NHS
South Western
Ambulance Service
NHS Foundation Trust

Directors' Meeting

Mental Health Nurse in the Clinical Hub Pilot Final Report

14 May 2019

Title:	Mental Health Nurse in the Clinical Hub Pilot Final Report
Version:	V1
Prepared by:	Wendy Boundy - Business Manager, Clinical Hubs David Boyle –Clinical Lead, Dorset
Presented by:	Jessica Cunningham – Executive Director of Operations
Main aim:	To provide a summary of the Pilot ran from the North Clinical Hub between 15 October 2018 – 14 April 2019 in order to inform discussions on future management support for Mental Health Patients
Recommendations:	To note the issues and achievements of the Pilot, and use the report to inform the discussions on future support and management programmes for Mental Health Patients
Previous Forums (as Interim Report):	Senior Management Team Meeting 02/04/2019 Directors Meeting 09/04/2019

1. Introduction

1.1 A Pilot was undertaken between 15th October 2018 and 14th April 2019 with a Mental Health Nurse from Avon & Wiltshire Partnership NHS Trust (AWP) working in the Bristol Clinical Hub. Cover was provided between the hours of 1600-0000, initially Thursdays-Sundays inclusive, and then 7 days a week as of 25th February. The nurses receive referrals of appropriate 999 calls (from within the BNSSG area only) from 3 routes-

1. Emergency Medical Dispatchers (EMDs) prompted via the C3 CAD to electronically transfer Category 3, 4 or 5 Psychiatric Protocol incidents (as approved by the Executive Medical Director)
2. Hub Clinicians transferred incidents after ruling out of addressing other medical concerns
3. Operational Crews transferred incidents following on-scene assessment, for advice and assessment with appropriate care pathways

1.2 All referrals were subject to the agreed exclusion criteria (incident out of BNSSG area, patient 15 or under, a transport request from a HCP or MHP or fourth party caller with no contact details for the patient).

1.3 The C3 Specialist Desk Module was initially funded on a trial basis for three months to support the Pilot, and subsequently purchased by the Trust as a product of wider value to the Clinical Hub function.

2. Purpose of this Report

2.1 This Report intends to:

- Confirm what was delivered by the Pilot via qualitative feedback from staff from both Operations and the Clinical Hub, and a review of the data available
- Recognise the strengths and weaknesses of this Pilot through lessons learned
- Provide the information available to support discussions around future provision of support for incidents relating to Mental Health Patients

3. Financial Review

3.1 The funding was a lump sum of £65000 agreed in March 2018 for Ambulance Resilience Winter Pressures.

3.2 The Project has been cost neutral. If SWASFT were to move to recruiting a mental health nurse, direct employment would be a cheaper option than going via an alternative provider (other factors would need to be considered).

3.3 Further analysis of the benefits of the trial would be required to indicate the cost benefit.

4. Clinical Hubs Feedback

4.1 Clinical Hub staff were enthusiastic about the Trial and disappointment about it ceasing has been expressed. Staff also said they wished the trial area had been larger. Comments expressed on the Clinical Hub Facebook page were –

4.1.1 'Fingers crossed it becomes a permanent thing and is rolled out to both hubs and all areas. When we had a mental health nurse in Exeter Hub it helped loads' (Dispatcher).

4.1.2 'This is a real shame! They are so beneficial. Why are we losing them?' (Dispatcher).

4.1.3 'This is a shame, both (nurses) are lovely and I think the mental health nurses are a great asset. It is a shame we can't get them covering more areas as I always get a lot of calls that are in different areas so can't pass them through MH nurse' (EMD).

4.1.4 'It's been a pleasure working with them. And such a useful resource' (Clinical Advisor).

4.1.5 'Having them has been fantastic, and when we were able to hot transfer has been a god send on some calls that we might have been on for ages. Not to mention lovely people in general' (EMD).

4.2 It has been suggested by Hub Clinicians that the integration and subsequent shared learning may have been better achieved if the Mental Health Nurse was situated closer to the Hub Clinicians (as GPs have been in the past).

4.3 The Mental Health Nurses were not profiled on MiDOS (Directory of Services) at the start of the project as a referral route.

4.4 Compliance with tagging was an ongoing issue. There are many other buttons/codes/ tags that EMDs and Hub Clinicians are required to use and integration of new tags has always required prolonged persistence. One suggestion was that for any future Nurse to check all appropriate tagging has been completed at the end of their incident management process.

5. Operations Feedback

5.1 There has been limited feedback from operational staff but it has all anecdotally been positive.

6. AWP Feedback

6.1 AWP were generally very positive about the benefits of the scheme. See Appendix A for a Case Study Report from the Mental Health Nurse (Specialist Practitioner), Ndidi Ariemugbovbe.

6.2 AWP commented that if such an initiative were to go ahead, an agreement would be required on the best way to provide clinical supervision for the mental health nurses due to their remote working from AWP and their hours being predominantly unsocial.

7. Data Analysis

7.1 Clinical Hub staff were advised to identify on the C3 incident record (via the Inform Tab), the referral method (i.e. EMD Auto Prompt, Hub Clinician Referral or Attending Crew Referral) and the reason for any appropriate incident not being passed to the nurse (i.e. suitable but no capacity, suitable but no cover, suitable but out of Pilot area or suitable but exclusion criteria applies). The Mental Health Nurse was instructed to log the Outcome of each call attempted.

7.2 The Clinical Lead (Dorset) reviewed the outcomes and other data supplied on tableau reports and Excel spreadsheets by the Information Management team, covering the dates 18th October 2018 – 18th April 2019. It should be borne in mind that the hub nurse staffing increased to 2 Nurses from 25th January to attempt to provide 7 day cover. Although the data is limited due to reasons discussed elsewhere in this paper, the following paragraphs describe the overall results. The headline outcomes have been presented and are followed by a discussion.

7.3 **Data results**

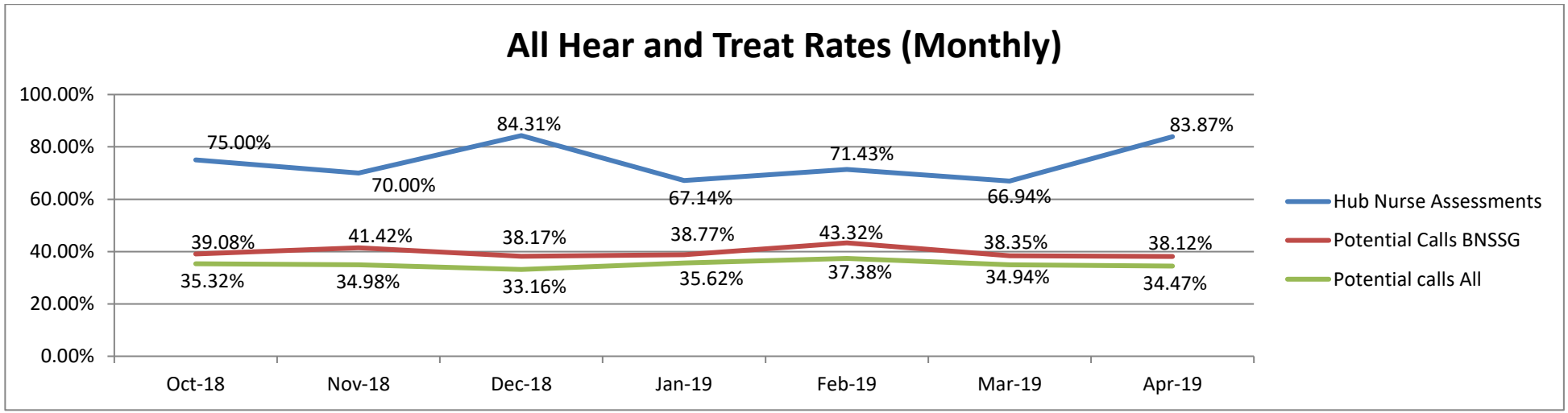
7.3.1 Table 1- Outcomes/Overview

Month	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	Total
Total Patient Assessments	28	60	51	70	105	121	62	497
Assessment undertaken, no attendance required (H+T)	18	23	23	29	44	53	35	225
Assessment undertaken, referred to MH service (H+T)	1	0	0	0	2	0	0	3
Assessment undertaken, referred to specialist services (H+T)	1	1	0	2	1	0	3	8
Assessment undertaken, self care advice (H+T)	1	3	0	0	4	1	0	9
Assessment undertaken, transport to specialist services	1	0	0	0	1	3	1	6
Assessment undertaken. ambulance attendance required	3	15	3	13	18	27	11	90
Unable to complete assessment, ambulance attendance required	1	2	2	15	12	17	3	52
Unable to complete assessment, attendance not required	2	16	23	11	23	20	9	104

7.3.2 *Table 2 - Outcomes: Trial vs Standard response*

		Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	Total
MH Hub Nurse Assessments	**Hear & Treat**	75.00%	70.00%	84.31%	67.14%	71.43%	66.94%	83.87%	**74.10%**
	See & Convey	7.14%	10.00%	7.84%	18.57%	14.29%	19.01%	9.68%	12.36%
	See & Treat	17.86%	20.00%	7.84%	14.29%	14.29%	14.05%	6.45%	13.54%
Potential Calls BNSSG	**Hear & Treat**	39.08%	41.42%	38.17%	38.77%	43.32%	38.35%	38.12%	**39.60%**
	See & Convey	23.69%	22.65%	23.96%	24.28%	24.29%	27.07%	20.79%	23.82%
	See & Treat	37.23%	35.92%	37.87%	36.96%	32.39%	34.59%	41.09%	36.58%
Potential calls All	**Hear & Treat**	35.32%	34.98%	33.16%	35.62%	37.38%	34.94%	34.47%	**35.13%**
	See & Convey	25.51%	25.51%	27.91%	26.08%	24.57%	26.73%	24.46%	25.82%
	See & Treat	39.16%	39.51%	38.94%	38.30%	38.05%	38.33%	40.70%	39.00%

7.3.3 Figure 1 - Outcomes: All Hear and Treat Rates by Month



7.4 Discussion

7.4.1 Although the initial dataset during the period where only one Nurse was available (October to late January) only captured 125 calls, some positives from the pure data aspect could already be seen; particularly around “Hear and Treat” rates. As the nurse capacity increased to two from 25th January, it can be seen that these rates were not an anomaly; although pure numbers of cases dealt with increased, Hear and Treat rates remained well above the standard response. Table 1 describes the outcomes as logged by the hub nurse. As can be seen, the various outcomes favour the “hear and treat” (H&T) options listed, along with specialist input where assessments were not completed but specialist expertise appears to have diverted the need from the ambulance service response.

7.4.2 Table 2 simplifies the data to show the usual comparators of 999 call outcomes, presented alongside all calls identified as potentials in both the wider BNSSG area as well as the entire Trust region. Potential calls are classed as category 3-5 calls with a dispatch code of 25 where the patient is over 16, as per the pilot scope. It is clear that the Hear and Treat rate from the pilot averages around 75%, with the see and treat/ see and convey equally sharing the remaining 25% of cases. When compared with the Trustwide standard response (35% hear and treat, 25% see and convey, 40% see and treat) it is clear that the pilot shows the potential of having expert input at the point of contact, with the benefit of reducing responses sent and subsequent call cycles (notwithstanding potential improvements in patient experience from speaking to the right clinician at the right time).

7.4.3 Figure 1 simply illustrates the “hear and treat” rate alone, and describes the constant elevation of this rate over the standards response, as discussed above.

7.4.4 One point that could not be elicited from current data was the referral route of such calls; the options were for CAD auto-prompt (from 999 call), via the hub clinician or from ambulance crews already on scene with an appropriate case. Unfortunately, the calls were not tagged in the majority of cases. Should this scheme or similar be continued, this should be mandatory to understand the impact on each section of the call cycle.

7.4.5 This section has clearly looked at “hard data”, and must be viewed as part of a wider scheme to improve the care provided for those suffering mental health crises. What the data cannot describe is the “soft” data, such as value of expert input (even where conveyance is required), nor the opportunities for cross pollination of learning and professional development for all involved. As will be described elsewhere, the case study from the hub nurse highlights the almost immeasurable quality impacts of their interventions.

7.4.6 In summary, from a clinical point of view, this exercise should be regarded as a “proof of concept”, whereby a small scale pilot has intimated that a scaled-up full approach is potentially viable and should have the potential to increase H&T rates at source, whilst better serving the needs of a cohort of patients that deserve parity of esteem as

highlighted by the Mental Health Crisis Concordat. Indeed, as the recently published NHS 10 year plan states, there are plans to "…*introduce mental health transport vehicles, introduce mental health nurses in ambulance control rooms and build mental health competency of ambulance staff to ensure that ambulance staff are trained and equipped to respond effectively to people experiencing a mental health crisis".* This is therefore an opportunity to place SWASFT ahead of the curve.

8. Interim Pilot Review

8.1 Strengths of the Pilot –

i. Specialist advice on appropriate Pathways, supporting Clinical Hub and Operational staff, and therefore Hear & Treat performance and Trust quality
ii. Benefit to the patients of right care
iii. Access for SWASFT via the nurse to RIO
iv. Informal training exposure for Clinical Hub staff

8.2 Weaknesses of the Pilot –

i. Initially, the Pilot was only operational for 32 hours per week, causing difficulties with staff knowing when the desk is operational, and only one Mental Health Nurse meant a lack of resilience and the desk being unmanned during periods of sickness etc. Since 25th January 2019, the Pilot has been operational 56 hours per week, with the availability of a second Mental Health Nurse
ii. The Pilot only includes the BNSSG area
iii. Not all the activity of the nurse is captured (reportable) from the C3 CAD
iv. Poor use of tags by Clinical Hub staff has meant the referral method or reason not passed is not always known
v. There was no dedicated Manager/Project Manager assigned to the Pilot throughout

9. Conclusion / Recommendation

9.1 AWP provided SWASFT with cover between the hours of 1600-0000, 4 days a week between 15th October 2018 and 25th January 2019, when cover extended to 7 days a week until 14th April 2019. Weekly check-calls were held with AWP.

9.2 This Trial covered a limited sample size and it should be noted that analysis only explored call outcome and does not indicate if the patient representation to SWASFT was for the same issue. Furthermore, it was not in the scope of this report to explore if the Hub Mental Health Nurse resolved the issue or if onward support was required from wider health and social care providers. A study of this type would be recommended if long-term provision was agreed, to ensure the interventions from the

Hub Mental Health Nurse were addressing the patients presenting complaint in contrast to simply moving the issue to another provider.

9.3 In addition, if this project were to continue, it is recommended there be wider analysis to ensure patients are not re-presenting within 24 hours or simply being moved to other areas of the health and social care system (with a plan of how this will be managed).

9.4 There would be clear advantages to the availability of Mental Health Nurse specialist support either within or through the Clinical Hubs. The form in which this should be delivered needs to be considered. One option would be for the service to be led by the Mental Health provider (similar to the Maternity Advice Lines hosted within the Clinical Hub).

9.5 This report will be shared with our partners at AWP and with BNSSG / Commissioners via their Mental Health Lead.

Wendy Boundy
Business Manager – Clinical Hubs

David Boyle
Clinical Lead - Dorset