Daily Summary from Workshop 1 – Day 3 (Wednesday 2 May 2018)

Access to Community Mental Health Services

Context

The group summarised the work carried out throughout the last couple of days and reflected on the Fringe feedback.

Support was shared for a mental health call centre and the idea of one number although there is some hesitation around accessibility to crisis contacts via this single pathway.

Please note: In all tasks, the delegates were given free rein in describing what might be possible – some of the logistics will not yet have been fully considered.

The information shared in this workshop builds upon that shared in previous workshops from the days prior – this is day three of five for Workshop one.

Morning session

Delegates asked to get into four groups to discuss the 'standard operating procedure' from various points of view:

1. Physical health – how will we ensure this is captured/considered when people get in touch?
2. Person/job specification for people answering calls, and who they escalate to
3. Warm transfers from and to others e.g. 111, Social Care etc.
4. GPs – getting advice (From doctors, about medication)
    - Making referrals (remembering we can refer ourselves)

This exercise helped participants describe in some detail the impact on different personal aspects and roles and how they will need to be formed around an evolving mental health service.

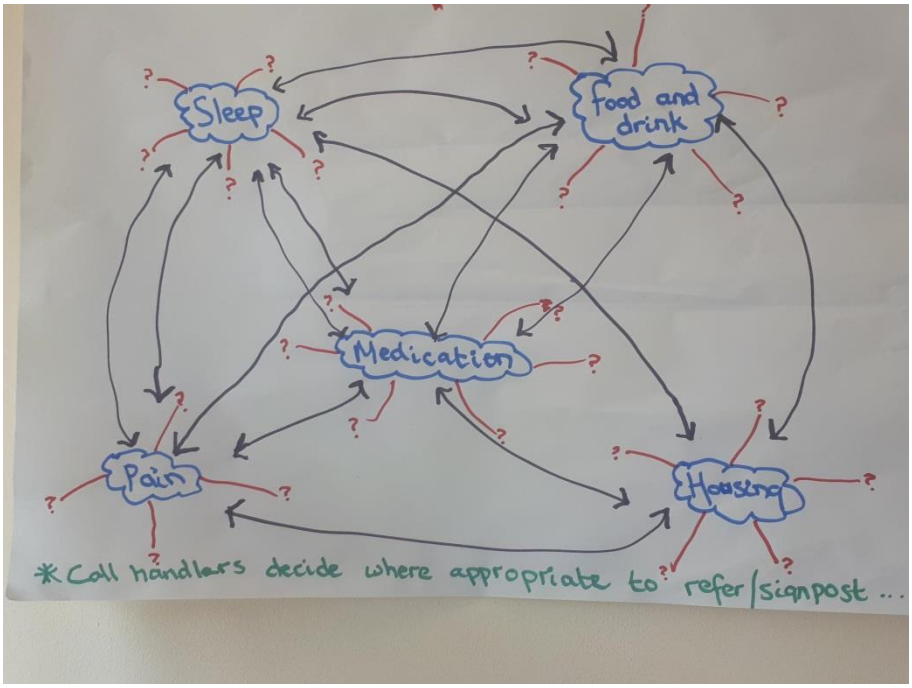
Key themes from the first session include Empathy, Training, Technology and Systems.

- **Physical health**

The overriding statement from this group was that "physical health impacts on mental health":

- The current, immediate crisis must be addressed and de-escalated before further questions can be asked
- Questions such as 'Do you have any physical health problems?' and 'Do you have a GP?' will help call handlers to identify and access patient records to better sign post them to care
- The ideal call handlers will be professional, skilled and trained in specific areas
- All services across the board need to be on the same system for everyone to access the same information
- Training is essential – call handlers must always be empathetic, respectful and patient

- The team identified five main areas of focus for questions – Sleep; Food and drink; Medication; Pain and Housing
- Once the relevant questions have been asked, there will be reliance on call handlers to know where to direct –relevant training for these people to enable them to signpost or direct to relevant procedures or people
- Training is needed in various scenarios, living conditions, empathy, medicines and how to access records. For example, a clear understanding that physical health can cause mental health i.e. chronic pain causes sleeplessness which impacts heavily on mental health
- Validation – participants agreed that sometimes all you need is validation from the call handler that it is okay to feel a certain way



- **Skills – person spec of people involved in access situation**

The group split the person specification into two areas for essential criteria and desired criteria:

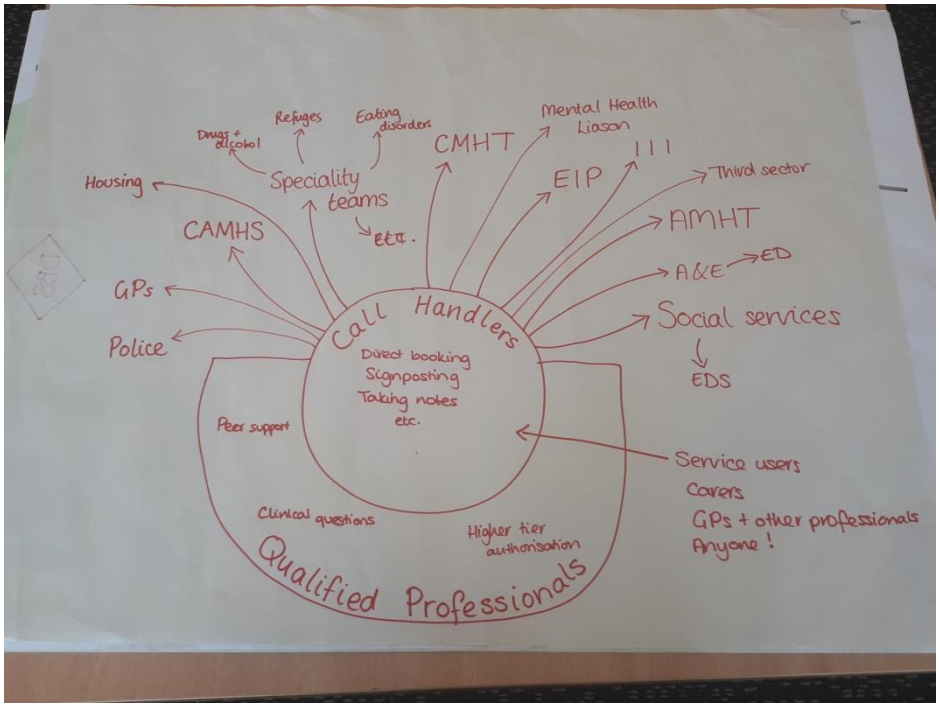
Essential criteria:

- Training before the job has started
- Ability to type quickly, picking up new systems
- Basic IT knowledge needed prior
- Interpersonal skills with kind and reassuring manner
- Passion for supporting mental health
- Taking responsibility for the decisions that you make –problem solving
- Pathways – comparison to 111 – assess immediate needs and who to signpost to i.e. clinician, GP, hospital etc – scenarios create direction –" NHS 111 directory of services will underpin this service"

- Using your own initiative to think through scenarios to signpost

Desirable

- Previous experience in mental health services and a similar working environment
- NTW and 111 have screens on the wall monitoring incoming calls – similar approach needed for this centre
- Working knowledge of demographics enables a better placement to support people
- Can build in levels of training within the hub to progress
- Understanding of safeguarding, person-centred cared
- Day working may differ to night working – out of hours – working out demand and skills needed – whether or not something can wait – how will urgent response be monitored?
- Where professionals should be placed and accessible – what can be handled within the call centre
- NTW call handling service and crisis team sit in the same room – during the day reps from all community teams come in



- **Warm transfers – making sure people have a smooth/direct process**

Main concerns included wait times, the inclusion of other services and their understanding of the systems and understanding how other agencies work and the links between.

- Understanding new ways of working – shared system needs to include people's diaries – check availability of clinicians relevant etc and sign post elsewhere if they are unavailable
- Inbound and outbound management of calls – staff to work on feedback and follow ups
- No benefits in professionals contacting the hub – not a professional switchboard however can have this function if needing to contact somebody new...

- One number given to service users but professionals still have the ability to contact each other separately
- 'Levels of contact' was a popular subject that gained a lot of response. Participants discussed how the method of contact would first be framed to people i.e. they can still contact their own nurse or care co-ordinator but also call the centre number for further support if needed. Certain rules will be put in place to ensure contact is reliable.
- What kind of cover will be provided i.e. number to hubs, teams, individuals – risk of giving out phone numbers – how to keep staff safe and ensure patients have a simple route of access to professionals when needed
- Wait times – a dial back function will help to reduce wait times. Staff should also determine wait times to the caller when transferring as wait times can cause anxiety – "decent" music makes a difference to waits (Pink Floyd was one suggestion!) – no interruptions - "thank you for your call" can mislead that you have been answered
- Call centre to link up with other services such as Southern electricity who can help vulnerable people – signposting function

- **Responding to GP feedback – getting advice and making referrals**
  - A simple system is needed with one number for everyone. Calls will be answered with the correct response using an intelligent call system to avoid waits and confusion.
  - Call handlers will be provided with a map of services to know when to pass to a doctor
  - Rota in place to call the GP back rather than have somebody sitting there waiting – call backs can be made appropriate to clinical staff including pharmacists, medics and nurse practitioners

Why do mental health patients have to pay for prescriptions?

- Mental health being made accessible to everybody
- Recording theoretical conversations for unnamed patient s. There is defensiveness around how the culture is handled and protected.
- "Technology is the problem – its weighing us down"
- Strong agreement that patient names need to be given if advice is required

We need to ask the wider group of medics how they record advice calls if they don't know the patients name.

- Working out what is the most efficient process while supporting patients and keeping them safe
- There should not be a specific mental health system – working with system one – avoiding the stigma attached to mental health
- 'Virtual ward' – meetings which keep notes from MDT meetings
- GPs make one phone call to receive either referral or advice – one place, one number and call handlers have a referral form to follow
- Reasonable time frame – GPs need reassurance for urgent response i.e. having someone in the consultation room
- Access to this system relies on regular education and training of GPs and practice staff

- Don't necessarily need a new number just no queue – GPs want instant access if someone is in the consultation room seeking an answer
- Technology – what support can it provide to call handling – current services use technology to filter calls – already exists and used for commercial

Afternoon session one

Participants were asked to consider if they were a person with mental health needs who didn't wish to use a telephone and wanted to be seen face to face. 'Walking into somewhere to ask for help' – what is the ideal?

The group agreed that people already known by services should have individual plans in place (in an ideal world) therefore the focus was on those unknown to service or with no access to a phone.

Key points:

- The ideal scenario: Community hubs that are accessible – town halls, community centres, libraries – staff with nurses and HCAs, or a health liaison based at QA Hospital. However a drop-in service may result in increased wait times – being in a quiet space may make the wait time more bearable
- 7 days a week but not 24/7 – based on data that supports the busiest time and base opening hours on this data
- Local – perhaps in the form of smaller hubs
- Age limited to 18+ to avoid a youth hub. QA has a paediatric hub, something similar should be created for mental health
- Staffing can be determined by needs and demand in that area but staff members can be via peer support, clinical staff, therapy students
- Screening and safety of patients and staff, managing who is there and using the service and the placement of the service
- Services on offer will include wellbeing groups, holistic therapies and other health groups
- Night buses are paid for by pubs to ensure safety at night time – can something similar be used for mental health services?
- Physical health needs and self-harm support – ensuring people coming in to the service have the facilities to look after themselves should they come in with wounds
- Links to SPA
- Include a quiet zone with no phones
- No smoking

One group designed a wellness house made up of three specific areas; a quiet space (easily accessible, sounds, textures, sensory room); 1:1 assessment rooms (data capture, risk assess, referrals to SPA); and a café style, warm and comfortable area that can also be moved into the community as a pop up café, linking to peer support.

- Ground rules: substance use, enabling equipment, general behaviour

- Staff need to be confident and assertive as well as kind and compassionate
- Internal décor: avoiding visual stress – neutral
- Accessibility: transport routes and parking come into consideration – easy access for families
- Need for the first contact to be appropriate and empathetic –availability of people i.e. personality match, flexibility, gender, culture
- Self-help library available to all
- Offer of therapeutic alternatives to s136 suites when appropriate
- Utilising technology to remain interactive with people – use of tablets instead of computers at desks

Linking up to the current phone line which will be very effective – various hubs can link into this as the main go to place. The main hub would be placed near the two main hospitals and run 24/7. Other, smaller hubs will be better placed within the community. Key aspects of the hubs:

- Provide more therapeutic care than a hospital setting.
- Groups and therapy delivered on site
- Highly trained staff can deliver outcomes
- Co-located with other third sector organisations

Afternoon session two

Groups were asked to address how various individuals would contact the mental health phone line:

1. Homeless service users – how will they use this system?
2. Anonymous callers to the phone line
3. Calls to make a complaint or give a compliment
4. Consent around information – what about when things get difficult?

- **Homeless service users**
  - Having an outreach team linking with triage
  - Short term assertive outreach team
  - Support with daily scripts
  - Shared clinic teams
  - Maslows hierarchy of needs
  - Warm transfers of care
  - Mental health or substance use and then warm transfer to an appropriate clinical team
  - Currently – homeless people have to be registered to a gp
  - Guildhall walk will take homeless people
  - People can fall through the let due to lifestyle complications i.e. change of numbers
  - Vivid – housing provider – will be putting in a wellbeig practitioner to help people with mental health or complexneeds to maintain living situation or address homelessness – housing providers in southern and ports mouth are looking to provide this service locally – at least two reps per area. Radian and Hyde housing associations are also looking to follow suit to help the situation
  - Supporting people to live in better places (overall)

- **Anonymous callers**
  - Either calling about themselves or another – or tip offs about concerns
  - Call handlers/professional needs to be building trust and information gathering
  - Identify risk about the caller – leads to procedure about where you will signpost this person to i.e. if emergency services are needed
  - If you can persuade the individual to share info – potential to pass on to safeguarding teams or housing
  - If no info shared – capture that info and record it – can give general advice or signpost to another service – encourage them to call back if they may want to share some more info in the future
  - Reaching out to people
  - Audit trails needed to record a reference number

- **Complaints and compliments**
  - Both compliments and complaints should be logged officially and carefully and signposted to the relevant people
  - Handling of complaints as soon as possible to de-escalate the situation
  - Case workers can be assigned to complaints to handle from start to finish; this provides a point of contact, consistency and regular updates. Ownership and involvement of the complainant will then give them control in the situation and allow for a rapport to be created with the case worker
  - Learning from the compliments is key and acknowledging positivity within teams
  - Group morale is that recognition should be increased, a consensus of being 'behind the scenes' or supporting mental health means you're forgotten as it's not a visual illness

- **Consent around information**
  - Rules to abide by i.e." you have the right to change your consent at any point"
  - Taking levels of consent into consideration, for example, if the police need to be called or the situation is life-threatening
  - Proportionate to what an individual is saying

What do you think of these ideas? Please remember they have not been tested for logistics or affordability, they are concepts at this time.