Report on
Supporting People in a crisis event

17/07/14
8.30-12.30
We are 336 (336 Brixton Rd)

1. **What the Collaborative has done to date and setting the scene and case study from NEFLT – Supporting crisis at home through enhanced HTT.**

Please find below the presentation used embedded below. The presentation includes:

- What the Collaborative has done to date and setting the scene
- Lambeth Street Triage and
- North East London Foundation Trust Home Treatment Team.


Crisis Presentation 170714.pdf

2. **Supporting people to manage crisis design sessions**

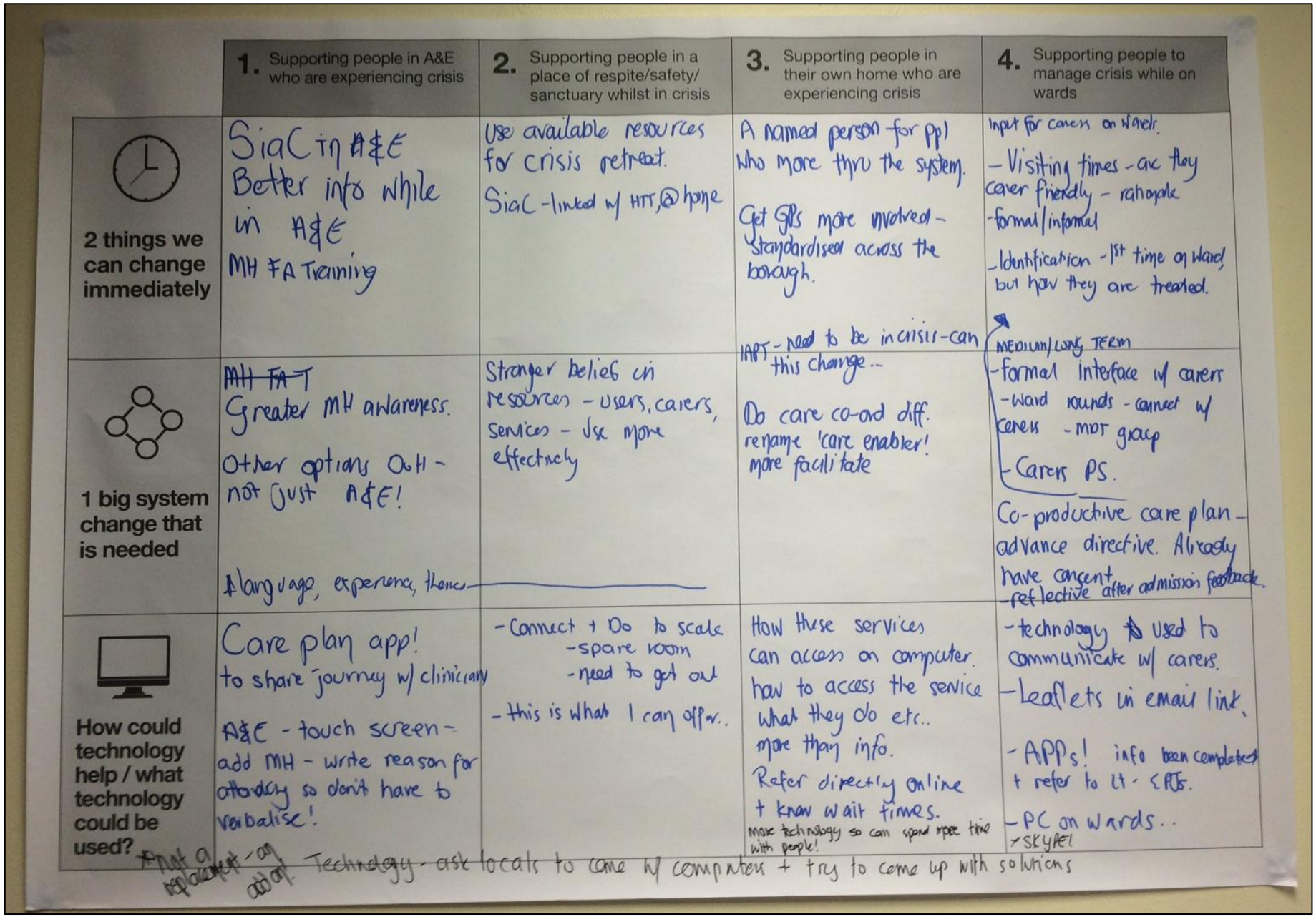
Delegates were asked to attend one of the four design sessions:

1. Supporting people in A&E who are experiencing crisis
2. Supporting people in a place of respite/safety/sanctuary while in crisis
3. Supporting people in their own home who are experiencing crisis
4. Supporting people to manage crisis while on acute wards

The delegates were asked to look at what happens currently and look at what works well, and what could be improved. The facilitator then had to feedback at the end on:

1. Two things we can change immediately
2. One big system change
3. How technology could help / what technology could be used.

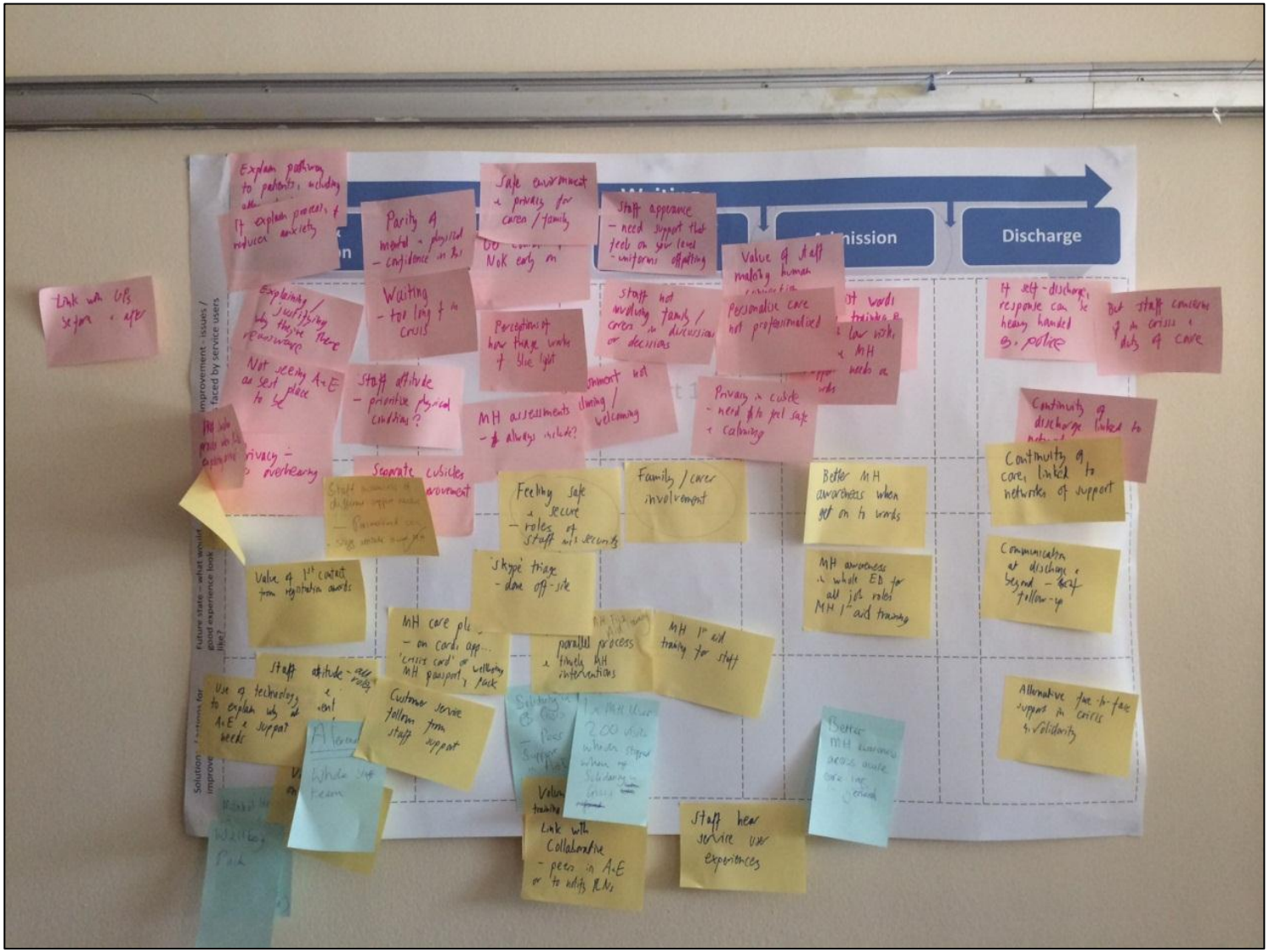
Summary of feedback from each groups discussions.



	1. Supporting people in A&E who are experiencing crisis	2. Supporting people in a place of respite/safety/ sanctuary whilst in crisis	3. Supporting people in their own home who are experiencing crisis	4. Supporting people to manage crisis while on wards
2 things we can change immediately	SiaC in A&E Better info while in A&E MH FA Training	Use available resources for crisis retreat. SiaC - linked w/ HTT, @ home	A named person for ppl who more thru the system. Get GPs more involved - standardised across the borough. HTT - need to be in crisis - can this change..	Input for carers on ward: - Visiting times - are they carer friendly - rationale - formal/informal - Identification - 1st time on ward, but how they are treated.
1 big system change that is needed	~~MH FA T~~ Greater MH awareness. Other options OoH - not just A&E! Language, experience, theirs	Stronger belief in resources - users, carers, services - use more effectively	Do care co-ord diff. rename 'care enabler' more facilitate	MEDIUM/LONG TERM - formal interface w/ carers - ward rounds - connect w/ carers - MDT group - Carers PS. Co-productive care plan - advance directive. Already have consent, reflective after admission feedback.
How could technology help / what technology could be used?	Care plan app! to share journey w/ clinicians A&E - touch screen - add MH - write reason for attendance so don't have to verbalise! ~~Not a replacement~~ - an add on! Technology - ask locals to come w/ computer + try to come up with solutions	- Connect + Do to scale - spare room - need to get out - this is what I can offer..	How these services can access on computer. how to access the service what they do etc.. more than info. Refer directly online + know wait times. More technology so can spend more time with people!	- technology ~~to~~ used to communicate w/ carers. - Leaflets in email link. - APPs! info been completed + refer to it - CPTS. - PC on wards.. - SKYPE!

1. Supporting people in A&E who are experiencing crisis

This group looked at the interactions in A&E for people with mental illness. It looked at each stage from arriving at A&E through to discharge.



Guy's and St Thomas' NHS Foundation Trust

Waiting

	Arrival & registration		Triage		Being seen / treated		Admission		Discharge
Areas for improvement - issues / challenges faced by service users	• No explanation of pathway to patients, carers or family • Anxious – do not know what to expect • Users feel they have to 'justify' their attendance – made to feel that I should not be there • No privacy – others can over hear at reception /. Registration desk • Waiting too long – if in crisis, waiting a long time exacerbates the crisis further • A need for better links with GPs – GPs taking more responsibility for helping service users to avoid crisis • A&E should be the last resort and it is not always the best place – there should be other options that either prevent escalation of crisis and other options in a crisis BUT users should still feel that if they approach the service that they will be treated with dignity and respect • Need quiet place to wait, safely – busy and noisy waiting areas not calming	Long waits exacerbate crisis and anxiety	• Better consideration by / attitude of clinicians toward mental health crisis – parity between mental health crisis and physical / medical conditions • Mental health crisis should be considered, as much as a priority as some physical conditions • An improved approach to triage – assessing both mental and physical health • Ensuring service / staff ask for details of a service users support network support network • Query whether to always include MH assessment as part of triage? • Users unsure about role / purpose of triage in the process • Unclear how triage functions if arrive by blue light (i.e. police or ambulance) • Users felt their concerns have been taken more seriously when referred to A&E by GP	Long waits exacerbate crisis and anxiety	• Calming surroundings – give thought to decor and furniture • Need to feel safe and calm • Staff appearance - uniforms , in particular, no white coats , these can be intimidating / off-putting and create barriers • Talk to me on my level, but don't patronise me • Personalised care – don't over-professionalise and be flexible with protocol • Staff ignore my partner / carer / support network if they are there – involve them in discussions / decisions about my condition / care • Not having to repeat myself to different staff • Know more about users condition / care	Long waits exacerbate crisis and anxiety	• Limited MH awareness among staff on wards – mental health needs need to be supported by ALL staff, not just PLN team input • MH condition may present low risk to self or others, but this should not diminish the need to be mindful of MH support needs during a stay on hospital ward		• Response to self- discharge (i.e. Patient / service users decide to leave against advice) can be too heavy handed e.g. Police arriving on doorstep – think of other ways that the service can check safety / well-being off service user, which do not create further distress for user and family / carers • Improve continuity of care and contact – A&E staff think beyond the walls of the A&E and make sure service users leaves with appropriate onwards advice / contacts ./ follow-up in place, where necessary • Improve care planning and user access to own care plans
	• Information about what to expect • Staff awareness of and attitude toward MH / service users	• Waiting	• Feeling safe and secure / reassured • Staff attitude toward and awareness of MH care needs • Improved information and communication		• Involvement of family / carer • Information and communication		• MH awareness among ALL staff		• Continuity of care and support • Using existing service users care / support network

Future state – what would good experience look / feel like?	• Improved experience - all staff see the value / importance of that first contact / first impression that can help to reassure / relieve anxiety
	• Service to provide clear information about what to expect from arrival to discharge to help reduce anxiety of users and carers
	• Better awareness of MH service user needs across ALL staff, clinical and non-clinical
	• ALL staff (from arrival / registration through to discharge) have awareness of MH and can identify someone in MH crisis
		• Reduced waiting times
		• Better info / being kept up to date about waiting times
			• Service users feel safe and reassured by improved staff awareness and attitude
			• A more 'holistic' approach to triage, which assesses MH support needs, where appropriate
			• Better information about:-
			  • the purpose of triage
			  • what happens during that interaction and;
			  • What service user can expect after the point of triage
			• Other options for triage / assessing condition and support needs
					• Improved support and advocacy for those attending A&E in MH crisis through 'peer support and 'MH First Aiders'
					• Carers / support network involved in interactions / discussions / decision about care – see the value of the carer / family member / friend.
							• Greater MH awareness among all staff – we have achieved this for Dementia with Barbara's Story, but what about MH and MH crisis?
							• MH support needs assessed as part of care / discharge planning
									• A&E team / hospital team do not simply' discharge duty for care' but 'transfer care' to source of support / other service to help manage current and prevent future crisis escalation
									• Shared care plans to aid continuity of care and user communications about their preferred care
									• Care / discharge plans involve carers and users wider support network, as well as recognise needs of carers
									• Improved use of existing services / care networks, including third sector providers

Solutions / actions for improvement	1.Display waiting times and ensure updated 2.Ensure staff provide verbal updates about expected waiting times on arrival and at regular intervals 3.Explore ways to exploit opportunity of developing e-check-in / self-check in for service user to be able to add details about their reason for attendance – this would be more discreet than having to discuss at reception desk. However, option to speak to someone on arrival must be available 4.Use self-check technology or other digital technology / display to explain to those arriving / waiting, what they can expect –design it with users 5.Visual / digital displays depicting what patients can expect to happen e.g. pathway depicted 6.Mental Health Passport or Well-being Pack – a portable care plan, design / format co-designed by users and staff (e.g. A care plan app that draws from existing models e.g. LD passports, My Health Locker)		1.Triage assessment / forms reviewed & redesigned by users and staff 2.Mental Health awareness training developed and delivered together with service users 3.Create opportunities for staff to regularly hear from / and reconnect with user experience (possible that staff become de-sensitized) 4.Other options for triage / assessing condition and support needs – e.g. Exploit technology, use Skype / tele / video medicine approaches to avoid user having to attend A&E		1.*'Solidarity in Crisis'* (peer support model) Opportunity for Trust to develop partnership with third sector provider that can provide on-call volunteer peer support for those in MH crisis e.g. Certitude (existing service has shown evidence of being able to reduce A&E attendance) 2.MH First Aiders and MH awareness training for ALL A&E staff, also includes / emphasises role and value of carer / informal support network – courses co-designed and delivered by users, carers and staff 3.PLN and A&E clinicians – parallel process of treating mental health and physical condition		1.*'Solidarity in Crisis'* (peer support model) Opportunity for Trust to develop partnership with third sector provider that can provide on-call volunteer peer support for those in MH crisis (e.g. Certitude) – provide additional support during period of admission 2.MH First Aiders and MH awareness training for ALL staff across emergency care pathway, from arrival to admission discharge 3.PLN and A&E clinicians – parallel process of treating mental health and physical condition during spell / stay in hospital		1.Develop / agree protocol for managing / responding to self-discharge to ensure needs of / impact on users and carers are considered 2.Discharge plan that encompasses MH needs, prior to leaving A&E / acute med / specialist ward , to ensure follow-up and continuity of care 3. Portable MH Passport / well-being pack / care plan app - ensure care plan encompasses preferred approaches / support to avoid and if necessary manage crisis in future, looking at range of services / support available 4.Improved link with GP – more immediate communication to ensure GP can offer follow-up 5. Whole system challenge – to find alternatives to A&E and invest in crisis prevention 6.Staff resources with access to information about MH services to which they can refer MH service user upon discharge

'Supporting people in crisis in A&E', Lambeth Living Well Collaborative, 17 July 2014, Andrea Carney & Jamie Keddie, Patient & Public Engagement Team, Guy's & St Thomas' NHS Foundation Trust,

2. Supporting people in a place of respite/safety/sanctuary while in crisis

Things we can change immediately

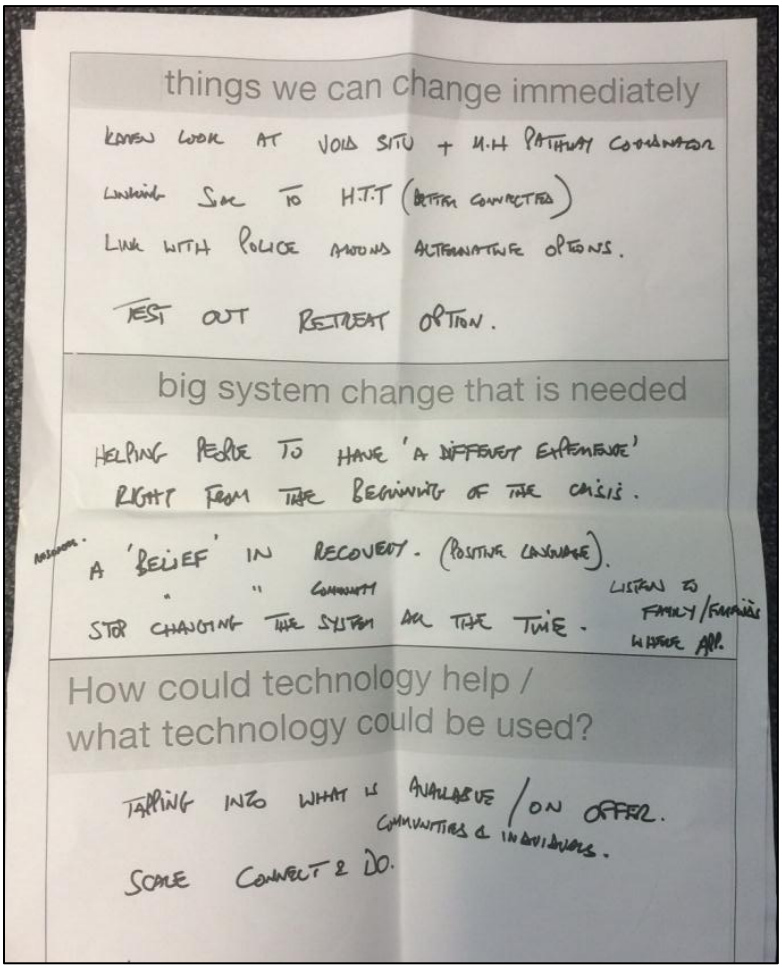
- Could immediately look at void situations and have a mental health pathway co-ordinator.
- Can link in Solidarity in a Crisis with Home Treatment Team to be better connected.
- Use social media to promote Solidarity in a Crisis.
- Can link in with police around alternative options and inform police of the options so they know what they are and how to refer people to them.
- Could test out with accommodation already available for a retreat options.
- Look at easy access and being able to self-referral on a 24hr basis.
- For people experiencing crisis feel they are being listened to.

Big system change

- To create a belief in recovery and the community.
- Look at getting support earlier to help people have a different experience, right from the beginning of their crisis.
- The system is constantly changing and is difficult for people to follow the changes. Stop 'changing the system' all the time.
- Involve and listen to family and friends where it is appropriate.
- To get people to believe in the resources and the solutions available within the community, whether in groups or individuals.

How could technology help/what technology could you use?

- Look at what communities and individuals use already and build on that.
- Look to scale Connect and Do to reach others.



3. Supporting people in their own home who are experiencing crisis

Things we can change immediately

- Care co-ordinators keep in contact with people on the wards to keep a seamless process.
- For GP practices to be more accessible through a named GP – who knows them in the community, and being able to book double appointments
- A named person who is involved with the person in crisis that works along side HTT. Could use the Living Well Network for this.
- Psychological services to work alongside HTT, however there should not be an exclusion criteria.

Big system change

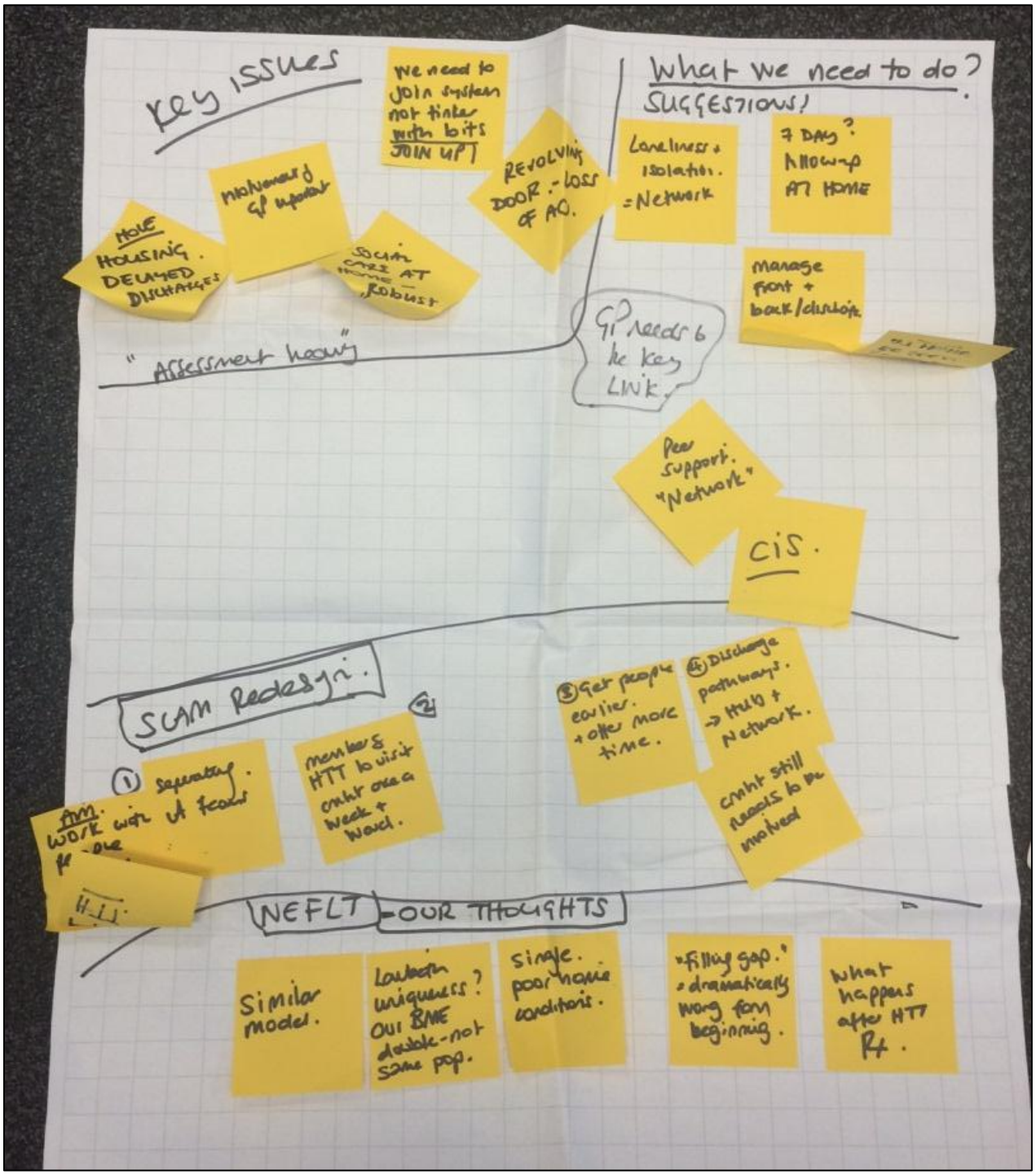
- Use care co-ordinators differently. Can they be outside of secondary care?
- Need an enabler, but it does not need to be a mental health practitioner, there is clinical responsibility, could this been a GP surgery?
- Need to link the Living Well Network to everything. i.e. benefits advice, therapy, housing etc.

How could technology help/what technology could you use?

- The Collaborative offer could be accessed via IT solutions. i.e. Peer Support, Benefits, with a timeframe on how long the wait would be.
- Ensure that it is timely and systematic. Look at the acute medical scheme taking place elsewhere.

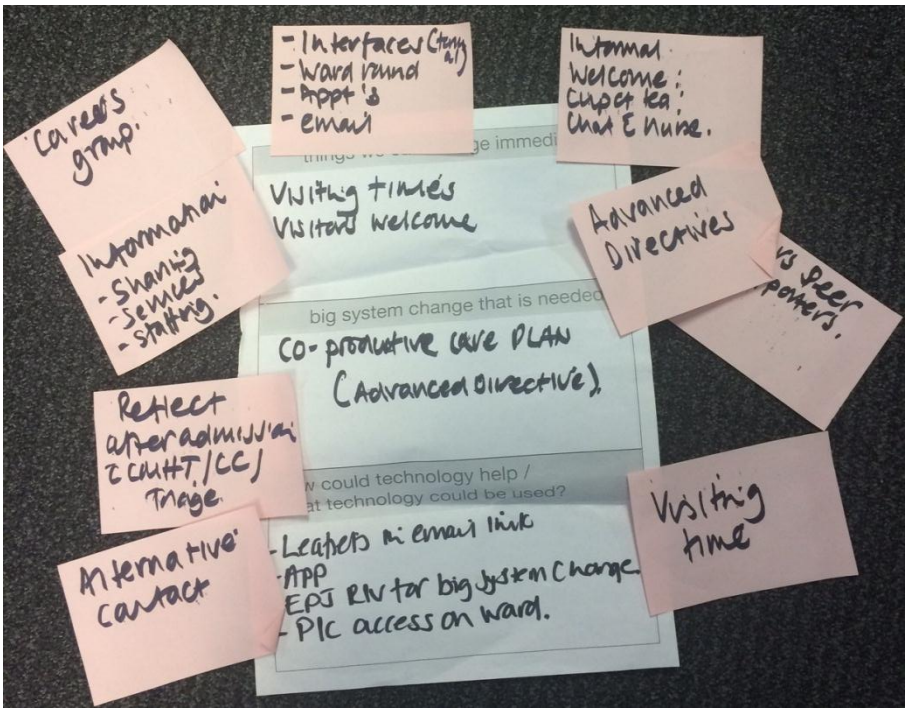
Key Issues and suggestions

During the Supporting people in their own home who are experiencing crisis Session key issues were also discussed and suggestions on how they can be overcome.



4. Supporting people to manage crisis while on acute wards

The focus on this group was around carers and how they can be more involved with people who are on the wards. Embedded is the information that was provided to the group.



Things we can change immediately

- Could change the visiting times to make them more suitable, and welcome the visitors, even if they have been on the ward, and offer them a cup of team.
- Provide an alternative contact
- Look at the ward rounds and the appointments to make them more user friendly.
- Establish a carers group for people who care for people who are on the wards.
- Look at sharing information more easily between staff, people on wards and their carers and families.
- Have carer peer supporters on the wards.

Big system change

- Look to have a co-productive care plan (advance directive)
- Have a reflection after admission with CMHT / CC / Triage about what they have learnt on their time on the ward.

How could technology help/what technology could you use?

- Put leaflets of information on a website, or have them electronically and be able to email the link for people to download the leaflets. This would save a lot of time for staff.