HC&V STP Workshops with service users and staff
Clifton House
Humber Centre
Stockton Hall

Gaps in services

- Gaps around housing and early intervention were identified as the main issues for this question

Appropriate housing provision
Lack of supported accommodation placements for step down
Lack of accommodation to support people moving from secure provider to community
Challenging York/NY lack of accommodation is a barrier to discharge – need to invest in this area
Early interventions (substance work, working with young people) – young offending
Linking in to CAMHS for assessment and early intervention
Replacing missing types of staff
Learn about local provision for service users when moving out of York area
Specialist trauma – informed therapy (particularly for female PD client group) – self-harm
No good in just identifying gaps without plans to address these
Linking in more to probation services
No female MS/LS PD service
Supporting patients in secure services with an ASD diagnosis – ASD service needed
Information on mental health act and legal legislation – support with this
Improve carer support
What is service provision in – Whitby, Northallerton, Richmondshire, etc?
Barrier: transfer to CMHTs from FOLS – not good service FOLS caseload stuck
Real world vocational opportunities whilst in LS settings
Improving physical health provision for community patients
Housing application process – job application process (interviews/CVs/transferrable skills).

Treatment focus

- Giving people a choice around treatments and interventions where possible
- More Psychological input
- Treatment in the community – increased opportunities for treatment out of hospital

Prioritising care
Giving people choice – which treatment/intervention that they feel is right for them
See if it is suitable for my needs – cross over between MI, PD and LD
Staff more aware – given more training opportunities
Treatment in community – increase provision in options for treatment in community - - either returning to inpatient unit or more staff able to deliver in home
More psychological input to address underlying issues eg DBT, managing anger, coping skills
Treatment not holding people back if can take place in lesser security
Support with continuing Psychology
Sometimes find it hard in groups and prefer to work 1:1
Recovery college
Better treatment courses available – substance misuse, Specific treatments focused around addictions
More specialist trauma treatment available
If skills – greater ability to utilise internet, bidding for housing, etc
Enable contacting outside services using internet
Advice for future job applications eg basic process, CVs, interview practice, transferrable skills
We are very York-central focused (ie converge, explore, library links – York learning)
Same treatment/therapy provided at each service therefore don't remain in one service to receive treatment
Imagining a different life exploring new choices
Opportunity to develop (a range of) interpersonal and life skills

Face the challenging issues
I want a reduction in meds
Not much treatment

The Workforce

- Increase in numbers
- Staff with the skills to support discharge and community support

Increased staffing numbers
Specialist social workers, nurses, assistant practitioners - with skills to support discharge and community
Staff more aware and given more training opportunities
Regular staff on the wards
Named nurse, care plans, psychiatrist, OT activities
Evenings and weekends
Clearer roles – Health care workers expected to do dual roles, doesn't work
Social worker
Staff to help with cooking, 1:1 support, Psychology
Opportunities to shadow other teams within the trust
People who understand me
Specialist therapists in drug and alcohol
More staff with a specialist skill set to deliver courses. There was more of that at Rampton.
Staff training/development opportunities – links to treatment
Skilled at having difficult conversations to facilitate change
Ensure adequate finance for staffing
More emphasis on community teams through recruitment of appropriately qualified staff
Education surrounding culture
Staff trained to work with me
Healthy Role Model
Activity organiser role

Improved experience and outcomes

- Avoiding repetition of work – continue specific pieces of work when moving placements
- Hospital stay driven by outcomes
- More opportunities to carry out treatment in the community

Avoid repetition of work when moving between hospitals/placements
Not spending lots of time in hospital without any outcomes
We should be able to carry out specific pieces of work between different placements
Discharge the patients to community services – so you get the support you need and don't have to stay in hospital
Improving choice and opportunities for people without leave
Voluntary work for patients
Seeing family more
Learn more about benefits and paying bills
Quicker discharge
Utilise questionnaires – patient experiences
Use of e-cigs should be introduced
Getting a job in the community with own shared accommodation
Fewer restrictions
More opportunities for section 17 leave
Improved funding for therapeutic opportunities
Being able to use e-cigs in hospital
I don't have any leave and would like to go to places like 30 Clarence Street, what can I do, who do I inform?
Taking therapeutic risks

Reducing out of area placements

- Concerns about repatriation – negative influences, wanting a fresh start

- Positive about being closer to family and friends

Would it be beneficial for somebody to 'start afresh' in a new area – avoiding negative social influences/substance misuse, etc
In area fund housing to move on to
What if I don't want to go back?
Be able to do my treatment where I was born
Some people need to move out of area to reduce risk
Need to be close to family and friends
Early intervention CAMHS and community
More links with housing and supported accommodation for out of area
Provide funding
Not everybody wants to return to their home area and some are unable to due to restrictions
Not always possible to go back – restrictions and MoJ – choice for new start
Child mental health services
Maintaining family links/support network
Would this mean a longer waiting time?
Facilitate equipment
Community services
Create more beds across STP

Integrated pathways

- Need for a clearer definition and agreement of pathway on admission
- Better links with community support
- Standards and consistency around preparation for discharge

Much clearer definition and agreement of service user pathway on admission, eg what is to be achieved in first 6 months
More links with housing supported accommodation
Build links with community support and services as part of the pathway
Better links/liaison between partner services
Understanding obstacles in order to challenge them
Standards to be written around preparation for discharge
What does assessment and treatment mean? Shared standards that can be shared across services
Better treatment courses available. Substance misuse, DBT, CBT
Staff following the patient
People communicating better
Local authority to be involved even if social worker (s/w) in hospital
More involvement for family and friends
Single pathway for the STP
Better use of technology

Transitions – what needs to be in place?

- Understanding of "home"
- Suitable housing support
- Better preparation for community living, technology
- FOLS

Hybrid MS and LS whilst in transition complete
Better communication between MDT
Trial leave periods are too long "on edge for 6 months". Everything was on hold.
More locked rehab placements and community placements
Understanding where the patient's links are. Home might not be the "area"
Suitable housing – supported – independent
Preparing for community living particularly when individual has been in services for a number of years and may be institutionalised – overnight leaves to potential placements
Opportunities to work in the community (artwork, Woodwork, Gardening)
No re-assessment on transitions
Input with psychiatry and psychology sooner
Identifying support network – crisis plans – emergency contacts (family/prof network)
Trial leaves before discharge or transfer

Involvement of FOLS or CMHT
Support with things like Psychology
Can't move back home – need gatekeeping for where I would like to go
Support from named nurse
Hope and – stigma. Creating obstacles for acceptance and positively moving forward
Meeting named nurse, Dr's and peers
Working with people actively to prepare for transitions
How would I go about transferring hospital?
Sometimes when people transition between services they have to repeat work they have already completed elsewhere. How can this be avoided?

Redesigning Provision

- Joint working – reduce admission to secure
- Gender specific treatment
- Patients to hold their own portfolio of treatment – avoid repetition
- Technology
- More early intervention

Consultation to other services to reduce admissions to secure – joint working
Community teams to be part of all MDTs – better communication
Linking in with youth offending teams to provide early interventions "early interventions team"
Use of technology – patients to hold their own portfolio of treatment and work they have completed.
Could help to share information and avoid repetition.
Gender specific treatment/therapy options
Community teams to be part of all MDT's
Patients to hold their own portfolio of treatment – avoid repetition
Education – attending college, etc – positive links beyond York
Enable more use of the internet
Use of smart phones on wards
Positive links beyond North Yorkshire
Investment in housing so we can deliver a service around supported tenancies.
Recruitment drive
Utilising and building on what you already have
Employing a social worker in NHS role to case manage out of area service users
Regular staff on wards (as possible)
More specialist therapists ie drug and alcohol
Increased staffing numbers
Better communication
Recruitment drive
Linking in with youth offending
Utilizing and building on what you already have

Charter ideas

People don't like the terminology of a "Charter" – don't know what it means – also looking at other charters as examples they seem to be about values based statements and everyone thought that if we are going to write something it needs to be more tangible and measurable… The plan that everyone was happy with was to arrange a follow up meeting at Sandal or somewhere that all 3 services could come together and think more collaboratively about a Charter – here are some initial ideas from Clifton House:

- Care co-ordinator will be in place and will follow them between services- local authority – Health
- Treatment will be based on specialised assessments by a qualified team
- Transitions equipping people with technological skills to use in the community
- Out of area placements – reduce – closer to home but choice ? building up links where you are
- Outreach – FOLS – but also in-reach. FOLS – Diversion – joint working and supporting other providers – prevent admission
- Housing – appropriate – transition
- Transitional – tech, trial leaves, managing crisis, not repeating things, transition not always positive – or in the right direction
- Workforce – lack of appropriate staff not negatively affecting progress
- Quality – good enough/sometimes not good – what does it mean? Who governs that?
- Governance – across too many aspects – whole pathway