London Clinical Senate Forum:

7th February 2019

What More Does London Need to do to Enable People in Mental Health Crisis to Appropriately Attend Emergency Departments?

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London Clinical Senate

February 2019

Summary / overview	This provides a high summary of the discussion at the February 2019 London Clinical Senate Forum that focused on Londoners who are experiencing mental illness and who attend Emergency Departments.
Action required / requested	Consider the discussion points in response to the question: ‘What Does London Need to do to Enable People in Mental Health Crisis to Appropriately Attend Emergency Departments?’

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Key Messages: What Does London Need to Do

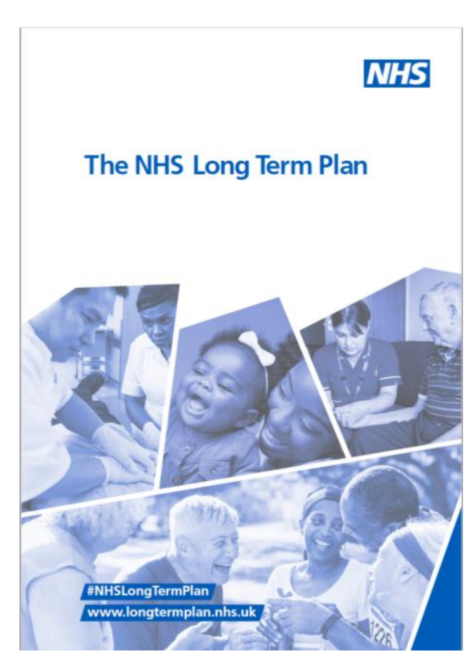
- More community and inpatient crisis mental health capacity is needed to avoid the need for Londoners to go, and/or limit time spent in Emergency Departments. That would mean "go to A&E' could be taken out of MH Crisis Plans.
- There is stigma. Respectful 'Human' interactions with NHS staff aids recovery. All NHS staff involved need to be trained in Mental Health and to work closely and supportively with parents and carers.
- Londoners brought to or attending ED departments have real mental health needs that require care and treatment (including the basic needs and importantly, safety) that starts at admission and minimises waiting times.
- Open wards in A&E do not provide the privacy, dignity and safety someone experiencing a mental health crisis should rightly expect; especially for making very difficult statutory decision making on detention or discharge, based on whether it is safe for a patient to leave ED.
- When a Londoner needs a bed, a resolution mechanism to the frequent disputes on responsibility and the amount of time spent trying to find one is needed. This includes understanding where beds are available.
- Better joint working between agencies (LAS, Metropolitan Police Service) will provide better outcomes for Londoners, and reduce demand for police, LAS and other NHS services.
- Staff across the NHS and partners to not have the ability to share important information necessary for managing risk and improving outcomes.
- There is a need to bring acute hospital ED departments together with community and inpatient mental health services, as part co-producing improvement in a complex system; and this should include both:
    a. Elements of standardisation, such as a single point of contact through 111, and to improve the interface between NHS organisations (inter-hospital transfer standards), and between NHS and partner organisations like the police and Local Authorities; and
    b. Ensuring local needs are met in a way that is informed by many examples of good practice in London, examples that need be surfaced, celebrated, spread.

Policy Context: The Long Term Plan and Mental Health Crisis

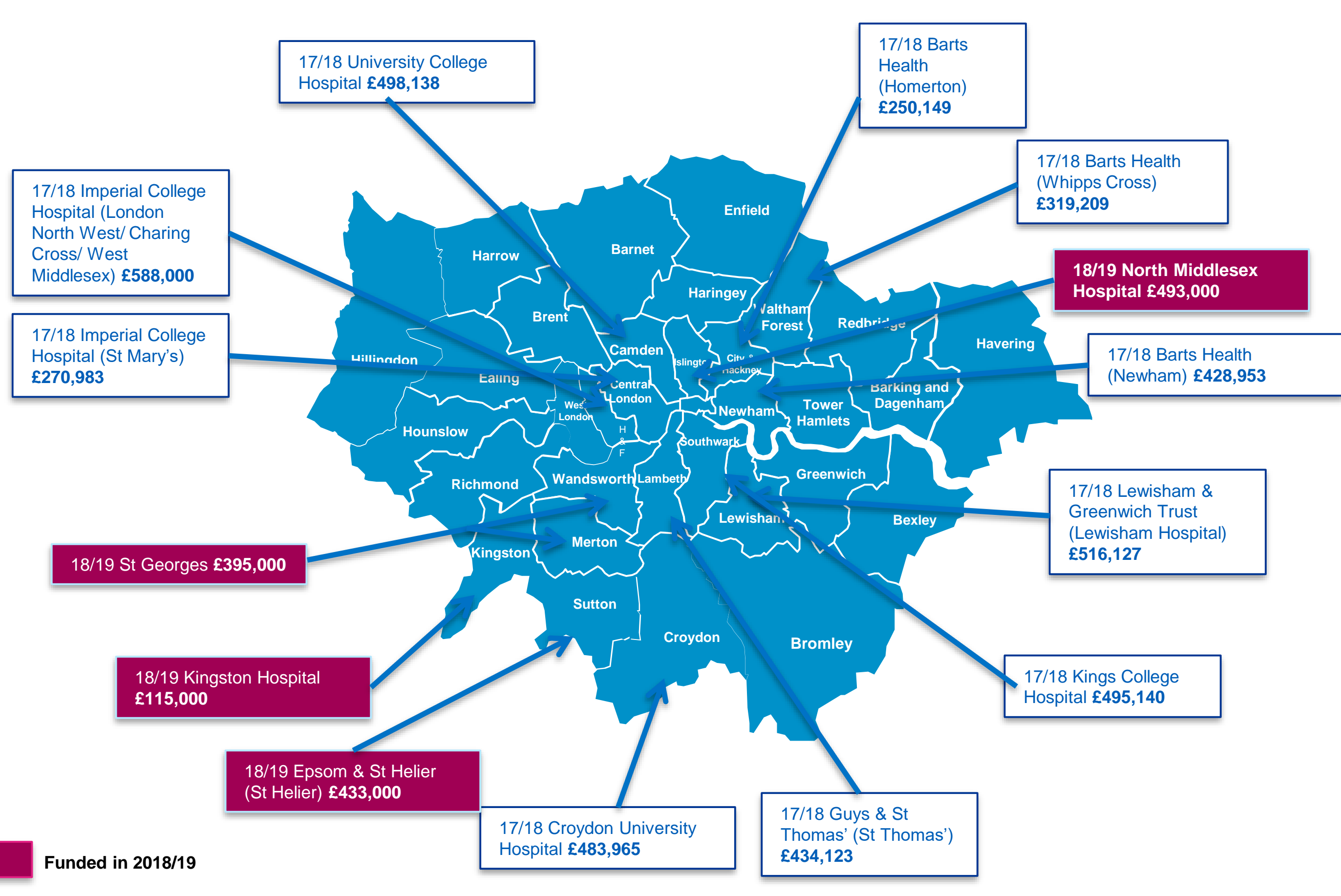
LTPs ambition to deliver **'world-class' mental health care, when and where children, adults and older people need it.** The NHS Long Term Plan published on 7 January 2019 commits to grow investment in mental health services faster than the overall NHS budget, and faster for children's mental health than mental health overall.

This creates **a new ringfenced local investment fund worth at least £2.3 billion a year by 2023/24.** Further, the NHS made a new commitment that funding for **children and young people's mental health services will grow faster than both overall NHS funding and total mental health spending**. This will support, among other things:

- The NHS will provide a single-point of access and timely, age-appropriate, **universal mental health crisis care** for everyone, accessible via NHS 111.
- Services are resourced to offer intensive home treatment as an alternative to an acute inpatient admission.
- Ensure by 2020/21 that no acute hospital is without an all-age mental health liaison service in A&E departments and inpatient wards
- At least 50% of these services meet the 'core 24' service standard as a minimum.
- By 2023/24, 70% of liaison services meet the 'core 24' service standard, working towards 100% coverage thereafter.



London Context: Psychiatric Liaison in ED Transformation Funding 2017/2018, 2018/2019



London Context – National Comparison

The 4th Annual Survey of Liaison Psychiatry in England (LPSE-4) aimed to place a focus on the composition of Liaison Mental Health teams and on how the teams meet patient needs, all London trusts completed the survey

	CORE 24 Criteria	National	London
	Liaison Mental Health service on site	100%	100%
CORE 24 Operational compliance criteria	24/7 Emergency Department	66.2%	92%
	LMH service is commissioned to meet 1 hour response time	83%	96%
Operationally CORE 24		58%	89%
CORE 24 staffing compliant (11 FTE MHPs and 1.5 FTE consultants)		32%	57%
Fully CORE 24 (operationally plus staffing)		29.7%	57%

Citizen Perspective of being in ED

Adult Service Users: Peter Jones and Suzi Lee

- Being told that you are ‘attention seeking’ by the NHS when you are experiencing a mental health crisis illuminates the stigma that mental illness attracts within the NHS.
- NHS staff are often talking to each other and not the ill person gives the impression that administration is more important than the human contact, so valued by patients.
- If you have to wait when you are in a mental health crisis and it looks like you may be detained, you will very likely abscond when you are most a risk to yourself.

‘We don’t want to die when we are off our trolley, we want [the NHS] service to hold and keep us safe’.

- Staff need to have the right attitude and be able to provide basic care and complete basic risk assessments.
- We would like our basic needs to be met, dignity and comfort, a cup of tea and some food, especially when we are waiting for long periods.

Citizen Perspective of being in ED

Carer of Adult Service User: Matthew McKenzie

- Carers have an essential role in persuading people to seek help earlier to avoid a mental health crisis, but this is hard knowing where that may result in admission.
- Carers are often ignored. A positive experience of a first contact is essential to providing hope.
- Carers need to be listened to as they can often explain the symptoms when the ill person can’t.
- Carers are expected to cope without support for long periods when sent home with someone who is very poorly without support.
- Professionals need to be clear about their expectations of carers in ED and when sent home.
- Carers are sometimes left out of care being coordinated and planned by professionals, not even knowing where their loved one is or is going.
- Carers are often left with strong feelings of guilt when the outcome is an admission.

Citizen Perspective of being in ED

Young Person Service User and his father and carer: Dan and Dr David Sharpe

- Staff can be kind and efficient, but some can openly express pejorative views.
- There are long waits without medical review (medication), during which young person deteriorated significantly, this wouldn't happen for other conditions.
- Safety should be paramount from the beginning of admission.
- There are long waits when a person needs admission, and basic needs are forgotten.
- The A&E environment is unsuitable, and there is a direct impact on other patients.
- The following needs to change:
    1. More acute mental health beds to move young people quickly
    2. Early medical review that listens to parents
    3. If we have to wait care should be from point of admission (food, fluid, medication, safety including a safe private room (ligature etc. risks).

Professional Perspective: City and Hackney Crisis and Home Treatment Team

Dr Sally Daly (Consultant Psychiatrist) and Andrew Horobin (Service Manager, Urgent Care)

- Offer is 24 hours, 7 days a week, Community Assessment , 2 clinicians (1 + 1 on-call 22.30-8.00) and referrals via a Crisis Line as an alternative to ED and aims to remove barriers to accessing mental health treatment.
- Urgent Assessment Team provide urgent 4 hour response for: Acutely suicidal with plans/intent, Psychotic symptoms with risks to self/others, significant self-neglect, post-natal women in mental health crisis, carers of children with psychosis/ suicidality/ anxiety impacting or likely to impact on child.
- Home Treatment Team (HTT) provide: Scheduled visits (8.15 – 21.30), community clozapine titrations, Average length of stay – 2-3 weeks, funded caseload 45 (with no cap), Discharge planning, and work with 24/7 crisis line, SOS – Service User Network Outreach Service and Crisis Café. Users can refer themselves back.
- Often staff are going to see people they know nothing about, and if a risk of violence or violence then call the police.

Professional Perspective: City and Hackney Crisis and Home Treatment Team

Crisis Network

Support to Avoid a Mental Health Crisis

A new approach for local people who struggle with mental health issues

Crisis Café

An open door, drop-in service providing light refreshments. The Café offers a safe, supportive and therapeutic environment promoting independence, opportunity and recovery for people with mental health issues.

Open Monday to Thursday 6.00pm to 9.00pm and Saturdays 12 noon to 4.00pm.

Address: Raybould Centre,
C&H Centre for Mental Health
Mob: 07393762366
Email: crisiscafe@elft.nhs.uk

Location of Crisis Café

Service User Network (SUN)

Support, workshops and strategies to help you manage during a crisis and put together a plan that best meets your needs. The Service User Network supports individuals to develop effective ways of coping, to prevent a crisis developing and reduce emergency A&E visits. For individuals who experience frequent mood changes, emotional instability, self-harm and/or who have thoughts of suicide.

Tel: 07508 842 688 **Email:** SUN.referrals@elft.nhs.uk

City & Hackney 24 Hour Mental Health Crisis Helpline

020 8432 8020

Professional Perspective – Metropolitan Police Service

Inspector Elaina Usher – (MPS MH Team) and PC Graham Alldus – King's College Hospital Liaison Officer

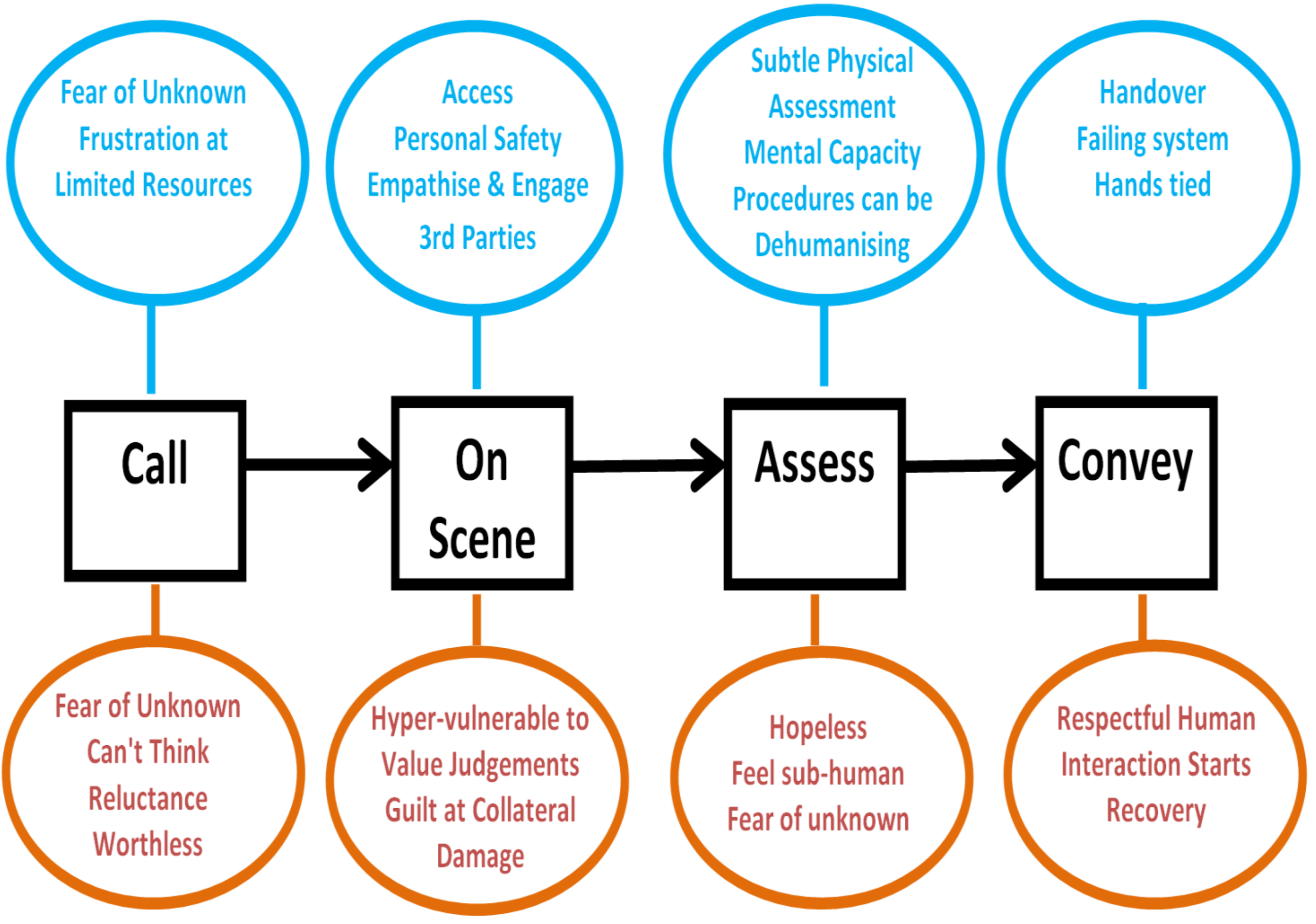
- MPS work with many Londoners in crisis, they are really poorly with high acuity.
- MPS want to improve the experience of mentally ill Londoners in contact with police.
- Enormous demand and pressure on the service: 112,362 MH flagged incidents in 2018 (one every five minutes, a 33% increase last 5 years). Section136 has increase 31% last 3 years). 83% of calls to MPS are not crime related.
- **What is working well?:** Pan-London all age Section 136 Pathway by HLP, MH advice lines (legal requirement), integrated MH and MPS responses and joint crisis care plans to reduce repeat attendances, local crisis cafes / support groups, vulnerability framework 'ABCDE' for consistent handover (HSJ award winning).
- **What isn't working well?:** ED is rarely a safe and welcoming environment, inconsistent ED triage systems, physical treatment often a priority (parity of esteem), expectation for police to remain (hospital security's role after handover), IT systems don't align for sharing risks etc..

Professional Perspective London Ambulance Service

Ben Lawrie - Mental Health Paramedic Lead

- LAS has 13,000 calls per month for patients presenting with mental health needs, a vehicle is sent to 8,000 patients (10% of all activity), more than half of these patients are conveyed to ED.
- **What isn't working well?:**
  - LAS often the first on scene, at the peak of the crisis, LAS staff have no access to patient record and the fragmented pathways often leave little choice but ED
  - Patients may decline our treatment plan, leaving staff concerned about their wellbeing and safety. Often this with a stressed informal carer. LAS staff experience a sense of having our hands tied and doors closed. This sense of rejection can also be felt by the patient and adds to a lifetime of stigma and rejection.
  - LAS staff training does not reflect the MH needs of patients.
- **What is working well?**:
  - Dedicated Mental Health Team in call room
  - MH nurse with paramedic means 80% of attendances are 'see and treat' against 30% for those without a MH nurse.

Professional Perspective: London Ambulance Service



Professional Perspective: ED Psychiatric Liaison

Michael Dunning (Service Manager) UCLH, Whittington, Royal Free Hospital Hospitals

- EDs are the interface between huge number of public agencies and can feel like an Airport or train station.
- There are a large number of people involved: Police, LAS, Nurse In Charge, Local Authority AMHP, Independent Doctor, security personnel, Liaison Nurse and Psychiatrist, A+E Doctor, Crisis team workers.
- There are significant pressures and ED has no control over how many Londoners might attend: ***"We're full, have you tried the next hospital"*** ***"We've tried everywhere***"
- Detention or discharge and the statutory responsibilities: ***"Can you show me the way out please?" "Can I talk to you first…? "*** Making a call on whether it is safe for a patient to leave ED can be a very difficult call; several times a day.
- The most common and most frustrating issue is MH bed availability including disputes regarding responsibility for the patient (GP or home address). Huge amounts of time is spent trying to find MH beds.

Professional Perspective: Approved Mental Health Professional (AMHP)

Shaun Last: Lead AMHP Lambeth Local Authority

- Mental Health Act 1983 (Amended 2007) introduced the role of the AMHP, which replaced the old Approved Social work role to open role to other profession.
- Legislation requires medical and socio-legal perspectives to be considered before a person can be detained. AMHPs role is to balance to the medical perspectives and to provide comprehensive risk assessments, and they must explore least restrictive alternatives to hospital.
- **What works well:** Psychiatric liaison services (arranging place of safety and conveyance), assessment room away from 'bustle' of ED department, Registered Mental Nurse and ED security presence.
- **Challenges for AHMP Services in ED:** Availability especially out of hours, delays in accessing S12 doctors, lack of appropriate interview spaces, issues of medical fitness and sedation, lack of suitable Psychiatric Beds and the time spent trying to find beds.

Appendix

Table Discussion Notes

What is your current experience of people in mental health crisis attending emergency departments? Please give any examples of good practice that you have seen

- Pilot for GP for emergency care out of hours with other practices had significant impact not only for people with MH problems
- Escalation for MH patients and mediation/clinical support involved early on – with CSU as a neutral mediator
- Bringing professionals together – dynamic risk register (CAMHS)
- Bed flow in west London and Worcester – red to green programme
- Croydon patients getting worse rather than better
- Moving patients to safer areas
- Skype assessment at H+F
- System challenges – where people are from
- Separate commissioning of acute vs MH services
- Waiting times
- Children around 17 years old – in between CAMHS and AMH
- Turn-over in ED staff makes MH training difficult
- 136 issue – not nice to hear conversations as patients shunted around
- Deal with patient and sort money after
- Patients need to be escalated thoughtfully
- Re-inventing wheel
- NHSI don't always hear of problems of MH – needs to be more transparent
- Disproportionate long wait – 1 in 5 wait 12 hours or more
- 17 year olds – stuck in the middle between children and adults services – not all HBPoS accept children so default to A&E
- System working against patient stuck in the middle
- Fatigue in system/bottleneck
- Challenge regarding where you're from – particularly homeless
- System challenges – problem commissioning separated acute and MH services
- Challenges of high staff turnover making training difficult
- Limited experience of ED doctors in MH
- Lack of space in EDs
- Croydon – patients getting worse rather than better whilst waiting for a bed
- 136 issue – difficult for all people involved to hear conversations
- Escalation: often spending more time on escalation than on the patient (make it thoughtful and meaningful)
- Having assessment lounges where possible. Taking patients into a safe area as quickly as possible
- GP at hand/Hammersmith and Fulham area (skype assessment)
- Sort out a bed first and then deploy money thereafter – bed protection
- Not nice for patients to hear conversations about them
- Issue that commissioning of acute and MH services are separate
- Many getting worse not better
- Hammersmith and Fulham offer Skype assessment while people are waiting
- ELFT – no bed shortages/flexible
- A&E important with health problems (physical)
- Majority could avoid A&E
- Proper coverage enable shift
- Appropriate triage
- 111 has facility to crisis lines
- Where can paramedic go instead of hospital?
- Crisis line
- Bed availability
- Team called crisis line have no answer/call-back
- Importance of good on-call matron/relationships in ED
- Not losing sight of the patient
- Trauma informed care

Appendix

What is your current experience of people in mental health crisis attending emergency departments? Please give any examples of good practice that you have seen

- Being seen quickly/empathy from staff
- Correct patient details being provided
- Insufficient beds
- Judgement and stigma e.g. for self-harming
- No SPoA for MH crisis
- A&E is the wrong place for MH crisis but need integrated care
- Slow culture change introducing more focus on MH within CCGs
- Cambridge model 111*2 – good crisis management
- CAMHS – early assessment by experienced personnel
- Poor access to beds
- Home treatment creates waits in ED
- Funding not focused on patients in crisis
- ED not the right place to see patients -delays in access to CAMHS beds - find it impossible to see CAMHS overnight
- Good: acute and MH trusts together, ED safe netting, psychiatric liaison service – people in ED
- No space/capacity
- Inadequately trained staff
- Trusts now working more closely together
- Single point of contact for other health professionals
- Recent increased focus on MH
- More MH staff/service in A&E
- Some areas now sharing data (CQUIN)

Appendix

What do you see as the challenges of people in mental health crisis attending emergency departments?

- More people that understand the system
- Humanising the professionals and acknowledging that they may also have MH issues
- Change practice and bed management teams across London
- Capacity
- Relationships and system working
- Bringing community and acute systems working together
- Crisis teams who can filter what needs to be done
- Not just ED and GP that have to manage this and let patients and carers know there are other options
- Better access to food and drink provision in A&E – needs to be monitored
- Lack of clear pathway and barriers between providers
- Lack of education in ED staff
- A&E only place with access 24/7
- Patient needs to be supported and appropriate escalation
- Proportion of MH patients living outside London
- How to manage patient care plans and how to share
- Managing new patients with no MH background – end up in A&E
- Response time could be weeks for GP
- Lack of pathway
- Barriers – separate organisations
- A&E only public access 24/7
- Not resourced appropriately to deal with problem
- Challenges in crisis services
- Basics – food and drink
- Knowing about other options – consistency lacking
- Money needs to be sorted afterwards
- New patients not know to system
- Lack of pathway
- Barriers – often organisational boundaries
- Staff experience and training
- Guarding budgets/resources
- Lack of consistent offer in primary care
- Carers not aware of options other than A&E
- Decision to admit is loaded – with pressure on targets/funding etc.
- A&E only 24/7 service available
- Better access to food and drink provision
- Training of ED staff affected by turnover rates
- Waiting times
- Insufficient beds and resources
- A&E wrong place – need integrated care and alternatives to A&E
- Not trained properly
- Urgent care centres need more capacity and training
- Too many points of rejection
- Regional commissioning rules
- Frustrated with team asking questions that were not so explicit – not heard?
- Service users know the routes and feel safe
- Street triage
- Not enough beds
- A&E not the right place for MH crisis (in most cases)
- Supporting staff
- No continuity of care – get this in crisis café
- Demand
- Waiting times
- Adequate training of staff
- Raising the profile of MH v physical health – Cinderella service
- Insufficient beds and resources
- Staff able to manage MH conversations
- ‘Go to ED’ tradition
- Getting beds - must jump hoops - bed managers have the wrong attitude - don’t understand MH need
- Under investment in liaison work

Appendix

What do you see as the challenges of people in mental health crisis attending emergency departments?

- Poor quality care start to finish – not equal to physical health
- Community case load significant and response poor
- Appropriate environment
- Appropriate and adequate staffing
- Funding issues at heart of problems
- Different IT systems and information sharing
- Not joined up
- ED not equipped to deal with MH crisis
- Lack of consistent approach to search policies and security
- Unhospitable environment – particularly in MH crisis
- Lack 'social model' of care and support
- High users/'frequent flyers'
- No coordination of care – lack of communication between departments/services
- Lack of beds

Appendix

What do you think causes these challenges and what solutions could there be?

- Push for MH to be on same parity as physical health
- Shared understanding of capacity
- Ensure sufficient signposting and safe pathways
- Learning from a crisis to prevent a crisis
- Reframing the caring issue
- Low level prevention and early intervention of the workforce
- Interface with spec comm, NHS E, MH trusts and all working as a whole system
- Complex beds – need to get this right
- An agreed point for out of borough patients
- Reduction in community support causes issues
- Decision to admit is loaded with targets
- A&E gets all patients – requires some sort of MH A&E walk in service which allows them to be seen/admitted (reduce wait times)
- Reduce stigma from other staff/patients in A&E
- Mental health passport or chip with history and care plan
- When patients book in have their care plan on the system with basic information flagged on the system
- Cambridge put chips in the back of bus passes: https://fabnhsstuff.net/fab-stuff/bus-pass-becomes-care-card-to-join-up-health-and-care-services
- Start drugs chart ASAP
- Staff being updated on bed policy
- Training ED staff
- Prevention
- Breaking down barriers – shouldn't need escalation
- Centralised sharing of data and digitisation
- Cambridgeshire – chip in back of bus pass
- Community support decreasing
- GP waits
- Food/drink
- Start doing chart/speaking to family etc. as soon as decision to admit
- Central point for OOA (outside London)
- Demand/capacity for MH trusts
- Queen's – ED MH is part of induction now. Similar training for nurses. Senior staff trained in assessment.
- Paeds/teenage pathways
- Sedation policy
- Reduction in community support. Not all cases need to end up in A&E.
- Response time (often waiting times to your GP can be weeks so patients end up in A&E as wait can be as short as 4 hours)
- Have they had food/have they had a drink?
- Once you have decided to admit start doing a drugs chart/talking to families
- Making space in the department
- Staff being fully aware of bed policy
- For patients who don't live in London have a central point where they can be dealt with
- Local teams to focus on local patients
- Prevention – investment in community services to take pressure off ED environment
- Training – offering key training to all staff in ED
- Data – centralised way of sharing data whether held by patient or managed digitally across borough/London
- Barriers – shouldn't need to escalate patients or negotiate between departments – should be clearer patient pathway and if needed an arbitrator
- Need to capture before
- Cambridge model
- Prevention: families/carers need to be more aware
- Relationship based approach – support staff more effectively
- Crisis staff are often unsupported
- Continuity of care
- Need more of a choice – not just A&E
- Culture change – focus on MH within CCGs
- Challenges: funding, training, attracting good staff
- Proactive/planned approach
- Attach MH support workers to 111 centres

Appendix

What do you think causes these challenges and what solutions could there be?

- Crisis cafes
- Primary care networks
- Disparity of care across London
- Postcode lottery Greenwich overnight for children
- 24/7 crisis line NW London – not always connected or linked in middle of night i.e. link to GP
- Crisis houses, cafes, living rooms – example in Arizona
- System reconfiguration
- Having a resourced home treatment team
- Funding
- Attracting good staff
- Training
- Solutions: collaborative thinking/planning
- Creative solutions and thinking out of the box
- Need more of a choice and not just A&E
- Causes – lack of empathy perhaps due to stress/culture of defence
- Open dialogue approach to be considered
- MH support workers attached to 111 centres to talk to people calling with MH problems
- Crisis cafes – patchy provision – need more and longer hours but need clinical input
- Have separate place for MH – quiet, no ligature risk
- Urgent care centres – need more capacity and training
- Training around MH for LAS e.g. MH course at St George's for non-MH professionals
- Build MH capacity within MDTs in primary care networks and hospitals
- Sharing best practice across UK/internationally
- Fragmentation
- Have access to crisis services so that patients don't need to use A&E
- Example of a solution – Hackney crisis pathway
- Active decision re ED safe net – training and support
- Admission process – medical – remodelling
- MH decision units (purpose built)
- Reconfigure community services to reduce load on A&E
- Medical/clinical model not always most appropriate

Appendix

How do we ensure that good practice is shared across all services?

- More Senate Forums to learn from each other
- More pan-London – less trust level – share knowledge – ELFT example
- Willing to change and leadership
- Network exists
- Being less London-centric – learn from practice across the country
- Building skills and knowledge of commissioners to share best practice
- Remove territorial behaviours in order to share
- Take competition out of the system (CQC)
- Reward good practice of individuals and publicise this
- Identifying best practice
- Sharing best practice – how can this be done?
- Find out what sets out the standard of good practice and share it
- Give good practice awards for it to be recognised further
- Documentation and research on how good practice works
- Funding
- Map out the services for all to see and understand
- Good news stories promoted internally – need pan-London Forum
- Already areas of practice – NHSI sharing info/social media – needs coordinating – make the time
- Get evidence behind good practice – get NHSE and HLP to test this out and question where variation – removing this
- Show incremental improvement
- Who is target audience? – depends on
- LMH network disseminating data and patient
- No time given to trial out good practice – accept don't always improve first time/permission to fail
- Feedback sessions with patient
- Time
- Making sure funding gets upstream
- Events that share best practice
- Signposting (A&E everyone knows)
- Understanding where data records are
- Network exists but power? Chaotic
- Coordination – HLP NHSE/I
- More shared practice
- Testing the evidence and question variation (e.g. GIRFT)
- Many Forums for good practice – not separate/different but on evidence base
- Check target audience, changing perception – patient stories for professionals/clinicians
- MH network role to play in dissemination
- Giving time to deliver improvements – value and measure time and headspace – permission to fail and reducing expectation of delivery
- User voice – service users
- Different levels and people knowing where to go – implementation has to be local
- Actions from this event should lead somewhere
- STP level – connection between levels
- HLP – mandate but not providing solutions
- Agencies listening to each other
- CCG disconnect/variations locally
- Pockets of good practice need propagation
- Bringing together of services – listening/talking – actions and results - good practice strategy
- Network development
- London mental health transformation board

Appendix

What support do services need in developing different crisis care pathways?

- Freedom to speak out
- New ways of funding – pan-London
- Learning from other STPs/boroughs who are doing well
- Pathway wrong language for MH
- Knowledge/understanding/mapping of services available in every area including voluntary sector
- Learning from others of what works
- Drive from those who are passionate/leadership
- Funding, but it's not the complete answer
- Encourage people to contribute good ideas
- Passion and drive – get people interested
- User voice to meet with managers and middle managers – how does it translate
- Need to safeguard time to make improvements and free space
- Systems change and some fundamentals
- Signposting of where to go
- Pan-London approach and hub for information but implementation has to be local
- Recognise co-dependence of physical and medical
- Feedback
- Mesh medical/mental silos – medical clearance
- Peer-mentoring in A&E
- Various model in silos
- Ask service users when well what would work well
- Safe space open 24 hours that is not A&E
- Dual training/competencies/nurse rotations
- Training started in medical school for MH training
- Working together needs resourcing
- A model and guidance
- Crisis concordat plan – what happens to their work that could benefit other parts of the service
- Resourcing teams to work together
- Who does what? Vital links, communication of different roles
- Simple, single point of access, reliable, 24/7, sustainable
- Joint up thinking, planning and treatment
- Pathway inappropriate term for MH – matrix more suitable?

Appendix

What can be done across the system in London specifically to improve the experience of those in mental health crisis?

- Use QI – get job done
- Willingness to change – willingness to put the patient first
- Involving service users at all levels
- Keep testing out ideas until you find the one that works
- London led STP coordinated approach
- 111 – 1st point of care
- Triage MH nurse
- Building recognition of voluntary sector services and what can be done there
- Incorporate proper co-production by including patients and service users on the development cycle
- Find ways to get around IT systems not talking
- Look for simple solutions by talking to people on the frontline about where the blocks are (e.g. the voluntary form police share with ED staff on risk assessments and background)
- Feedback what is working so others can learn from the systems
- Champion what is working
- Send people to educate others about what systems are working or failing (Healthwatch?)
- More discussions about the importance of such systems in place (education)
- Co-production
- Training in MH for staff to avoid segregation
- Deciding about whether ED is the place
- What is the pan-London role? – who? – NHS E/I – London led STP approach
- 111 with triage by MH nurse
- Prevention service
- Working across boundaries
- Common risk assessment, risk management, care plans and reviews
- Community treatment is not prevention it is treatment that avoids crisis/or may do
- CCG links acute and MH trusts
- STP led ownership
- Common format and process – dynamic
- Boundary-less working
- STP coordinated approach
- Community based mental health services
- 111 coordinated response – triage with mental health nurse