Evolving Communities | healthwatch Gloucestershire

Experiences of urgent mental health care in accident & emergency:

A Gloucestershire perspective

Local health and social care shaped by you

[Updated Nov 2020]

Contents

Abbreviations:

ED	Emergency department
GHC	Gloucestershire Health and Care NHS Foundation Trust
GHFT	Gloucestershire Hospitals NHS Foundation Trust
MHLT	Mental Health Liaison Team

References

NICE (2016), ***Achieving better access to 24/7 urgent and emergency mental health care – Part 2: Implementing the evidence-based treatment pathway for urgent and emergency liaison mental health services for adults and older adults – Guidance.*** NHS England.

Healthcare Safety Investigation Branch (2018), ***Investigation into the provision of mental health care to patients presenting at the emergency department.*** HSIB.

Introduction

Healthwatch Gloucestershire is the county's independent health and social care champion. It exists to ensure that people are at the heart of care. A dedicated team of staff and volunteers listen to what people like about local health services, and what could be improved. These views are then shared with the decision-making organisations, so together a real difference can be made. This report is an example of how views are shared.

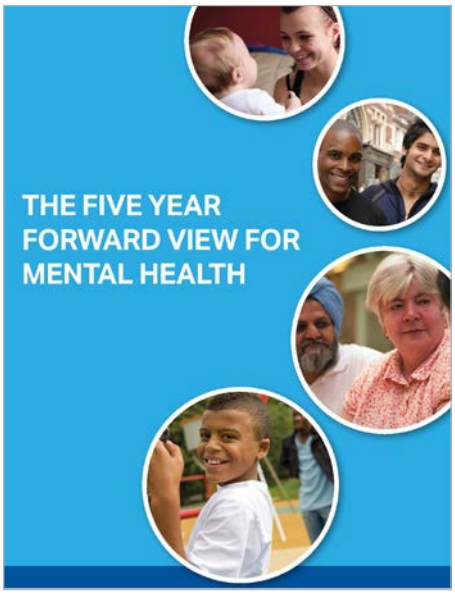
Evolving Communities is a community interest company. Its consultancy service specialises in patient, public and stakeholder engagement and insight to drive improvements in health and social care.

Working with Evolving Communities Consultancy, Healthwatch Gloucestershire has been talking to local residents about their experiences of accessing urgent mental health support in accident and emergency departments (A&E) in Gloucestershire. This report tells you what they said when we spoke to them about their experiences.

Background

In 2019, Healthwatch Gloucestershire explored the views of local people on mental health services in the county. A key message from that work was that people had difficulties in accessing support when in crisis: people were unsure of who did what, they did not know where to go to seek support, or were being left to fend for themselves.

For someone suffering a mental health crisis, the emergency department (ED) is generally their last resort. In England, it is estimated that 5% of all hospital ED attendances are primarily due to mental ill-health (Healthcare Safety Investigation Branch, 2018).



NHS England's ***Five Year Forward View*** aims to achieve parity of esteem between mental health and physical health services. It stated that by 2020/21, no acute hospital should be without all-age mental health liaison services in EDs and inpatient wards, and at least 50% of acute hospitals should be meeting the 'Core 24' service standard as a minimum. To meet the minimum 'Core 24' criteria, services must be:

- commissioned to operate 24/7, as an on-site distinct service
- sufficiently staffed with appropriately skilled people
- able to respond to emergency referrals within an hour, and urgent referrals from inpatient wards within 24-hours.

National research by the Healthcare Safety Investigation Branch (HSIB, 2018) found that there is an inconsistent approach to the assessment of mental health conditions in EDs compared to physical conditions. They made recommendations as to how relevant standards and policy ambitions could be achieved.

The HSIB report also noted that EDs treat approximately 222,000 cases of self-harm a year. Given the link between rates of self-harm and suicide, and in accordance with the National Suicide Prevention Strategy, HSIB point out that every presentation to the ED following self-harm represents an opportunity to intervene and improve outcomes in this respect.

Healthwatch Gloucestershire wanted to explore more closely the experience of people with mental health issues attending the EDs of Gloucestershire Royal and Cheltenham General Hospitals. Therefore, we asked Evolving Communities Consultancy to carry out a short, exploratory piece of work on this topic.

What is a mental health crisis?

In this report we have used the definition contained within relevant National Institute for Health and Care Excellence (NICE) guidance.

> "A mental health crisis is a situation that the person or anyone else believes requires immediate support, assistance and care from an urgent and emergency mental health service." ***NICE, 2016.***

What is the picture in Gloucestershire?

Urgent and hospital care is currently a key issue in Gloucestershire and forms part of the One Gloucestershire ***Fit for the Future*** agenda[1]. The ***All Age Mental Health & Wellbeing Strategy for Gloucestershire 2018-2023***[2] discusses building services that focus on the person, and the importance of merging services that provide care for those with 'physical' conditions with those specialising in mental health conditions.

In Gloucestershire, mental health services are provided by the Gloucestershire Health and Care NHS Foundation Trust (GHC). A crisis phone service is available 24-hours a day, 7-days a week, but if there is an immediate danger to life, patients are advised to dial 999 or go to their nearest ED.

The Crisis Teams provide a 24/7 service to those in an emotional crisis, a mental health crisis or experiencing psychological distress. The service is for those individuals who may require immediate help, matched to their needs and assist in resolving their current difficulties and reduce recurrence. Initial contact can be made via self-referral or from any person who is concerned for another.

The Crisis Team aim to provide:

- Timely response to people at their point of need
- Access for all communities, including those least likely to engage
- Seamless and rapid transition on entry, exit and transfer where ongoing care is required
- Appropriate signposting, advising and liaising with statutory and non-statutory agencies
- Collaborative working with all of the county's emergency services
- Short-term (up to 6-8 weeks) intensive home-based treatment to avert hospital admission during mental health crises where appropriate.

[1] https://www.onegloucestershire.net/yoursay/fit-for-the-future/
[2] https://www.gloucestershire.gov.uk/media/2089555/mental-health-strategy.pdf

ED staff can in turn refer patients to the Mental Health Liaison Team (MHLT) based at Gloucestershire Royal Hospital. There are 22 members of the MHLT located there; however, the team also cover Cheltenham General Hospital and the seven community hospitals across Gloucestershire. The service comprises of the following teams: working age, older age and alcohol. Staff work across all patient groups, assisted by their partnerships with other agencies. The role of the team is to provide a full psycho-social assessment of anyone referred to the service. This involves a full background review for those unknown to mental health services. The team also seeks to involve families and carers in developing packages of care that take the needs of the whole family into consideration.

The 2017 Care Quality Commission report of Gloucestershire Hospitals NHS Foundation Trust (GHFT) found that the mental health liaison service worked closely and collaboratively with the ED at Gloucestershire Royal Hospital. However, patients who attended the ED with mental health needs were not always accessing prompt assessment and support from mental health practitioners, especially after hours.

Self-harm and suicide are a local public health priority as reflected in the ***Gloucestershire Suicide Prevention Strategy***[3] and more work is currently being done to reduce levels of self-harm in the County. During 2018-19, a partnership piece of work was carried out led by Gloucestershire County Council, to understand and improve pathways for people who self harm.

Understanding the experience of those who have accessed ED as a result of a mental health crisis is therefore a vital part of the ongoing review and development of service provision that is aimed at achieving these ambitions.

Our aim

The aim of this piece of work was to gain a picture of how well the needs of people accessing mental health support at Gloucestershire Royal and Cheltenham General Hospitals' ED are currently served. The information gathered will inform service change and developments by the GHC and GHFT.

What we did

In developing and refining our approach we shared our plans with staff from GHFT, GHC and Gloucestershire County Council. In particular, we spoke to representatives from:

- MHLT
- Cheltenham General Hospital ED
- GHFT Patient and Public Involvement Team
- Public Health Commissioning Team.

We ran a short, online survey from 29 January 2020 until 29 March 2020. We also offered the opportunity to take part in either a face-to-face or telephone interview with one of our consultants.

[3] https://www.gloucestershire.gov.uk/media/2918/gloucestershire_suicide_prevention_strategy_2015_final_rev_280716-64216.pdf

We publicised the work on the Healthwatch Gloucestershire and Evolving Communities websites, newsletters and social media channels. Additionally, we directly emailed over 70 individuals from over 50 organisations and teams across the voluntary and community sector in Gloucestershire and reached many more through various networks and partnership forums.

In response, a number of organisations confirmed that they had further publicised the survey through their own contacts and social media profiles and others were also kind enough to suggest others we could contact directly.

Who did we want to speak to?

- People with a mental health condition/issue, who have used ED in the past year at either Gloucestershire Royal or Cheltenham General Hospitals.
- Those who care for someone who has a mental health issue, and family members of people with a mental health condition, who have used ED at these hospitals.
- Staff and volunteers from voluntary and community organisations in Gloucestershire who work with people who have mental health issues.

What we asked

We wanted to know about the background and circumstances of people's attendance at ED, their experience whilst there, and discharge and follow-up arrangements.

We did this by having semi-structured conversations about the story before, during and after ED attendance. Follow-up questions were used to expand on aspects of their experience and to elicit further feedback of the service. The survey questions were produced to match the questions asked in interviews. Survey questions can be seen in Appendix A.

Who we spoke to

We interviewed 10 individual service users, family members and carers, or those whose work has involved supporting people who have accessed the ED. Many of these respondents spoke about their experience of more than one, and in many cases multiple visits, which mean that a wide range of encounters were drawn on.

A further 11 individuals completed the survey. Three of these respondents were answering on behalf of their friend or family member. All of the respondents had accessed Gloucestershire Royal Hospital. Full demographics of survey respondents can be seen in Appendix B.

Key messages

1. People told us that that they are often reluctant to access mental health support in the ED. For those who do access the ED, they are often at a 'desperation point'.
2. Prior experience (or lack of it) not only further contributes to the level of anxiety people experience but also informs their expectations. Every contact counts and can inform the likelihood of people accessing further support.
3. The people we spoke to expressed that feeling heard, understood and not being judged by ED staff was an important factor in feeling safe.
4. People reported being left for long periods, left in busy environments, left in isolation without being checked on, and left without any indication of timescales. This was especially difficult for those in a fragile mental state and in some cases resulted in patients discharging themselves before treatment.
5. Some people reported only receiving medical help for their presenting physical health needs. However, these were often only a symptom of a bigger mental health problem that also needed addressing.
6. During assessments, positive feedback was associated with the framework of assessment being used to engage with and get to know the person. Negative experiences were associated with assessments being rigid and feeling like a tick box exercise.
7. For those we spoke to, leaving the ED rarely equated to the mental health 'episode' being over. Clear follow-up and care plans that incorporated families, carers and signposting to ongoing support were seen as being the most beneficial for helping people on their mental health journey.

What people told us

It is important to remember that the experiences of the people we spoke to during this engagement activity may not represent the experiences of everyone who has used the ED. To situate the sample size in context, during the time period that this engagement ran, the MHLT saw 600 patients. Due to the limited timeframe of this project, the in-depth and sensitive nature of the interviews and the inability to collect data from within the ED, we were unable to access a larger sample size. We aim for this report to be a snapshot of experiences, and to be used to feed into future broader investigations.

However, behind each interview or survey response lay an individual experience, each needing to be taken on their own terms. But taken together, there were clear underlying themes surrounding the experiences in the ED. These themes are discussed below.

Quotes are taken from interviews and survey responses but are left anonymous to protect those who we talked to.

Presentation at emergency departments

Most of the people we spoke to had attended the ED because they, or others, were concerned for their safety and physical health. This was due to actual or threatened self-harm, actual or threatened attempts of suicide, and the harmful consequences of other coping behaviours.

People attended on their own, and with friends and family. They also attended on their own initiative, and that of others (for example, the prompting of friends or family, and advice of health and care services). Some made their own way to hospital; others were given lifts or were brought by ambulance or the police. The great majority of attendances were at Gloucestershire Royal Hospital.

Some had been, or were in receipt of, mental health services while others were not. We heard from those for whom this was their first attendance, and others who had attended many times. Some had accessed other services in the lead up to their attendance, others had not. Respondents ranged from those with diagnosed, longstanding mental health conditions and a complex array of needs, to those experiencing their first mental health crisis.

Feelings

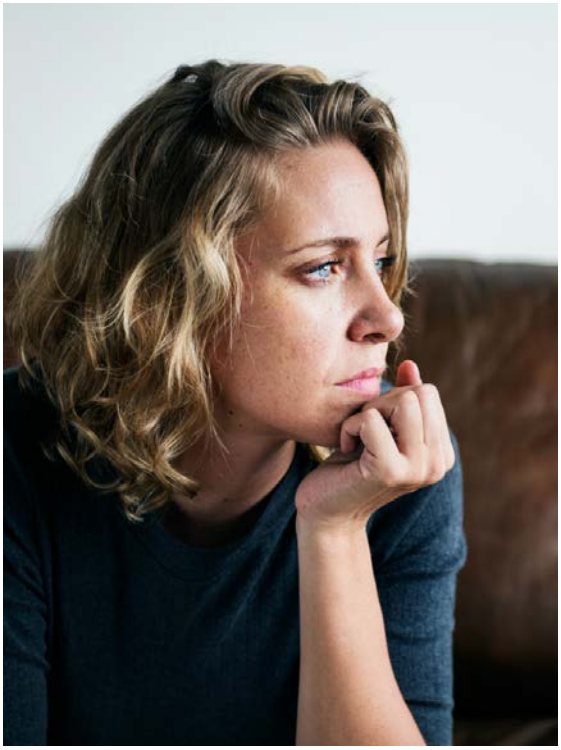
> "People who have self-harmed or attempted to kill themselves often feel isolated, alone, a burden."

For the people we spoke to, feelings of low self-worth and 'not wanting to be a bother' mean that they are reluctant to access the ED, even when advised to do so. In circumstances of overwhelming and uncontrollable emotions, already existing feelings of anxiety are themselves further heightened by the prospect of a visit to the ED. We were told this is often because of the uncertainty involved and the deeply personal nature of the underlying reasons for their visit.

The consequence of this can be a conscious or unconscious 'shutting down', further complicating the combination of a need and call for help with a reluctance to access and then engage with services.

> "Asking for help is the last thing people will do - people are at desperation point."

We were also told that this can also mean that people have been unable or unwilling to access other services aimed at providing support and will either avoid or address mental health crisis in other ways.



Expectations

For the people we spoke to, prior experience (or lack of it) not only further contributes to the level of anxiety experienced, but it also informs their expectations. Those without prior experience were unlikely to know what to expect and so felt that they had to place themselves entirely in the hands of others.

Those with prior experience approached their visit accordingly and, whether seeking to minimise or maximise engagement around the topic of their mental health, often faced a dilemma in deciding how much they reveal about themselves. Furthermore, it was impressed on us how even the most self-aware, experienced, and usually articulate person can struggle to express themselves at a time of crisis.

It is also the case that on arrival at ED, people anticipated a negative or positive experience according to who they saw was on duty, and how therefore they will be judged.

Being listened to

We learnt that people approach the ED seeking a place of safety, with one worker experienced in supporting those who self-harm describing that this is 'a huge part of it'.

The degree to which people we spoke to felt that this expectation was going to be met, depended in large part on how much of a voice they expected to have. They wanted to express themselves, to be heard, to be understood, and to not be judged.

For some, their experience meant that they chose not to access ED in the first place despite the consequences and having been advised to do so.

At the end of a conversation dealing with these themes and many more, and fully appreciating the challenges involved, one respondent summed up the challenge for staff, as well the necessary approach to be taken: "Take the opportunity to get beyond the presentation and find out 'what's your story?'"

> "Just because you can't see something doesn't mean it isn't there - it takes a lot for people to get to you; don't assume that they are making it up."

> "....therefore the human connection is vitally important. That someone has the time to talk to and really support them can make the difference between someone taking their own life or being alive."

Experiences on emergency department admission

Environment

The waiting and waiting environment of ED, were commented on frequently by those we spoke to. Respondents spoke about being left to wait for:

- long periods;
- in busy environments;
- in isolation without oversight;
- without being checked on or any indication of timescales.

All of these had a negative impact on people's already fragile emotional state and were major factors in people becoming inclined to, or actually, walking out of the department.

> "It felt very cold and impersonal. I didn't know how long I will be waiting or what will be happening."
>
> "Little things mean a lot, for example being asked: are you OK or would you like to sit somewhere quieter?"
>
> "There was no quieter waiting place other than the very busy corridor. This increased my anxiety and distress."
>
> "The environment was also further distressing, there could be a quieter, comfortable room for people with mental health issues to wait in if they'd prefer."

The result in one instance was a person with suicidal intent leaving Gloucestershire Royal Hospital at night to walk to Cheltenham General Hospital; his partner described that it was: "lucky he didn't jump off a bridge".

Another, who had explained they were actively suicidal, described being left on their own in a separate room without checks for approximately three hours with the means to act on their intentions. They felt that there was nothing to stop them doing so or leaving the premises.

For those who were referred to the MHLT, remarks also centred on the delay in, or in some cases the absence of, a response.

It was also commented on that the environment in which they encountered staff, from reception through to meetings with doctors, was: "not conducive to opening up about things of a personal nature".

> "...also, the room used when I was seen by the liaison team reassembles a police cell and is not a nice environment at all."

Parity between mental and physical health

> "I was surprised that mental health was not taken into account."

Another common remark was that people had only received support for their presenting physical health issue without consideration of their underlying issues, even when these were on record.

Again, this included a case where a pattern of behaviour associated with the lead up to suicide was ignored and only the consequence of the coping behaviour was addressed. The individual concerned, having been admitted to a ward, then chose to discharge themselves due to their frustration at not being listened to or heard.

For one young person experiencing their first mental health crisis but discharged after the briefest of consultations with a doctor, this meant that they were: "devastated that there was no response; does it mean no one cares?"

For another, the limitation of ED staff was indicated when in response to mental health issues being raised: "they could only point to the Mental Health Liaison Team". Not only were a lack of mental health awareness and negation of mental health issues reported, but also stigma and prejudice.

On the whole people did not criticise the quality of the treatment of their physical health needs, but it was remarked that these were attended to without reference to the mental health aspect of their condition. However, many felt that they received less favourable or different treatment because of the mental health reason for their attendance; in one case: "as if they were being punished for wasting A&E's time".

> "I was not even referred to crisis team - despite also being in minor injuries that SAME night due to self-harm. People were rude, acted like it was my fault I was there."
>
> "Felt like it was very much a case of 'oh well, you can go home now your bloods are fine'. Prior to the visit I was previously diagnosed (and un-diagnosed) with emotionally unstable personality disorder; was told 'people like you' and when questioned it was directed at that diagnosis, even though I no longer fitted that criteria. I had begged for help from the community services and then from the liaison team and was still given nothing."

"A diagnosis of personality disorder should not affect the treatment the patient received or the attitudes of staff. Every time I disclose my diagnosis, my treatment changes and the level of care drops (this is more with the A&E staff than the liaison team). Also, there needs to be an understanding that mental health is more than just depression or anxiety amongst all doctors."

"When I overdosed a doctor rudely asked me why should they help me?"

Assessments

We received a lot of feedback about assessments. This ranged from comments on triage, and informal mental health assessment by ED staff, through to formal assessment by the MHLT.

Negative feedback was associated with formulaic or routine approaches where the focus was on completing the form, or process, rather than the person. People with multiple experiences told us this led to them providing routine and formulaic responses in return; both parties thus managing to avoid, rather than address, the difficult issues at hand.

Positive feedback was associated with the framework of assessment being used to engage with and get to know the person: an example was given of an assessor 'going off script' and thereby opening up a line of conversation on which the difference between a positive and negative outcome turned.

Others pointed to the focus on the assessment of risk, and approach to assessing risk itself, as being too narrow:

"A&E risk assessment only looks at immediate risk. It doesn't take account of wider issues of risk and harm."

"The assessments aren't overly helpful if you've had them a lot of times before. Things are sometimes exaggerated - for example if someone asks you what you do during the week this is often written in the report as the patient making future orientated statements which isn't the case. Not for it just to be said you have the support already. Actively listen instead of being judged or taken as a joke."

"It's so difficult when your family are constantly dealing with mental health issues and are told you are on 'Green', so no further support or advice given."

"I felt extremely rushed to tell them what was going on, and she kept interrupting me so I couldn't fully explain it. Then when it came to a solution finding, it felt very much like she wanted to just get me out of the way and I just left feeling even more hopeless with no real plan."

"Actively listen to me instead of judging or treating me as a joke."

"Surrounding behaviours associated with people taking their own lives are ignored."

As well as good practice in regard to the above elements, we heard stories of the staff showing compassion and kindness and using their initiative to provide a caring service across the board. Positive outcomes were associated with 'being in the system', i.e. known to mental health services already and attending with someone who could champion their cause and help them navigate their way through the system.

"Those in crisis can't navigate services and need someone to walk alongside them."

"The Input of friends and family were key to securing service input, otherwise he would have fallen through the gap."

A common issue for service users and their friends/family/carers, and almost a defining measure of the quality of their experience, was having the steps and decision-making process explained to them. In addition, people wanted to be updated as to timescales, so that they knew what was happening and what to expect.

"Even though I was there with a physical issue, my mental health was affected because of the long wait, lack of sleep and pain. I was waiting in total for about 8 hours, before I was given some answers of what's going on. I wish I was informed more regularly about the process and that my mental health was taken into consideration."

The importance of this aspect of people's experience was also central to what people told us about discharge and follow-up arrangements.

Discharge and follow up

For those we spoke to, leaving the ED rarely equated to the mental health 'episode' being over and no one expected their visit to the department to be anything other than a step along the way of their mental health journey.

Comments on discharge and follow-up arrangements centred on how well people felt connected with existing or new services. Respondents spoke about wanting a reliable indication of timescales, points of contact and a care plan.

"Ongoing support is not something that the patient was given and despite several overdoses ending in him returning to hospital each time, he still has no support and was told by mental health practitioners at the hospital that he isn't depressed."

Swift follow-up appointments with relevant support services were hugely appreciated and seen to engender a sense of self-worth and reassurance that help was on hand as well as in confidence in services and hope for the future. The support of friends, family and other supporters were in some cases cited as the determining factors in achieving this sort of coordination.

The need for clear follow-up plans equally applied to family and carers.

"Families also need to know what to expect: timescales, points of contact, care plan."

"We were given valuable information: what to do if our son deteriorated, an information pack for him and overdose information for us. We felt reassured by this. Very good."

Follow-up arrangements that simply involved a record being passed to a GP or care coordinator were regarded as of limited worth.

There was frustration when what people were told would happen, and what actually happened next did not coincide.

"The mental health liaison lady was very nice and easy to talk to. She explained things well but what she said would happen next (with the crisis team) and what actually happened were very different. I was impressed with the treatment my husband got in A&E but unfortunately it's been shocking since then."

How experiences might be improved

As well as the lessons that can be inferred from the feedback received, we asked respondents for their comments on how things could be improved, and for any message they wanted to send to the service.

"More listening, more updates and info re process."

"24 hr mental health input."

"More caring attitude and approach."

"Better correspondence between what told about follow-up and what happens next."

"More private space. Acknowledge anxiety. Better environment."

"I wouldn't know where to start."

"A&E are in the frontline and therefore have role in unpicking what's going on."

"Repeat attenders shouldn't be pre-judged rather than each attendance being taken on its' own merit."

"I understand A&E work within constraints, but they should be given training on what keeps you safe, self-care and the ok to have conversations that show they care."

"They need to look beyond immediate risks and have awareness of other services."

"One of biggest things is families concerns not being listened to in highlighting something wrong, e.g. not taking notice of those who know (the person) best."

"A mental health specific service place that is easily accessible."

"People are more likely to stay if someone is with them. As an alternative make it possible for people to be supported by phone or text."

"Less discrimination around mental health. More support regarding someone experiencing a crisis. To be treated in a more private space instead of being asked to sit in a waiting room when physically sick from overdosing. For staff to acknowledge people are very anxious"

"Maybe specialist staff would have helped but more about being human."

"Just cared more. Understood mental health and that I should have seen someone from the Mental Health Liaison Team."

"Not just a piece of meat – think about how they might be feeling."

"Treating people as complex human beings."

"Importance of all staff."

Recommendations

1. People told us that that they sometimes felt judged and not listened to by the staff in ED. We recommend that the GHC and GHFT continue to deliver their regular mental health awareness training workstream with ED staff.
2. People told us about the environment of the waiting and assessment rooms of the ED not being suitable for those in a mental health crisis. We understand there is ongoing evaluation of the waiting rooms at GHFT hospitals as well as ideas for development including possible dedicated areas for those with mental health issues, and children and young people. We recommend that service users views are included in any improvement and development plans.
3. We were told that assessments were most useful when they were used as a framework to engage with and get to know the person. We recommend that the GHC and GHFT look at how their staff conduct assessments and emphasise that person centred care should be at the forefront of assessment.
4. Some people reported that they had only received support for their presenting physical health issue without consideration of their underlying mental health issues, even when these were on record. We recommend that the GHC and GHFT investigate this further to make sure that mental health is looked at in parity with physical health.
5. People told us that care plans and swift follow-up appointments with relevant support services were hugely appreciated and gave hope for the future. Including friends, family and other supporters in any follow-up was seen as beneficial. Currently, the MHLT is not commissioned to provide follow-up support for patients. However, since this project was undertaken, the MHLT have been conducting 48-hour follow-up calls to patients using the service during the Covid-19 pandemic. We recommend that they consider performing an evaluation of this new process. We also recommend that the GHC work with providers of follow-up services, to evaluate their follow-up procedures to make sure that people feel suitably supported once they leave the ED.
6. Healthwatch Gloucestershire recommend that the GHC and GHFT undertake further evaluation of their mental health services in ED. We understand that there has been change in the department over the past year, and therefore ongoing evaluation is of great importance. Further evaluation could also incorporate the views of their staff to make sure that any improvements are manageable. We also recommend that they make use of the opinions of service users in any future service improvement activity. We do acknowledge however that many evaluation projects may be delayed due to the ongoing Covid-19 pandemic.

Next steps

We know that it is important that people know what has happened as a result of them sharing their experiences.

We will be working with GHC and GHFT to respond to the issues raised during this engagement.

We will also be sharing this report with other organisations and services that are involved in crisis mental health care in Gloucestershire.

Stakeholder's response

Nathan Gregory: Deputy Director for Urgent Care and Speciality Services (UCASS), GHC

"GHC welcomes the Healthwatch report of people's experiences of urgent mental health care in the A&E department in Gloucestershire.

"This report is important to ensure that people receive parity of esteem for both their mental and physical health care needs and GHC supports the recommendations made. The ongoing delivery of mental health awareness training with A&E department staff is vital to ensuring the completion of person-centred assessments which include peoples mental and physical health care needs.

"GHC is looking forward to working with Healthwatch regarding the recommendations made in the report."

Jim Welch: Clinical and Operational Lead Nurse, GHC

"The shared work undertaken here is illustrative of the benefits of partnership working across statutory and non-statutory services, giving a valuable voice for shaping services for the future.

"I look forward to further developing the interface between mental health and acute services and achieving improved experience and outcomes for the people of Gloucestershire."

Professor Steve Hams: Director of Quality and Chief Nurse, GHFT (November 2020)

"We welcome this report, and the insight it provides, as this will support the ongoing improvement work regarding patients with mental health conditions accessing our urgent care services. Our initial responses below (see Appencdix C.) show work that has already been agreed to date, and we will continue to develop our response to each of these recommendations into an action plan that will be monitored internally, and through our quarterly meetings with Healthwatch Gloucestershire.

"Caring for those with urgent mental health needs in Gloucestershire is a responsibility for all organisations, and we are keen that Gloucestershire hospitals play its part in providing a responsive, kind and focused service to our patients and their loved ones. We recognise there is still more for us to do, and the report gives us some helpful areas to further strengthen our work with patients, their loved ones and our community."

Acknowledgements

Healthwatch Gloucestershire would like to thank everyone who took the time to contribute their views and experiences through the engagement activities described in this report.

We would also like to thank Gloucestershire County Council for commissioning the work and staff from GHFT and GHC for contributing and commenting to the original work plan.

Finally, we wish to thank the voluntary and community sector organisations who helped to support the engagement activity.

Appendices

Appendix A. Survey questions

1.	Are you answering on behalf of someone else? If so, please answer the questions as if you were them. Yes/No If yes, what is their relationship to you?
2.	What was your living circumstance before accessing A&E? • Own home • Rented home • With family/others • Supported housing • Temporary accommodation • Other (please specify):
3.	Had you been diagnosed with an ongoing mental health issue/condition prior to accessing A&E? Yes/No/Prefer not to say
4.	Which A&E Department did you visit?
5.	What date did you visit? If you visited more than once in the last year please write the last date you visited.
6.	Had you had any contact with mental health services prior to visiting A&E (this can be one-off or ongoing support)? Yes/No
7.	How did you get to the A&E department?
8.	What was the primary reason for your visit to A&E?
9.	Who did you talk to/were seen by at A&E?
10	Was your mental health discussed with you?
11.	Did you feel like you were listened to by the staff?
12.	Did you have to repeat your story to multiple people?
13.	How satisfied were you with the environment of A&E?
14.	If you had a carer with you, were they involved/included?
15.	Did you feel that you were treated the same as those who may have been in A&E for only physical health conditions/issues?
16.	When you were discharged, were you given any information, care plans or arrangements for ongoing support?
17.	What could the A&E have given you on discharge that you think would have helped you?
18.	What worked well when you visited A&E?
19.	What, if anything, do you think the A&E could have done differently to improve your experience of care?
20.	Finally, is there anything you would like to tell the A&E/Mental Health Liaison Team staff?

Appendix B. Demographics of survey respondents

A total of eleven people took the survey. Three of these respondents were answering on behalf of someone else.

Gender	Response total
Female	8
Male	2
Self described: appear female	1
Sexual orientation	**Response total**
Hetrosexual/Straight	10
Self described: Queer	1
Age	**Response total**
18-25	5
26-35	2
36-45	2
46-55	1
56-65	1
Ethnicity	**Response total**
White British	10
White Other	1

Appendix C.
Gloucestershire Hospitals NHS Foundation Trust response to recommendations made in this report

Recommendation 1

People told us that that they sometimes felt judged and not listened to by the staff in ED. We recommend that the GHC and GHFT continue to deliver their regular mental health awareness training workstream with ED staff.

GHFT response:

"We will work with GHC colleagues to review the training provided to ED colleagues which includes mental health awareness and management of people with mental health conditions. The Trust has just launched our new values and behaviours, putting an emphasis on the importance of compassion. In our most recent Urgent and Emergency Care National Patient Survey, we scored 8.9/10 for patients saying they felt they were treated with respect and dignity, which is about the same as other organisations."

Recommendation 2

People told us about the environment of the waiting and assessment rooms of the ED not being suitable for those in a mental health crisis. We understand there is ongoing evaluation of the waiting rooms at GHFT hospitals as well as ideas for development including possible dedicated areas for those with mental health issues, and children and young people. We recommend that service users views are included in any improvement and development plans.

GHFT response:

"The Trust understands the value of the involving service users in our improvement and development plans and will continue to do this to ensure feedback is gained as part of our on-going engagement and our Strategic Site Development work which will seek to improve our urgent care facilities. The Trust is currently developing an Engagement and Involvement Strategy which emphasises our commitment to working in partnership with our patients and communities, and will be published in November 2020."

Recommendation 3

We were told that assessments were most useful when they were used as a framework to engage with and get to know the person. We recommend that the GHC and GHFT look at how their staff conduct assessments and emphasise that person centred care should be at the forefront of assessment.

GHFT response:

"Our lead for Mental Health Liaison and our Emergency Department matron have been working on a quality improvement project that uses the Australasian Triage Tool to identify priority 1 and 2 patients for an early mental health review. Person-centred care should be at the forefront of all assessments undertaken and this work will be reviewed in partnership with GHC."

Recommendation 4

Some people reported that they had only received support for their presenting physical health issue without consideration of their underlying mental health issues, even when these were on record. We recommend that the GHC and GHFT investigate this further to make sure that mental health is looked at in parity with physical health.

GHFT response:

"People who present in our acute Trust with a physical health issue do get a mental health assessment using the Australasian triage tool, which enables us to review patients who present in the department and provide appropriate care with the support of our Mental Health Liaison Team. This approach will be reviewed in partnership with GHC."

Recommendation 5

People told us that care plans and swift follow-up appointments with relevant support services were hugely appreciated and gave hope for the future. Including friends, family and other supporters in any follow-up was seen as beneficial. Currently, the MHLT is not commissioned to provide follow-up support for patients. However, since this project was undertaken, the MHLT have been conducting 48-hour follow-up calls to patients using the service during the Covid-19 pandemic. We recommend that they consider performing an evaluation of this new process. We also recommend that the GHC work with providers of follow-up services, to evaluate their follow-up procedures to make sure that people feel suitably supported once they leave the ED.

GHFT response:

"We will work GHC to conduct the evaluation of the follow-up support process offered by the Mental Health Liaison Team."

Recommendation 6

Healthwatch Gloucestershire recommend that the GHC and GHFT undertake further evaluation of their mental health services in ED. We understand that there has been change in the department over the past year, and therefore ongoing evaluation is of great importance. Further evaluation could also incorporate the views of their staff to make sure that any improvements are manageable. We also recommend that they make use of the opinions of service users in any future service improvement activity. We do acknowledge however that many evaluation projects may be delayed due to the ongoing Covid-19 pandemic.

GHFT response:

"We will work GHC to review patient and staff feedback to identify improvements required for the service."

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