any of the services were not available at night?

The majority of participants indicated that they had not been provided with alternative support if any of the services were not available at night. A few participants indicated who they would contact or where they would go during the night.

North Derbyshire - Negative

- “No” x 17 participants.
- “No, because no services come out at night. The crisis team do not come out and see you after 5pm, they are not a 24hr service.”

North Derbyshire - Positive

- “Yes, Pathways for homeless people or A&E.”
- “Yes, Samaritans.”
- “Re-Think, Chesterfield.”

South Derbyshire - Negative

- “No” x 16 participants.

South Derbyshire - Positive

- “Always staff on duty at Chilwell House.” (Also, had contact with CPN).

- “It is always staffed at Chilwell House and CPN makes regular visits.”

South Derbyshire - Mixed

- “No. My only support came from R.E.A.L Education.”

Question - How did you get referred into crisis team; GP, 111, A&E, Samaritans, other?

Participants talked about what happened to them at crisis point, the services they contacted and what action was taken. Although some responses appear negative and some positive, responses have not been categorised into positive/negative as many participants just explain what happened to them without expressing a sentiment.

North Derbyshire

- “The referral was very difficult. It was done via Pathways (support group for homeless people). Pathways rang the crisis team and was told, ‘not us’ (even though suicidal), referred to police. Pathways rang police and told, ‘not us’. Back to crisis team and again told, ‘not us’, back to police who advised about new policy and back to crisis team who eventually came out. This process took 3 hours of ringing around.”
- “My mum contacted the GP when I hit crisis and I was told to go and see my GP but again nothing was done.”
- “I did not get any referral. I was just put on anti-depressants.”
- “If I wanted the crisis team, I would have to sort out myself as I do not feel the GP listens to me.”
- “GP has never referred me into the crisis team even when I have been suicidal and in tears.”
- Through CPN x three participants.
- “Ambulance took me to hospital and they referred me into the team.”
- “Via the hospital - Stepping Hill.”
- “My GP referred me because they felt threatened by me.”
- “First occasion, rang myself. Second occasion, tried my GP and after waiting two hours for a call back from the GP, I rang Corbar View for help.”
- “Crisis team got involved as ex-partner rang police as I had breakdown on street, so they reported me to the police for safety. Crisis team got involved once I went into hospital.”
- “My next door neighbour rang the police.”
- “The crisis team got involved after police involvement when I lost it.”
- “The police.”
- “The crisis team saw me in hospital at the Hartington Unit.”
- “Via my GP, but the crisis team rejected me because of the support I required. They said I needed re-assurance and ‘next steps’ and they said that was not what they were there for. This was after I had overdosed.”

South Derbyshire

- A&E x six participants.
- CPN x two participants.

- “Mum rang an ambulance.”
- Participant was making suicidal threats and had taken themselves to the train line. Their mum managed to stop them taking their own life and took them home. Their mum then rang the Out of Hours and managed to get an appointment for later in the afternoon at Ashgate Medical Centre in Chesterfield. However, participant was in that much distress that their mum dialled 999 and a first responder and ambulance arrived. The ambulance then escorted participant to their appointment at Ashgate Medical Centre.
- “GP referred me to the crisis team but it wasn’t straight away so I had to go home and wait for them to visit/contact me.”
- Support worker advised participant to go to Chesterfield Royal Hospital and was on a medical ward to help stabilise bloods and build up weight. Ended up admitting themselves voluntarily into the Hartington Unit as was not able to build up enough weight, “In the past I have been in there a lot they don’t really help me. However, when I went there in January I was there for eight weeks and things were much better than when I was there years ago.”
- Over the last 12 months the participant has tried to access crisis support on numerous occasions. First experience, they went to their GP feeling very suicidal and the GP referred them to the crisis team. They were told to go back home and wait to hear from the crisis team and they felt very positive as the crisis team, “Came to visit me and told me I was going to get a lot of support and then I heard nothing until four days later when they showed up and then they just discharged me!” The participant also felt as though, on this occasion, they were not listened to and their wishes were not adhered to as when they were told the crisis team would come and visit at home. Participant said, “Do not go to the address you have got on my records, I have now moved.” However, the crisis team ignored the request and knocked on participant’s mum’s front door and said, “Hello, we are the crisis team here to see (participant).” Participant didn’t want their mum to know. More recently, participant explained that they began to feel very suicidal and wanted to contact the crisis team, so rang 111 and told them that they wanted help but did not require an ambulance, but they sent one anyway. Also was asked not to be taken to Chesterfield Royal Hospital but was also taken there too.
- “My therapist from Talking Mental Health.”
- Police x one participant.
- GP x one participant.
- Participant began to feel very poorly and contacted their friend and explained that they were feeling very low and suicidal, they managed to get an emergency appointment with the GP and was prescribed Diazepam, which did not help. Two days later they went to see another GP who said they would refer into the crisis team but was told it could be up to a two day wait. The participant went home but began to feel worse so their friend took them to A&E at Royal Derby Hospital.

The following additional information was provided by participant’s friend.

“[Participant] rang me and said how they would end their life. I rang the GP and got an appointment and the GP rang the crisis team but we were told that would have to wait. We went home and waited and heard nothing and as I was so worried and I did not know what to do we went to Royal Derby Hospital A&E. We waited in A&E for six hours and all we saw was the triage team. I could not wait any longer in A&E and so I rang someone from Rethink and they kindly came and sat with my friend as I was worried that they would walk out of the hospital if left alone and go and kill themselves. Whilst we were there the staff kept saying, ‘Why don’t you go home and think it over?’ This was wrong and it was as if they wanted

[participant] to leave. After the three week's stay in Radbourne, and when they got ill again within a few days I went with them to A&E again and we had to wait eight hours before they were seen to properly."

- Participant not been referred to the crisis team and has put in complaint to their psychiatrist. It is only because of this, and because participant has stopped taking medicines, that someone has now been to see them and told them that they will be getting a CPN in the next two weeks.
- Participant took an overdose and went to the Royal Derby Hospital via ambulance and was referred to the crisis team via the hospital's Mental Health Liaison Team.

URGENT AND EMERGENCY ACCESS TO CRISIS CARE

Question - Was it treated urgently?

Many participants describe services that responded urgently, often when the police were involved. Other participants speak positively of the response given by health services, whilst others felt they had not been treated urgently and had been passed around between services.

North Derbyshire - Negative

- "No, it took three hours of ringing round."
- "No, crisis team said they were too busy, so taken to casualty in the first instance at Chesterfield Royal Hospital. Tranquilisers were prescribed as they thought not ill enough to go to Hartington." (Carer added that patient was by this time 'talking ridiculous/psychosis/very poorly').
- "No" x two participants.
- "I was suicidal and I rang 111, I had to wait four hours before they rang me back. I was getting so frustrated with all of the questions and it made me feel more anxious as they were asking how I felt on a scale of 0-10 and every question just seemed pointless. I don't know how but an NHS number phoned me back and I got some counselling over the phone. I am waiting for some further counselling but I have been told it could be 12 months for an appointment."
- "Not by the GP - no."
- "No, I had to wait six weeks before they came to visit me at home."

North Derbyshire - Positive

- "Yes, I tried to jump off a bridge. The police attended."
- "Yes, very urgently."
- "Yes, I collapsed in my flat after a massive overdose. I managed to ring someone before I took the overdose, they called the police."
- "Yes, two police attended, one male/one female."
- "Yes" x one participant.
- "Yes, in terms of being taken direct to Hartington Unit by friend. She made contact with the Hartington Unit before taking me and they said for her to take me straight up there."
- "Yes, I was arrested by the police and detained under S136 as I had a knife in my hand and was in the street. I had a breakdown; I did not know what I was doing."

- “I can only recall that ‘I lost it’ and police took me to the police cells at Chesterfield Police Station.”
- “Yes, the police came straight away.”
- “Yes, the police attended.”
- “Yes, by my GP.”

South Derbyshire - Negative

- “No” x two participants.
- “No, not by the hospital”
- “My mental health continued to deteriorate so I rang 111 and they sent me an ambulance out and took me to A&E. I arrived in A&E and was left alone from around 9am till 3pm in a cubicle.”
- “No.” Participant kept waiting at A&E which made them feel very agitated. The crisis team suggested that they should take part in a group session but they didn't want to as when they entered The Hub they were put on edge by a man who was taking drugs which made them feel very uncomfortable.
- “No, we were advised by the doctor at Ashgate Medical Centre to attend A&E.” The participant said, “This made me feel that there was no point,” as they would go to A&E, be left to sober up and then get sent home with no support for the real underlying issues. When they returned home the family began to ring around for urgent help. A family member contacted the crisis team and was told the individual didn't live in their area. They also contacted the Hartington Unit but was told there were no free beds. No telephone numbers/information for support or advice were provided.
- “No, because I wasn't drunk and I hadn't taken an overdose.”
- “No, because I had a CPN.”
- “No, because I was in hospital and I was physically well.”

South Derbyshire - Positive

- “Yes, an ambulance arrived quickly and they were taken into hospital for a medical.”
- “Yes” x two participants.
- “Yes, sort of, when we arrived at A&E they examined them physically and the key worker from Chilwell House said, ‘They need admitting, we cannot take them back like this.’ The mental health team then came and assessed, and asked the crisis team if a bed was available and they said ‘yes.’”
- “Yes, I was put on the top of the list for a bed on the Ridgeway Ward.”
- “Yes the therapist rang the crisis team quickly.”
- “Yes police always come quite quickly.”
- “Yes.” Once they made sure the participant was physically well, the mental health liaison team came to visit, “They were lovely” and took the participant into a side room and had an in-depth conversation and told them that they would refer to the crisis team.”

South Derbyshire - Mixed

- “Yes, this time it was but I have been to A&E three times because of an overdose and was never listened to or taken seriously in the past year or so.”
- “Not at first by the GP, but once friend went with me I was treated quickly, as the GP made a referral to the crisis team.”

Question - How long did you have to wait?

Participants reported how long it had taken from making contact with services at crisis point to getting a response/action. Some accounts of events would suggest that services responded quickly whilst others point to longer waits to be seen, sometimes at A&E.

North Derbyshire

- “Three hours.”
- Eventually CPN decided to take patient to Hartington Unit, along with mother and his sister.
- “Despite trying, never got any contact, even though I had taken an overdose.”
- “I was taken direct to Stepping Hill, P3, mental health ward.”
- “Four hours.”
- Police attended. They kicked in the door. “I was totally out of it, I was fitting. I was taken directly to Stepping Hill and put on a general ward.”
- “I rang Corbar View after waiting for two hours.”
- “Twenty-four hours.”
- “Six weeks.”
- “They contacted the team straight away.”

South Derbyshire

- “Was seen straight away.”
- “Currently on a three year waiting list to see a forensic psychologist.” (Referred by his GP).
- Waited for five hours to be seen in A&E at Queen’s Medical Centre, “This didn’t help my mental health.” Was later transferred to the Royal Derby Hospital and said, “When I arrived at Derby it all happened quite quickly and then I went to Radbourne.”
- “Over 24 hours I had to wait in A&E.”
- “Seven hours for appointment with GP. Also waiting for a long time in Royal Derby Hospital A&E before decision made on where to go.”
- “Arrived at A&E at 10pm and was not seen by anyone until the morning.”
- Individual with suicidal tendencies was left on their own on Saturday by an NHS mental health team who told them they’d be back in the evening, before this happened there was an incident which ended with the police using a Taser on them.
- They waited for a long time before someone from the crisis team came out. They had been to the GP with a friend in the morning and the GP made a referral straight away. The crisis team rang and told them to go home and wait and someone would come ‘later’. They came much later in the day and it was lucky that a friend stayed with them to prevent them from harming themselves.
- “On Ridgeway for 10 days and then went to the Hartington Unit.”
- “Two days. The crisis team rang and did a brief assessment over the phone and said they didn’t require help from the crisis team. This was very poor.”

- “The crisis team contacted [participant] the next day and offered to come to the house but they did not want people knowing they were involved with the crisis team so arranged to go to them.”

Question - Were you understood?

Some participants describe a feeling of not being listened to or taken seriously because of the actions (or lack of) taken by services. Others felt that they had been understood by services and they had responded to their needs.

North Derbyshire - Negative

- “Not really. No-one seemed to want to do anything.”
- “No” x one participant.
- “No, they only focussed on the alcohol element, not how I felt.”
- “No, as they wanted to send me home straight away - which they did. My friend was really angry about this, and said I needed hospitalisation.”
- “I don't think I was, even though I'd explained everything about my history with mental health.”

North Derbyshire - Positive

- “Yes - in particular the police were very kind.”
- “Yes” x one participant.

South Derbyshire - Negative

- “No” x two participants.
- “No, the mental health team came to assess me and just told me I do not have mental health problems, the ward matron got me another assessment and they said the same thing.”
- “No, they were not listening to me.”
- “No, and was not taken seriously by the mental health liaison nurses at the Chesterfield Royal Hospital. They asked me if I was doing any self-help techniques for my suicidal feeling, I said ‘yes, swimming’ but I do not like deep water so I stay in the shallow end. My mental health liaison nurse said, ‘Well, you don't want to die that much then do you?’”
- “No. Not having the feeling of support is horrendous and can be devastating.”

South Derbyshire - Positive

- “Yes” x two participants.
- “Yes definitely by the crisis team at Derby”.
- “Yes definitely.”
- “Yes the mental health worker who comes out with the police is brilliant, they are a life saver.”

Question - Was communication good?

Participants describe, based on their experience, if communication was good or not. Some participants describe a lack of communication between different services, and other participants felt that communication was positive and they knew what to expect, and when.

North Derbyshire - Negative

- “No, and being homeless there were other issues such as having to meet with them in a place that I could get to, having no money and no transport.”
- “No” x four participants.
- “No and this applies to Corbar View as well. I was a solvent abuser and was ignored by my psychiatrist. I had no proper help, no signposting to any substance misuse organisations.”
- “No, not between the crisis team and the psychiatrist.”
- “No it wasn’t, they weren’t aware of how chronically ill I’d been with my mental health condition.”
- “Not in police cells as I had overdosed and they did not realise.”

North Derbyshire - Positive

- “Yes in terms of (a) knowing there was a bed and (b) told to wait for emergency doctor.”
- “Yes, probably due to my CPN being so good.”
- “Yes” x two participants.

South Derbyshire - Negative

- “No” x six participants.
- “Not between Queen’s Medical Centre and Royal Derby Hospital, when they arrived at Derby they had to explain the full situation all over again.”
- “No, had to wait for long periods and did not know what was happening.”

South Derbyshire - Positive

- “Yes” x five participants.
- “Yes, the surgery put an alert on their system so that if I rang up again it would flag up on their system to get an appointment as soon as possible.”

South Derbyshire - Mixed

- “Key worker explained everything, but also felt there was a period where I was left not knowing what would be happening then everything all came at once, which was quite overwhelming.”

Question - Were your wishes adhered to?

Some participants expressed that their wishes had not been adhered to, and the course of action they wanted did not happen. Others had struggled because services did not appear to acknowledge the mental health needs they felt that they had.

Others felt that their wishes had been taken in to account or felt that when their wishes hadn't been adhered to, this was in their best interests.

North Derbyshire - Negative

- “No” x three participants.
- “I wanted to see my psychiatrist because he knew my history, but the crisis team refused. Despite the fact that I wanted to remain in hospital I was told that Hartington Unit was full and there was no other hospitals in the area available, I was offered London. The crisis team asked, ‘What do you want to do?’ Despite all this, I was sent home.”
- “No, the CPN just told me to deal with my mental health problem.”

North Derbyshire - Positive

- “Yes” x one participant.
- “Yes, I didn't want an ambulance so they didn't send one.”

North Derbyshire - Mixed

- “No, but I understand why, I was in a state and was uncooperative but I am now thankful for what they did. I didn't want the crisis team but they really did help me.”
- “I don't think they were, but I understood why because I was at risk of hurting myself and others.

South Derbyshire - Negative

- “No, I wanted help and all I was told is that I do not have mental health problems. Then when they tried to discharge me I was told that if I do not go they will put me on a section 5.”
- “No” x three participants.
- “No, I needed support but because I was physically ok I was discharged.”
- “No.” Participant has little support and wants a CPN to help get into some accommodation where there are support workers all the time, as they feel that they need this to help stay well

South Derbyshire - Positive

- “Yes” x seven participants.
- “Yes, I wanted to go to the Hartington Unit.”

South Derbyshire - Mixed

- “Not really but was taken to crisis house so did get help eventually.”

Question - Were you listened to?

Some participants felt that they were not listened to, with several feeling that they weren't ill enough for treatment/support. Other participants spoke about how well the services they went to listened to them.

North Derbyshire - Negative

- "No" x eight participants.
- "No, because I wasn't well and yet told, 'you are fit to go home.'"

North Derbyshire - Positive

- "Yes" x four participants.

South Derbyshire - Negative

- "No" x six participants.
- "No, when the hospital was not listening to me I walked out and went home but they phoned the police and they were kind and took me back to Radbourne."
- "No, how ill do I have to be before I get help? You have to get really poorly before you can get any help."
- "Not at A&E." Professionals also told their parent that they do not have mental health problems.
- "I do not feel listened to and that was why I have stopped taking my medication, I am sick of waiting."

South Derbyshire - Positive

- "Yes" x five participants.
- "Yes I felt that someone was finally listening to me."
- "Yes definitely by 111. The mental health liaison nurse at Royal Derby Hospital was also really nice but she had a lot of paperwork and I felt like I needed someone to be keeping a close eye on me, rather than just filling in forms."

Question - Were you treated with dignity and respect?

Some participants felt that they were not treated with dignity and respect by the individual or service involved. However, many participants responded to this question positively, with the police highlighted positively on more than on occasion.

North Derbyshire - Negative

- "No, I felt they didn't see the person, just a situation and a diagnosis."
- "No" x two participants.
- "No, because the CPN kept telling me that I didn't have a mental health problem and they failed to acknowledge my past problems."

North Derbyshire - Positive

- “Yes” x three participants.
- “Yes, I remember I was treated fairly by the police.”
- “Yes, completely, everyone was kind and spoke to me as a person.”
- “Yes, the police kept stopping to get fresh air into the car and checking how I felt.”
- “Yes, the police were fine as they knew me from previous occasions.”

South Derbyshire - Negative

- “Not in A&E” x two participants.
- “No” x four participants.
- “Not really. On one occasion when I was under the crisis team, they came to visit but the worker forgot to bring my telephone number. The crisis team worker then went into the reception where I live to ask where I was. They told the staff member on reception who they were and who they were going to see. So now the staff know I have mental health issues and the crisis team is involved.”

South Derbyshire - Positive

- “Yes” x seven participants.
- “Yes, by the staff at Royal Derby Hospital A&E.”

Question - Was there any physical restraint?

The majority of participants had not been restrained. Of those that had, handcuffs had been used on four occasions and two participants had been restrained by the police, but on one occasion this had not been explained.

North Derbyshire responses

- “No” x 13 participants.
- “Yes, handcuffs” x four participants.

South Derbyshire responses

- “No” x 16 participants.
- “Police did, they did this safely but with no respect. They did not explain why I was being restrained.”
- “Yes, the police did and they explained why.”

Question - Were family informed of your whereabouts?

Participants describe if/how their family became aware of their whereabouts. There are no apparent issues raised by the responses given.

North Derbyshire responses

- “No” x three participants.
- “Yes” x two participants.
- Family present when admitted
- “Yes when I ended up in A&E.”
- “Yes, the police rang my main carer.”

South Derbyshire responses

- “Mum wasn’t aware until just before I was admitted to Radbourne.”
- “Yes” x four participants.
- “No, did not want them to know” x four participants..

Question - Were you sectioned?

There is a significant difference here with north/south with nine sectioned in the north, and only one in the south. The reasons for this are unknown.

North Derbyshire responses

- “No” x 11 participants.
- “Yes” x nine participants.

South Derbyshire responses

- “No” x 19 participants
- “Yes” x one participant.

Question - Did you end up in police cells?

Two participants had been in police cells, and they describe their experience.

North Derbyshire responses

- “No” x 19 participants.
- “Yes, I was in police cells, I had overdosed and they did not realise. Then I was taken to A&E but they said if there wasn't a bed at the Hartington Unit I would have to return to police cells, even though I had overdosed. I could not get to see the CPN until 9am the following day. I ended up in Crisis House in Derby as there were no beds at Hartington or presumably the Radbourne Unit.”

South Derbyshire responses

- “No” x 19 participants.

- “Yes. Taken to Chesterfield Police Station and locked in a cell for 12 hours even though I was having panic attacks and I was handcuffed all night.”

Question - When you reached mental health crisis, where were you taken if anywhere?

Participants explain where they were taken, and then if they were transferred.

North Derbyshire responses

- Hartington Unit x 7 participants
- Bassetlaw Hospital
- Stepping Hill x 6 participants
- Tameside Hospital
- A&E at Chesterfield Royal Hospital, then Crisis House in Derby.

South Derbyshire responses

- Radbourne Unit x 2 participants
- A&E and then transferred to the Radbourne Unit x 2 participants
- A&E at Queen’s Medical Centre.
- A&E at Chesterfield Royal Hospital x 2 participants
- A&E at Royal Derby Hospital
- Trevayler House x 2 participant
- Hartington Unit
- Cheshire at the Priory Hospital due to limited bed space.

Question - Quality of treatment and care when in crisis

Participants describe the care and treatment received in crisis by various services.

Hartington Unit

- “The care is good at Hartington; it’s just the problem of actually accessing the service.”
- “The Hartington Unit is really good. Staff are warm, kind, friendly and seem as though they really do care. The first time I was there for four weeks, discharged, and returned two weeks later - this time to Morton Ward where I spent another two weeks. The second time I was readmitted I was warned that I may have to go outside Derbyshire but they sorted it and I went back into Hartington.”
- “A nurse and police officer kept an eye on me. I was taken to a (Section) 136 room. I was there for about five hours. It was a small room, small window with moveable chairs. I was then taken onto Morton Ward, there was a bed ready. It was very good, nice nurses. I was on Level 3 which means I had to be checked every 15 minutes. I had one week in and then one week out, but I couldn’t cope, so I went back in and then allowed out for just two days at home. I coped better.”
- “The food was good but I think there are a lot of hidden calories in the meals and I didn’t really know what I was eating, what had a high fat content and what the calories were. I put on two stone whilst I was on the ward as I didn’t do much

exercising either. They say that doing exercise is good for your mental health but there isn't anything organised on the ward. I had no complaints about the staff. I couldn't go on the ward at first because of the section I was on but I did go after a while. I was on the ward for nine months."

- "I had been in Hartington before so they remembered me. I had been on every ward. The nurses were nice. I was allowed to go to The Hub and I made a bird box and bird table."

Bassetlaw Hospital

- "When I went to Bassetlaw A&E (after taking overdose), I had BP checks etc but they did not confirm I had taken an overdose. Therefore I was not referred to crisis team or for assessment."

Stepping Hill

- "I was on P3 mental health ward. It was awful. They have 'padded' rooms - bean bags and padded tables/chairs. I had to ask to go to the toilet and when I did, I had to have someone with me. I hated it. I held my urine back and as a consequence I had a water infection because I could not go to the toilet with someone, particularly a male, watching. The nurses were horrible. I suffer from PTSD and stress related anorexia. I do not want people to see my body."
- "I was on a general ward. The crisis team came in to see me and said I was fit to go home. I was sometimes put in an isolated room at Stepping Hill due to my issues. Going in and out of hospital provides me with a safe and social environment. I am isolated when I get out."
- "I was taken to Stepping Hill. I can't fault them but initially I was left in the main area. I felt very vulnerable and waited whilst they searched my bags. It was frightening. I was left waiting for two hours. I had to wait to get into the unit as it was late in the evening. The bed I was given was still dirty from the last patient. My head was messed up by the time I got to my bed. The nurses were brilliant but the initial introduction was hard."
- "Only spent one night at Stepping Hill, nurses were nice."

Tameside Hospital

- "I also presented with self-harming cuts in A&E but I lied and said that I had fallen. I have been quite a few times with self-inflicted cuts but I would have thought they would have cottoned on and seen through my lies. I was suicidal but I masked it which doesn't help the situation because they can only go on what I tell them."

Radbourne Unit

- "It's a bit clinical, the showers are not good, they are communal." The participant had to be watched while they were showering, in case they harmed themselves which was very distressing. "There is no occupational therapist there. You can have tea and coffee when you want in the day but during the evening/night you can only have cold drinks. The dining room closes in the evening until 6am. There are no activities just a TV and radio. They did have a sensory room which was good with comfy chairs and, as I was leaving, they were setting up a recreation room but they had to close a dormitory to be able to do this. You can never get help at weekends as it seems to be more bank staff, and they do not know what they are doing and they do not care. There was one time I was put on Level 2 and had to be supervised

24 hours a day and some of the bank staff really lack understanding and it was very inconsistent. I think it is due to lack of correct training rather than just not caring. Staff need to be clear about what they should and should not be doing.”

- “The food is bland, there are no activities, showers were not nice, but I understand the reason as to why they were basic for safety reasons. Some of the staff at the unit are really rude and they could be more caring.”
- “I was in the Radbourne Unit for three weeks. It was clean, the food was nice and I felt safe. I was in a three-room dormitory on ward 33. I had a named nurse, I saw him in passing but never to speak to. In general the nurses were okay but one was quite 'cold'. I saw a psychiatrist once per week for a quick assessment.”
- “The unit is clean, the beds are ok and the food is not bad. But, the main issue was the fact that staff need to have more time for the patients. When I was there, I knocked on the door to speak to a member of staff and was told, ‘you need to wait we’re busy’ and then had to wait for around 20-30 minutes until able to speak to someone.”
- “I was told that I had a named nurse whilst I was in Radbourne and was there for two weeks but I never met them.”

Trevayler House

- “They are very supportive and helpful. I am struggling to sleep at night so tonight they are going to help me with a sleep routine. They give valuable 24 hour support.”
- “The staff here are excellent and this place is excellent, if I had not come here I would be dead now.”
- “I felt safe the minute I walked in, I felt at home very quickly. They have different activities that you can take part in, they have a really nice garden and a greenhouse so I have spent a lot of my time gardening which helps me to relax.”
- “The environment is relaxing and I really like the garden and can practice Yoga. I also feel that the peer support I have received has been invaluable as it makes me feel not alone.”
- Has now been at Trevayler for one week, although was involved in the decision that a crisis house would be the best place for them to be. Was not given an option in terms of location but has been to Trevayler House in the past. The crisis team, CPN and the participant all agreed that Trevayler House would be best, and was kept very well informed about when a bed was becoming available. “Trevayler House is clean, welcoming and I like that fact that you can just knock on the door and someone is always here to talk to me and they spend as long as you need.”

The Priory

- “At The Priory there were about 25 different ways to hurt myself there in the bedrooms such as cords, mirrors etc.”

Question - Was your medication regularly reviewed?

The majority of participants felt that their medication had been reviewed with one negative experience reported.

North Derbyshire - Positive

- “Reassessed upon presentation.”
- “Put on sedatives, already on Lithium.” (Medication for treatment of Bipolar).
- “I was given a sedative to calm me down but I didn’t understand the other meds.”
- “Yes, because I was already on anti-depressants and heart tablets. I didn’t understand about the medication given to me on the ward, all I knew was that it made me sleep.”
- “Yes, the support was to make sure I was taking my medication as I have got Bipolar.”
- “Yes my medication, Venlafaxine, was reviewed because of side effects.”
- “Yes they put me on different medication for my mental illness. They started me on a depot injection which I now have every fortnight. This is to balance my brain.”

South Derbyshire - Positive

- “Reviewed medication at Trevayler House on the day of arrival.”
- “Yes by psychiatrist, to me that’s all they do, deal with my medication.”

South Derbyshire - Negative

- “No, not really, GP says it’s the psychiatrist’s job to sort medication, and vice versa.”

Question - Were any concerns you had about medication (side effects) listened to/acted upon?

Very few participants responded to this question. Those that did indicated that they had flagged up any side effects and this information was acted upon when possible.

Question - Longer term support; decisions about treatment?

More participants felt that longer term support had not been established, than had been established.

North Derbyshire responses

- Longer term support not established x eight participants.
- Longer term support agreed and established x six participants.

South Derbyshire responses

- Longer term support not established x 10 participants.
- Longer term support agreed and established x four participants.

Question - Were your rights explained?

An equal split of participants indicated that they had, and had not been made aware of their rights. Many participants added that they had been given information on arrival/admission but couldn't take the information in at the time.

Question - Did you receive any advocacy support?

Most participants indicated that they had not had advocacy support, were not aware about this or didn't feel it to be relevant to their needs. Additional comments received are as follows: -

- "This was offered two weeks prior to being discharged, but never received it and then was told I could not have it as was not under a section."
- "No because I was not under a section."
- "No, but someone from a advocacy agency used to visit once per month on the ward at Hartington and a mental health worker from Citizens Advice Bureau visited once a month. But although both were available, neither of them were promoted on the unit."
- "I did see an advocacy worker in Hartington while I was there but I felt I did not need it."
- "Yes, via CV2."

RECOVERY AND STAYING WELL

Question - Was information provided (e.g. substance misuse information, housing, support agencies)?

Participants respond by saying what, if any information they had been provided with and if/how they have used this information since.

North Derbyshire responses

- Nothing x eight participants.
- Information was received about Rhubarb Farm from Job Centre.
- "They told me about Rhubarb Farm, I have been going there ever since."
- "The private psychologist advised me to go to a group for my depression but the group wasn't suitable because the group leader hit on me so I couldn't go back. I have no support now. I found about Beardwood Natural Living Project on my own and it is brilliant, it really helps with improving my health and wellbeing."
- "Amber Trust, Buxton have really helped me."
- "Upon discharge, I had nowhere to go. I was told by the unit that they were trying to get me a flat. I was told this may take about two months. I made a call and managed to stay with a friend but the flat took much longer - six months. Now I have a council flat although still sleeping on pallets/mattress. My Housing Support Tenancy Officer helps me. I was also referred to Pathways via DAAS as started drinking."
- "Yes about the Bipolar group that is run from DORA."

- “I had a Housing Tenancy Officer and they helped me get in touch with the crisis team. I go to Rethink and DORA and they are both great, I get newsletters from both groups to inform me of what is happening.”
- “DORA, Eckington Craft Group is brilliant. I have been coming here for years and it is good because I can connect with others about mental health issues. I get picked up by a volunteer and I am able to go to craft events and on day trips. Rethink are really good as well, I go to play pool on Tuesdays.”

South Derbyshire responses

- “No” x four participants.
- “When I left the Radbourne Unit I was given leaflets for different services but nothing was explained to me.”
- “No, a lady from the crisis team told me, ‘Why are you here, we deal with mental health, not housing!’”
- “No.” Participant went to see their GP to find out what support options would be available. However, there was no help for them or others like them other than the Addaction telephone line. “We feel that it is poor that our family GP couldn’t offer any more help and support other than this.”
- “All I was made aware of was a lunch club/colouring in session but I wouldn’t have been able to attend anyway as I work. On another occasion in the last year or so, the crisis team have said they would refer me to the Derbyshire Federation for Mental Health. However, they then said that they would not make the referral for me, and I would have to do this myself. This is very confusing.”
- “No, was not given any information by crisis team or CPN, have only ever been told about Focusline.” The participant found out about MHAG through a leaflet and contacted them independently. “There is information out there but everyone thinks Derbyshire Mind and Rethink are these big organisations that no one can touch.”

Question - Was a plan developed?

Some participants indicated that a plan had not been developed. Other participants did have a plan, and gave some information about what the plan involves.

North Derbyshire responses

- No plan made/not aware of plan x ten participants.
- “Yes, I now have a social worker and a support worker, I am supported to do Yoga every week and we go for a coffee after for a chat.”
- “Yes, I have three monthly check-ups and monthly visits to my GP.”
- “Yes, a worker from Shirebrook (CMHT) is coming to see me.”
- “Yes, in terms of the crisis team visiting me for 2-3 weeks.”
- “Yes, only for me to see the CPN at Corbar View.”

South Derbyshire responses

- “No, the crisis team were meant to come and see me on Sunday but they didn’t turn up, and then they were meant to come yesterday (Tuesday) and they didn’t show up. It just keeps changing every five minutes. I think the issue may be that the

crisis team. I am linked to it in Chesterfield and there may be a staff capacity issues to get time to come to Derby.”

- No has no support plan. CPN and social worker keep saying they will sort a care plan.
- “Yes, but was not involved in developing the plan. At the time of discharge, was told, ‘we have given you a different medication now and you will be fine with 24-hour support.’” The participant also wanted to go back home to Derby but CPN and staff from Chilwell House had a long meeting in which the participant was not involved. “I just found out the outcome which they have decided that I am not well enough to go home and I have to go back to Chilwell House.”
- “Yes, I have a support plan and feel very involved.”
- “Yes with CPN, however within the last six months I have had four CPN's. They don't tell you either, you just get dropped. It is very off putting and it makes you lose confidence as you do not want to give too much of yourself. It makes my recovery harder when my CPN keeps changing.”
- Yes, a psychiatrist suggested that they should continue their recovery at Trevayler House following discharge from the unit. They made the arrangements for this and they knew about three days before the day that they were leaving. However, when discharged they had to make their own way from Hartington to Trevayler. This was over a two hour journey on buses from Chesterfield to Derby and then another trip on Burton Road. The OTs at Hartington worked closely with them. Very happy with the help that the OT service provided.
- “The people who came to see me about my complaint and getting a CPN said they can help with doing a plan. I have wanted this to happen for years.”

Question - Were you provided with a follow-up appointment with mental health services when you left crisis care? How long did you have to wait for a follow-up appointment?

Participants give an account of the arrangements made for follow-up appointments after crisis care.

North Derbyshire responses

- “I see someone at the Hartington Unit.”
- “With CV2 at Manchester Royal.” (Four week wait).
- “Yes, I see my CPN every two weeks for an injection.”
- “Corbar View took over.” (One week wait).
- “Yes, with psychologist.” (Four week wait).
- “A CPN came to visit me shortly after I was discharged.”
- “Yes with the psychiatrist at Hartington Unit.”
- “Yes, CPN at Corbar View.”
- “I went to a self-harm group which was very good. It was a six month course at Tontine Road.”
- “Two months for a review at the Hartington Unit, I think that this is acceptable.”

South Derbyshire responses

- “Yes with a psychiatrist, and was able to bring forward if wanted/needed to.”
- Two month wait, “Would have been better for this to be quicker.”
- “Yes, a lady came from the crisis team to help with an assessment and her attitude/body language was very unprofessional. As soon as I mentioned that I am a qualified social worker, her attitude changed. I felt like I had to assert myself but I had no assertion left in me. All people need is to be treated the same with dignity and respect irrelevant of what job they do, or if they have a job.”
- “Yes, but not with the mental health team at the hospital, I was taken for an assessment which brings everything to the surface and then it’s so dangerous because there’s no consistent support. In the last year or so I have had 11 different assessments and they bring things to the surface and then nothing is resolved. It feels like this makes people feel worse if you get no help after you have just spoken to someone about your mental health concerns. Staff should do what they say they are going to do and not let us down all the time.”
- “I was assigned a CPN.”
- “In early June I was meant to have an appointment with my psychiatrist. I was still in Trevayler at the time, but he cancelled the day before because he was ill. I have now received another letter with an appointment date for 2017. What am I meant to do until then?” The participant is planning to chase this up and hopes they continue to feel well enough to do this.
- “Yes, when I left Hartington I was told the crisis team would come and visit in two days at Trevayler. Two days later a participant from the crisis team visited and said, ‘In two days’ time you will receive another visit.’ However, the next day I got another visit from the crisis team and just discharged me. When I left Trevayler I was given a proper plan on how to deal with everything. While I was in Trevayler I went on lots of courses through ‘blue sky’ and I think they are some of the best courses I have been on.”
- Still in the crisis house - but is being visited by the crisis team every day and is creating a future plan.

Question - How could services be improved?

North Derbyshire responses

- “Housing problems for homeless people should be linked with hospital. What is the point of sending a person to Pathways for them to have to contact Deventio Housing for advice and assistance when Hartington Unit could refer direct to Deventio?”
- “I can’t remember what happened to me as it just was a blur. I would like a piece of paper explaining what services I came across and what my behaviour was like including the progress I made.”
- “Counselling, waiting lists - currently about 12 months wait.”
- “Better access to crisis team, a better understanding of people and their needs.”
- “By ensuring that clients have direct phone contact to CPN. Not wait until a breakdown happens.”

- “Better CPN and more community support to stop me from hitting crisis.”
- “After care, it is very frightening when you come out of hospital, I wanted to go back. I started drinking but day by day I got better. Hospital does provide a 'safe' place. Another issue is that I am dyslexic and, as such, cannot note numbers quickly. Therefore, if you are ringing Corbar View for example and have to take down a number from an answerphone, it can take a number of call backs to get the number correct.”
- “Crisis team should check our medical records to say what problems you have had before, and if you have had a psychiatrist. They should then be able to contact that psychiatrist direct and discuss your case.”
- “I would also like to say that I think the police need more training on mental health issues, some are lacking. I had overdosed and they did not realise, and I ended up in the cells.”
- “GPs understanding mental health, and the ability to see the same GP to improve the trust, so I would talk more about mental health.”
- “A better understanding by the crisis team, particularly as I have mentioned how I behave which they should understand. They said I needed re-assurance and 'next steps' and they said that was not what they were there for. This was after I had overdosed.”

South Derbyshire responses

- “More consistency with GPs knowledge of mental health, and they should give more information sheets with correct and up-to-date information on. They should also have better knowledge themselves.”
- “I wish there weren't any mental health hospitals so you could be treated at home.”
- “There should be more places like Bank House, I have been coming here for the past six years.”
- “I would like to have one GP because I struggle with anxiety and I do not want to have to keep repeating myself.”
- “More activities at Radbourne.”
- “Radbourne Unit could be more homely with plants and pictures.”
- “If you are in crisis you shouldn't have to wait hours in A&E.”
- “Easier access to 24 hour support.”
- “Clear line of who to contact when in crisis.”
- “GPs should be consistent with the ‘Scale of Mood Assessment’. It would be better to carry out this assessment on each visit so the doctor can monitor how people are feeling. Consistency with the same GP. More awareness of healthy eating, exercise, other wellbeing strategies that can be used at the early stages to work as a preventative for anxiety and depression. More acknowledgement to how we can care for ourselves and for GPs to stop focusing on prescribing medication as a quick fix and provide support to resolve the underlying issues.”
- “GPs should have more knowledge around eating disorders and should be more willing to support them.”
- “Especially communication and consistency of staff so you do not end up getting conflicting information. The crisis team is very difficult to access as you cannot ring them yourself.”
- “I think it is bad that they are constantly changing my CPN. They do not tell me, or keep me informed about this. You need to build up a relationship and trust and if

you have this, and good communication, then you stay better for longer without having to go into crisis. At one point I was without a CPN for nine weeks and I was only told about this the day before. I was told that if I needed anyone to talk to in the meantime that I could ring St James office. This felt like such a long time and it puts you in a vulnerable position.”

- “Easier access to services and to know the correct routes to be able to ask for help/support when needed.”
- “Easier access to support.”
- “More continuity with staff, I have had five psychiatrists in 11 months.”
- “In the past my needs for Type 1 diabetes have not been taken into account. Having to worry about physical health should not be happening when you are on a mental health ward. On another occasion when I was in Hartington, I was due to have MRI scans because of my arthritis and they said I could not go to them as they were in Derby. I asked if they could be done in Chesterfield but this did not happen either. The physical side of my health was disregarded. I then had to wait for another appointment. The staff in Derby were annoyed as they had not been notified that I was not coming.”
- Long wait to get a CPN x 2 people.
- “Radbourne staff need to have more time to be able to speak with the patients.”
- “A&E should do safe and well checks to people who present at A&E about their mental health.”

8.0 Recommendations

1. Provide clear information for patients, friends, family and carers about where to go, and what to do in a developing crisis situation.
2. Work to develop coordination of, and show real ownership of developing crisis situations.
3. Address access issues to Focusline.
4. Maximise access to, availability of and continuity with CPNs.
5. Support General Practice to deal with and respond to mental health crisis.
6. Improve referral systems to social care and community support.
7. Work to improve patient experience in Accident and Emergency.
8. Address police ability to identify and respond to potential overdoses.
9. Police to explain restraint when used.
10. Address and seek to minimise use of police cells for people in mental health crisis.
11. Consider distress caused by supervised toileting/showering in acute inpatient units, and consider alternative solutions.
12. Develop role/purpose of name nurse in acute inpatient units.
13. Consider provision of appropriate activities in acute inpatient units.
14. Consider how physical health needs are accommodated by acute inpatient units.
15. Appropriate awareness raising of advocacy in a range of settings and its purpose.
16. Consider and take any necessary action required to address reported self-harm risks in rooms at The Priory.

9. Service Provider Responses

Response from Chesterfield Royal NHS Foundation Trust

The Trust welcomes patient feedback and Healthwatch reports, as they help us to understand and plan ways that we can improve patient experience.

The findings of this report have helped us to understand the patient perspective with regards to care and treatment of those who are in mental health crisis. Furthermore, findings have crossed over with some of the discussions we had in a recent substance misuse focus group; therefore, the report has also been useful in helping us to identify both the potential for multiple needs of patients and the potential benefits of joined up improvements that can affect a variety of patient groups.

Since reading this report:

a) We have already made the following changes:

- The Trust already has good links with the Liaison Team, employed by Derbyshire Healthcare NHS Foundation Trust. Previous focus group discussions suggested that there is good mental health support available for patients via the team, who are available 24 hours a day, 7 days a week; every patient who sees the team receives a mental health assessment.
- The Liaison Team has meetings with the staff from the Emergency Department (ED)/Emergency Management Unit (EMU)/Clinical Decisions Unit (CDU) every other month which is also attended by Service Users and Child and Adolescent Mental Health Service (CAMHS) - we have recently welcomed the Enhanced Support Team to the meetings.
- Mental Health Awareness Training is delivered for all staff groups by the Liaison Team as requested.
- The Liaison Team have been providing regular teaching sessions for the ED staff and are rolling out this training to staff on EMU and CDU. These sessions have become more formalised for recognition and continued educational needs.
- The Liaison Team undertake regular audit/survey work to review patient and relative experience of their service as well as the regular feedback from the service users who attend the alt monthly meetings - this was previously provided by Derbyshire Voice but due to funding changes, the service user forum group is now Derbyshire Mental Health Alliance.
- Over the last few years we have been regularly reviewing the initial assessment process that mental health patients receive - we currently use a double sided pro-forma that is completed by the initial assessment ED nurse.
- The issue of waits/delays for ED are constantly being reviewed as per Department of Health and Royal College of Emergency Medicine performance standard. Generally initial assessments should take place within 15minutes of attendance; more specifically for this cohort once the patient is deemed medically fit and referred to Liaison for a review in the ED they will be seen within one hour - if they need admitting to CDU this will be a review within 24 hours of referral. The latest

data on the referral to assessment times for the team are very good - 95% and 94% at June 2016. We do encounter prolonged waits for Mental Health Act assessments for the purpose of sectioning due to waiting for MH consultants and AMHP Social workers to congregate, and also waits for mental health specific beds (there is a national shortage so not specific to Chesterfield).

b) We will be making the following changes:

- We are looking to increase our remit in Liaison Team meetings to include representation from Acute Medicine, Care of the Elderly/Frailty Unit, Gastroenterology, Critical Care and Surgery as well as amalgamating the Trust Substance Misuse Steering Group agenda to these regular meetings. This follows on from the 16 month service evaluation of the Liaison Team by the North Derbyshire and Hardwick CCGs.
- As part of our CQUIN (Commissioning for Quality and Innovation) work for 2017/18, we will be focusing on improving services for people with mental health needs who present to the Emergency Department; this particularly refers to high impact users (those who attend ED 10 or more times a year).
- We will implement rolling health messages on Emergency Department TV screens and bespoke materials to hand out to patients, to provide information on mental health support. This will be included in the Emotional Support ambition of our Quality Strategy.
- We will undertake a period of focused patient feedback, looking at experiences of mental health patients in our Emergency Department.
- 6 e-learning packages have been developed by the Liaison Team on a range of mental health priorities identified by the Trust. The next stage is to make them widely available to staff by uploading onto the Trust's e-learning platform.
- We will ensure that support and training from the Liaison Team is promoted with staff in the Emergency Department and across the Trust, to raise awareness of this valuable resource.
- The Urgent Care Village project proposal includes an assessment area to support people with mental health needs when waiting in the Emergency Department; however, there is no firm date for this at present.

Response from Derby Teaching Hospitals NHS Foundation Trust

The Mental Health Liaison team see all patients in Emergency Department (ED) within one hour and we have an internal steering group who meet monthly to review this and also implement further improvements on staff training and quality of patient care. We also held a full mental health training and awareness day for over a hundred of our Senior Nurses on 29th September 2016 and this was exceptionally well received.

We are also planning to employ a Registered Mental Nurse in our ED and Medical Assessment areas to assist with caring for patients and staff support. We are fully committed to increasing the knowledge and skills of staff on caring for patients with mental health needs through general training and also through this level of one to one support and mentorship.

We are also currently exploring with the Mental Health Trust how we can involve patients in co-designing our services.

The Trust is very aware of the long waits in the Emergency Department (ED) for some patients who require specialist mental health assessment and access to a specialist mental health facility. We are working closely with our Partners and Commissioners to improve this.

Response from East Midlands Ambulance Service NHS Trust

1. Provide clear information for patients, friends, family and carers about where to go, and what to do in a developing crisis situation. *Relevant for all concordat group. EMAS will continue to support the development of clearer referral routes in a crisis.*
2. Work to develop coordination of, and show real ownership of developing crisis situations. *EMAS are linking in with the Derby triage hub on partnership working and shared support mechanisms with locality mental health provider, police and AMHP's.*
3. Address access issues to Focusline. *More relevant for wider concordat group.*
4. Maximise access to, availability of and continuity with CPNs. *EMAS would welcome greater available of in hours secondary mental health care to prevent a crisis from occurring.*
5. Support General Practice to deal with and respond to mental health crisis. *More relevant for wider concordat group.*
6. Work to improve patient experience in Accident and Emergency. *Where clinically appropriate EMAS would like to see a further reduction in ED conveyance with greater access to partnership working and pathways.*
7. Address police ability to identify and respond to potential overdoses. *EMAS will be working closely with the police as part of our collaborative hub model and be able to assist police around medical treatment for overdoses with toxbase support.*
8. Police to explain restraint when used. *Police to respond to this. It is an EMAS ambition going forward to rely less on the police around low level safe holding under best interests or mental capacity act where there is a life threatening emergency and a patient lacks capacity to a temporary or permanent impairment. A 2 year trajectory of training to frontline staff around mental health, legislation and safe holding commenced in August 2016 and will be rolled out to all frontline operational staff.*
9. Address and seek to minimise use of police cells for people in mental health crisis. *EMAS will continue to build on Health based places of safety and work with police to reduce unnecessary S136 detentions.*
10. Consider distress caused by supervised toileting/showering in acute inpatient units, and consider alternative solutions. *For provider to respond.*
11. Develop role/purpose of named nurse in acute inpatient units. *For mental health provider to respond.*
12. Consider provision of appropriate activities in acute inpatient units. *For mental health provider to respond.*
13. Consider how physical health needs are accommodated by acute inpatient units. *For mental health provider to respond.*

14. Appropriate awareness raising of advocacy and its purpose. *EMAS cover the role of advocacy with our mental health training and will continue to work with local partners in Derbyshire on more consistent access to advocacy roles.*

15. Consider and take any necessary action required to address reported self-harm risks in rooms at The Priory. *For provider to respond.*

Response from Derbyshire Healthcare NHS Foundation Trust

Thank you for the time taken and invested in visiting our Trust and partners and listening to the members of our community in relation to their expectations and their experiences of health and social care services before, during and after mental health crisis. We also thank you for sharing the outcome and recommendations with our organisation and providing the vehicle for our Trust to improve our services.

This survey represents the voices of forty respondents with a split representation between both the North and the South. This, although a smaller sample, does echo some care findings from our community Mental Health survey 2016 where although our benchmarking score was comparable to Good and Outstanding organisations, we did have an area for improvement, in our community knowing what to expect from their health service, what to do in a crisis and where to access support.

The Five Year Forward View for Mental Health and the National Confidential Inquiry for Suicide and Homicide, both outline Crisis teams as an area of national priority and investment. If we are able to focus our crisis offer and provide an accessible twenty four hour service with capacity to meet demand, this would be an excellent step forward for our County. This level of service is fundamental to providing good care. We will use the learning from your review to consider our own community and our crisis response services and see how we can use this learning and the voice of our community in feeding back their experiences.

As a specialist community health and mental health provider we also have a duty to support our community partners in providing support to understand mental health and to be psychologically minded in their approach. We will work with commissioners to find out if there is more that we can do to support our primary and secondary care colleagues in offering full support to gain access to our services.

It is clear from this activity that there have been some positive experiences of care, but that there are also some significant areas for improvement in the patient experience, knowing what the route to access is and what to expect from the commissioned service, and that at times people do not feel that their needs have been met. We will commit to exploring how we articulate our care offers, both as an organisation and as a system and put in place measures to improve. As a single stakeholder in a multi-agency agreement, we have developed an action plan that addresses those recommendations within the report that we are able to effect, and provide an overview of the plan here.

If you are agreeable, we would ask for your assistance in writing an article in your newsletter and having some information on your website on where and what you can do to

access help in a crisis; we would like to co-design this with service receivers and our commissioners to really listen to your feedback and try and improve.

Meanwhile, we maintain our commitment to work in partnership with other agencies in a shared approach to the success of the Crisis Concordat.

Recommendation	What we are doing	What we will do
<p>Provide clear information for patients, friends, family and carers about where to go, and what to do in a developing crisis situation</p>	<p>The DHCFT website provides details on how to access support in a crisis http://www.derbyshirehealthcareft.nhs.uk/getting-help/mental-health-crisis/</p> <p>In addition, people who receive our services have a care plan, and may have a crisis contingency plan, a safety plan and a staying well plan - these plans help the person and any carers/family to recognise early warning signs when a person may be coming unwell, and provide details of how to contact a range of services and resources that may be helpful in an emerging crisis</p>	<p>We will develop more detailed crisis contingency plans so that people know exactly what to do in an emerging crisis from our Trust and the community offers.</p> <p>In addition we will revisit the section of the 'My Care' leaflet and revise it based upon your feedback.</p> <p>We will continue to work in partnership with people, families and carers in the development of advance statements (plans that tell us how people would like care to be delivered when they are in a crisis or acutely unwell), staying well plans and safety plans so that people feel more informed about how and when to get help from the right people at the right time</p> <p>As part of the Derbyshire Sustainability and Transformation Plan (STP) we will work with partner agencies to increase the presence of mental health specialism within primary care, so that people have more rapid access to advice and the right help in an</p>

		<p>emerging crisis.</p> <p>If you are agreeable, we would ask for your assistance in writing an article in your newsletter and having some information on your website on where and what you can do to access help in a crisis, we would like to co-design this with service receivers and our commissioners to really listen to your feedback and try and improve.</p>
<p>Work to develop coordination of, and show real ownership of developing crisis situations</p>	<p>We are holding workshops in our inpatient units to increase our focus on developing staying well plans with people who receive our services</p>	<p>We will increase the presence of mental health specialism through our link working within primary care</p> <p>We will review how well the new Mental Health Advice and Assessment Hub (MHA AH) service is working to inform future service development- this service aims to help people who may otherwise attend A&E in a mental health crisis</p> <p>We will improve the interface and mechanisms between our community and urgent care services so that people do not have to contact more than one service in an emerging crisis</p> <p>Through our STP plans, we will work in partnership with other agencies, to make sure that responses are better co-ordinated and we will share information proactively, with consent.</p>

Address access issues to Focus line	We feedback any access issues to our partners in the Crisis Concordat	We will continue to provide feedback to inform future service provision
Maximise access to, availability of and continuity with CPNs	We have increasing pressure in our community services, which we received a partial settlement for in our contracting round in 2016. We are embarking on a programme of work to try and improve capacity and flow in our community services, however this is with the knowledge that referrals to the service have increased significantly over the last year. We have set in our strategy we would like to work in partnership with our commissioners to improve our community offer to deliver on the aspirations of our trust strategy to deliver a weekend and 7 day per week community offer in addition to community services.	We will continue to work internally and externally to our organisation to find system changes, internal innovations and develop ideas to reform and adapt our services to try and meet this objective.
Support General Practice to deal with and respond to mental health crisis	We are meeting regularly with GP surgeries and working with our GP colleagues through GP Quest events, to provide advice, support and education to GP's in terms of managing crisis situations. The Crisis Resolution Home Treatment Teams (CRHT) offer a consultation/liaison response to support GPs in responding to crises.	<p>The new care model within the Derbyshire STP will have better links between mental health specialists and GPs, with more integrated models of working so that people can get the right advice when they need it.</p> <p>We are developing a plan with Public Health in Derbyshire, to deliver Suicide Awareness and Response training to General Practice and Primary Care</p>
Work to improve patient experience in Accident and Emergency	Our mental health liaison teams meet their target of assessment taking place within one hour of referral from the A&E triage staff	We will review how well the MHAAH is working to inform future service commissioning and development

Address Police ability to identify and respond to potential overdoses	Mental health professionals work alongside the police, providing support and education to officers working with people who may take or may have taken overdoses	We will review how well the MHAH is working to inform future service commissioning and development
Police to explain restraint when used	Our mental health professionals will continue to support police officers through education around working with people who have mental health problems	We will review how well the MHAH is working to inform future service commissioning and development
Address and seek to minimise use of police cells for people in mental health crisis	Mental health professionals work alongside the police, and offer support and education to officers working with people who may have mental health problems, ensuring that they are directed to the right environment for their mental health needs to be assessed	Together with the police, we will review how well the MHAH is working to inform future service commissioning and development
Consider distress caused by supervised toileting/showering in inpatient units, and consider alternative solutions	<p>We aim to provide care in the least restrictive environment. At times, in order to maintain a person's safety, we may need to provide care that can be intrusive, including the provision of one-to-one care in our inpatient units - this is sometimes known as 'observations'. To limit the impact this care has on a person's privacy and dignity:</p> <ul style="list-style-type: none"> • An 'observation' level care plan is developed with the person • The care plan is reviewed with the person regularly in order to reduce any restrictions as soon as it is safe to do so • The person is offered access to advocacy • The person is cared for on a gender specific ward 	<p>We will promote the use of advance statements for people who use our inpatient services and may require one-to-one care, so that we can include their preferences in care plans and minimise distress</p> <p>We will make sure that our observation care plans meet required standards through audit processes.</p> <p>We will share your report and feedback with our quality teams and ask them to reflect upon this valuable feedback and how our care is experienced.</p>

Develop role/purpose of named nurse in inpatient units	<p>All people using our inpatient units are allocated a named nurse, however, recent audit work carried has highlighted some variance in practice.</p> <p>Work is being carried out across the inpatient units to clarify the expectations of the role of named nurse with nursing staff</p>	<p>By March 2017, the named nurse role will be explicit within</p> <ul style="list-style-type: none"> • Job descriptions • The nurse preceptorship program • Management supervision <p>And will be measured through regular audit of both clinical records and what people tell us about their experiences of care</p>
Consider provision of appropriate activities in inpatient units	<p>There is a wide variety of activities and resources available to people who spend time in our inpatient facilities. These can be accessed directly from the ward, for example, recreational activity, art materials, and quiet areas. The Hubs in the Hartington Unit in Chesterfield, the Radbourne Unit in Derby and the OT Department at Kingsway have a range of activities which have been designed to meet the needs of individuals or groups, through structured therapeutic intervention</p> <p>In addition to this we have community links to wider support networks and resources which people can access prior to and following the time they spend within our inpatient facilities</p>	<p>We will ask the people who receive our inpatient services, what additional activities they would like to receive, and develop a plan to respond to your helpful feedback that we need to reflect upon our care offers</p>
Consider how physical health needs are accommodated by inpatient units	<p>Routine screening and assessment of physical healthcare needs is carried out for all people using our inpatient services</p> <p>We work in partnership with specialists in supporting people with specific physical healthcare needs while they are</p>	<p>Pieces of work are underway across all of our inpatient facilities to improve physical health care monitoring and physical health promotion. This is a wide ranging piece of work looking at diet, sleep, exercise,</p>

	an inpatient	access to outside space and relaxation, as well as the monitoring of physical health, for example diabetes care, asthma care and venous thromboembolism assessment.
Appropriate awareness raising of advocacy and its purpose	The named nurse makes people aware of how to access Advocacy Services in both of our inpatient units. The Hartington Unit holds weekly advocacy sessions, and a peer volunteer runs a 'your service, your say' resource in the Hub.	<p>The Radbourne Unit will meet with the Advocacy Service to identify ways in which the service could be better promoted for inpatients.</p> <p>The named nurse role is being clarified as detailed earlier in this report and will include responsibilities relating to advocacy. We have included advocacy posts and how to access advocacy in our booklets. We will in addition add this to our website and provide this information to Healthwatch for your newsletter and website so we can reach as many individuals as possible</p>
Consider and take any necessary action required to address reported self-harm risks in rooms at The Priory	<p>We respond to service receivers' feedback in relation to the experience of care from external providers</p> <p>We work closely with commissioners in the evaluation of standards of other providers</p>	We will continue to listen and respond to our service receivers' experiences of other care providers and maintain open communication channels with providers and commissioners

Joint response from the Clinical Commissioning Groups in Derbyshire

The Clinical Commissioning Groups (CCGs) welcome this report. It is very timely as we are due to refresh the concordat action plan. We have invited Health watch to our meeting of the concordat in order to continue to provide challenge to our systems of emergency care. The report recommendations will be incorporated into our Concordat action plan. The report demonstrates that progress has been made but we also have a long way to go. For example, the use of police cells to detain people who have committed no offence but have a mental health problem has dropped substantially. In the last 8 months we have had

no one taken to a police station on a section 136 -the police holding power. We work closely with the police and have a team based out of office hours in the Police Control Room providing advice and access to mental health support. We are pleased to see such good reports of people using the Richmond Fellowship Crisis House service. Trevayler, which is a service we commission and is integrated with the crisis and home treatment teams of Derbyshire Health care Trust. As a health and social care community we have just released our Derbyshire Joined Up Care Plans (sometimes referred to as STP). These include a number of areas specifically designed to address the issues that people have reported to Healthwatch Derbyshire.

We intend to develop increased support to primary care as we recognise that this is where most people go for help initially.

We are reviewing help lines (recognising the difficulties in accessing Focus line) and want to increase mental health support to the 111 service so there is one place people can turn to and get access to the right advice and if needed help. We are trialling Focus line staff being based some of the time at 111 to see if this helps with access. We have created an advice and assessment hub out of hours which can take calls from 111 and from ambulance crews and the police. So care can be more joined up and purposeful.

We have plans for an alternative safe place - so people can get help there rather than going to the Emergency Department. This builds on our investment in the Emergency Department of the liaison teams who already see people 24 hours seven days a week. We have expanded the services in the south at Derby Royal Hospital to include a response for young people and we intend to do the same in the north of the county for Chesterfield Royal.

We are intending to increase the hours of operation of the community teams so they are more accessible and can respond locally.

We note that there are frustrations of having changes of staff and of waiting for care coordination. We have invested in increased staffing in 2016 but we recognise recruitment has been a significant challenge and remains so for the foreseeable future. In future having less teams working separately from each other, as they do now, will help in providing more of a personal service based on people's localities. It will make it more likely if a crisis develops people will be seen by someone in a team who knows them and their circumstances.

We have plans to develop community resilience, self-help and other ways of preventing crisis occurring and enabling people to manage in their communities. This will include better information and sign posting on where to get help.

People have had some negative experiences as inpatients with different providers. We will raise these issues in our contract arrangements with them. We support the need for clarity of named nurse roles, provision of activity and physical health care.

We have a suicide prevention strategy with DHcFT which includes ligature removal and will take up issues of concern on environmental risks with independent sector providers. The advocacy service in the county has just been retendered by the County Council and we anticipate greater clarity and focus on the use of advocacy in 2017.

The report provides valuable feedback on people's experiences in using a wide variety of services. We will raise these wider issues with all the providers we commission.

We have noted recommendations 1 and 2 the need for people to be provided with clear information on what to do in a crisis and for there to be coordination a sense of ownership of developing crisis services. This goes to the heart of the concordat declaration and as a system we have agreed to keep the concordat meetings going a further year to ensure we continue to make progress in a joined up way.

Response from Trevayler

Healthwatch and their participants have provided a valuable insight into the experiences of those seeking help at a time of Crisis. The report comes at a time of great pressure for services and, whilst mental health teams work to effect positive change under ever tighter circumstance, it helps to ensure the focus of improvement is directly informed by Derbyshire residents.

At Trevayler, we are keenly aware of the value and importance of safe and effective crisis provision. Our aim is to provide a responsive and tailored service that works to promote an individual's sense of dignity, respect and recovery. It is encouraging to see that the attentive, well considered approach of the Trevayler team is reflected in participants' positive experiences of the Crisis House.

Response from Tameside & Glossop Integrated Care NHS Foundation Trust

Tameside & Glossop Integrated Care NHS Foundation Trust has carefully considered the findings and recommendations within the report. Steps will be taken to review areas highlighted identified within which relate specifically to services provided/ supported by the Trust, particularly in relation to crisis management within the Accident and Emergency Department, raising awareness of advocacy and in support of General Practices in the dealing with and responding to mental health crisis.

Tameside & Glossop Integrated Care NHS Foundation Trust has robust, dedicated patient experience processes in place to allow and actively encourage patient feedback in order to improve the services we provide, along with staff training around patient experience, quality care delivery and service provision and to support improved communication. The Trust will take the necessary steps to highlight to staff the need to ensure fairness and equity for everyone accessing our services going forward.

Response from Derbyshire Constabulary

Address police ability to identify and respond to potential overdoses

Where police officers are aware of information suggesting that someone has taken an overdose medical assistance will be immediately sought to ensure timely medical assessment and treatment is provided.

Police to explain restraint when used

The police use of restraint is only used where absolutely necessary and as a last resort. This is often done to ensure the safety and welfare of not only the officers, but also members the public and in particular the individual being dealt with. Restraint is also only

used for the minimum time necessary and officers are required to de-escalate their approach as the situation develops. Throughout the use of restraint officers will speak with individuals in an effort to gain their compliance, and to explain what action they are taking and why - all in an effort to de-escalate. Training has been delivered to police officers in response to the Crisis Care Concordat which included hearing from those who'd had dealings with the police when in crisis.

Address and seek to minimise use of police cells for people in mental health crisis

The use of police cells has significantly reduced with no detentions under the Mental Health Act since February 2016 (as of October 2016). There may still be occasions where police custody is considered the best place for someone who is in crisis but such occasions will be exceptional, and would then be reviewed through multi-agency protocols to ensure it was both appropriate and to identify any learning.

Response from Derbyshire Health United

DHU as an organisation are signed up to The Mental Health Crisis Care Concordat in Derbyshire and attend the meetings.

From 14/11/2016, within the NHS 111 and Out of Hours services we are piloting a new service for our 18+ Mental Health patients in Derbyshire. This is called on the electronic Directory of Services (DoS):-

MH -Derbyshire Focusline (North)

MH -Derbyshire Focusline (South)

This service is for Patients and Carers of those experiencing Mental Health difficulties. Helpline workers can provide emotional support in a crisis situation and are able to signpost callers to other services.

Staff must try to warm transfer the call to the on duty Focusline worker by calling the designated internal extension before selecting the Dos profile.

At the moment if the line is engaged or not answered within 30seconds the Health Advisor will select another service. However, after Christmas we are enabling them to have a queue so patients will not get the engaged tone if accessing via NHS 111 rather than dialling Focusline direct.

This service is available: 1700-0100 7 days a week

Access via NHS 111 or the Out of Hours does not factor highly in the report. However, please note that during the period of your engagement activity (May - July 2016 as per page 4 of the report) we did have Mental Health Nurses working within the NHS 111 service providing direct support to patients. This pilot has recently ceased as they have now been moved into the Derbyshire Police Control Centre @ Ripley. Although we are confident that we are going to regain access to this valuable service via the Directory of Services (DoS).

We are working with the DHCFT and the County Council on this project.

We have also obtained NHSE Workforce funding to employ our own Mental Health Nurse within the NHS 111 Clinician workforce over the winter period.

10. Appendix

PROMPT SHEET FOR MENTAL HEALTH / 'HITTING CRISIS' PROJECT WORK

Reminder to note:

- Focus Group/venue/date/area
- Number of participants
- Gender(s)
- Age(s)

Access to support before crisis point:

- Did you have access to support 24 hours a day?
- When you asked for help, were you taken seriously?
- Were you provided with telephone numbers to ring in the event of a mental health crisis?
- Were you told if the numbers provided were staffed 24 hours a day?
- Were you provided with alternative support if any of the services were not available at night?
- How did you get referred into crisis team; GP, 111, A&E, Samaritans, other?

Urgent and emergency access to crisis care:

- Was it treated urgently?
- How long did you have to wait?
- Were you understood?
- Was communication good?
- Wishes adhered to?
- Were you listened to?
- Were you treated with dignity and respect?
- Was there any physical restraint?
- Were family informed about your whereabouts?
- Were you sectioned?
- Did you end up in police cells?
- Where were you taken?

Quality of treatment and care when in crisis:

- Explore the actual setting (e.g. acute hospital ward, psychiatric unit), location of such, for example, close to home.
- Was your medication regularly reviewed?
- Were any concerns you had about medication (side effects) listened to/acted upon?
- Longer term support; decisions about treatment?
- Rights explained?
- Any advocacy support?

Recovery and staying well:

- Was information provided (e.g. substance misuse information, housing, support agencies)?
- Was a plan developed?
- Were you provided with a follow-up appointment with mental health services when you left crisis care?
- How long did you have to wait for a follow-up appointment?

General:

- How would you rate the services you have received? (Excellent/Very good/Fair/Poor)?
- Is it easy to talk about mental health?
- How could services be improved?
- Do you think there was effective communication between the mental health services during and after the crisis care episode?
- Was there any carer/family involvement?
- Other services, any comments? (eg. ambulance services, GP etc.)
- Access to IAPT?