Healthy London Partnership

Health Based Place of Safety and Emergency Department Rotational Nursing Programme

End of pilot report

July 2018

Supported by and delivering for London's NHS, London Councils, Public Health England and the Mayor of London

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Introduction

This report outlines the development and initiation of a rotational nursing programme (RNP) between Health Based Place of Safety (HBPoS) sites and Emergency Departments (EDs). It explains the rationale behind the programme and progress to date. Through focussing on the early activities and experiences of those involved, the report explores the feasibility and potential benefits of a rotational nursing programme between HBPoS sites and EDs.

Background and development

Since 2015, Healthy London Partnership (HLP) has worked in partnership with London's health and care system including service users to develop and implement a pan-London, new model of care for individuals detained under s136. The new model aims to improve the quality of care for people in mental health crisis across London and emphasises the need for HBPoS sites to be staffed with 24/7 dedicated teams. Importantly, the model also identifies the need for the physical health competencies of these teams to be improved[1]. In order to achieve this, a radical and sustainable change to training is required, together with breaking down the boundaries of organisational and professional silos to facilitate more holistic care for patients.

In late 2017, HLP worked with Health Education England (HEE) and four of London's mental health trusts to develop a proposal for the scoping and development of a HBPoS and ED Rotational Nursing Programme (RNP). In early 2018, HEE granted funding to the following trusts:

- Barnet Enfield and Haringey Mental Health Trust (BEH)
- North East London NHS Foundation Trust (NELFT)
- South London and Maudsley NHS Foundation Trust (SLAM) and;
- South West London and St George's Mental Health NHS Trust (SWLSTG).

Approach and aims of the programme

In line with the new model of care, the trusts already had (to different degrees) a dedicated team in place at their HBPoS site. Once funding was granted, each trust appointed a clinical facilitator. The facilitators formed a collaborative network to support development of the RNP further and to share learning; the development phase is outlined below as Phase 1 and the implementation of the programme as Phase 2.

As a collaborative network the clinical facilitators outlined the overarching aims of the rotational nursing programme:

- Improve quality of care for mental health patients in crisis who attend EDs and HBPoS sites.
- Provide more integrated physical and mental healthcare at EDs and HBPoS sites for mental health patients.

[1] Mental Health Crisis Care for Londoners: Section 136 pathway and health based place of safety specification (2016). Healthy London Partnership p66

- Encourage and support development of programmes pan-London to improve integrated care for crisis care patients.
- Support maintenance and development of a skilled mental health workforce.

Phase 1: Developing the programme: Understanding the training requirements

Competencies and training needs

A significant part of the programme focussed on identifying the desired competencies for mental health and acute nursing staff as well as establishing training needs and staff interest in the programme. Once the competencies for both HBPoS and ED staff had been identified, a baseline questionnaire was developed and completed by ED and HBPoS staff. Staff generally reported high confidence in many of the competencies listed within the questionnaire, there was less confidence amongst the mental health nurses in areas such as:

- Phlebotomy and in the ability to take bloods safely;
- Ability to take a basic sexual health history including risk factors for blood born viruses and signpost to appropriate services where needed;
- Ability perform basic wound assessment;
- Ability to perform an ECG and understand / act upon required governance protocols;
- Ability to conduct a risk assessment for deep vein thrombosis and escalate as appropriate
- Ability to perform an ECG and understand and act upon related protocols.

It was recognised among HBPoS staff that they could only undertake limited vital signs and observations meaning that individuals detained under s136 were often referred to EDs (sometimes unnecessarily). Both groups expressed a lack of confidence in their ability to take a smoking history, deliver basic smoking cessation advice and initiate nicotine replacement therapy/ refer as needed. A lack of confidence was also reported in knowledge around self-harm guidance and procedures. Nurses in the ED spoke about wanting to recognise the signs and symptoms of specific mental illnesses and how to manage/treat these in the department.

Understanding current ED Transfers

In addition to the questionnaire, information was gathered through an ED audit on the numbers and reasons why patients were transferred to ED prior to or after being taken to the HBPoS.

- 22% of s136 patients attending BEH from January to March 2018 were transferred to ED (either prior to attending the HBPoS or after presenting to the HBPoS).
- Across the trusts that provided data sets, the majority (84%) of s136 patients presented to a HBPoS via ED (as opposed to being transferred from a HBPoS).
- 33% of transfers were due to self-harm (the treatment of injuries and overdoses) and a significant number were related to intoxication.
- For 12% of transfers, a non-specific ‘medical clearance’ reason was given.

Whilst the clinical information is limited, there is an indication that a number of ED transfers taking place could be addressed through skills developed in the RNP. This information along with the insights from the questionnaires and focus groups were used to focus training efforts for the RNP.

"This RNP has the potential to have phenomenal impact on staff but most importantly on the people who are in mental health crisis. The focus groups highlighted, that having confidence in being able to attend to the physical health needs of their patients was a key contributing factor to them wanting to be part of the pilot". Facilitator, June 2018

The clinical facilitators explored various training opportunities such as in-house physical health competency training (stemming from the results of the pre-implementation questionnaire) and external simulation training packages.

System support

There has been broad support and interest in the RNP from HBPoS, ED and Liaison Psychiatry Service (LPS) colleagues. The majority of respondents felt that the RNP would be beneficial to both staff and patients and would help improve physical health competencies thus preventing unnecessary ED referrals. When asked about the current relationship between HBPoS and ED staff, the majority of respondents recognised that it needed improvement. Furthermore when asked how they felt the relationship could be improved upon, there was a clear indication that increasing the experience, confidence, skills and knowledge on both sides (HBPoS and ED) through training and collaboration would help.

Phase 2: Implementing the programme

The benefits of the RNP

Dip-in shifts occurred with staff from Health Based Place of Safety sites and corresponding Emergency Departments. Staff who took part found the shifts enjoyable, exciting and could see the tangible benefits of the shifts going forward. Some key points from the shifts are outlined below:

- Some shifts took place in an urgent care centre instead of an ED which was seen as beneficial as staff were exposed to lower acuity physical health issues and therefore able to practice skills that would be frequently used in a HBPoS.
- Staff commented on an improvement in the collaboration and relationships between HBPoS and ED staff and increased collaboration between management at the Trusts. For one Trust this has led to further partnership working between the two teams to improve mental health pathways.
- The multi-disciplinary collaboration at the London level to drive the programme, including the creation of the supportive network was seen as a success. It was clear that the process of implementing the RNP was valuable in terms of enabling more integrated care, improving peer support and also the sharing of learning across London trusts.
- Over time, the clinical facilitators all agreed the benefits of the programme would include the retention and recruitment of staff at HBPoS sites as it is seen as another (more cost-effective) training opportunity for staff to increase and broaden skills.

Considerations for broader pan-London implementation

Adequate time for planning and relationship building

A large amount of time, collaboration and planning went into the getting the RNP to its current stage. While the support and willingness had existed across the trusts, people's capacity, governance processes, and the sign offs required as well as the specialised nature of healthcare roles and the cultural barriers between them, meant that it took longer than anticipated to implement.

Senior level buy in and good communication

Importantly the RNP needs senior level support from both the ED and HBPoS in order to progress. Senior level support is required not only to aid the development of the programmes' aims, objectives, training plans and supervisory arrangements, it is also crucial to getting the approval required to allow the shifts to go ahead. Senior level buy-in also helps to increase interest in the programme and maintain momentum. In order to get senior level buy in good communication of the benefits of the programme is crucial.

"The main challenge has been with engaging the acute Trust at a senior level. Without this, the RNP appeared to lose some momentum both for those who had expressed interest and for myself as clinical facilitator. This was eventually overcome by drawing on the relationship that the director or nursing for the mental health trust had with senior nurses in the acute trust". Facilitator, June 2018

Pilot shift planning & consideration

The dip-in shifts raised a number of considerations, including where the RMNs should spend their time while on shift in the ED. Facilitators' needed to think carefully about the sorts of cases that the nursing staff could get involved in in order to maximise value from the experience. It is crucial that staff do not feel as though they are a burden and that they feel they have a part to play/skills to impart to their counterparts. Each shift should provide reciprocal benefits; the correct placements and supervisory arrangements need to be in place to ensure this.

Leading from the front and choosing participants wisely

Those involved in the development of the RNP (e.g. the clinical facilitators) should try where possible to undertake the dip in shifts in order to lead by example, and understand how the programme works in practice. Potential participants expressed apprehension around undertaking a shift, if the facilitator undertakes the first one then they can help alleviate colleagues' anxiety around what to expect. Choosing participants wisely and making use of key players in both the ED and HBPoS was another area to consider. The ED nurse identified to undertake the dip in shift at SLAM's HBPoS was the mental health champion for the associated ED. This had added value as they were in a strong position to cascade the learning to other colleagues in the ED.

Evaluating the programme

The RNP working group developed a robust evaluation framework that could provide an evidence base to inform future support and development of the RNP and similar

programmes. While some evaluative activities have taken place during the pilot, the facilitators struggled to get staff members to complete the online questionnaires. If a reliable baseline is established pre-implementation and this is then measured post-implementation it would be easier to see the benefits of the programme which can then be used to attract further funding and ensure the programmes are implemented long term across both Trusts.

Patient engagement

One area that the facilitators struggled to adequately address was how to meaningfully engage patients in the programme and how best to capture their feedback. This was partly to do with the fact that none of the trusts had patient feedback collection methods embedded. If the RNP is sustained past the pilot then this is an area that should be further explored as the ultimate end goal of the programme is to improve quality of care and overall patient experience.

Capacity and funding

The funding from HEE was for the initial development of the RNP over three months (Jan - Mar 2018) this included the four facilitators' time on the project. The continuation of the programme thereafter depends on each individual trusts' time, capacity and funding arrangements. While some trusts have managed to secure a project manager to see the RNP through to full implementation, others have not. When asked what the biggest risk was to the RNP, the facilitators responded that funding to sustain the RNP was a key issue.

Conclusion

It is widely accepted that there is a need to increase the physical and mental health competencies of HBPoS and ED nursing staff respectively in order to improve quality of care for patients in mental health crisis. There is also a recognised need to increase collaboration between staffing groups to deliver more integrated mental and physical health care.

Initial evidence indicates that there is a strong likelihood that the RNP will help achieve these aims if sustained past the pilot. The facilitators valued the opportunity to be involved in the RNP and to collaborate with their ED and LPS counterparts. Their enthusiasm for the work has been equally shared by their senior and frontline colleagues both at the MH and acute trusts. The opportunity to share experiences and learning has been a positive experience for the facilitators. Moreover, being able to take the time to talk with colleagues meant that those involved have gained a much greater insight into the complexities of their crisis care work, the issues faced and importantly, the learning and development needs of staff.

"The experience has been a positive one. We have been able to engage with staff across a number of organisations. There has been a lot of joint working on this project and other rotations. The focus group gave us a real insight into the complexities of Suite 136 and provided a greater insight into the learning and development needs of the staff to support them into working in an emergency care environment." Facilitator, June 2018

"I strongly believe that this programme has the potential to significantly impact on the care received by people in a mental health crisis…ultimately, this is a unique opportunity to do some work around shifting cultures, contributing to the parity of esteem agenda". Facilitator June 2018