Partnership working in mental health
Joining up the dots, not picking up the pieces

Summary report of our mental health collaboration summit
April 2016
“The moral and the economic case for improving mental health care is overwhelming. Mental ill health costs the economy up to £100 billion a year and the impact on individuals and their families is incalculable.”

Norman Lamb MP, chair of West Midlands Mental Health Commission
One in four adults experiences at least one diagnosable mental health problem in any given year.¹ Yet despite its severity and prevalence, there is still a lack of understanding about mental illness and a stigma associated with it. This matters because the impact of responding to issues related to an underlying mental illness does not solely sit within the remit of health professionals. With many parts of the public sector needing to respond and each facing significant financial pressures, collaboration around this issue is essential if savings are to be found and the best care provided for the individual.

The need for greater collaboration across the mental health system happens at many points.

Individuals with mental health problems often manage their conditions well and lead full and productive lives. However, accessing mental health services when they are needed can often be a challenge due to waiting lists and referral times. While this is in part due to demand on services, in some cases it is because responsibility for commissioning and providing services is fragmented.

The unpredictable nature of mental health symptoms can also mean that the first point of contact is via emergency services, with fire and rescue or police officers being present. As a result, the cost of services not being available at the right place at the right time can be huge, in terms of the personal suffering of individuals and costs to the wider system.

More broadly, people with mental health issues are also much less likely to have a job and stable housing and their life expectancy is lower.² This has an impact on different parts of the public sector, including the criminal justice system, housing associations and the benefits services.

Mainstream funding for mental health services comes from NHS clinical commissioning groups and local authorities and in his 2015 autumn statement, the Chancellor committed to spending an additional £600 million on mental health in areas such as crisis care and treatments like counselling.

However, current funding for mental health still remains far behind that for physical health and both sectors are facing significant financial pressures, while demand for services increases. Furthermore, the cost of emergency hospital admissions takes first call on the existing health budgets. These are already fully stretched, leaving limited funds available for investment in mental health prevention and treatment.

The true scale of the problem, however, is hidden by the fragmentation of the prevention and responsive services for mental health patients and the lack of robust data to make a definitive assessment.

Often, relatively modest amounts of money targeted at specific initiatives such as street triage or community cafés can make a huge difference in improving the availability of important services. Our case studies also demonstrate that this can be done without the need for expensive structural change – but it does require a genuine approach to collaboration and putting the patient first.

Collaboration on the ground
While this is the general national picture, local and regional bodies are striving to find their own solutions. This paper draws together examples of successful collaboration between public services and feedback from a West Midlands round table discussion – the West Midlands Combined Authority having set up a mental health commission – to look at how different services have overcome some of the traditional barriers and demarcation lines between organisations.

¹Government Mental Health Task Force report
²The Five Year Forward View for Mental Health in England published by NHS England in February 2016
Both the round table and the case studies illustrated the success of many of the existing initiatives – from small-scale street triage to wider alliances between trusts – in helping to meet the stern challenges that the sector faces. Investment in collaborative initiatives focusing on the needs of mental health patients was undoubtedly resulting in savings to the public purse elsewhere. This reinforces that collaboration needs to be across the wider public services – police, ambulance, fire, local authorities, NHS commissioners and providers and the voluntary sector – if front-line mental health services are to be improved.

Working together was also seen as a key way of focusing on prevention and early intervention which can be effective in stopping mental health related issues escalating and can significantly improve the wellbeing and recovery of individuals. As such it was perceived as being far better than an emergency response when a vulnerable person has reached crisis point.

Almost all collaboration cases occurred where traditional organisational boundaries were put to one side and the focus was on the best interests of the patient. They were also achieved with little money or resource.

While there are many examples of innovative collaborations and other initiatives in the mental health sector, it was recognised that these projects are too often reliant on relationships between willing personalities, rather than culturally or organisationally embedded cases. That the individuals driving this collaboration generally held other responsibilities meant they had limited capacity to drive the collaboration forward more significantly. In addition, it meant that these examples were only sporadically present around the country. Other people therefore needed to be brought on board to widen awareness of the importance of early, joined-up interventions and to provide empirical evidence of success to persuade others. This was particularly the case where small amounts of funds were being withdrawn, resulting in a far larger cost to the emergency services and public purse.

Sharing data was another significant barrier. In the future, predictive technologies will help mental health teams anticipate where and when patients are most likely to reach crisis point. Teams will then be made available to intervene and provide care at those high-risk times – in the same way that the police and ambulance services are able to position their emergency response vehicles at high-risk times and locations.

A further barrier to applying successful strategies more widely is the commissioner-provider split. In some cases, overcoming the deep-rooted cultural barriers would require a structural transformation at a national level. However, events on the ground have shown that there are still ways to improve this relationship.

It was agreed that the key was to keep pushing for change at a national level, while continuing to try new things at a local level. New practices must produce solid evidence of improvement to help convince others. It was encouraging to see the participants of this summit working in all these areas with such dynamism and enthusiasm.

### Recommendations

All public sector organisations operating in this sector should:

- set the tone from the top in respect of providing leadership that champions the importance of collaborating together for mental health services
- foster a culture that puts the patient first, irrespective of traditional organisational boundaries
- measure themselves against some of the initiatives highlighted in this document and identify how their arrangements compare against some of the collaborative practices identified in our case studies
- identify the key individuals in their organisation who are making a difference by embracing collaboration in their day-to-day operations and use them as role models
- involve staff at all levels in the organisation to ensure opportunities for future collaboration are nurtured from an early stage and provide support to overcome any barriers
- explore how technology can improve services to patients through better sharing of information.
Collaboration

Examples of mental health collaboration already exist across the UK in: NHS providers and commissioners; local authorities; housing associations; fire services; police services; ambulance services; and in the voluntary sector. Our discussions and research identified a range of these including:

One particularly good example of positive outcomes from collaboration is street triage, also known as crisis groups. These comprise mental health workers, ambulance and police working together as one team to prioritise responses to mental health related crises. There are a number of successful crisis groups in operation.

Many services are also collaborating to tackle the issue of early intervention in mental health, for example by setting up cafés, crisis centres and drop-in centres for young sufferers. Information sharing has become a crucial part of this approach and technology such as predictive analytics could play a big role in future.

Fire services are playing an important role too as they have come to recognise the strong links between house fires and mental health issues such as dementia and alcohol and substance abuse. Fire fighters have started tackling these issues in a number of ways. For example, they are offering training and support to vulnerable people in their home and are making rooms at fire stations available for training or other mental health related activities.

Some fire officers have also been trained to work with vulnerable people, such as those suffering from dementia, alongside other agencies.

“Commissioning needs to be collaborative. We won’t make a difference if we carry on working in silos across the city.”

Round table participant
Again sharing information with other groups is helping to protect those with mental health issues.

But for most areas, there is much more to do in all these areas and many obstacles to better outcomes remain. This round table revealed that successful collaborations are only sporadic. They tend to arise because of relationships between personalities on the ground who have the will to make them happen, rather than from any structural change.

Indeed the biggest challenge is often to make sure existing structures do not get in the way of these relationships. A longer-term aspiration is to change these structures to align with broad mental health outcomes. This change can only come from government and those who set targets across these sectors.

While there are a few very early signs that policy makers are listening to these needs, there is a long way to go before the full benefits of collaboration can be realised. In the West Midlands, the local authorities have joined forces to set up a mental health commission to take the initiative here (see box out).

Case study:
West Midlands commission tackles all areas

The West Midlands Combined Authority recently formed a commission to assess the scale of poor mental health across the West Midlands and its impact on public sector services, the economy and communities. The commission is reviewing local, national and international best practice in addressing these impacts.

The commission will make recommendations to Government and the West Midlands Combined Authority on:
• how public services should be transformed to reduce the impact of poor mental health
• how current spend on managing and treating mental ill health can be re-directed to measures that keep people mentally well and enable recovery
• the potential for a devolution deal for mental health
• the outcomes that public sector reform can deliver within existing resources.

The commission is also exploring mental health issues through employers and how the region might attract new types of investment to scale-up successful schemes, such as through social finance.

It estimates that if it could invest around £10 million over three years that would help up to 10,000 people.

The commission is also looking at: the role of primary care and how it works with people with mild to moderate mental health problems; what works in the area of early intervention; and mental health issues relating to housing and the criminal justice system.

Locally, it will run a citizens’ panel of 25 people who have current or previous experience of mental health illness. It will also run three listening events and has commissioned a specialist organisation called Social Futures to help with this.

The aim is to finalise the report in June or July 2016.

It has administrative and analytical support from Public Health England and resources from NHS England to support the initiative.
Case studies on collaboration

**Street triage**

There was general consensus from delegates that joint teams comprising individuals from police and ambulance services and mental health nurses worked well in providing a street triage service, particularly at certain times of night in built-up areas. Regardless of whether they are based in a car, minibus or even on foot, the teams provided an important service and freed up the time of emergency police cars and ambulances. There were also examples of where fire fighters, the voluntary sector and housing officials joined these teams to focus on groups of vulnerable individuals, such as the homeless.

Such teams worked best when the “right individuals” were put on the team, and they set aside their traditional allegiances to their employing organisation.

“Leave the uniform to one side, and look at what is best for the patient.”

Round table participant

There was some frustration that the national ambulance service targets, with their focus on response times, might remove attention from the best outcome for those patients with a mental illness who needed the most appropriate response, not necessarily the fastest ambulance. Specialist mental health responders, such as street triage cars carrying a mental health nurse as well as an ambulance professional were felt to be much more appropriate in certain cases.

The Welsh Ambulance Service pilot was hailed as a great example of how policymakers can affect a structural improvement that incentivises everyone to collaborate by replacing narrow targets with those based on wider outcomes for users. The hope is that this pilot and other such changes could produce solid evidence of their success and become standard practice in time.

**Examples at a glance:**

*Street triage*

- **Birmingham and Solihull Mental Health NHS Foundation Trust** joined forces with West Midlands Police and Ambulance Service to launch a street triage scheme in January 2014. Mental health nurses, paramedics and police officers respond to 999 calls together, where those concerned need immediate mental health support. Between January 2014 and November 2015, these interventions resulted in a 50% reduction in detentions under section 136 of the Mental Health Act.

- **Nottinghamshire Healthcare NHS Foundation Trust** launched a street triage service alongside Nottinghamshire city and county councils. From April 2014 to January 2015, there was a 39% decrease in s136 detentions compared to the same period in the previous year. This scheme won the Police and Crime Commissioner’s Partnership Award in 2015.

- **Cheshire and Wirral Partnership NHS Foundation Trust** teamed up with Cheshire Police to provide mental health support to relevant police call outs. This triage has led to a 92% reduction in s136 detentions. The Trust was honoured at the North West Coast Research and Innovation Awards 2015.

- **Kent Police’s** pilot street triage scheme had a nurse going out on patrol with the police in Canterbury. This resulted in a 30% reduction in the number of people sectioned under the Mental Health Act. However, because police lacked the resources to roll it out through the county, the project was stopped and replaced with a call system where officers at the scene can seek advice from mental health experts 24 hours a day, seven days a week.
Round table participants expressed frustration that excellent work with crisis groups has not become more widespread across the country.

“We know it works, but other areas are closing theirs down – what is the rationale for that? Also we have some areas that won’t touch triage – how do we steer it to them? We have worked with commissioners, but we feel that our crisis group services are still a pilot.”

Round table participant

“Such collaborations tend to arise because of relationships between dedicated personalities on the ground, rather than through structural innovation.”

Round table participant

“Without the 10 to 20 personalities who have the will to do this, our crisis groups wouldn’t happen. So we need more than just those personalities as they will move on and it will lose momentum. We need to build structure behind it and that has to come from the top. For example, ambulance service targets, which are just about response times, not about cross-sector outcomes. Targets like those have to change.”

Round table participant

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**Case study:**

*Birmingham street triage scheme in numbers*

2,491 incidents in the first 12 months:
- Attended 1,871 incidents to conduct assessments
- Made 333 S136 detentions (previously 686)
- Incidents on the street – 938
- Incidents in private premises – 1,553
- Carried out a physical health assessment where A&E attendance would have previously occurred – 647
- Conveyance of persons in the street triage car to a place of safety instead of using an emergency ambulance – 316
Early intervention
Emergency services working together in street triage and similar schemes frequently ‘pick up the pieces’ after a crisis event with children, young people and adults. There is a recognition that early intervention with children and young people can pay dividends in the future, but also concern that this needed to be provided in the right way, with the correct care available in the right place at the right time.

Examples at a glance:
Early intervention

Early intervention is a crucial element in improving outcomes for people with mental health problems. There are many opportunities for services to work together to help prevent crises developing.

- At least 10% of five to 16 year olds in Birmingham suffer from a mental health condition. Forward Thinking Birmingham is an initiative, set to go live in April 2016, that aims to stop mental health problems becoming a barrier to children and young people achieving their dreams. Its services are based around prevention, enhanced access to services and integrated care. Its partners are Birmingham Children’s Hospital NHS Foundation Trust, Worcestershire Health and Care NHS Trust, Beacon UK, The Children’s Society, Priory Group and a number of CCGs in the Birmingham area

- Derbyshire Healthcare NHS Foundation Trust provides the Derbyshire Early Intervention Service aimed at those between 14 and 35 experiencing psychosis for the first time. Each service user is assigned to a case manager who can offer a range of interventions. Research shows that engagement with the model promotes recovery, with 80% remission of symptoms within six months. The team remains involved for three years to monitor, support recovery and educate in order to reduce vulnerability to further episodes

- South Essex Mental Health Services provide specialist services to those aged between 14 and 35 who are experiencing their first episodes of psychosis. A community-based multidisciplinary team provides the services, and joint working across a number of public sector and voluntary bodies is key to its success
Some emergency services had analysed frequent 999 callers to see if a more appropriate response or care plan could be put in place. One example was given of a lady who had dialled 999 more than 250 times and the police had attended on over 140 occasions. This was considered to be neither a good use of police time, nor the best way of helping the underlying medical condition.

Some examples of intervention to head off emergency call outs and provide more appropriate care include “crisis house initiatives”, “out-of-hours services” or even simply “community cafés”. Nationally, there are already a good number of these initiatives, many of which are dependent upon collaborative working and funding from a cross sector of organisations drawn from GPs, CCGs, local authorities, NHS trusts and the voluntary sector.

**Crisis house initiatives**

“Sometimes the response is clinical when the need is social.”

Round table participant

**Examples at a glance:**

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Crisis house initiatives

- **Crisis Point** is an open-access mental health crisis centre run by Turning Point in Manchester. It offers bespoke support to resolve crises and prevent future ones. Seventy percent of service users would normally require an acute hospital admission. Crisis Point won the Mental Health Providers Forum 2015 Award for Crisis Care. Turning Point is a social enterprise that involves other local stakeholders such as the police and crime commissioner and other front-line staff in the voluntary and community sectors.

- **In Bristol**, a mix of public and voluntary sector organisations are delivering a new model of NHS-funded mental health care which helped over 25,000 people in 2015. This established a leadership team to make sure the various organisations work well together, that there are no gaps between services and that users always get help from the right person. The men’s and women’s crisis houses in Bristol offer 24-hour supported accommodation for those experiencing mental health problems where hospital may be the only alternative. Health or social care services, GPs, A&E departments, voluntary agencies and the police can all make referrals.

- **The Edinburgh crisis care centre** is open 24 hours a day, every day of the year, to provide emotional and practical support at times of crisis. Over 1,300 people contact the centre each year, referred either from a GP, the voluntary sector, or by the individuals themselves. Carers can also use the service. The crisis centre is part of mental health and social care services in Edinburgh and has effective working relationships with partners across all sectors.

- **In Nottinghamshire**, Haven House opened in January 2015 through a partnership between Nottinghamshire Healthcare NHS Trust, local CCGs and the housing association and charity. Haven House provides support for up to five days for those who are experiencing a mental health crisis and may otherwise require hospital admission.

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8 Partnership working in mental health
Examples at a glance: Community cafés and out-of-hours services

• Manchester Mind created the Young Adults Services and Projects (YASP) café in Manchester 12 years ago in response to high suicide rates and a low take-up of mental health services. This is a drop-in centre and resource for 15 to 25 year olds, where 25% of unemployed users have gone on to find paid employment. The voluntary sector runs YASP and it receives Big Lottery funding and support from Manchester City Council.

• The Dragon Café, a mental health café in London, opened its doors in October 2012 and has proved successful. The café’s innovative style creates a good environment for patrons to relax and be themselves. It does not provide formal therapy, but a wide variety of activities is available such as tai chi and mindfulness coaching. The voluntary sectors support this café and it won the Celebrating Diversity Award in June 2015.

• Cambridge and Peterborough NHS Foundation Trust, in partnership with its local CCG, launched a project in July 2015 to improve mental health crisis care. The main benefit is providing 24/7 mental health crisis services by co-ordinating out-of-hours emergency responses with other mental health services across the CCG.

• In April 2014, Swale Borough Council in Kent began providing access to out-of-hours support for people experiencing a mental health crisis. To ensure greatest public access, Café Haven opened in 2015 providing a safe place for those with mental health problems. A multi-agency team from across primary, secondary and tertiary sector organisations staff the café and it works with other bodies such as GPs and housing associations. The main aim is to identify frequent attendees at A&E and to prevent s136 detentions.

• MCCH – the mental health, learning disability and autism charity – launched a safe haven out-of-hours service in Aldershot. It did this in partnership with Surrey and Clinical Commissioning Group and North East Hampshire and Farnham Clinical Commissioning Group.

Focus on commissioning

While these projects are applauded, public sector services are under immense pressure and there was a perception that funding for many mental health trusts had fallen in the last two years. Participants saw better engagement between commissioners and providers – for example, commissioning that draws more on the providers’ expertise and knowledge – as a way to overcome this.

Part of the task of commissioners must be to think about how organisations can work together and draw together human and financial resources to improve outcomes.

“Twenty-five years of commissioner-provider split has seen mental health inequalities increase. There is discussion in the department of health and other places about ending the commissioner-provider split. That has to happen because it is the only way to stop the inconsistencies.”

Round table participant
Case study:
Spectacular detention avoidance in Nottinghamshire

Two years ago, Nottinghamshire Police started reappraising its approach to dealing with mental health problems, with a view to reducing s136 detentions.

It looked at the issue from the perspectives of people in crisis, victims of crime, police staff and other organisations involved in the s136 process. It found a complex set of problems with each, but most importantly that police were overusing their powers because poor information sharing meant they were not aware of the alternatives.

The solution was to hand part of the management of such cases to one of the region’s CCGs as part of a pilot, due to end in March 2016.

This approach has shown spectacular results. Mental health sufferers now only go into a cell if they are unmanageably violent. Two years ago, Nottinghamshire detained 1,052 people under s136, with over a third going into a cell instead of hospital. The number going into a cell has fallen by 59% and in the month of November 2015 there were none.

There are obstacles to applying this model more widely, for example some CCGs cannot or will not bear the associated cost. Plus there might be issues around geographical boundaries and which organisation operates where. But, having experienced this success, Nottinghamshire Police is determined to continue with the new approach.

“A police perspective

If the police are involved in attending an incident involving an individual with a mental health condition, then this can be an indication that the care system has failed that individual. Accessing mental health services is not always easy. Facilities are not always available in the right place at the right time and patients do not always know when they will require them. In many cases, the police involvement arises from sections 136 and 135 of the Mental Health Act 1983:

- s136 provides emergency powers for the police to deprive a person of their liberty temporarily, if the person is in a place to which the public have access and certain conditions are met. The police may remove the person if it appears to the police officer that they are suffering from a mental disorder and are in immediate need of care or control, and that it is necessary to remove that person to a place of safety in their own interests or for the protection of others
- s135 powers are similar to s136, but require a warrant for the police to execute and gain entry to the individual’s own home

Effective use of both powers requires fully joined-up planning between the police, the ambulance service, the NHS or voluntary sector providers of the place of safety. At our round table there was recognition that any misunderstanding or unnecessary delays affected patient care and wasted police time. Unfortunately, there were examples of where these delays were happening.

In other cases, the police involvement might be triggered by a 999 call or the suspicion of a criminal offence. From the police perspective, whether it’s in the custody suites, the joint triage teams, any attendance at court or in the emergency responses, dealing with people with mental health conditions places extra demands on police time. Occupying a police cell is not a good treatment for the individuals concerned and doesn’t address the underlying health issue.

“A police cell should not ordinarily be considered a place of safety.”
Round table participant

Often the cost to the individual, the wider public as well as the police and the criminal justice system can be significant, particularly when compared with the costs of some of the preventative early-intervention measures discussed earlier.

Where police and health bodies have focused attention collaboratively in this area, there can be big improvements (see Nottinghamshire case study).

“Most members of the public won’t think of the police in relation to people with mental health needs. The police catch criminals, arrest lawbreakers and deal with violent thugs. Unless you have done something wrong, or been a victim of crime, you won’t expect to come across a police officer. Yet all too often, it is a police officer who responds to the vulnerable person in crisis.”

Theresa May, Home Secretary, Review of the Operation of Sections 135 and 136 of the Mental Health Act 1983, Department of Health and the Home Office, December 2014
Role of the fire service in supporting mental health

Although considered by many to be an emergency service that responds to 999 calls, the fire service has a very different response model to police and ambulance services. Both NHS England and the Chief Fire Officers’ Association have commented in recent months on the opportunities of using the “fire service as a health asset”. With the demand for dealing with emergency fire and rescue situations falling, many fire services have been using staff on prevention activities (see box out). Sharing information can be a challenge, however.

“The fire service has time (because of the response model) to go into people’s homes and help them. So we became health navigators and vulnerable person officers, supporting people to stay out of the system or supporting the system in the home. But this potential is underused, as we don’t share information well enough. So how can we be more effective in helping people and the other services?

For example, we could complement or support the ambulance service and support the wider flow of information. All these issues are closely interlinked and we need to get this message across clearly, because otherwise organisations don’t see the benefits for them. I don’t hear this enough across the sectors.”

Round table participant

Examples at a glance:

Fire services counselling

- **Staffordshire** fire stations are available, free of charge, for community activities such as health and education on crime and disorder, and support for those with mental illness. A government private finance initiative scheme and a consortium known as Fire Support funded the project.

- World-renowned public health expert Sir Michael Marmot has endorsed the **West Midlands Fire Service** for its work in tackling health inequalities. It has trained 1,322 fire officers to deliver basic health messages and trained more than 100 officers as vulnerable persons officers (VPOs) to work alongside agencies such as Age UK, local housing associations, local councils and Dementia UK, and carry out ‘safe and well’ visits.

- Over one third of people killed by fire in Manchester have mental health issues. To address this, Greater Manchester Fire and Rescue Service and Manchester Mental Health and Social Care Trust set up and jointly funded the **Manchester Fire and Mental Health Liaison project**. This group allows both entities access to each other’s systems and to coordinate joint home fire safety checks and referrals to occupational therapy assessments.

- Over half of all fire-related deaths and injuries in the home happen to those aged over 60. **Kent Fire and Rescue Services** has emerged as the UK fire and rescue leader on dementia and it has offered its online training programme to all 1,665 fire officers and support staff in the organisation. The officers’ training allows them to identify people with the condition and tailor their fire safety support around them. Where appropriate, they can ensure they receive the necessary help from the NHS.
Although there were some frustrations with the fragmented approach of commissioners in some areas, there was some evidence that more joined-up thinking was emerging as Staffordshire County Council has demonstrated.

**Case study:**

**Staffordshire applies radical strategy**

Two years ago, Staffordshire County Council reappraised its mental health strategy.

Mental health had not featured highly on the council’s agenda beyond statutory provision and the focus was always on treatment. The new strategy highlighted the need to look at mental health from a much wider perspective.

Structures are complicated in Staffordshire, with eight district councils, five CCGs and two mental health trusts. The county council is bordered with Stoke on Trent City Council, a unitary authority, where there is also another CCG. Although the police and fire services cover the geographical footprint of the county council and the city combined, the ambulance service covers a much wider part of the West Midlands as well.

This had made partnerships and collaboration difficult, so the strategy team spent a long time working on broad, shared outcomes that everyone in the county could sign up to, with no time limit.

The council’s strategy aimed to:

- change fundamentally the way it commissioned and delivered services for people with mental illness
- embed mental health into everything it does across public services
- ensure that all services consider mental illness equally with physical illness
- recognise the links between poor life chances, unhealthy lifestyle and mental illness
- increase collaborative working among and across agencies to embed this understanding
- make integrated care a ‘must do’ priority to break down the barriers caused by separate funding streams.

Board partners – including the ambulance service, clinical leaders, the police, public health and local authorities – lead the strategy jointly so that everyone owns a part of it. While housing, NHS providers, the third sector and users are not on the board, these organisations link in to the strategy separately.

The biggest obstacle to implementing this strategy was the commissioning culture, which only tends to focus on contracts, finance and the bottom line – not on shared outcomes. So the strategy avoids a focus on commissioning and contracting and instead emphasises collective outcomes. This highlights the wider change in culture that is necessary to bring commissioners and providers together.

Staffordshire’s strategy has achieved a lot already, including:

- a police and community triage and custody diversion strategy
- work with ambulance services to look at frequent attendees as part of psychiatric liaison services
- successful work with employers
- a mental health helpline which professionals can also use, helping to reduce the number of police visits to vulnerable people
- an ongoing programme of engagement with the public on mental health issues
- a successful 24/7 safe house delivered by the third sector in South Staffordshire, with a view to replicating that in the North.
Innovation

Although almost all the examples of collaboration included an element of innovation, this was often reflected in individuals simply adopting a different approach by putting traditional organisational boundaries to one side and focusing on what was truly in the best interests of the patient. Putting themselves in the position of the patient had produced much better outcomes, without requiring much in the way of new monies or resources to drive the innovation, other than common sense.

There are a number of examples where mental health nurses have been deployed in innovative ways such as:
- placing mental health nurses in the NHS 111 call centre in the West Midlands
- locating mental health nurses in the police control rooms in Norfolk
- joint working with British Transport Police on suicide prevention on the railways.

The participants at the summit all had experience of where the collaborative initiatives improved outcomes for patients, but there was a strong desire to provide solid empirical evidence of success, to persuade others to find ways to use these methods more widely.

The discussions explored how the innovation could take a quantum leap forward and be even more innovative, particularly where the innovations were currently sporadic and often still in their early stages of development.

Significant obstacles to more widespread collaboration and innovation remain, but there is increasing determination to overcome these barriers. The biggest issues revolved around:

1 Sharing information
There are barriers to sharing information between the NHS, social services, the police and fire services. The fire and rescue services in particular reported that there were frequent examples where the service might be called out to an incident without the background knowledge needed to be able to respond properly.

Often the individuals would have medical circumstances or a history of calls to the other emergency services that were not shared with the fire service. Such information was also not routinely shared with housing associations or voluntary sector associations, thus losing opportunities to provide joined-up care. The overall care for these individuals could be improved by more extensive sharing.

In the future, delegates felt that better use of predictive analytics could help make services even more responsive by helping them to put intervention plans in place before a crisis point was reached and to anticipate mental health emergencies. Some participants contrasted the intelligence used by mental health providers to the impressive predictive intelligence used by the police and ambulance services which enabled emergency response vehicles to be in the right place at the right time.

“Police and ambulance services know from experience exactly where to park their police cars and ambulances, but NHS providers don’t.”
Round table participant

2 Relationships with commissioners
CCGs have a vital role to play in the commissioning of services that could make the biggest difference to patient care. However, delegates commented that the attention given to this area by the CCGs was mixed. Some services are also commissioned by NHS England and some by local authorities. Delegates felt that mental health commissioning was not given the same priority as the acute sector and, in some areas, commissioning was fragmented and inconsistent. There were concerns that market testing could result in a myriad of providers making joined-up delivery a challenge. There were also examples of arguments and different interpretations as to whether a particular service was in the contract or not.

Frustrations exist that relatively small amounts of money are being withdrawn in the name of ‘savings’ when the financial impact on the police, ambulance or fire services is likely to be far greater and therefore cost the overall public purse more.

The discussions noted the police and ambulance time which had been freed up by the Birmingham street triage car and the feedback from some CCGs elsewhere in the country that were considering withdrawing funding for similar schemes.
“Commissioning and saving schemes need to be viewed in terms of the wider public purse rather than just a short-term saving for the CCG.”

Round table participant

3 Recognition that different areas required different solutions

The physical location of places of safety might be geographically remote from the location of the individual patient. Police and ambulance services in particular had to think carefully about the potential damage to the welfare of the patient if they transported them out of their familiar surroundings to a place 20 miles away or more, not to mention the officer time that might be spent doing something of questionable value to the patient.

Some of the examples of where collaboration might be on the verge of a big step forward came from Birmingham and Solihull Mental Health Foundation Trust (see box out).

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Case study:

**Innovation from Birmingham and Solihull Mental Health Foundation Trust – Pioneering partnership working and analytics**

Birmingham and Solihull Mental Health NHS Foundation Trust has been involved in some of the best examples of partnership working between health, ambulance and police in the country; particularly in the area of mental illness crisis care. This is the result of a variety of factors, not least the approach of commissioners and of individual personalities.

Simon Stevens, NHS England Chief Executive, is launching a series of innovation ‘test beds’ in a bid to modernise care.

One of these will see Birmingham and Solihull partner with Accenture to offer more proactive support for people at risk of mental health crises. Patients will have access to digital tools such as online support, risk assessments and crisis intervention plans that will enable care professionals to better support patients in managing their conditions. The test bed will also use predictive analytics technology to better identify those at risk of crisis, enabling mobile crisis workers and tele-triage workers to provide prevention support.

This venture will provide £2 million for the project on predictive crisis care with a view to selling that model around the world.

This is a crucial development, as it should help the trust allocate its resources more effectively.

The trust has fantastic examples of services sharing information in a triage car, but cannot replicate this at organisational level without spending more on management costs.

Birmingham and Solihull has also forged an alliance with mental health trusts in Coventry and Warwick, Black Country, Dudley and Walsall. The alliance is to become a ‘vanguard’ site for new care models.

The alliance recognises that only by coming together can it effect the large scale transformation needed to improve productivity, cost savings and long-term viability in acute services, while maintaining the quality of care.

Whilst retaining local autonomy, the trusts will work together to solve efficiency, workforce, equality and policy implementation challenges, sharing best practice and creating models that can be replicated across the NHS to make health care more sustainable.

NHS England has awarded the alliance around £5 million over the next three years to support working together in clinical areas.

The next stage of development might be to get permission for a structural change to merge commissioning and provision.

That would be a huge change for providers, who would then become accountable for delivery and have to deal with competition issues – for example, how much one trust gives itself versus other trusts.
**At the table:**

<table>
<thead>
<tr>
<th>Name</th>
<th>Position/Role</th>
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<tbody>
<tr>
<td>Steve Appleton</td>
<td>Managing Director, Contact Consulting, Project lead for West Midlands Mental Health Commission</td>
</tr>
<tr>
<td>Dawn Jennings</td>
<td>Staffordshire County Council (responsible for commissioning mental health services)</td>
</tr>
<tr>
<td>John Short</td>
<td>CEO, Birmingham and Solihull Mental Health NHS Foundation Trust</td>
</tr>
<tr>
<td>Robert Cole</td>
<td>Head of Clinical Services, West Midlands Ambulance Service</td>
</tr>
<tr>
<td>Steve Vincent</td>
<td>Area Commander for Community Risk Reduction, West Midlands Fire Service</td>
</tr>
<tr>
<td>Kim Molloy</td>
<td>Chief Inspector, Nottinghamshire Police</td>
</tr>
<tr>
<td>Natalie Allen</td>
<td>Partnership and Delivery Manager – Birmingham Changing Futures Together, Birmingham Voluntary Service Council</td>
</tr>
<tr>
<td>Marina McQuade</td>
<td>Non-Executive Director, South Staffordshire and Shropshire Healthcare NHS Foundation Trust</td>
</tr>
<tr>
<td>Sean Russell</td>
<td>Chief Inspector, West Midlands Police</td>
</tr>
<tr>
<td>James Cook</td>
<td>Director, Public Sector Assurance, Grant Thornton</td>
</tr>
<tr>
<td>Mark Stocks</td>
<td>Partner, Head of Public Sector Healthcare Assurance, Grant Thornton</td>
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At the table: Partnership working in mental health
About us

Grant Thornton UK LLP is a leading business and financial adviser with client-facing offices in 24 locations nationwide.

We understand regional differences and can respond to local needs across public, private and third sectors. Our clients can have confidence that our team of NHS and local government specialists is part of a firm led by more than 185 partners and employing more than 4,500 professionals, who together serve over 40,000 clients.

Grant Thornton has a well-established market in the public sector. We believe the current public sector reforms present real opportunities to redesign and integrate service delivery, with the public at its heart. We are passionate about supporting cross-sector solutions to health and social care challenges and are developing our business to support this important agenda.

We have been working with the NHS and local authorities for more than 30 years and are the largest employer of CIPFA members and students in the UK.

Our national team of experienced NHS and local government specialists, including those who have held senior positions within the sectors, provide the growing range of assurance, tax and advisory services that our clients require.

We are the leading firm in the NHS audit market and the largest supplier of audit and related services. We are the largest provider of public sector audit nationally. Our nationwide NHS practice clients comprise 23 FTs (15% of the market), 35 non-FTs (38%) and 67 CCGs (32%).

Through proactive, client-focused relationships, our teams deliver solutions in a distinctive and personal way, not through pre-packaged products and services. Our approach combines a deep knowledge of the NHS, supported by an understanding of wider public sector issues, drawn from working with associated delivery bodies, relevant central government departments, and private and third sector organisations operating in the sector.

We understand the challenges and issues facing our clients and regularly produce sector-related thought leadership reports, typically based on national studies, and client briefings on key issues. We also run seminars and events to share our thinking on the NHS and local government.