Guy's and St Thomas' NHS Foundation Trust

Waiting

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

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

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