Trust Innovation

Northumberland, Tyne and Wear NHS
NHS Foundation Trust

Delivering Together Newcastle & Gateshead

How do I Stay Well?
Workshop 4

Summary Report

16th – 20th October 2017

Introduction and Context

In June 2016, following public consultation, decisions were taken around services in Newcastle and Gateshead:

1. Creation of new inpatient facilities at Newcastle's St Nicholas' Hospital, and the opportunity to innovate a wider range of improved and new community services
2. Closure of Gateshead's standalone Tranwell Unit, as well as the Hadrian Clinic in Newcastle
3. Older People's services in Newcastle consolidated at St Nicholas' Hospital, closing wards based on the former Newcastle General Hospital site

The money released from these changes will be invested into new and enhanced services that will create a better way for people to be supported and cared for in their own communities, minimising the need for inpatient care because new innovative services will support people when needed.

Since then, further stakeholder workshops took place in February and July of this year, which have confirmed a widened scope – this now also includes:

- Older People's Mental Health services in Gateshead
- Third Sector Mental Health services, and the wider community and Voluntary Sector
- Social Care and other Local Authority services
- Interface with GP services
- Interface with employment and housing

This report captures the final of a series of four events, was held from 16th -20th October 2017, and focussed on 'How do I Stay Well?'. Professionals from a range of providers worked alongside Service Users and Carers in the final week.

The work builds on Workshop 1, 2 & 3's ideas of a telephone/electronic Single Point of Access and Walk-In Hubs, on how information is gathered and recorded, how assessment and service delivery by the relevant agencies and organisations is coordinated, and what those services will include. The skill set of those working in this multi-agency system was considered, as was training and ongoing support within the service, for staff, for Carers and for GPs and Practice Nurses.

The following pages aim to provide a summary of the fourth design event - the full discussion notes, ideas and products designed are presented in a separate Full Outputs Report.

Workshop 4 (16/10/2017) – The Royal Station Hotel, Newcastle

The final workshop was held at the Royal Station Hotel, Newcastle and was attended by 29 participants and stakeholders across the week from a range of organisations, both statutory and voluntary sectors, and Service User and Carer representatives, including:

- Newcastle City Council
- Mental Health Concern
- Mental Health Matters
- Gateshead Council
- Public Health Gateshead
- Gateshead Health NHS FT
- Northumberland Tyne & Wear NHS FT
- VOLSAG
- Member of the public
- Service Users/Carers
- Gateshead Mental Health User Voice

Welcome

Chris Piercy (CCG) opened the first day of the workshop in the absence of Ian Renwick (Chief Executive, Gateshead Health NHS Foundation Trust and sponsor of the programme). Chris also attended the report-out on Friday, giving thanks and closing remarks with regard to next steps and moving forward.

Workshops were held in July 2017 with stakeholders, who were asked to consider what 'good' services would look like and feel like:

- Involve Service Users and Carers - co-produced wellbeing plans, with empowerment and ownership, respect and excellent communication built in
- Planning towards goals and end points, management of expectations - promotion of meaningful lives, and working together across organisations to support this
- Peer Support for both Service Users and Carers
- Staff are respectful, approachable and honest
- Person-Centred, focussed on need
- Able to access support when needed, via new Access system
- Involvement of Carers/family/friends in planning

The participants in the second workshop were given a list of things they needed to work on during the week:

- Specifications for how Service Users and Carers will co-produce their wellbeing and recovery plans, and be empowered in owning those
- Specifications for how information sharing will take place, and how transfers of care will be facilitated
- Specification of how individuals will access support when needed
- Consideration of administrative and IT processes
- Ensuring consent and confidentiality are built into the system, and that communication between all parties is timely and effective
- Understanding of the skills and roles of staff undertaking the process
- Open to new ways of working, including technological solutions

Activities – Idea Generation:

The tables were asked to discuss various elements of existing ways of working, to think of the problems in the current system in delivering individual needs, and then discuss possible solutions. These were shared with the rest of the group, and ideas for the week generated.

Through discussion on current problems and ideas to solve them, the group noted the following:

- Problem: Housing, homelessness, vulnerabilities – advocacy availability needs to increase, Primary Care and Mental Health services to join up on this, encourage engagement, better access to GPs and specialists. Increase the number of safe places to go. More flexibiity on inreach to inpatient areas to give support. Improve management of complexity, and of safeguarding
- Problem: Substance misuse – difficulties to access services - no door should be wrong door
- Problem: Housebound, frailty, vulnerable , lonely, older people – increase outreach, making every contact count – train up Fire Services, Housing providers and others
- Problem: Capacity to meet demand in the Crisis Team - work more constructively with resources and use partner agency support more in preventative work, and in alternatives to admission
- Problem: Demand on non-clinical services - consider how resource is managed, alternative roles, support roles to release highly skilled staff time
- Problem: Access to services – develop a culture of working together, and providing quality in a timely manner, parity of esteem in CCG funding, staff trained to the right levels, promote independence and confidence in re-access, support Housing providers in getting help
- Problem(s) – communication and engagement with Carers – improve Carers assessments, respect and take Carers seriously, share information when possible, improve complaints process
- Problem: Information flow with GPs and how to get the right balance – better use of IT systems, sharing of 5P's and WRAP training/strategies
- Problem: Co-ordinated support for people with Dementia and ongoing needs is patchy – create a multi-provider support service, with access via a single point, and give support to Carers in their role
- Problem: Isolation – resource for VCS facilities and promotion of these, vocational work needs to be better and work with DWP to find safe and manageable ways to give meaningful employment, etc.

Activity – Principles of a good 'discharge' from services

The participants were then split into groups, and were tasked with considering the principles of what a good 'discharge' from a service or services would look like, from the perspectives of different stakeholders.

Service User perspective

- Being in control of the process- how, when, who and what support - CHOICE
- Involvement in planning/coproduction of discharge plan
- Basic needs will be met, having food and income in addition to a good discharge
- Support needs are met
- Carers, family, friends will be supported and will understand how they can re-access services if needed
- A good discharge should feel like a transition - it is a provocative word - change it, it is always a transition to something else including the GP
- Discharge with the tools/knowledge/skills to remain as well as I can
- I will have dignity and pride about who I am, I will not feel stigmatised or labelled

Carer perspective

- Clear, agreed outcomes by MDT, GP and Carers assessed and documented
- A combined discharge between inpatient and community services would be over a phased period of time, identified at discharge planning meeting, with key workers identified and enough medication
- Reassurance that crisis services/teams are available 24/7 - no discharging on a Friday or weekend if reliant on weekday services
- Carers assessment and services in place for Carers
- Services to be proactive instead of reactive
- Information on access to services and on rehab/care/respite
- New Carers to have training around medication, moving and handling, etc. as applicable

Statutory Organisation perspectives

- Discharge planning needs to be considered from the outset, robust and includes risk and expectations
- Agreed communication and collaboration with Service User and Carers
- "Watching waiting"- we must work hard on getting routes back in smooth and quick first.

GP perspective

- Knowing who is involved in care - contingency plan and re-access plan
- Single side of A4 information - medicines and therapies - what did and didn't work; risk assessment and plan; physical health - what's done, what's to do; Carer's details; advanced care plan/changes
- Shared medicines agreement

Secondary Care Physical Health perspective

- Co-working with Mental Health in complex Physical Healthcare, e.g. diabetes, COPD A&E, etc.
- Feedback loops to GP, including risk and balances of medication – link up prescribing systems/processes

VCS and other non-statutory services perspective

- Need good understanding of what risk means on a practical and detailed level – quality of information passed to the services receiving the individual – candid/appropriate information about risk and vulnerability, openness with the Service User about this
- Quick/ responsive access back into services if needed- quick access to knowledge/expertise (called 'scaffolding')
- Services that are being referred to are matched to the needs of the person and statutory services know what is out there – ability for services to see active referrals, discharge options and all acknowledge their role with communication with other services
- Discharge can be led by the Service User (opt out) - it shouldn't be absolute, can vary in intensity

What do Service Users need to help them to stay well?

The group was asked to split into 5 tables and consider what Service Users and Carers need to help them to stay well and live meaningful lives, and what different organisations can offer them and each other to support this:

What do Service Users need to help them to stay well and live meaningful lives...

from statutory organisations?

- Courage
- Strengths-based assessment and support approach, social prescribing, adapting pathways to meet needs
- Availability of services when needed, consistency of messages across all – shared vision
- Triangle of Care approach
- Support to reduce medications
- Community Treatment Orders used sensibly and effectively
-

from the voluntary sector?

- Employment skills
- Effective social prescription

from a GP?

- An appointment!
- Continuity of care
- To be supported
- Consistency of approach to use personal budgets
- Creativity and confidence
- Encourage supported risk taking

What will service users do themselves to stay well and live meaningful lives?

- Getting involved in services/activities
- Training
- Challenging stigma
- Evaluation
- Peer support
- It's down to the individual
- Focus on positives /strengths
- 5 ways to wellbeing

What do Carers need to help them stay well and live meaningful lives?

- If person being cared for is well supported, Carers often feel they need less support
- Feel truly involved and listened to
- Availability of respite and crisis support
- Peer support
- Training and education on conditions and services
- Easier access to support for themselves
- Financial advice and travel expenses

How will statutory and other organisations enable Carers to stay well and live meaningful lives?

- WRAP- acknowledging Carers are integral
- Compliant with Triangle of Care across services not just NTW
- Respite - access to urgent and planed according to need
- Crisis support
- Clear information and explanations of eligibility availabilities of services including peer support group
- Training and education in conditions, services (and how to access)
- Telephone advice and information for between visits
- Easier access to health providers for carers
- Financial help for carers on low income and assistance if required
- Staff - improved attitudes towards Carers and their value as experts by experience
- More efficient complaints procedures and service provides adhere to their duty

How will GPs enable Carers to stay well and live meaningful lives?

- Longer Term Conditions - depression screening – wellness recovery planning
- Directing
- Prescribing
- Single Point of Access
- Part of discharge WRAP plan
- Clarity of IAPT for older people
- Proactive physical health, exercise, diet advice

How will the VCS enable Service User and Carers to stay well and live meaningful lives?

- Raising awareness – profile of VS and varying guides
- Transforming workforce- upskilling/parity
- Building social capital connectedness
- Speaking to each other
- Tailoring our provision based on need rather than statutory responsibilities
- Location/ accessibility in communities and of the community
- Being able to challenge and address stigma further
- Providing value for money- passion leading to enhanced workforce
- Agent for system change and innovation - more flexible/ adaptable potential

What can GP's do to help other Organisations in delivering this?

- Best practice to be made universal
- Clarity over who does what
- Difficulty in standardisation of what GP's offer
- Secondary care wish to refer back to GPs/GPs may feel over loaded
- IT management within NICE, request maybe reasonable
- Build follow up into what CCG will fund e.g. anti-psychotic prescribing
- Engage with GP educational initiatives/Timeout-NTW
- Include Mental Health component in appraisal
- Promotional material in GP surgery's and online and TV
- House outreach services – Clinics - VCS
- Engagement forum
- Co-working with secondary care psychiatrists
- Quality referrals
- Social care – safeguarding

What can organisations offer each other?

- Scale – larger, helping the smaller (back office) e.g. infrastructure, business development
- Awareness of potential to compete for same tenders
- The big picture – shared vision
- Sharing of expertise, networks, resources, buildings, skills, learning
- Raising profile of other VCS organisations
- Core agreements for links for statutory services
- Being a critical friend to each other
- Explore options to have quality standards /accreditation for VCS

Healthwatch feedback

Healthwatch Newcastle and Gateshead ran fringe events throughout the workshops. Questions were sent to Steph Edusei (Chief Executive, Healthwatch Newcastle) which were posed to the event participants as well as the online community. Steph then attended the workshop twice, and provided feedback, which was built into the work of the group.

NTW Feedback

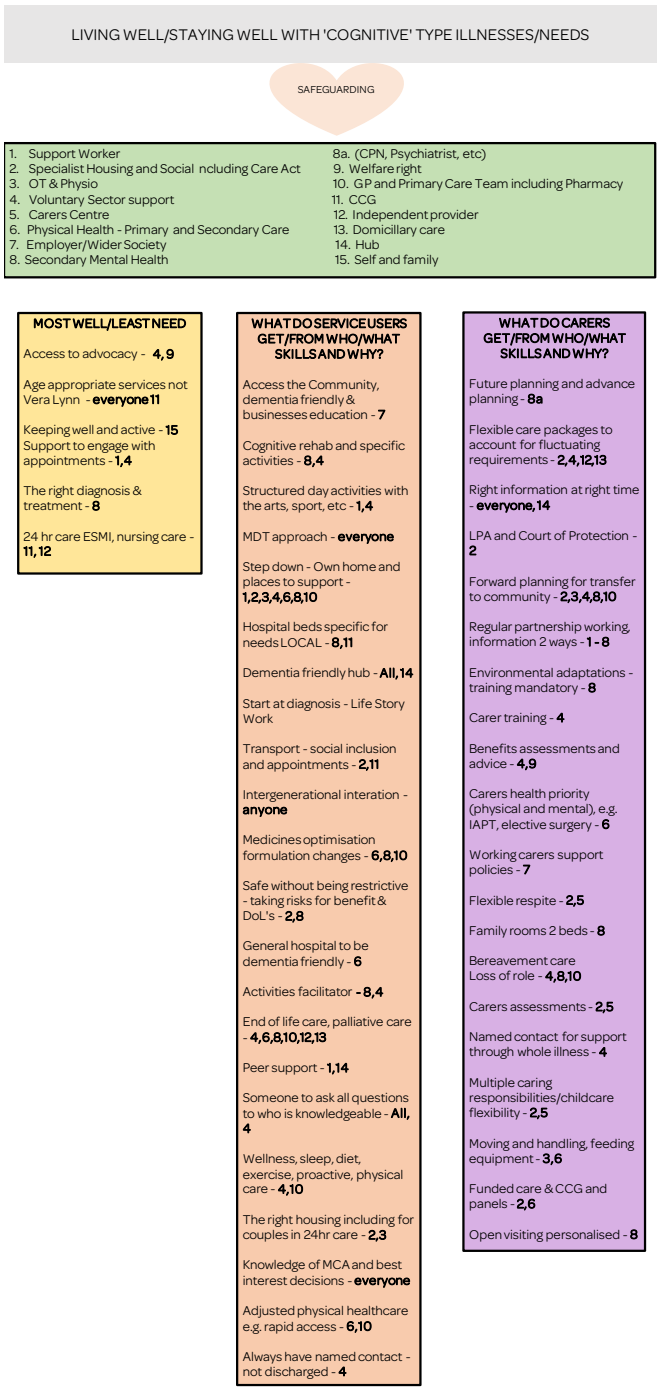
NTW also asked the same questions of its staff that were posed at the fringe events held by Healthwatch. These questions were posed to staff teams within Gateshead and Newcastle. Tony Quinn (Directorate Manager) provided feedback, which was built into the work of the group.

Staying Well Pathways - what can be offered and what skills are required?

The group was split, with one group looking at the Psychosis pathway, one looking at the Non-Psychosis pathway, and one looking at the Cognitive and Functional Frailty pathways.

Within each group, the participants were asked what could be offered to Service Users and Carers to help them to stay well – this was on a continuum from being 'most well/having least need' to being 'most unwell/having greatest needs', and what skills would be required to deliver that.

Living Well with Cognitive-type Illnesses/Needs



Living Well with Functional Illnesses and added Frailties

LIVING WELL/STAYING WELL WITH FUNCTIONAL ILLNESS & FRAILTY/ASSOCIATED NEEDS

ALL
SAFEGUARDING

1. Support Worker
2. Specialist housing, social work including Care Act
3. OT and physio
4. Voluntary Sector
5. Carers Centre
6. Physical Health Primary and Secondary care
7. Employer/Wider society
8. Secondary mental health - CPN, psychiatrist, etc
9. Welfare rights
10. GP and Primary Care team including pharmacy
11. CCG
12. Independent provider
13. Domicillary care
14. Hub/navigator
15. Self and family

Primary Care Based Navigation

Community Treatment

Crisis

Hospital

MOST WELL/LEAST NEED

Looking after yourself - diet and selfcare - **1,4,10**

Support for engagement with appointments - **14**

Housing Suitability - **2**

MDT approach - **all**

Named clinician involved throughout - **8**

Mental Health Liaison Teams in general hospitals - **6,8,11**

WHAT DO SERVICE USERS GET/FROM WHO/WHAT SKILLS AND WHY?

Wellness - balance and mindfulness exercise - **1,4,14**

Advance plan and relapse plan - **8**

Access to evidence based treatment/improved IAPT access - **8**

Rehab to independence and maintaining - **3,4,8,10**

Access to home based treatment - **8**

Environmental adaptations - **8**

Social engagement/tackling loneliness - **1,4,7,14**

Optimisation of long term conditions & co-working - **6,8,10**

Location of care considered, e.g. home visit - **4,6,8,10**

Outreach from ward and partial hospitalisation - **8**

Easing transitions by getting to know people early - **4,8**

Accessibility, transport and appeal of hubs & adaptations - **15**

Keeping well and active - **15**

Joint working in physical healthcare - **6,8,10**

Medicines optimisation & administration & review - **6,8,10**

Readiness for retirement education - **4,7**

Preparation for and managing life stages - **7,15**

Information in understanding format - **1,4,5,8**

Access to advocacy - **4,9**

Access to the right Crisis Teams - 24/7 SPOA & Hub - **8,14**

Knowledge of MCA & best interest decisions - **All**

WHAT DO CARERS GET/FROM WHO/WHAT SKILLS AND WHY?

Carers assessment - **2,5**

Carer training and education - **1,4,5,8**

Carer health optimisation and long term conditions - **10**

Opportunity to speak separately - **8**

Moving and handling training - **3,6,10**

Carers family rooms and open visiting - **6**

Living Well with Psychosis-type Illnesses/Needs:

Most well/least need	What do Service Users get - from who - what skills and why?	What do Carers get - from who - what skills and why?
Access to MH Solicitor Advocacy	Voluntary engagment with community rescources - informal	Carer peer support - Carers or voluntary sector
Determine root cause of psychosis ie trauma, drug or alchohol abuse, severe stress	General community resources (not Mental Health specific) Family therapy - Psychologist, CPN-trainers	Young carers (Banados) - voluntary sector and carers
Befriending Dance therapy **Voluntary Sector support**	Appreciation and skills of older person's age "blip"at the age of 50 -60	Carer advanced statment - CPN, social services, GP, Psychitrist
Medication review **GP - psychiatrist**	Refer to my WRAP with support from peers	Carer assessment & reassessment - Social services
Recoco **Peers - practitioners support**	Hearing voices group/other support groups	Carer Advocacy - Voluntary Sector
Voluntary work Paid work Education	Access care packages to maintain Mental Health	Carer advice on advanced statement - NTW, social services, Voluntary Sector
Trauma informed approach	Trusted Assessors linked with GPs	Carers to be heard and respected - Voluntary and NTW
Alternative Therapies **Nutrition- Dietician - advice - CPN-Peers** **Dance Therapy - studios, groups, peers, OT** **Psychological - CBT, DBT, CAT- MOI, Talking therapists, nurses and OTs**	Access to GP	Respite for carer or service user - Voluntary Sector, social services
Community Resilience Social Prescribing Service - GP - NTW - transition Orthomolecula Psychiatry Nutrition, exercise and activites at all levels of care Mindfulness Self Analysis Education on brain fucntion-Hormones, fight or flight,trigger, adrenaline etc Breathing exercises	Telephone helpines - all types, services and people	Power of Atourney - Carer, social, CAB, voluntary and Social services
	Talking help and counselling for everyone	Carer - education & advice in Psychosis - Voluntary sector and NTW
	Regular monitoring support from CPN	Carers - talking therapies - NTW - GP-voluntary and social services
	supported learning (flexible)	
	Detox clinic , Antipsychotic withdrawals - CPN, Psychiartrist	
Physical Health more Thorough, Blood tests - kidney, liver toxisity	Improvment - refer to advanced directive, Open dialogue- new better ways of working	
	Sympathetic access to emergency services / police	
Primary care link worker to support Service User to appointments	Access to MHA assessment crisis support hospital crisis beds rather than hospital beds	
	Someone to look after pets /children / house while I am unwell	

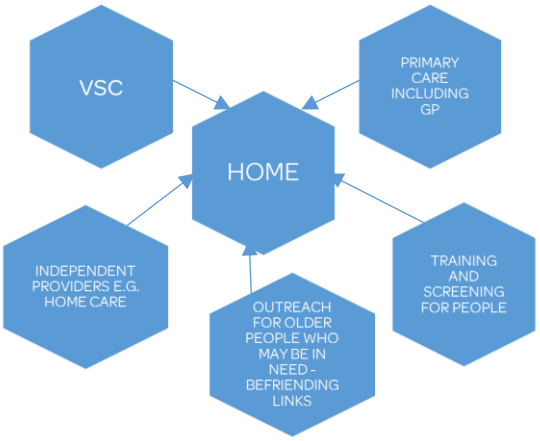
Living well, staying well with "Non-Psychosis" type Illness/Needs:

Most well least need	What do service users get/from who/what skills and why?	What do carers users get/from who/what skills and why?
Men in sheds	Self-care- family friends, exercise	Care- GP telephone or surgery consult, hub, self-help NTW- VCS MH training
Management of VCS resources in creative/leisure/educational	Service user- early symptoms GP- IAPT Navigator	Patient information leaflets and advice and education
Peer support can help people stay well	Vol Sector	Vol Sector
Cultural support understanding language	Service user- symptoms accelerated- attached CPN- Psychiatrist call line, hub	Carer early symptoms – advocacy carer care
Determine root cause at soonest point possible. Such as cause of depression, substance abuse, debt etc. To nip things in the bus to help prevent exculpation and reduce cost	Educational training based models need to be available- be delivered by peers Alternatives to hospital	First responder hub
OOH 111 > hub	Mind the "GAP" People	CPN role of secondary needs
First responder Hub	CPN- complex needs	Primary care and VCS carer needs
Where do we put personality disorders in this?	Suicidal CAT Psychiatrists (Primary Care)	End of tether, no space no time, go on holiday keep busy
Vol sector providing specialist services	Specialist psychologists	Physical health GP- VCS
Together in a crisis, people in crisis but non clinical	In patients services	MHA Amps
		Carer suicidal CAT hub Helpline
Least well most need		Peer Support

Innovations and Step Down Processes

The groups were then asked to look back on the previous task and pick out the innovations from their discussions and develop a step down process.

Cognitive and Functional Frailty Stepping Up/Down Discharge Process



HOME BASED TREATMENT
MULTI-DISCIPLINARY FRAILTY CRISIS TEAM
Mental health and physical health 24/7
Equal parity
MDT supported
Step up & Step Down
Integrated with domicillary care 24/7
AHP's - OT, Physio, medicines optimisation
Funding sustained by decrease in length of stay and better outcomes in acute (physical) bed-based care

STEP UP

STEP DOWN

SOCIAL CARE

Flexible respite and care packages reflecting fluctuation

Flexible 24 hr care to enable couples to stay together

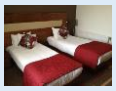
HOSPITAL:

Mental Health - Organic beds - Functional beds

&

Physical Health

Mental Health Liaison Teams
Joined up working in mental health and physical health for mixed conditions

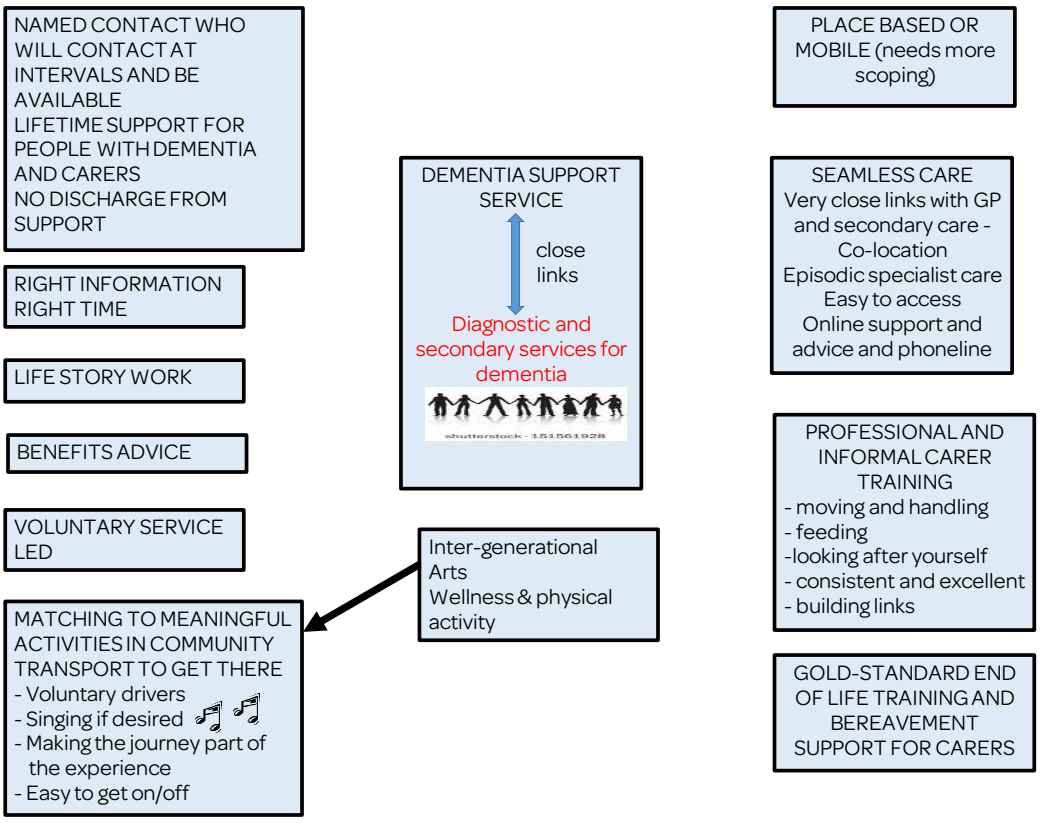
Family rooms  Open visiting

ACCESS TO STANDARD CRISIS TEAM IF NEEDS FIT

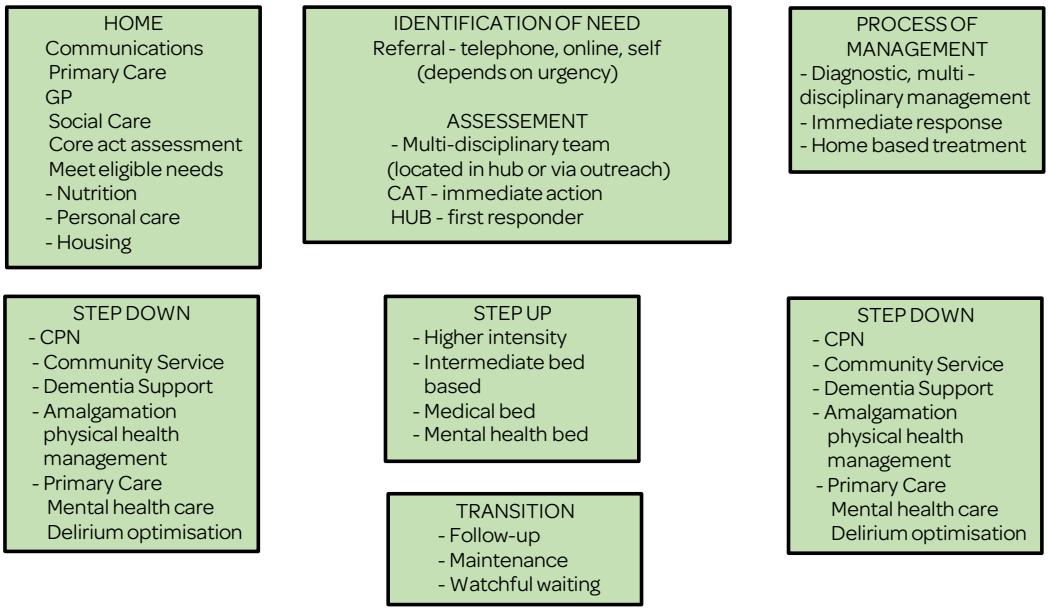
OUTREACH NURSE TO DOVETAIL TO COMMUNITY

PARTIAL HOSPITAL FOR FUNCTIONAL PATIENTS

Cognitive and Functional Frailty Innovations

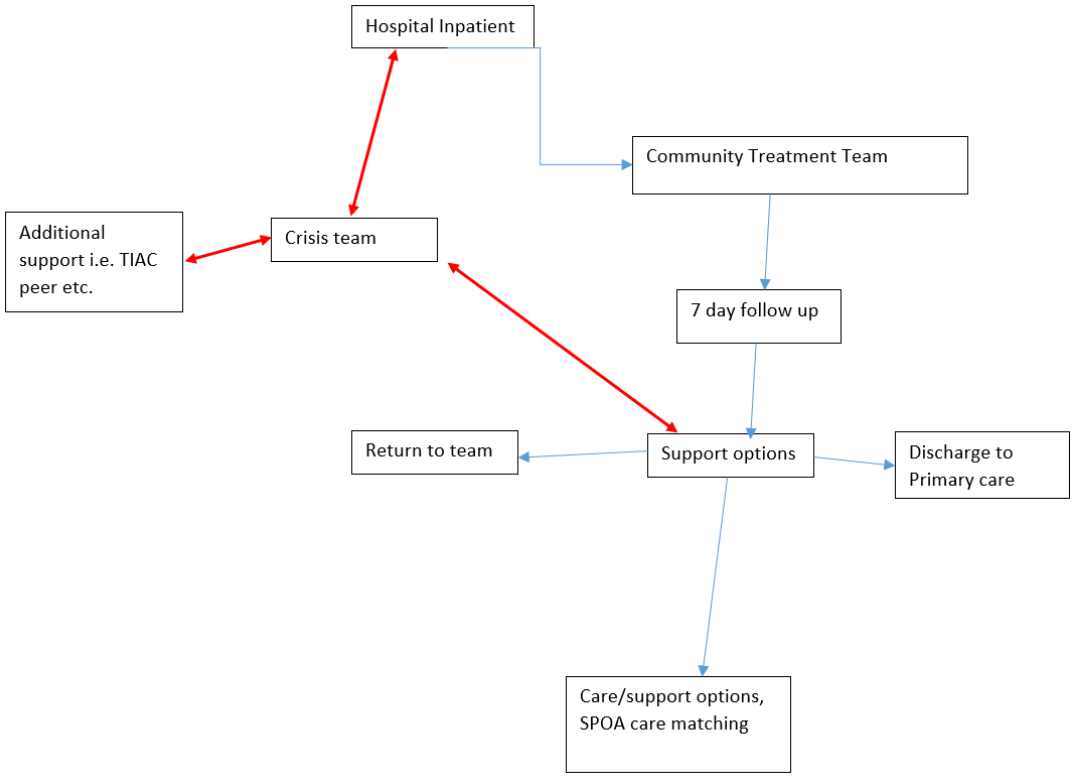


Proposal for Process Required to Stay Well in Dementia/Frailty



- Transition between support services is important - Dementia is ongoing, life-limiting – must have an easy route back into services if needed – circles of support and advice are important
- The system has a collective responsibility, but the person has ownership

Psychosis Innovations and Step down Process



Innovation in Psychosis in teams

- We must ensure that in these transitions we have sufficient clinical expertise to meet the needs of people with psychosis
- We must also ensure enough capacity for older people, and for people misusing substances with psychosis

Areas where more work is needed:

1) To map pathway of need/support for people with psychosis in crisis/pre-crisis to ensure that need-support is properly balanced
2) Build opportunities for apprenticeships and peer support for people with lived experience of *psychosis* to become peer workers
3) Target multiple/complex needs at CMHT level
4) Commission –
    - Peer led crisis nurse
    - Reconfigure commissioned bed based resources to clinically supported crisis housing
    - Common more social supported houses
    - These recourses can be base as both step up and step down
    - Consider what we need in community before we close any beds

5. Open Dialogue approach-
    - make contact with experts to find out what this has been in practice
    - build in principle of equality in MDT/person centred – 1st line of defence is dialogue and problem solving
    - review evidence base
    - include family therapy
6. Talking therapies for people with psychosis including family, trauma therapy and CBT for psychosis and someone to just talk to
    - Invest in pre-therapy preparation work- staff training programme- build into clinical/service pathways
    - More CBT for psychosis capacity- enough for a 0 waiting list → AQP type approach
    - Invest in more peer support
7. Structured programmes for people to reduce/stop anti-psychosis meds (where appropriate)
    - Training package for all anti-psychosis prescribers- co produced with Service Users embedded least dose/no dose principle
    - CQUIN target on dose reductions
    - Engage with mind
    - Commission research project on link meds/lifestyle/experience of psychosis link to NTW R&D department
8. Alternatives to hospital admission
    - Freedom card for all gyms in NCL/ GHEAD
    - Dietician/nutrition review
        - ➢ On 1st prescription
        - ➢ On transition
        - ➢ Reviews in community
        - ➢ Invest in social prescribing, link work, group work
9. Trauma informed practice to be embedded into all practice areas/services
    1. Commissioned a T&D programme (including VCS)
    2. Build into service specs
    3. Embed PIEs into all teams as part of supervision structures
10. Ensure 5 ways to wellbeing is incorporated in heathy Child Pathway

11. Employment for people recovering
    - Commission Individual Placement Support (with good fidelity to model)
    - Extend retention to look at work retention too

Non-Psychosis Innovations and Step down Process

Innovations

- Understand what the needs are at point of discharge
    - This needs to be a clear plan to direct future services
    - Bio-psycho-social holistic planning

- Engagement with the other parts of the system (last 3 workshops)
    - Single Point of Access
    - Navigator role
    - Not just 'dropping people off' – working shoulder to shoulder

- "No discharge" principle
    - For some part of the system "discharge" is more appropriate but for other parts this is not the case – consider 'transitions'
    - Potential for bias – some people "want out"

It was agreed that the work which had been completed by the Psychosis group could also be applied to the Non-Psychosis group and they decided to work together moving forward.

Discharge / Moving On Plans

To facilitate staying well, the new system will encourage a person to consider, share and record what works, so, what being well currently looks like and which tools, techniques, activities and supporters are part of that.

A person will also be encouraged to share and record what happens when wellbeing breaks down and have advanced directive plans in place most obviously for crisis and also for times when appointments have been missed. In a DNA example, a person will have agreed how to be communicated with and the system will respect and value this and work together to facilitate this, seeking additional information when appropriate, including what can be done differently to aid attendance and reduce future lost time.

The system must buy in and share the ownership of that plan, WRAP or otherwise.

HOLISTIC "FORMULATION"

CONCISE EASY READ PLAN

BESPOKE SET OF SUPPORTS

Clinical / Medical	Housing / Home	Employment	Education & Training	Activities
Physical Health	Step Down Support	Job Centre	Further Education	Arts
Mental Health	Supported Housing	IPS	University	Gardening
			Vocational	Walking
				Cycling

Non-Psychosis and Psychosis Moving On Pathway

Physical Health

- Check
- Better Choices
- Public Health

Core Skills

- In communication
- John Lewis and Marks & Spencer's Customer Care Skills

Case Studies

- Sharing of good practice

Discharge Liaison Facilitator

- Step Down from community teams

Apprenticeships

- Experts by experience
- Mentors
- Trained to be a Peer Support Worker

Workforce training shared within the system

- Trauma informed care
- Structured Clinical Management
- DBT, other relevant therapies

Bespoke Supported Housing Solutions

- Requires a standard for level of complexity of need/risk/degree of challenge

Navigator Role

- Care Coordination
- To navigate pathway
- Knowledge of system
- Knowledge of person
- Selection of people to do this role, based on 'goodness of fit' of person's need
- Moving away from roles and professionals

Housing

- Clinically (flexible) supported housing
- Accessible throughout the pathway

Hub

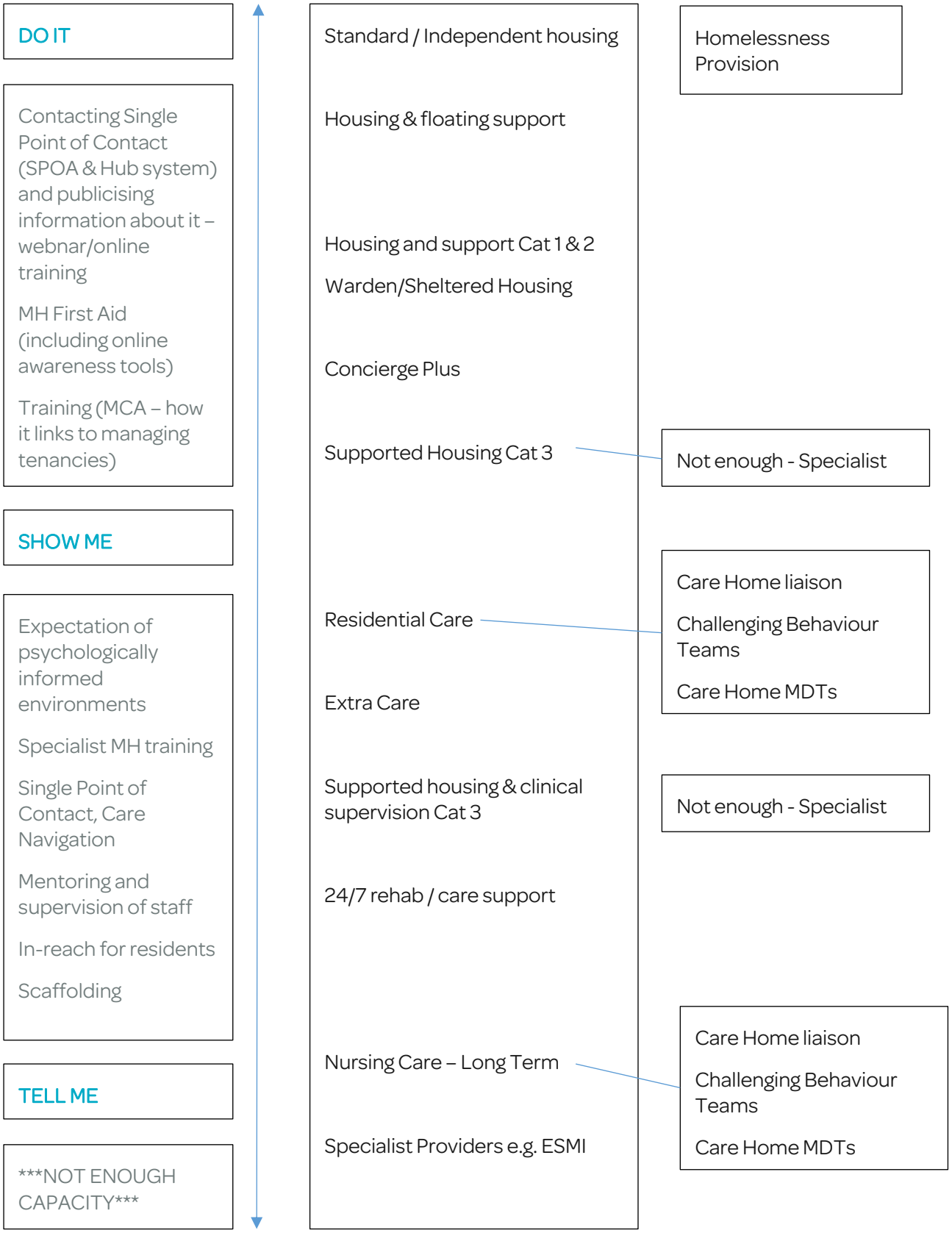
- Accessible
- Navigator to offer awareness of facility

Supporting others organisations to help Service Users and Carers to stay well - Housing Services

The group was tasked with looking at new and innovative ways that Housing providers could be supported by the new system - they felt that training of staff was key.

- The range should include Private/Council/Agencies/tradespeople to supported mental health housing and residential care homes
- Variety of training options/delivery options – the system does it for them, shows them, scaffolds them to do it themselves (specialists)
- Modular training online to be developed to suit the different levels of staff and their involvement/need for knowledge, to include Mental Health First Aid, Dementia Awareness, Safeguarding awareness, Capacity awareness, Benefits awareness – involve organisations such as Shelter
- Accreditation process would encourage participation

Support Needed



Did Not Attend (DNAs) and Disengagement

Taking into account the feedback from Healthwatch, the groups discussed Service Users who disengage from services or do not attend their appointments and what services should do in these cases.

- Remember it can be the Service User or the service that DNA's – services should respect this and keep Service Users informed
- If a Service User does not attend:
    - Be clear about Carer involvement/support and risk, etc. – informs the response
    - Have a good conversation first – provide information on what to expect and prompts in advance of appointments – do these go to the Carer too?
    - Accessibility flags – time of day, environment, interpreter (language and gender – the right interpreter with a good understanding of Mental Health)
    - Ask how the person wants to be communicated with (phone, text, letter)
    - If concerned about risk, may allow breaking of consent – 'door stepping' if needed
    - At least 2 attempts – phone calls made
    - Good communication with referrer
    - Navigator role – may be best in supporting engagement, particularly if lived experience (will liaise with others to agree how to proceed – flagging risk)
    - Culture of engagement and encouragement across organisations
    - See people quickly – don't leave them waiting as this promotes DNAs

After 2nd DNA:

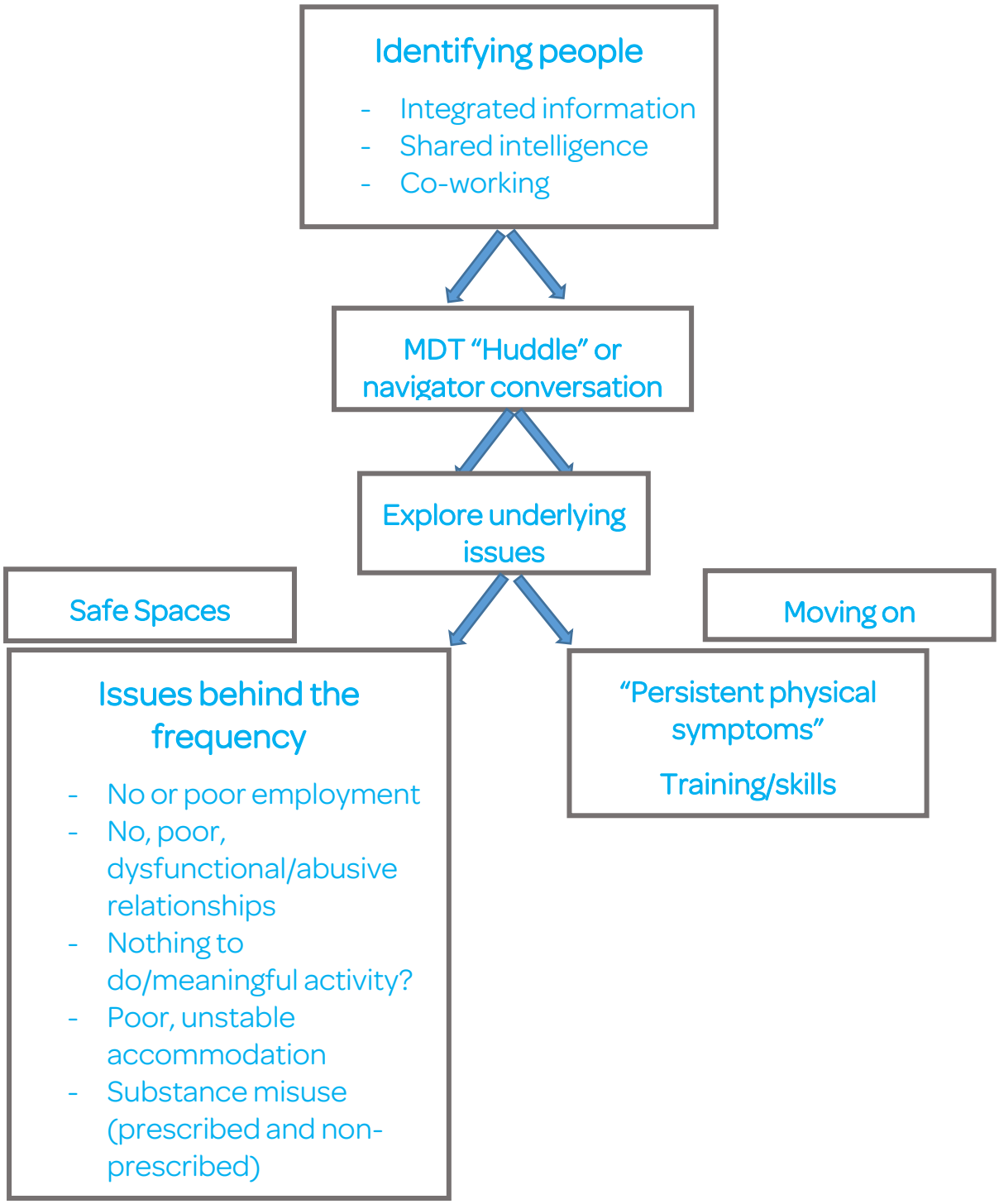
- If they don't attend a second time, contact should be made with others involved, including the referrer if applicable - Do they attend anywhere else on a regular basis where more info can be gained? What are the risks and needs? Can someone else get consent for a home visit?
- Culture should be one of engagement and sharing of information in a supportive way

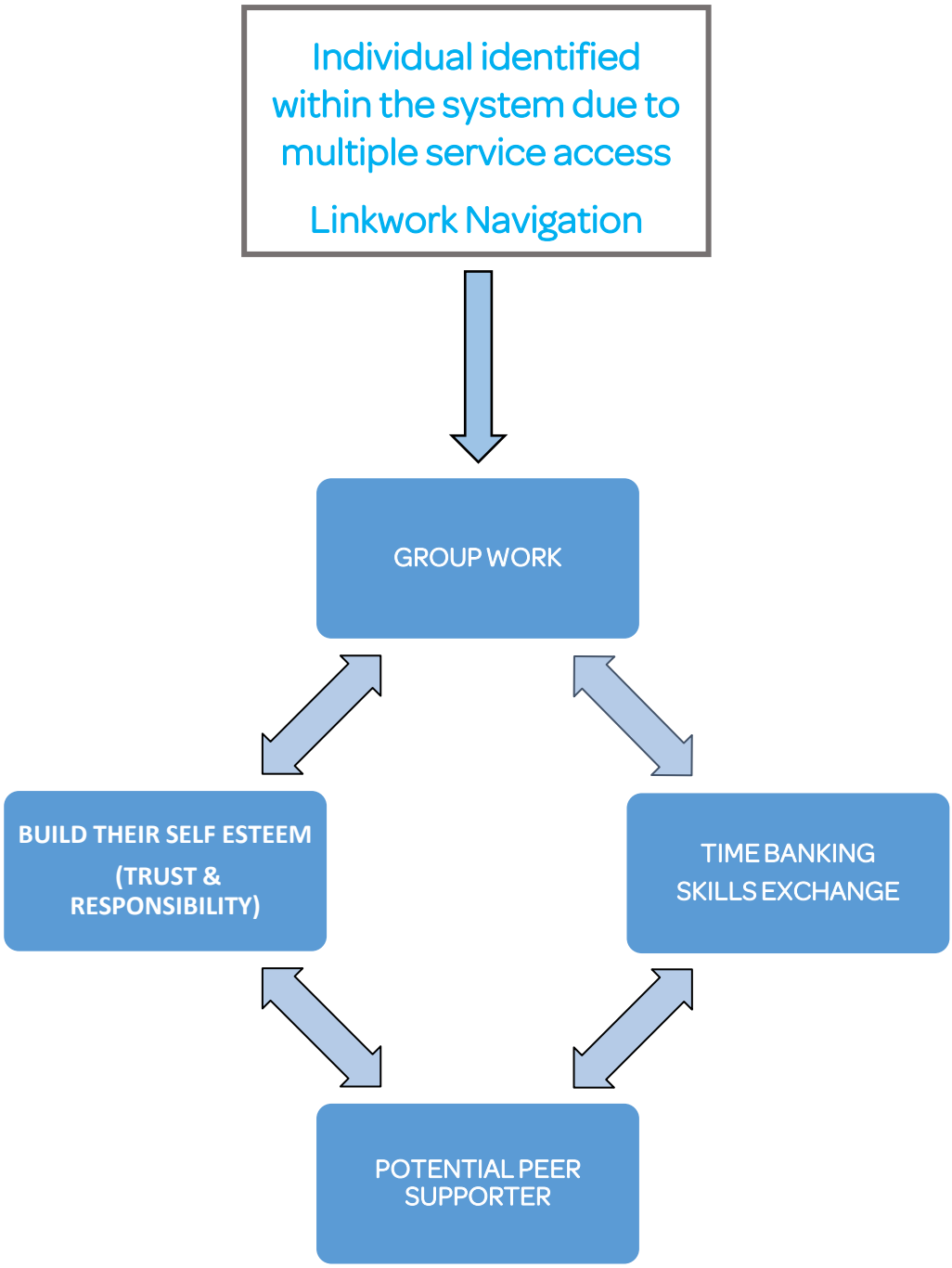
Disputes between parties

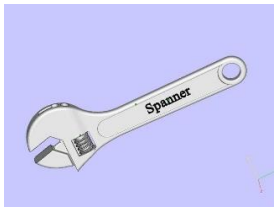
Taking into account the feedback from Healthwatch, the groups discussed instances where there are disputes between professionals, or with the Service User, or Carer, around the subject of 'discharge'.

- Culture
  - Equality of services and respect for Service Users and Carers - needs leadership
  - Open dialogue – communication is key
  - Can-do attitude - invest time
- Pre-emptive multi-agency approach, and a wider support network in the future
- Tools/framework to be holistic/view of risk/to be reviewed
- Talking it out - shared decisions - somewhere to take disputes to mediation to include rights under Tribunal for Service User and Carer, support with that and for second opinions
- Tools/frameworks are not unified, use best fit to scenario
- Needs confidence in new access and easy ways in and less anxiety around "discharge" (put on the table what people are worried about)

Individuals who frequently access a range of services, or are discharged and quickly return through the "Revolving Door" were also discussed:







Needs an I.T. Spanner to join systems!

For frequently returning Non-Psychosis Patients, the following ideas were considered:

- Reduce isolation, for example Community Support Groups – local people to run as they know the area and what's lacking, consider 'skills exchange' and peer support
- Availability of 'safe' places to be will increase
- Persistent physical symptoms (currently costing NHS £14 billion a year) - need more training for GPs and a pathway to follow
- Those with EUPD and chaotic presentation need skilled support
- Multi-agency review meetings to be triggered by 3 or more presentations to different services with the same issue - to resolve issues, look at underlying cause rather than 'sticking plaster' approach
- Use consistent language and don't use jargon

The Carer Pathway

Questions were posed around 'How will the Triangle of Care be delivered across all organisations in collaboration?', 'What do Carers get when the cared for person is discharged?', and 'What resources can Carers access to stay well and build resilience?'

Carer Support and the Triangle of Care

- Triangle of care adopted by the whole system
- Recognise different levels but principles universally adopted
- Significant training about issues, e.g. First Responder/EIP
- Agreements to share carers needs assessments appropriately, e.g. with GP practice
- Carers support using LTC principles of care. Also means access to carer specific and other services from across the system

Resources

- Newcastle Carers
- Gateshead Carers
- Carers Trust T&W
- GP Practices
- Advocacy
- Nationals – Carers UK / Carers Trust

Noted that this needs a workstream with more Carers and Carer organisations to add depth of understanding.

We recognised that people who have a caring role have often felt not listened to and, at times, like they are 'banging their head against a brick wall'.

The Triangle of Care is a serious and practical commitment to make sure that the person in need of Mental Health support, their Carer, whether they are young or older, and the professionals work together and listen to each other.

This needs to be adopted by every agency represented in the locality and monitored to make sure we all stick to our word!

Acknowledged not delivered well everywhere in NTW – needs a peer-led baseline position

Principles should be adhered to across the system

Sharing of 'Getting to Know You' type conversations across the system including with GP's – don't repeat the story

Training should be mandatory – part of the job – training should be co-delivered with carers

Long term conditions including dementia specific support – importance of Primary Care principles and escalation of needs of Carers - 

during intensive support period

Access to Carer specific support to be built in - encompasses Carers having own plan, etc.

Links with the Department of Work and Pensions (DWP)/Local Authority Benefits staff

The group were asked how can this new system/way of working support DWP staff and Local Authority benefits staff to improve the approach taken with Service Users and Carers?

- Knowledge of hub and advice will be made available
- Good information capture and sharing will take place
- Benefits expertise sources will be drawn upon
- Mental Health First Aid training provided
- Co-location options can be considered
- Senior leadership links should be forged, identify key people/contacts

Specifically for Job Centre Plus – front facing/DWP and their agents:

- Knowledge of the hub and access to it will be made available
- Awareness raising of working with people with Mental Health
- Crossing over – JCP based in Hub/Mental Health worker in JCP
- Senior leadership buy-in from DWP needed
- Ability to find your 'go to' people – for example when completing reports
- Information sharing about those who are known to mental health services/groups that need help from JCP
- Awareness of who can help people fill out forms – support

Specifically for Local Authority benefits staff including VCS groups, Service User and Carer Groups/CAB – anyone giving advice on benefits:

- A seat at the table – part of the pathway – integrated into the system itself
- On the directory
- All of the items above for JCP

The Hub

- Recording of a person's status re: benefits and employment on the personal profile when they contact the Single Point of Access
- Updated knowledge of how DWP/benefits/employment support works

Training, Employment and Meaningful Activity

- We acknowledge that they are key to good health, wellbeing and recovery - we now have a real window of opportunity to build this into the commissioning process.

Community Groups and their role in helping people to Stay Well

The group was asked to think about community groups/clubs and activities not immediately/explicitly linked to Mental Health. How will the new system support them/create a network/make these clubs/groups feel 'safe' places to go?

- Awareness of the new Hub – part of public campaign
- Become part of VCS infrastructure e.g. network meetings such as VOLSAG
- Service User/Carer recommended activities/clubs/groups (Trip Advisor model) Sharing peer reviews/intelligence on services (quality checkers, e.g. skills for people)
- Part of information available now – Newcastle or Gateshead (directory)
- Link navigator role/professionals (issues/tensions re: safety/responsibility if something is recommended and how services would be 'checked' if you were referring someone to them)
- Connecting Service Users/Carers with shared interests – join clubs/activities/start their own - light touch – personal choice
- Publicity of new system/service
- Awareness of raising (MHFA, etc.)
- Start-up of new groups – supporting this
- "Canny City" projects

Staff Wellbeing

The group was asked to consider how "professionals" should be supported to stay well themselves, noting that happy, healthy staff give better support to others.

- Lead by example - recognising that even "Mental Health professionals" can have Mental Health problems, and can be Carers of others
- Access to supervision, reflective practice, coaching, counselling, peer contact
- Staff/team WRAP and MBTI - opportunities to understand self/team better
- Register with a GP – resist the urge to self-medicate
- Workplace culture, e.g. having a lunch break is important, consideration of shift patterns – managers to support and monitor work/life balance, and give opportunities to work flexibly – encourage genuine team building activities (not always business meetings)
- Access to health and wellbeing knowledge and benefits – healthy eating , exercise, 5 ways to wellbeing
- Awareness of impact of their role on their wellbeing e.g. exposure to trauma, threat, stress, caring role
- Ability to get help outside of your working area to preserve confidentiality
- Promotion of the workplace pledge and use of the buddy system
- Advocacy on their behalf with HR and Line manager if needed
- Provide dedicated support for those professions with high suicide rate such as medical staff, and for senior staff in organisations as well as juniors
- No blame, learning from mistakes
- Time to pledge = plans in place

What do we think should happen next in this programme?

The group was asked to consider what should happen next in this programme of work and think about:

- What needs CCG leadership?
- What can organisations start working on?
- What can we as individuals do now?

In answering this question, most of the items identified can begin now, and the group were keen to share the good work that has started and to continue it.

- Audits of own capacity to take part, including training needs analysis
- Introducing idea of parity of esteem, changing cultures
- Talking to more people to find out more points of view
- Start to compile the Directory of Services
- Prep work – selling points – communication with staff
- Manage people's expectations – get message out
- Feeling and expressing confident that this will change and move forward
- Partnership working, emphasising trusted assessors, etc.
- Ask for clarity and transparency – continue to respond – not to be dominated going forward – equal table – power base for task force moving forward
- Stay with the process and be informed throughout ongoing challenging response
- Be fed back to as a group to ensure system response not individual organisations
- Timeframe and actions to be agreed
- Pilot easy access in and out in one community service
- Communication patterns between Primary and Secondary care could be reviewed
- 'Getting to Know You' to be delivered fully including physical health to be shared with GP
- Triangle of Care – implementing this in all areas of the service/system
- Spreading the Word – going back and sharing what we have done – keep pushing – keep asking - involvement and ownership
- Taking positive risks to move forward
- Communications to start sharing good work that people do

Detailed Pathway – this was added to in the week, and will continue to be built upon as more in depth work takes place in service planning