PUBLIC

Agenda item 3

DERBYSHIRE HEALTH AND WELLBEING BOARD

5 October 2017

Report of Chief Executive Healthwatch Derbyshire

PATIENT STORY

1. Purpose of the report

This report provides supporting information about the Patient Story provided by representatives from Healthwatch.

2. Information and analysis

A summary of the Patient Story and key issues for consideration are attached as Appendix 1.

In addition, an update on the actions taken since the publication of the Mental Health Crisis Report in 2017 is included for information and reference as Appendix 2.

RECOMMENDATIONS

The Health and Wellbeing Board is asked to note the Patient Story and consider any learning which can be ascertained from this patient's experience of accessing health and social care services.

Karen Ritchie
Chief Executive
Healthwatch Derbyshire

healthwatch Derbyshire

Patient Story

Content of story:

- This individual has experiences of mental health services dating back from 1975.
- Since then, they have only been treated for depression until they sought further help from their GP in July 2013.
- The individual feels that due to a lack of support, communication and transparency from mental health services, a downward spiral occurred, resulting in their mental health deteriorating and leading to restrictions being put on their access to mental health services and a Prison sentence.
- The individual is diagnosed with Borderline Personality Disorder (BPD).

Experiences before prison

In July 2013, I attended an appointment with my GP to request an increase in my antidepressants dosage. I was referred to a Psychological Therapy Service for counselling.

In August 2013, I attended my first appointment with them and was advised they could not help and was subsequently referred to a Multi-Disciplinary Team.

Issue: Inappropriate Referrals - can these be prevented? Delays access to the correct treatment.

In October 2013, an assessment was carried out by the Multi-Disciplinary Team where a referral was then made for a psychiatrist.

I then waited an agonising three months for an appointment with the psychiatrist, I was asked the same questions that I had been asked by the Psychological Therapy Service and Multi-Disciplinary Team. I felt frustrated having to explain my situation again, but was reassured by the psychiatrist that these questions were necessary so the methods of treatment could be established. This same psychiatrist, retired at the end of the week, he did not inform me of this in the appointment when he was asking me to repeat my story. So this just compounded the situation, as there was no continuity with the same professional.

Issue: Having to repeat information over and over to different professionals.

I then had to wait till April 2014, before I had an appointment with a new psychiatrist. During this appointment, I was advised that a referral would be made for a psychologist and a community psychiatric nurse (CPN).

In July 2014, I attended a second appointment where I explained that I had not been contacted yet by a psychologist or a CPN, but was re-assured by the psychiatrist that the referrals had been made. I was also advised that the psychiatrist would send a fax to my GP, requesting new antidepressants.

For a month, I had no antidepressants and became distressed. I was given an emergency appointment with the psychiatrist to discuss this in August 2014. The psychiatrist informed me that the fax had not been sent yet and there were no updates regarding the referrals.

In September 2014, I was informed that the GP received a letter from the psychiatrist advising that a referral for a CPN had not been completed. Panicked, I then phoned the Multi-Disciplinary Team to establish my position on the waiting list for a psychologist. They informed me that no referral had ever been made.

Issue: Lack of communication and transparency with regards to referrals. How can people be reassured that referrals have been made, or mistakes be prevented?

By this time I had been trying to get help and support for over a year, the waiting and lack of communication had led me to believe that if mental health services weren't going to help, then no one could help me. As a result my mental health deteriorated to the extent that I attempted suicide, and began acting unlawfully due to the frustration of the situation. This led to two defining events in my life:

Firstly I received a letter from the Mental Health Service requesting that 'I do not visit any of their premises unless I had a professional pre-arranged appointment', which to me felt like I had essentially been excluded from services.

Issue: This felt to the individual like a further barrier to getting support on top of those experienced above. She was not spoken to in person, only sent a letter. There was no time-scale on the letter or criteria for how she could rectify the situation. To this day she still does not know if this exclusion still applies.

Secondly, I served two prison sentences.

Issue: The individual feels that these prison sentences could have been prevented, had she received support.

Experiences in prison

During my time in a private prison, I felt that there was a lack of knowledge and awareness of mental health illnesses with managers, governors and staff. They described my behaviour as, "acting like a three year old" and "attention seeking". Due to this, I was sent to segregation where I met other prisoners who also had Borderline Personality Disorder (BPD); I was shocked by how many there were with many self-harming and one even committing suicide. Before prison, I had never self-harmed but during my time in there, I did; being in segregation where you are kept in a cell for 23 hours a day, sometimes without radio, books or anything to occupy yourself, was mentally challenging.

Issue: There is a lack of awareness and understanding of Mental Health issues in prisons and this is compounding the problem for individuals.

I did experience the In-Reach mental health team who were excellent and made a big difference to my life whilst I was there. It was much easier to access them when on the healthcare wing but even in other areas of the prison where it took much longer to get an appointment, it was still easier to access them than in the community. The only downside was the psychologist only worked 2 or 3 days a week so you often had to wait.

Release from prison

After being released from prison, I had no support from NHS mental health services and after a few months, I was reaching crisis point again.

Issue: Shouldn't a support plan be in place for individuals leaving prison who are known to have a Mental Health condition?

I phoned NHS mental health services as I felt they would understand my situation, but they advised "we can't do anything for you so phone 111". (The individual feels that this might be because she is known to services and again she doesn't know if the exclusion is still in place). I felt too embarrassed to call 111 as I was unsure how they would perceive me, so I viewed this as another sign that there was no help available and thus went on a downward spiral which landed me in prison again.

I am now on probation which will be ending shortly and I'm concerned about what will happen if I hit crisis point again.

Closing remarks

I now pay privately for support and although costly, this is the first time I feel that someone is trying to help me. Although I take full responsibility for my actions, I feel that if this support was provided in the beginning by the NHS without encountering the communication issues and barriers to accessing services, I would not have been sentenced to prison, tax payer's money would not have been wasted and all the people involved would not have had their lives disrupted.

I believe that my story is a clear example of what can happen if support is not provided in a timely manner.

If there was help provided from the beginning, I truly believe that this would have resolved things in the long run; all I wanted was someone to talk to.

Issues: With this in mind why is there no Personality Disorder Pathway in Derbyshire?

A further two points I would like to make are:

Firstly I found out that my psychiatrist was providing the police with information I discussed with him (i.e. mood books which outlined my fantasies and feelings). Although he had explained to me that if he had concerns he would need to pass information on, he had said he would tell me if he did, but he didn't, even though he continued to see me on a regular basis.

Secondly, when I have subsequently gained access to my NHS reports, it seems that information is copied from one report to the other. I feel this could result in information being inaccurate, if the information is not checked out with the patient to see if it is still correct. The copied information is not referenced, so it might seem like the condition is not improving, resulting in people receiving the wrong medication or treatment. Is this common practice?

Appendix 2: Mental Health Crisis Report update

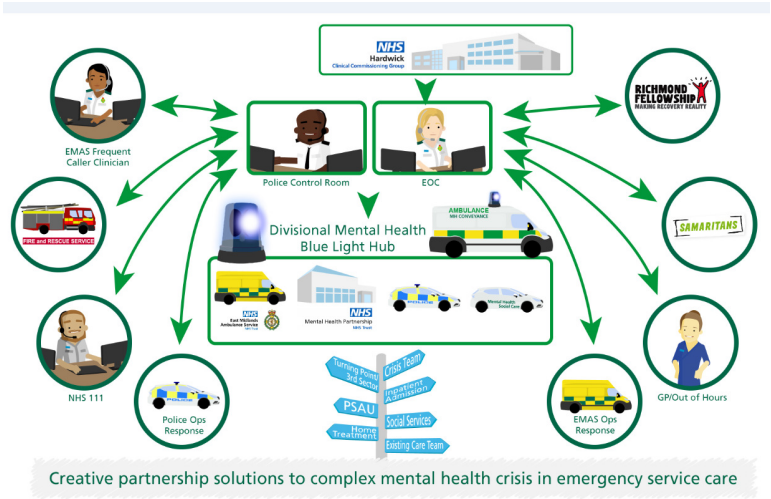
healthwatch Derbyshire

Update on actions pledged in response to recommendations made in the report:

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 (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 named 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.

WHO?	ACTIONS PLEDGED	PROGRESS UPDATE AUGUST 2017
Response provided by Hardwick Clinical Commissioning Group (CCG) representing all CCG's	The report recommendations will be incorporated into our Concordat Action Plan. We intend to develop increased support to primary care as we recognise that this	The Derbyshire Health and Social Care Commissioners, Police and Crime Commissioner, Police, NHS providers and Derbyshire and Derby City Councils as core members of the concordat considered the Derbyshire Healthwatch report and have incorporated the principle recommendations into a revised action plan.

	is where most people go for help initially. We are reviewing helplines (recognising the difficulties in accessing Focusline) 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 Focusline 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	We see the feedback that people need to know where to go to get help and advice and not to feel passed between agencies as fundamental to the concordat. This is an area that requires continued working across the health and social care system. We recognise that we need to deliver more effective community based services and to continue to improve the join between them. We have launched a mental health workstream within the Derbyshire and Derby Sustainability and Transformation Plan (STP) and there is also an Urgent Care STP workstream to enable us to address these issues. Within the Mental Health STP we have a focus on providing improved primary care support –a theme that came up several times in the Healthwatch focus groups. We want to achieve: • Increased primary care capacity to recognise and effectively manage people with mental health needs in their community • Easier movement between primary care and secondary services • Equity of physical and mental health by ensuring people with a severe mental illness get an annual health check • People with long-term conditions get to access psychological help. Since the report was published we have also: • Started a review of the helpline service, including having trialled the placement of MH helpline staff in 111, which has helped us identify a number of technical issues that need to be in place for this to work. We have consulted on future options for the Focusline service. • DHcFT has been receiving direct real time feedback on the experience of people on the acute wards through the engagement service. • Derbyshire Police and Crime Commissioner have been working with partners and commissioned support for homeless people in Derby • The Mental Health Triage Hub has continued to support the police and we are pleased that no one has been taken to a Derbyshire police station solely because of the mental health condition utilising the police powers to detain under the MH act S136.

	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 that 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 signposting 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.	• Continued work has been taking place to reduce long waits in the Emergency Department and "12 hour breaches "have reduced. • The Triage Hub has started taking calls from the Ambulance Service and there are plans being made to increase the take up of advice to ambulance crews. • The Triage Hub has started taking calls from out of hours GPs so they can obtain advice and access to appropriate records and crisis plans. • Children's Commissioners have been working on a plan for a safe place for children to stay, as an alternative to long waits in the emergency department or being taken to the adult place of safety. • The Concordat members have explored the ways in which people who frequently call emergency services can be better supported, and we are taking forward plans for closer joint working between the police and community mental health teams to work with people in a way that is likely to avoid crisis developing as frequently. • The crisis teams have been reviewed and we have identified areas we need to take action to enable them to work effectively. 

	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. 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.	
Chesterfield Royal Hospital	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.	**Patient feedback regarding mental health** Patient feedback is always checked for the Emergency Department (ED) and goes to ED meetings. The Patient Experience Team looks at themes and asks for any actions or changes planned by ED to make the service better for patients. Dignity and respect is often a theme for the Trust and any patient/public comments (good and bad) about mental health in ED would be shared as part of this theme. The Liaison Team also has audits/surveys to keep a check on the experience of patient and their families/friends. **Multi-disciplinary / multi-agency meetings**

	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.	The Liaison Team has meetings with service users and staff from ED, EMU, CDU and the Children and Adolescent Mental Health Service (CAMHS) every other month. The Enhanced Support Team, Acute Medicine, Care of the Elderly/Frailty Unit and Gastroenterology now also go to these meetings. Our Senior Matron for Emergency Care is talking to staff in surgery and intensive care to make sure they will join, as mental health and substance misuse can impact in both of these areas. **Improving services for people with mental health needs who present to the Emergency Department** As part of our CQUIN (Commissioning for Quality and Innovation) work for 2017/18, we are looking at making the ED better for people with mental health needs who come in 10 or more times a year. The ED and the Mental Health Liaison Team have reviewed over 100 patients with mental health conditions who come to ED. From this, they have found 15 patients where joint care planning would help and the ED are working with Community Mental Health Services, to ensure patients are treated in the right way when they come to ED and that they have less need for the ED. The ED are also looking at making more referrals to Derventio Housing Trust, to make sure other needs of people with mental health conditions are looked after, including: housing, finances and social impacts on mental health. **Mental health information** The ED Matron is linking with the Liaison Team to order leaflets that give advice and signposting to mental health support. As part of the Trust's Quality Strategy work on emotional support, our 'Helping Hands' contacts are being updated to include mental health support groups and helplines; these will be added to the Trust website and folders in clinic areas. **Training and education** The Liaison Team have written 6 e-learning packages on a range of important mental health topics and the Trust is working to make them widely available to staff. The Liaison Team works closely with our Clinical Educators to give training to staff.

	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.	**Urgent Care Village** The Trust's 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.
Derbyshire Healthcare NHS Foundation Trust	Summary of actions: 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. We will continue to work in partnership with people, families and carers in the development of advance statements, 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. 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.	This update provides current progress against some of the actions we detailed in our response report In February 2017. In addition to the developments achieved in the actions detailed within this report, we continue to progress against the commitments we made to you in November 2016, and look forward to telling you more about these as they move forward. The Crisis Resolution Home Treatment (CRHT) service has been subject to an extensive review (informed in part by the Healthwatch findings and recommendations) and findings were submitted to the Trust Leadership earlier this year with recommendations, which were agreed. We are now within a process of implementing those recommendations; this is a substantial piece of work that involves some reshaping of services and practice guidelines. It is expected that these recommendations will be fully implemented within 9-12 months, with some actions completed well within that timescale. Furthermore, additional actions have been identified through both the CRHT review and ongoing discussions and service development with some of our partners in urgent care, most notably the Police and Health Commissioners.

	We will revisit the section of the "My Care" leaflet and revise it based upon your feedback. 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. 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. We will also ensure that responses are better co-ordinated and we will share information proactively, with consent. We are meeting regularly with GP surgeries and working with our GP colleagues through GP Quest events, to provide advice, support and education to GPs 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.	**Provide clear information for patients, friends, family and carers about where to go and what to do in a developing crisis situation** The revised CRHT clinical model provides an increased focus upon supporting people post-crisis in terms of developing crisis contingency plans and advance statements, so that people know exactly what to do in an emerging crisis. The functions of our CRHT service are often misunderstood within the health community, not least because of the team name and so a leaflet is being produced, illustrating the revised CRHT model, which will be shared with stakeholders and people who use the service, so that they are better informed about what the service does, and who it will benefit. This leaflet will also provide alternative contact points for people who may be experiencing a crisis, so that they know who to contact when they need help quickly. The Derbyshire STP is currently exploring opportunities for mental health to be better integrated into the existing (and future plans for) urgent care pathway services. Once this is realised, details of how to access services urgently will be included in our service literature and within care plans. **Support General Practice to deal with and respond to mental health crisis** 'Train the Trainer' training for the Connecting with People accredited suicide awareness and suicide response training was delivered to a group comprising GPs, general practice staff and mental health practitioners in June 2017. These trainers have received substantial interest in the training from general practice across primary care, and roll-out of this is now well under way. This will mean that people in primary care health services will be better equipped to support people who have thoughts of suicide.

	We are developing a plan with Public Health in Derbyshire, to deliver Suicide Awareness and Response training to General Practice and Primary Care We will review how well the new Mental Health Advice and Assessment Hub (MHAAH) 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 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. By March 2017, the named nurse role will be explicit within ▫ Job descriptions ▫ The nurse preceptorship program ▫ Management supervision And will be measured through regular audit of both clinical records and what people tell us about their experiences of care. 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	**Address Police ability to identify and respond to potential overdoses. Police to explain restraint when used.** **Address and seek to minimise use of police cells for people in mental health crisis**. The Mental Health Advice and Assessment Hub (MHAAH) continues to demonstrate positive outcomes in terms of sustaining a reduction in the numbers of inappropriate detentions under Section 136 of the Mental Health Act (1983), positive working relationships with the police and proportionate information sharing between health and police. The working relationship with the Police continues to evolve. We have our Liaison and Diversion services based in custody suites 7 days a week and we are currently exploring an innovative proposal to work intensively, in partnership with the police and with people with the most complex difficulties to improve their experiences and reduce the need for them to use emergency services regularly. We have also joined our assessment services up internally in order to provide a more consistent experience for patients. **Consider distress caused by supervised toileting/showering in inpatient units and consider alternative solutions** Posters are now available within the ward areas, clearly explaining the levels of observation. Also, cards are given to individual patients when levels of observations have been discussed and agreed with them. **Develop role/purpose of named nurse in inpatient units** The role of the Named Nurse is now discussed through preceptorship forums and evidence from audits is fed through to the Named Nurse via supervision. Competencies are being developed for registered Band 5 Nurses.

	feedback that we need to reflect upon our care offers 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. The Radbourne Unit will meet with the Advocacy Service to identify ways in which the service could be better promoted for inpatients. 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. With regards to continuity and availability of CPN's - We have increasing pressure in our community services, which we received a partial settlement for in our contracting	The audit framework has been adapted to identify the link between 1 to 1 time with Named Nurse and the MDT processes for supporting and managing someone's care. **Consider provision of appropriate activities in inpatient units.** At the Radbourne unit, each ward has a designated area for recreational activity and a programme supported by the ward team. We are exploring opportunities to build links with Derby arts groups to enable people to access activities that will help sustain them beyond their hospital stay and episode of ill health through community arts groups. An example of this would be a recent dance workshop supported by Deda and a performance group from Manchester. The workshop received excellent feedback and gave great insight into the benefits of a broad range of activities and approach being available to the people who stay with us. **Consider how physical health needs are accommodated by inpatient units** This continues to be a focus for improvement. An audit of physical health assessments and care plans are completed quarterly. Bitesize training for staff on physical health care issues take place. There has been an increase in outside space exercise/activities, such as Nordic walking and football. There are on-going initiatives to promote better health within the inpatient units. There have been changes to physical healthcare monitoring forms and additional training for specific aspects of physical care and treatment. The dieticians have increased their involvements with the in-patient unit and provide support ranging from general advice to specific diet plans and assessments.

	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 that 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.	There is on-going work to improve the uptake of nicotine replacement therapy and smoking cessation support within the in-patient units North and South. **Appropriate awareness raising of advocacy and its purpose** The Radbourne Unit met with the advocacy service to identify ways in which the service could be better promoted for inpatients. There has been an increase in the uptake of advocacy services and we believe we are in line with national averages for advocacy support. However, this is an area for on-going monitoring and improvement. New posters and leaflets have been circulated to support individuals to use this local authority commissioned service. The Mental Health Alliance is also providing feedback in regards to access to support as experienced by our service user groups. **Continuity and availability of CPN's** This remains one of our aims in our trust strategy to work with commissioners to extend hours to evening and weekends. At this time, we have no resolution to this hope, which is based upon feedback from our patients and families. We remain committed to representing their voice. We would like to work in partnership with our commissioners to improve our community offer.
Royal Derby Teaching Hospitals NHS FT	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	I am pleased to confirm that we have now employed a registered mental nurse in our ED and Medical Assessment areas to assist with caring for patients and staff support. We remain fully committed to increasing the knowledge and skills of staff on caring for patients with mental health needs through general training and also though this level of one to one support and mentorship.

	for patients with mental health needs through general training and also though 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.	The mental health steering group continue to meet and take the opportunity to learn from incidents and complaints that may have been raised. Along with this we are working closely with our partner agencies to where possible improve the experience for patients in the ED particularly those who are waiting for a specialist mental health facility.

Next Steps:

- Monitor implementation of Crisis Concordat Action Plan.
- Monitor improvement of services through our service Mental Health Together for Derby and Derbyshire.