Quality Network for Crisis Resolution and Home Treatment Team (QN-CRHTT)

Patient and Carer National Report

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

QN-CRHTT
QUALITY NETWORK FOR CRISIS RESOLUTION AND HOME TREATMENT TEAMS

Foreword

We would first like to say how honoured we are to be part of the QN-CRHTT national report that focuses on patient and family/carer involvement within our member services. This national report provides you with essential information, a bit of encouragement, and a few good examples from services who have been successful in developing and implementing patient and family/carer involvement. There are plenty of existing guidelines and toolkits to support services to work co-productively, and we hope this report can be an additional resource and guidance.

Ingrid Baldwin and Vittoria De Meo

Compiled by the QN-CRHTT Team

Ingrid Baldwin, Carer Representative
Vittoria De Meo, Patient and Carer Representative
Konami Groves, QN-CRHTT Project Officer
Tia Thompson, QN-CRHTT Project Officer
Paris Wilson, QN-CRHTT Project Officer

With thanks to:
Cassie Regan, QN-CRHTT Programme Manager
Karishma Talwar, QN-CRHTT Deputy Programme Manager
Pranveer Singh, Consultant Psychiatrist, Essex Partnership University NHS Foundation Trust

Publication number: CCQI440

Preface

Families and carers of people experiencing mental health crisis have a pivotal role in supporting their loved ones as they are likely to be the first to identify mental distress.

Together with the Crisis Resolution and Home Treatment Teams, they can provide support and care for patients with illnesses and psychological distress. Such support is of utmost value when unwell people in crisis are treated at home. Without family and carers' support in many circumstances, the home treatment for patients in crisis is unlikely to be deliverable.

This report is based on learning derived from local draft reports and highlights that it is fundamental to involve families and carers in treatment and delivery of home treatment services. Involving carers and families in home treatment has clear benefits for the patient receiving treatment.

Effectively engaging patients in their care is essential to improving outcomes and satisfaction with the care experience. The planning of patient centred interventions should be discussed to fit in with the patient's needs, and patients need to be asked how they want family members and carers involved. Providing care agreed by patients and carers is a key factor to reduce acute distress, minimise potential for immediate harm and improve functioning. Positive patient experiences tend to lead to patients feeling more empowered, resulting towards positive outcomes. Crisis services and pathways must be co-produced with patients and carers to better understand what challenges and opportunities they face, contributing towards the creation of more effective services.

Those providing care must engage and communicate with families and carers and involve them in planning and collaboration. This includes assessing vulnerable family members' or carer's needs, offering and providing ongoing support, providing psycho-education to families and carers, and providing or recommending referrals to them. Involvement can reduce the burden often experienced by families and carers and promote positive outcomes for patients.

This report is a result of initiative undertaken by the patient and carer representatives of the Quality Network for Crisis Resolution and Home Treatment Teams. It is of great benefit to everyone who provides home treatment services.

On behalf of the Advisory Group, immense thanks to QN-CRHTT's patient and carer's representatives and to all those who contributed to this report.

Dr Pranveer Singh
Consultant Psychiatrist, Essex Partnership University NHS Foundation Trust
Chair of the QN-CRHTT Advisory Group

Contents

1. Introduction

How was this National Report developed?

This national report provides an overview of how teams performed against the QN-CRHTT 4TH edition of standards relating to patients and family/carers. Data from 29 Crisis Resolution and Home Treatment Teams (CRHTT's) who underwent a peer-review between January and December 2021 has been reviewed and collated for the purpose of this report.

What can be expected in the report?

As a network, we continuously emphasise the importance of patient and family/carer involvement within the development of Crisis Resolution and Home Treatment Teams. Therefore, we felt it was vital that patients and family/carers were involved in the development of this report.

This report has been co-produced with two of the network's patient and family/carer representatives and includes peer-review findings, recommendations, and best practice examples.

381 family/carer surveys collected.

441 patient surveys collected.

3 developmental reviews.

Data taken from **29** teams.

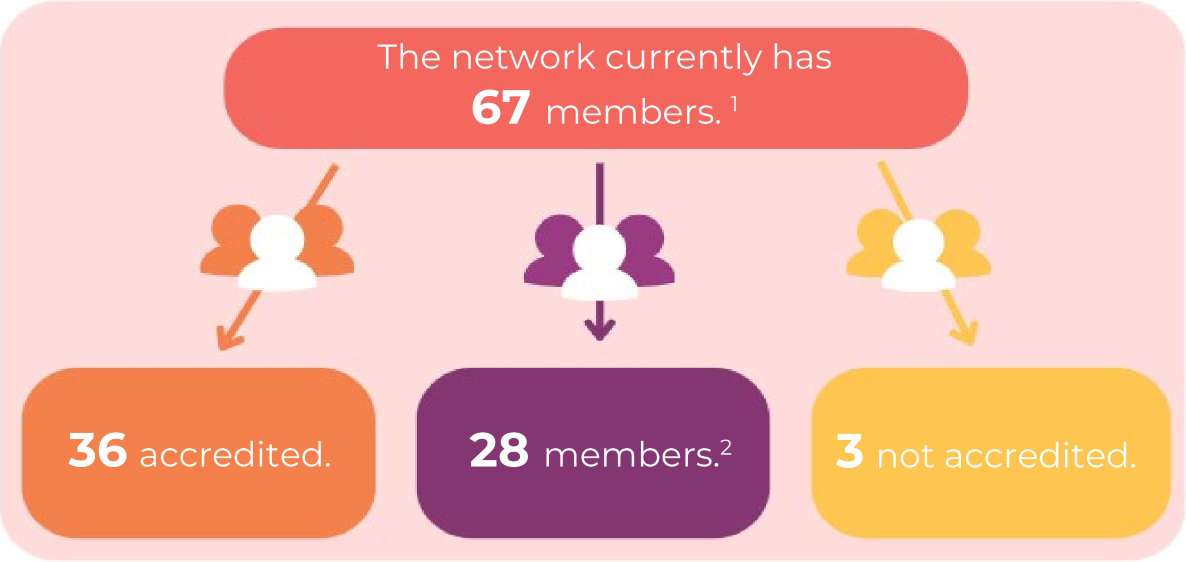
25 accreditation reviews.

1 discussion-based review.

What is the Quality Network for Crisis Resolution and Home Treatment Teams?

The Quality Network for Crisis Resolution and Home Treatment Teams (QN-CRHTT) was established in 2012. The network was originally established under the name Home Treatment Accreditation Scheme (HTAS).The network has since adopted the new title of QN-CRHTT to encompass all types of home-based crisis services and to reflect the quality improvement aspect of the network.

QN-CRHTT works with Crisis Resolution and Home Treatment Teams to assure and improve the quality of services for people with acute mental illness and their families/carers. The network facilitates quality improvement and service development using a peer-review model that encourages sharing of best practice across services.



The network currently has **67** members.[1]

36 accredited.

28 members.[2]

3 not accredited.

The Standards

The QN-CRHTT standards provide a clear and comprehensive guidance for CRHTT's and are developed from extensive consultation with professionals, patients, and family/carers.

The standards are reviewed every two years with the fifth edition published in June 2022. The QN-CRHTT standards (see Appendix A) cover the following areas:

- Service provision and structure
- Staffing and training
- Assessment, care planning and treatment
- Patient and family/carer experience

---

[1] *As of 12th June 2023.*

[2] *There are currently 19 teams going through the peer-review process in the 2022/2023 cycle.*

Patient and Family/Carer Representatives

Our patient and family/carer representatives have lived experience of accessing crisis resolution and home treatment services and are a fundamental component of QN-CRHTT.

> “As we have lived experience, we often have examples of specific practices that improved the patient and family/carer experience from our perspective.

Our representatives provide invaluable input and contributions and work across many different areas within the network including training, advisory groups and accreditation committees. They are also an integral part of the review process and provide crucial recommendations to services undergoing a peer-review.

> “...Staff hearing from patients and family/carers about what works or does not work in times of crisis, allows teams to develop their own patient and family/carer initiatives.”
>
> Vittoria De Meo and Ingrid Baldwin, Patient and Family/Carer Representatives, QN-CRHTT.

There are 5 patient and family/carer representatives within QN-CRHTT. Patients and carers hold a 3-year fixed term contract.

Our representatives are paid a fixed day rate of £140 and £70 for a half day rate.A day rate equates to hours worked over 4 hours and up to 8 hours.

QN-CRHTT holds half-day catch up meetings twice a year. These meetings are to check in with representatives on how their role is going and future developments.

Recruitment opportunities for patient and family/carer representatives can be found on the College website under 'Vacancies'

The Review Process

1. Self-Review

Services undergo a 12-week period where they mark their policies, procedures, and practices as ‘Met’, ‘Not Met’ or ‘Non-Applicable’, against the QN-CRHTT standards. Feedback is also collected from staff members, patients, family/carers, and an audit of case notes.

2. Peer-Review

The teams self-review data is validated during a one-day peer-review visit. The peer-review team includes a QN-CRHTT staff member, a patient or family/carer representative, and clinicians from other CRHTTs.

The findings from the review process are then collated into a draft report. Teams seeking accreditation will be presented at our accreditation committee for review.

3. Accreditation Committee (AC)*

The AC comprises of clinicians who represent key areas of expertise within CRHTTs, and patients and family/carers who have experience using these services. Services can be presented up to three times and to be accredited, teams must meet 100% of type 1 standards, at least 80% of type 2 standards and at least 60% of type 3 standards.

** New member services are required to first undertake a developmental review and will not go through the AC.*

4. Final Report

Reports are finalised and we strongly recommend teams share their report with the Trust, commissioners, and regulators.

5. Action Plan

Services can use their final report to complete an action plan, which is used to identify goals and targets for improvement. The action plan is used to provide updates during a team’s interim review and the next peer-review.

2. Key Findings

These key findings are based on patient and family/carer related standards. Data has been taken from draft reports of peer-review visits that took place between January 2021 and December 2021.

74% of patient and family/carer related standards were met.

Service Provision and Structure
79% of standards met.

Staffing and Training
47% of standards met.

Assessment, Care Planning, Treatment
88% of standards met.

Patient and Family/Carer Experience
74% of standards met.

82% of **Type 1** standards met.

72% of **Type 2** standards met.

48% of **Type 3** standards met.

All Patient and Family/Carer Related Standards

In the QN-CRHTT 4th edition of standards, there are 46 standards relating to patients and family/carers experience. On average, 74% of these standards have been met following a peer-review. The majority of teams performed above this 74% benchmark.

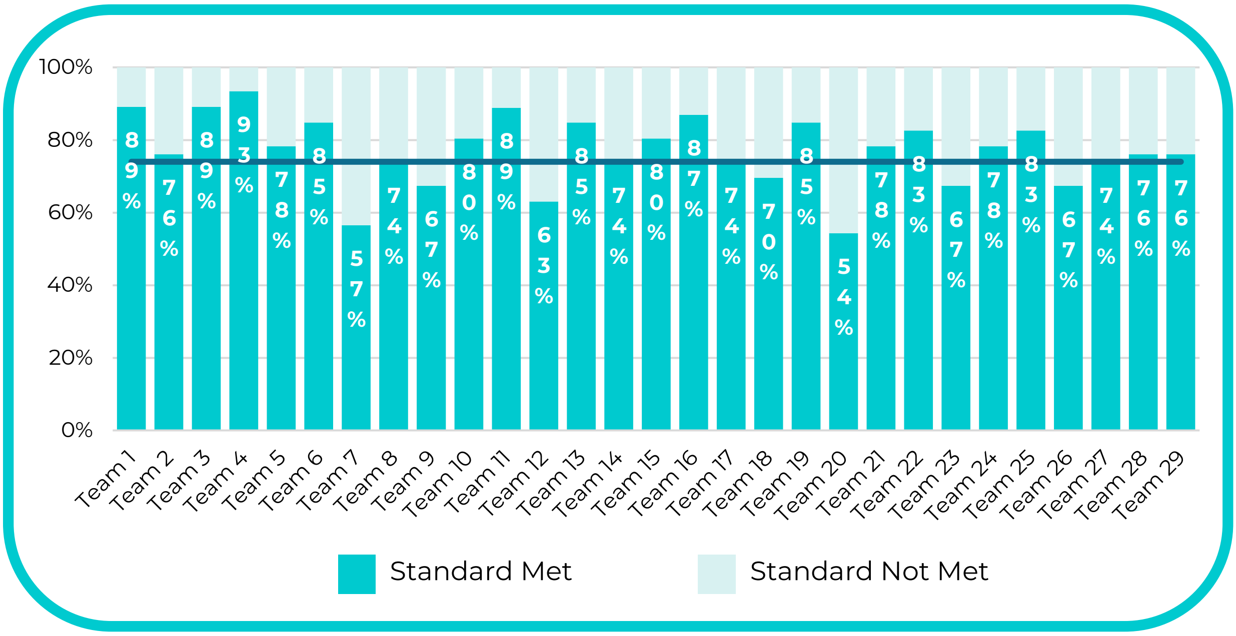


Figure 1. Percentage of patient and family/carer related standards met per team following the peer-review visit.

Contextual Information

QN-CRHTT collects a variety of contextual information about services. This information is submitted by each service during their self-review period.

Teams had a mean caseload of **37** patients, ranging between 14 and 82.

On average, patients were under the care of the team for **22** days.

86% of teams operate on a 24/7 basis.

Type 1 Standards

Type 1 standards reflect on the fundamentals of care, including the provision of evidence-based treatment. Failure to meet these standards would result in a significant threat to patient safety, rights, or dignity and/or would breach the law. On average, 82% of Type 1 patient and family/carer related standards were met following the peer-review visit.

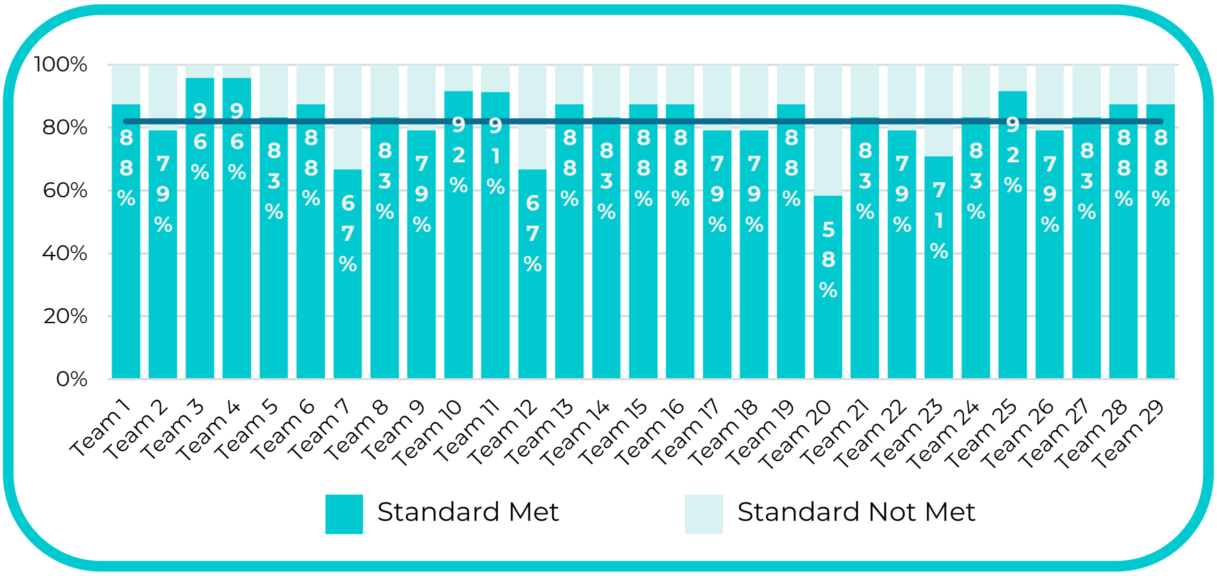


Figure 2. Percentage of Type 1 patient and family/carer related standards met per team.

Type 2 Standards

Type 2 standards are standards that teams going through accreditation would be expected to meet. On average, 72% of Type 2 patient and family/carer related standards were met following the peer-review visit.

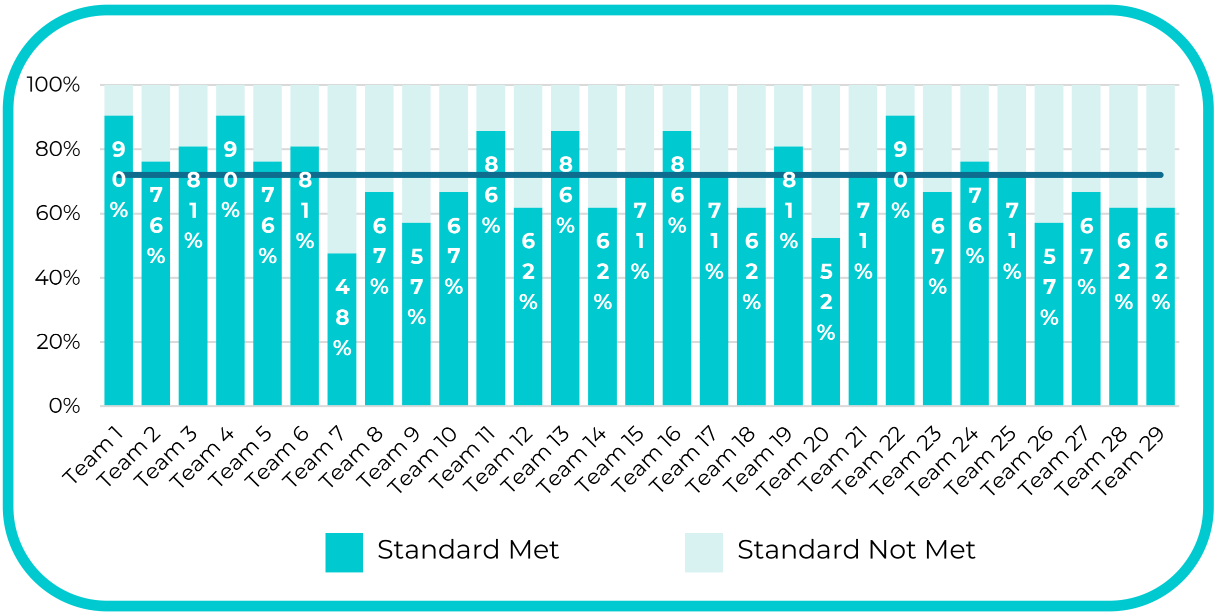


Figure 3. Percentage of Type 2 patient and family/carer related standards met per team.

Service Provision and Structure

This section of the report looks at the standards which focus on the following: information available to patients and family/carers, confidentiality, service development and gathering feedback.[3]

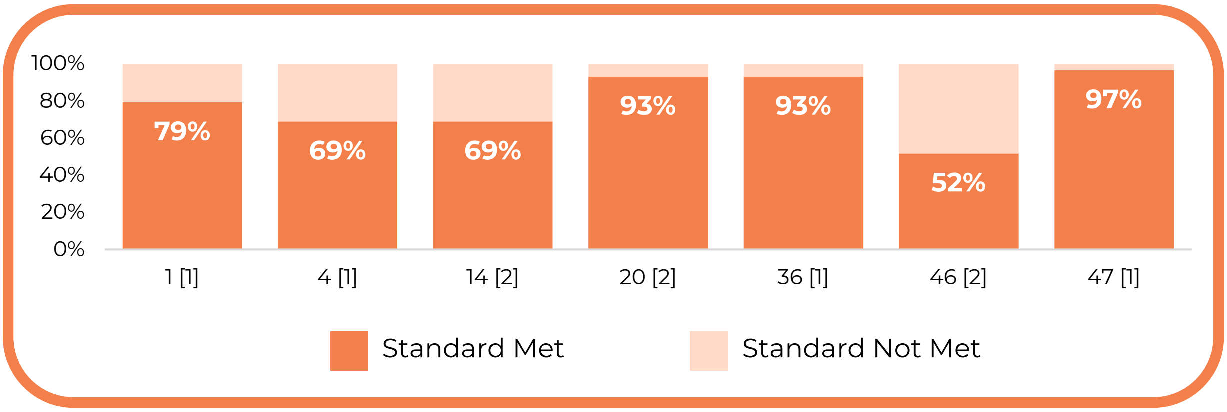


Figure 4. Percentage of each patient and family/carer standards under service provision and structure met across teams.

Areas of Achievement

- **97%** of services ask patients and family/carers for their feedback about their experiences of using the service and this is used to improve the service (47 [1]).
- **93%** of services provide patients and family/carers with information about expected waiting times for assessment and treatment (20[2]).
- Patients and family/carers felt involved in discharge planning from acute inpatient services to the CRHTT in **93%** of services (36 [3]).

Areas for Improvement

- **52%** of services actively encourage patients and family/carers to be involved in quality improvement initiatives (46 [2]).
- **69%** of services provide patients and family/carers with written and verbal information on confidentiality (4 [1]).
- Patients and family/carers are involved in the development of **69%** of services (14 [2]).

> Staff were delayed which made the patient feel anxious - 20[2] – **Family/Carer**

> The team give generously of their time and expertise – **Family/Carer**

> Highly professional, procedures were discussed and explained. I felt treated as a grown up and was given agency in my own care - 36 [1] - **Patient**

Reflection activity – Standard 14 [2] and 46 [2]

Think of a time when patient and family/carer involvement has made a difference to your service. Was the patient or family/carer involved in all aspects of the change? Do you think the level of their involvement could be improved and if so, how?

---

[3] To see the specific patient and family/carer standards please see Appendix A.

On average, 79% of patient and family/carer related standards in the Service Provision and Structure section have been met following the peer-review.

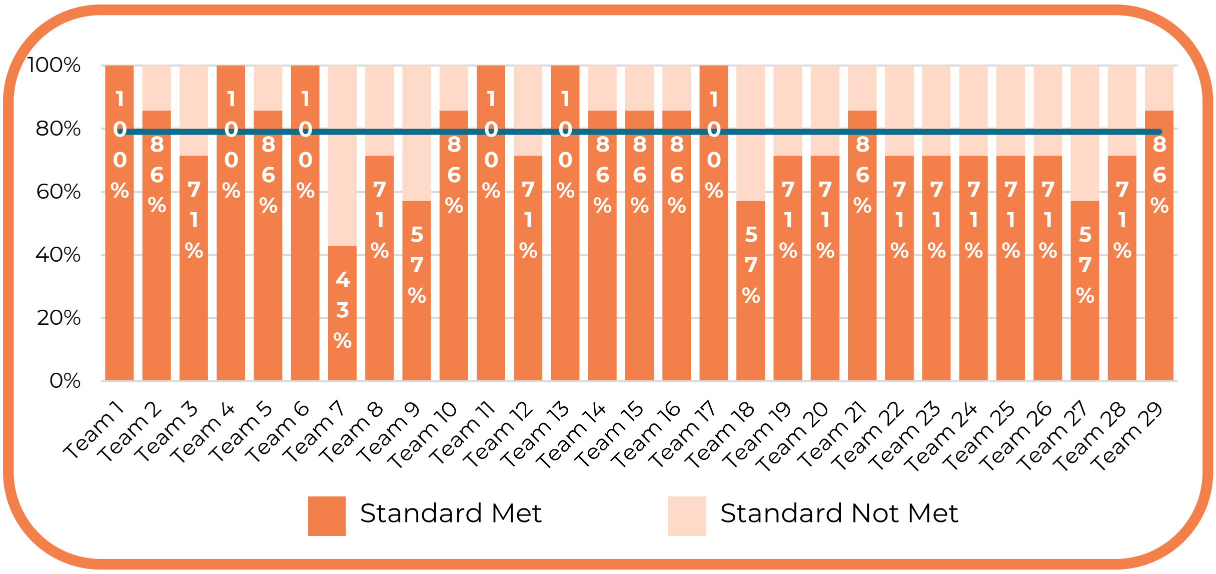


Figure 5. Percentage of patient and family/carer standards under service provision and structure met per team.

Best Practice Examples

The team have a “You Said, We Did” board to show patients and family/carers any actions that have taken place following feedback.

Lewisham Home Treatment Team
South London and Maudsley NHS Foundation Trust

Following patient feedback, a ‘Write to Me’ project was initiated to update the discharge letter template. The letters are written directly to patients and their family/carers with other services (the GP, etc) copied in. They are warm and engaging in tone, written in plain language and meets the required standards for information sharing. This model of ’Write to Me’ is now forming the basis of the policy review for sharing letters with patients and their family/carers and the record keeping policies.

Sunderland and South Tyneside CRHTT
Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust

Staffing and Training

This section of the report looks at the standards which focus on involving patient and family/carers within staff recruitment and staff training.

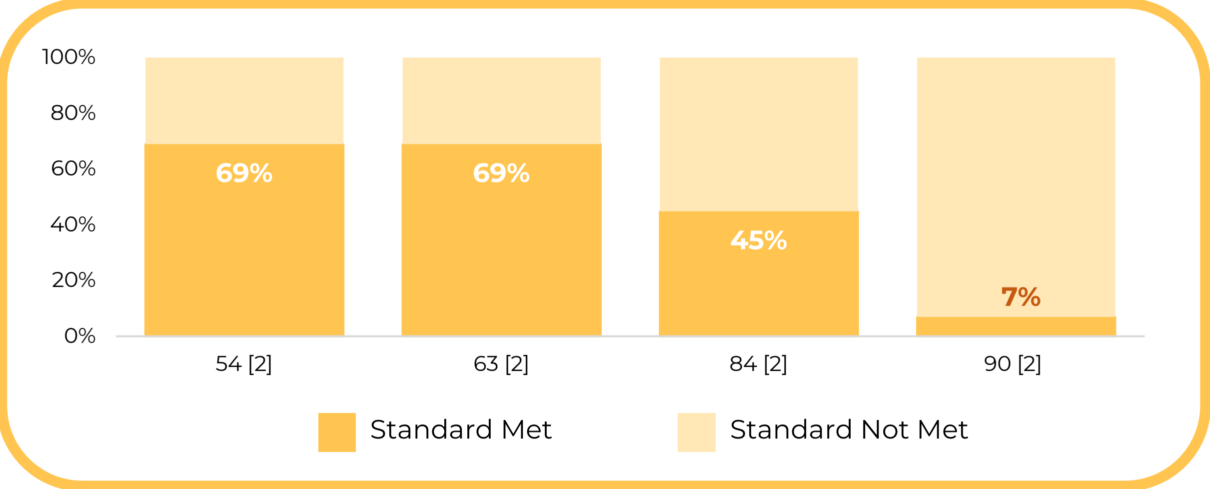


Figure 6. Percentage of each patient and family/carer standards under staffing and training met across teams.

Areas of Achievement

- Patient and family/carer representatives are involved in the interview process for recruiting new staff members in **69%** of services (54 [2]).
- **69%** of services have access to peer-support workers (63 [2]).

Areas for Improvement

- **7%** of services involve patients and family/carers in delivering staff training face-to-face (90 [2]).
- **45%** of services have received training on carer awareness, family inclusive practice and social systems, including carers rights in relation to confidentiality (84 [2]).

> It would be nice to not have to see many different people every day – **Patient**

> The support that I was given by [all] the staff was invaluable, especially as I was extremely reluctant to engage - **Patient**

> We were visited by many different team members who, at first, all asked many of the same questions. Limiting the number of staff involved with one patient would be preferable – **Family/Carer**

Reflection activity – Standard 54 [2] and 90 [2]

What are the barriers in your team when involving patients and family/carers? Refer to page 24 to see possible barriers and how to overcome them.

On average, 47% of patient and family/carer related standards in the Staffing and Training section have been met following peer-reviews.

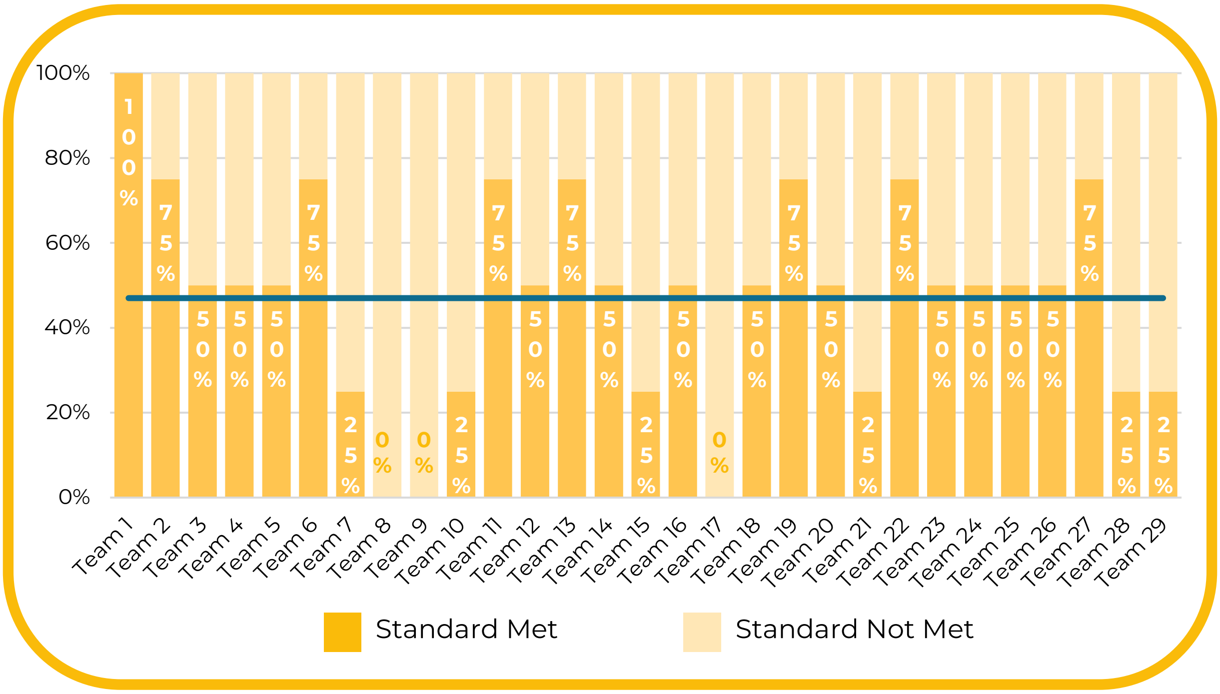


Figure 7. Percentage of patient and family/carer standards under staffing and training met per team.

Best Practice Examples

Staff members have received training in carer awareness. The training was co-facilitated by a carer representative.

Northumberland Crisis Team
Cumbria Northumberland Tyne and Wear NHS Foundation Trust

There are two designated carer leads within the team. The leads have weekly protected time to contact carers and offer support. This was implemented as a result of the COVID-19 pandemic and recognising the need for more carer support during the pandemic. The team has maintained this post-covid and it continues to work well.

Southwark Home Treatment Team
South London and Maudsley NHS Foundation Trust

Patients and family/carers are routinely involved in service development and quality improvement initiatives, and their feedback is valued and encouraged. For example, a recent development day was co-led and co-produced by patients and family/carers, and they are regularly involved in staff recruitment.

Haringey CRHTT
Barnet, Enfield, and Haringey Mental Health NHS Trust

Assessment, Care Planning, and Treatment

This section of the report looks at the standards which focus on providing patients and family/carers with information regarding their treatment, sharing appropriate resources and involving them with decisions about their care.

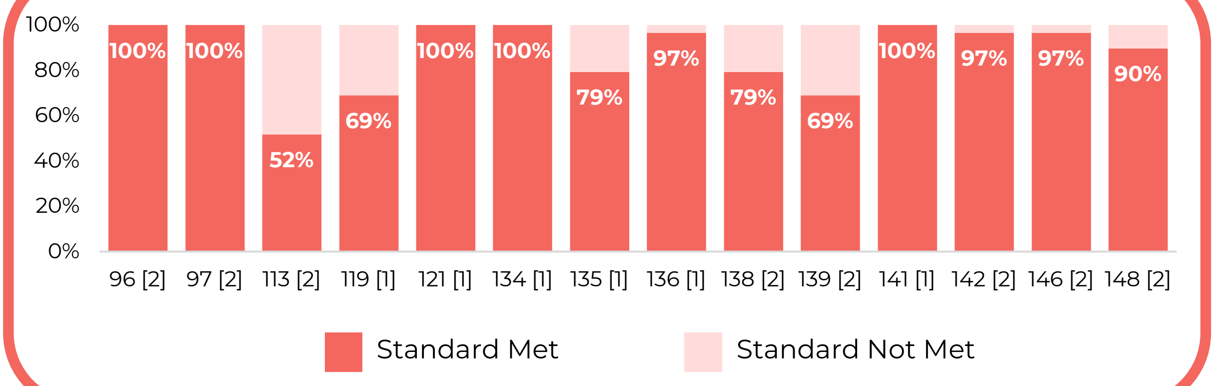


Figure 8. Percentage of each patient and family/carer standards under assessment, care planning, and treatment met across teams.

Areas of Achievement

- **100%** of services ensured that the patient and their family/carers understood the purpose of treatment (96 [2]).
- **100%** of services informed patients at the assessment that home treatment is a brief intervention, the expected length of time they would be involved with the team, and the nature of the team approach (97 [2]).

Areas for Improvement

- **52%** of services routinely offer family/carers the opportunity to meet separately from the patient to discuss risk management, where appropriate (113 [2]).
- **69%** of teams offer the patient and their family/carer (with patient consent) a copy of their care plan and the opportunity to review it (119 [1]).

> The team were very supportive and kind and helped me feel comfortable. They respected my choices - **Patient**

> It would be helpful to have my assessment in writing, so I can familiarise myself with the team and what they're suggesting – 97 [2] - **Family/Carer**

> I cannot praise the team enough. They saved my life. Not only were they looking after me, they offered their support to my family as well - **Patient**

Reflection activity – Standard 121 [1] and 148 [2]

Thinking about the service you provide, why is it important for patient and family/carers to be involved in decisions about their care? How does it impact their outcomes and recovery?

On average, 88% of patient and family/carer related standards in the Assessment, Care Planning, and Treatment section have been met in the draft reports.

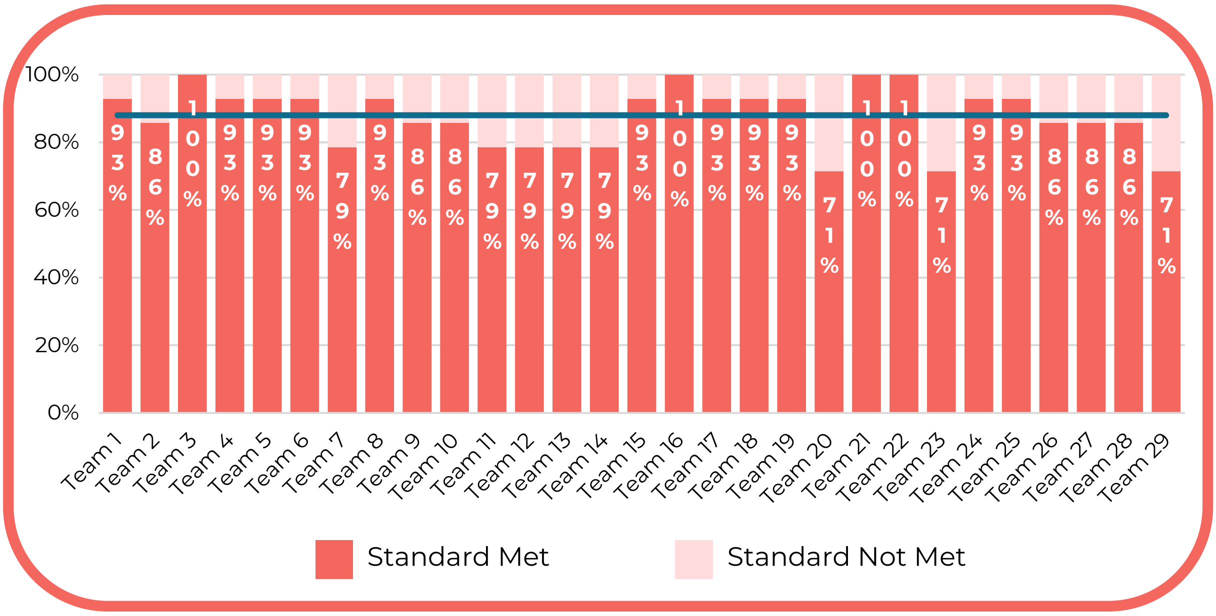


Figure 9. Percentage of patient and family/carer standards under assessment, care planning, and treatment met per team.

Best Practice Examples

Before referring to the home treatment team, the team encourages referrers to inform the patient that home treatment is a brief intervention, the expected length of time and that they will be seen by different clinicians. This has helped manage patients' expectations.

Kingston Home Treatment Team
South West London & St Georges Mental Health NHS Trust

The teams' pharmacy technician is available to discuss medications with patients and carry out home visits to patients and family/carers.

South Camden CRHTT, North Camden CRHTT, and Islington CRHTT
Camden and Islington NHS Foundation Trust

The team has a carer's lead in place and the team offers family/carers individual time to discuss any concerns.

Harrow Home Treatment Team
Central and North West London NHS Foundation Trust

Patient and Family/Carer Experience

This section of the report looks at the standards which focus on quality of care and the general support the team provide.

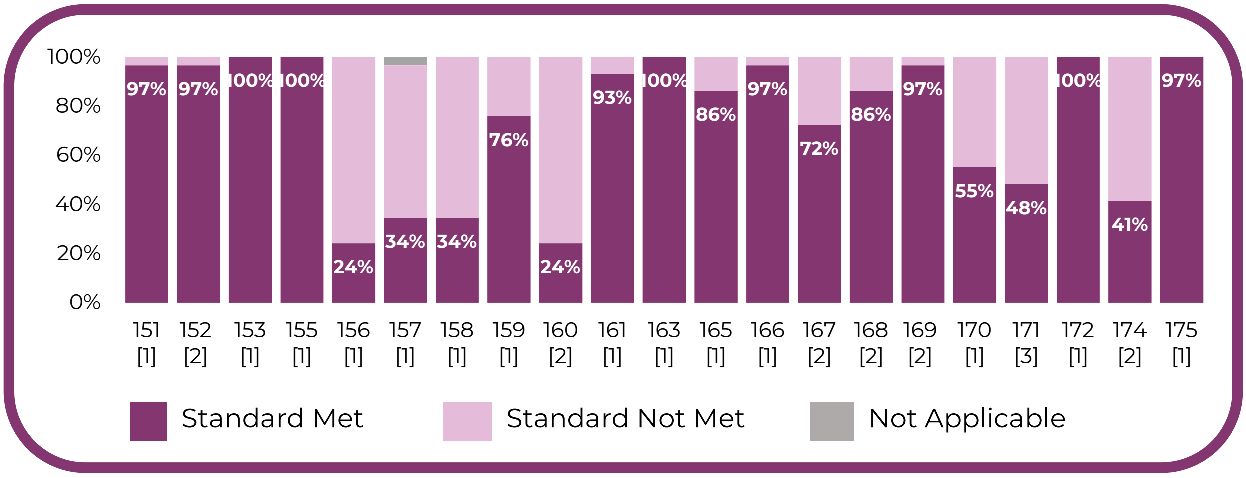


Figure 10. Percentage of each patient and family/carer standards under patient and family/carer experience met across teams.

Areas of Achievement

- **100%** of services give patients and their family/carers a direct contact number to access help 24 hours a day (153 [1]).
- **100%** of services treat patients with compassion, dignity, and respect (155 [1]).
- **100%** of services support patients to access housing, finances, and social services (163 [1]).

Areas for Improvement

- **24%** of services give patients accessible written information which includes how to access advocacy services and interpreting services, which staff members talk through with them (156 [1]).
- **24%** of services offer written information to patients and their family/carers about transitional support services (160 [1]).

> Their patience, kindness and generosity with their time really made a difference – 155 [1] - **Family/Carer**

> Staff went above and beyond for my family - **Family/Carer**

> The team was truly outstanding in terms of their expertise, diligence, professionalism, and empathy - **Patient**

Reflection activity

Think of a time your team received negative feedback from a patient or family/carer. Were any changes made as a result of the feedback? How did you learn from this experience?

On average, 88% of patient and family/carer related standards in the Patient and Family/Carer Experience section have been met following the peer-review.

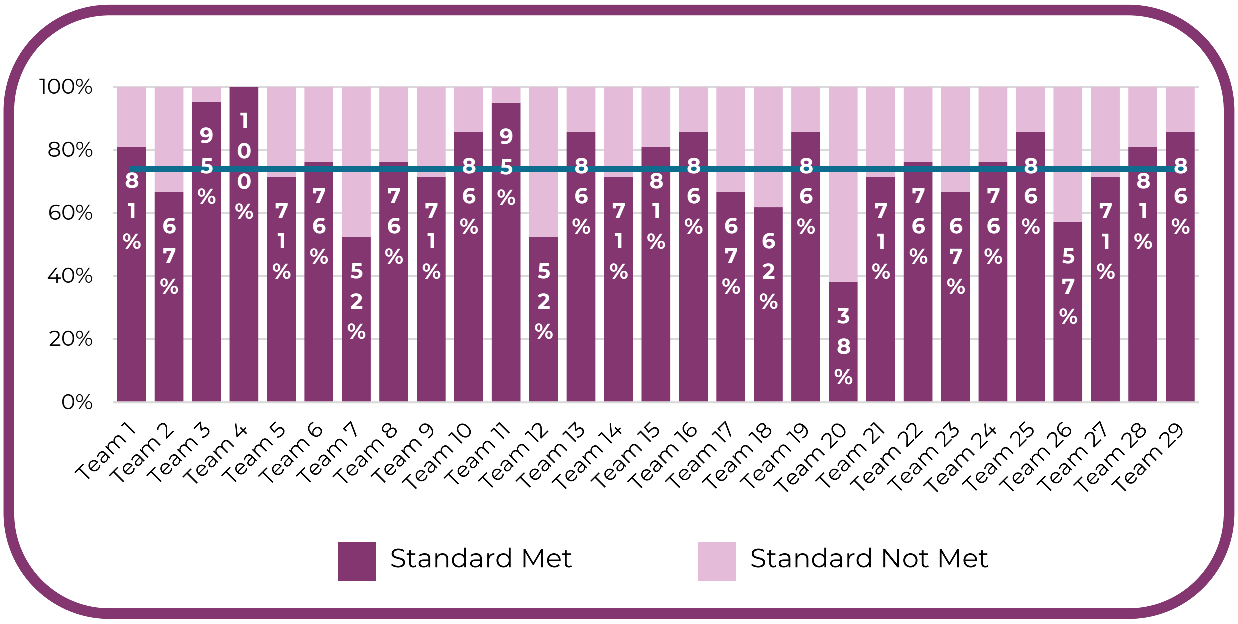


Figure 10. Percentage of patient and family/carer standards under patient and family/carer experience met per team.

Best Practice Examples

The team has a Crisis Café to help people who may need additional care and support. The Crisis Café has been used to gather informal feedback and is also an opportunity for staff to engage patients in volunteering and meaningful social activities, as well as providing additional skills to help when in crisis.

Grimsby's Older People's Crisis Home Treatment Team,
NAViGO

The team have strong links with patient and family/carer advocates and have worked together produce a carer awareness training package. They also have regular interface meetings to discuss service development, quality improvement initiatives and feedback the team have received.

Belfast Home Treatment Team,
Belfast health and Social Care Trust

There is a social worker in the team who is dedicated to providing one-to-one support with patients and family/carers once a week.

Wandsworth CRHTT,
South West London and St George's Mental Health NHS Trust

3. Including Patients and Family/Carers

Patient and Family/Carer Feedback

Standard 47 (type 1)

The service asks patients and carers for their feedback about their experiences of using the service and this is used to improve the service.

A common difficulty that Crisis Resolution and Home Treatment Teams face, is collecting enough patient and carer feedback. As part of the self-review, teams are required to gather feedback from at least 10 patients and 10 family/carers using surveys developed by the network. During the peer-review visit the peer-review team will speak either face-to-face or over the phone with an additional **three** patients and **three** family/carers. Feedback helps determine whether services are meeting standards relating to patient and family/carer care.

The feedback gathered is vital to the review process as it highlights the experience of those who have accessed the service. On average, member services collected 16 patient surveys and 14 family/carer surveys.

Top Tips for Collecting Patient and Carer Feedback

- Design questionnaires with patients and family/carers.
- Make it easy for patients and family/carers to give their views. For example, questionnaires should be quick, and available in different forms e.g., paper version, QR codes and web links.
- Capture feedback at the beginning and end of the patient and family/carer journey.
- Implement a Feedback Champion. This role could involve taking the lead on gathering feedback and highlighting areas of achievement/improvement with the wider team.
- Ensure patients and family/carers know how their feedback will be used. Create a 'You Said, We Did' board to highlight any changes that have been made due to the feedback gathered.

The Benefits of Working with Patients and Family/Carers

There are many benefits of involving and working with patients and family/carers. [4]

Staff can look at the values of the team and ensure that they are engaging and employing the right mix of staff.

Staff can gain insight and find their stereotypes helpfully challenged by the input of teaching from patients and family/carers.

Patients and family/carers can reinforce the value of person-centred healthcare which can sometimes be forgotten when working in a busy and pressured mental health setting.

---

[4] Lucy Keating, Urgent Care Deputy at Kensington & Chelsea and Westminster, Central and North West London NHS Foundation Trust.

Recruitment Panels

Standard 54 (type 2):

Appropriately experienced patient or family/carer representatives are involved in the interview process for recruiting staff members.

Having patient and family/carer representatives involved in the interview process is valuable as they can bring a different perspective on who would be right for the job. Qualities such as compassion, empathy, active listening, and willingness to be open are desirable traits in potential staff members. Patients and family/carers can develop questions which relate to some of the attributes they would want in a staff member.

Some examples of questions developed by patient and family/carers panels are:

- As a Consultant Psychiatrist you have a professional duty to contribute to the teaching and training of the next generation of doctors. How would you encourage a student to take psychiatry as a career and what would you tell about the pros and cons of the profession?

- Patients may have different experiences of care, varying from extremely positive and supportive to poor quality and difficult to manage. In your role you will work with partners from various settings. How would you embed an effective partnership working that can lead to a better service and support for patients and their family/carers?

- Please tell us about a mistake you have made in your career. What did you learn from it and how would you apply this learning to your new position?

Away Days

Standard 81 (type 2):

Staff take part in team building on an annual basis, training in colleague support and working within the team framework.

Away days are a great way for staff to get together with protected time for training and development, to discuss service improvements, and have some fun with their team Inviting experienced patients and family/carers to attend away days and deliver training can be a huge benefit for the team.

> “I have been involved in a few away days for different services. Each time the aim of my presence was very clear: raising awareness about the importance of involving patients and family/carers within a service.
>
> “In my last involvement at an away day in an opening speech, I praised the team for their amazing work and spoke about the importance of valuing staff and investing in their well-being so they can offer better care for patients. An away day can play a small part of that.”
>
> (Vittoria De Meo, QNCRHTT Patient and Family/Carer representative)

Patient and Family/Carer Governors or Councils

Some services have embraced the need for patients and family/carers to be represented at board level. For example, recruiting patient and family/carer governors or councils. Patient and family/carer governors are interested in the work of mental health services and Trusts. They work to ensure the voice of the community are heard at the top of all decision-making processes. They are responsible for representing the views of members and partner organisations to the board of directors and feeding back information about the Trust and its performance.

Cambridgeshire and Peterborough NHS Foundation Trust

Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) has introduced Carer Governors. At present, the Lead Carer Governor is Keith Grimwade who became a Governor to say, ‘thank you’.

> “I became a Governor for two reasons: a ‘thank you’ to the Trust for the support it had given to a family member with a serious mental health illness, and for the support it had given to us as a family. [I wanted to] support and challenge the Trust to improve carer support so that all families benefited in the way that I did.
>
> As a Lead Governor I have some extra responsibilities, including regular meetings with the Chair of our Trust. The main issues I have highlighted in my constituency are support for carers, how carers can best help their loved ones and getting the best possible care for our loved ones.”

Governors should support and challenge the Trust when improvements are needed, with a key factor being championing greater involvement with carers. Keith finds his role very rewarding and highlights the lived experience as a fundamental factor for change.

> “The best thing about being a Governor is being able to represent our constituencies and see changes for the better as a result; meet many inspiring and dedicated members of staff; and enjoy being part of something that is very worthwhile.”

Keith Grimwade
Lead and Carer Governor – Cambridgeshire and Peterborough NHS Foundation Trust

Peer Support Workers

Peer support workers are people who have lived experience of mental health struggles. They draw upon their personal experiences to support and care for others accessing mental health services. Peer support workers in crisis resolution and home treatment teams can offer a safe and non-judgmental place for a patient to discuss their difficulties. Gus Cavanagh, a peer support worker in the Islington Crisis Team, says his role empowers patients:

> We offer patients 10, hourly sessions over a period of three months after discharge from the crisis team. We use our lived experience of mental health challenges to support those recovering from a crisis. We work with people who don't already have a lot of support, using a strength based, empathic approach to empower service users to look after themselves independently. The relationships we form are reciprocal and the role is a great opportunity to make a meaningful contribution to people's lives. I enjoy sharing my own experiences, when it's appropriate, to foster hope and to help destigmatise mental health.

(Gus Cavanagh, Peer Support Worker, Islington Crisis Team)

Health Education England competence framework for mental health peer support workers[5] lists the following values of peer-support work:

Inclusivity
• Making sure that support is available to those who need it. • Working with people to help them identify and connect with their chosen communities.
Respect
• Being interested in each other as individuals. • Building an accepting and respectful relationship. • Respecting the person's background, culture or membership of a particular community. • Not making judgements or assumptions about the person's experiences or beliefs.
Reciprocity
• People benefit from sharing their experience and can learn from each other as equals. • Everyone learns and everyone's contribution is of equal value.
Mutuality
• Sharing experiences across dimensions such as mental health difficulties and use of services. • Understanding the person's experience from their perspective. • Feeling a sense of solidarity with each other.

---

[5] NHS Health Education England. (2020, October). The Competence Framework for Mental Health Peer Support Workers. Retrieved November 15, 2022, from https://www.hee.nhs.uk/sites/default/files/documents/The%20Competence%20Framework%20for%20MH%20PSWs%20-%20Part%202%20-%20Full%20listing%20of%20the%20competences.pdf

4. Co-Production vs Involvement

What is co-production and why is it important?

A common misconception is that co-production and involvement are the same. However, involvement is when a group or person is asked to input at a certain point in the project. Whereas co-production consists of an equal collaborative effort between two or more groups to develop, create and participate from the beginning to the end of a project.

Involvement is asking patients and family/carers for their feedback on training

Whereas

Co-production is developing training with patient and family/carers

Co-production is important in commissioning as it brings together patients and family/carers, commissioners, and staff to work together as equal partners in decision-making. Co-production can be a useful tool to improve the quality of care and improve patient outcomes.

Co-production has been broken down into the following activities:

Definition	Example
Co-design in the planning of services.	Developing staff training with patient and family/carer representatives.
	Patient and family/carer representatives attending service development meetings within the Trust.
Co-decision making in the allocation of resources.	Having patient and family/carer representatives on interview panels and developing interview questions.
	Patient and family/carer representatives developing resources (e.g. leaflets) with staff members.
Co-delivery of services.	Involving patients and family/carers in quality improvement initiatives.
	Patient and family/carer representatives delivering training to staff. This could be during the team's away day.
Co-evaluation of the service.	Gathering feedback from patients and family/carers and working together to make changes.
	Having a patient and family/carer involvement lead who works closely with patient and family/carer representatives.

Barriers and How to Overcome Them

The principles of co-production include valuing equality, diversity and inclusion. Acting in accordance with these principles helps to make co-production genuine and authentic. Services should ensure that patients and family/carers have an equal opportunity to contribute to and influence the development of their service. Patients and family/carers should feel their voices are heard and their input is beneficial.

Effective planning for participation is necessary to ensure engagement is accessible and inclusive. Below are a few factors to consider when working with patients and family/carers:

Virtual
There are pros and cons to both virtual and face-to-face platforms. Young people are misrepresented in engagement and introducing virtual platforms can encourage participation from this age group. However, some patients and family/carers may face digital barriers such as economic disadvantage, accessibility, and lack of digital skills.[6] Teams should plan in advance and identify any individual needs and preferences in relation to the platform of participation. Teams should offer extra support such as tech tests if digital platforms are used and a telephone option should also be available.
Payment
Patients and family/carers should be compensated for their time and input. Where possible, provision for transport should also be considered. Payment shows that patients and family/carers are valued, and their work is recognised.
Build trusting relationships
Teams should be aware that power dynamics can influence a patient and family/carers confidence and cooperation towards participation. Patients and family/carers should feel comfortable challenging healthcare professionals where necessary, and their views and opinions should be valued. Remaining transparent, discussing the structural issues of power within involvement and actively empowering patients and family/carers can help break down barriers and build trusting and respectful relationships. [7]
Knowledge and skill
It is important to remember to use language carefully, for example jargon should be avoided, and participants should agree on shared terminology at the beginning stages of co-production. All patients and family/carers are different, so it is best practice to find out from each person if they have any accessibility needs.

---

[6] Public Participation Team, *NHS England and Patient and public participation equality and health inequalities - full analysis and associated resources* (April 2016).

[7] Ocloo, J., Garfield, S., Franklin, B.D. et al. Exploring the theory, barriers and enablers for patient and public involvement across health, social care and patient safety: a systematic review of reviews. Health Res Policy Sys 19, 8 (2021). https://doi.org/10.1186/s12961-020-00644-3

Getting the timing right

If patients have recently (within six weeks) or are currently experiencing an acute episode and are under the care of a CRHTT, it is essential to consider whether participation will impact their recovery.

Collaboration

Finding patients and family/carers to be involved in service development is often identified as a struggle within the network. Teams should consider tapping into existing connections such as local community organisations. A dedicated community champion/lead could be implemented to help build closer one on one relationships.

Work can be done to recruit under-represented groups in your local population, for example speaking with religious groups or visiting community centres. Training in cultural awareness should be provided to all staff.

Teams should also value the diversity within their staff team. For example, if a patient and family/carer is within the LGBTQ+ community, they may feel more comfortable and confident sharing their experience with a staff member from the same community. The NHS Rainbow Badge Scheme is a method of offering this same space.[8]

Do not:

- Assume that all patients and family/carers wish to be involved.
- Set unrealistic timeframes.
- Use clinical terminology that patients and family/carers are unfamiliar with.
- Insist on specific meeting times and venues; patients and carers need flexibility to enable them to participate.
- Rely only on Trust involvement; teams should work independently to involve patient and family/carers.

Do:

- Ensure that patient and family/carers can contribute meaningfully, for example, patients should be well enough to participate.
- Provide patient and family/carers with information about expectations.
- Involve patients and family/carers in all aspects of planning and delivery.
- Adopt a supportive and equal approach towards patients and family/carers.
- Value everyone's personal knowledge and expertise.

Reflection activity

Think of the demographics of the population you serve. Is there a demographic of patients and family/carers you are not reaching? How can you further engage to improve accessibility for these under-represented groups?

---

[8] Bortoli, S., Din, S., Onerhime-Prince, L., (2022) How to incorporate Equality, Diversity and Inclusion (EDI) in Patient and Public Involvement (PPI) [Webinar] National institute for Health Research How to incorporate Equality, Diversity and Inclusion (EDI) in Patient and Public Involvement (PPI) - YouTube

Summary

We hope that this national report provided you with a breadth of useful information regarding patients and family/carers within CRHTTs.

Thank you to all of our member services for your constant engagement, inspiration and dedication to providing the best possible care for patients and family/carers.

We would like to end this report with our last reflection activity below:

Reflection activity

What did you learn from this report that you would like to take back to your teams?

Acknowledgements

We would like to thank the individuals and organisations that have generously contributed their time and expertise to this report, including:

Pranveer Singh, Essex Partnership NHS Foundation Trust

Anna Tuke, Cambridgeshire and Peterborough NHS Foundation Trust

Keith Grimwade, Cambridgeshire and Peterborough NHS Foundation Trust

Steven Jack, Tees Esk and Wear NHS Foundation Trust

Gus Cavanagh-Snewin, Camden and Islington NHS Foundation Trust

Lucy Palmer, Central and North West London NHS Foundation Trust

QN-CRHTT member services

Appendix A: Standards relating to patients and family/carers (4th edt)

No. & Type	Standard
Service Provision and Structure	
1 [1]	Clear information is made available, in paper and electronic formats, to patients, family/carer and healthcare practitioners on: A simple description of the service and its purpose. • Clear referral criteria. • How to make a referral, including self-referral if the service allows. • Clear clinical pathways describing access and discharge (and how to navigate them). • Main interventions and treatments available. • Contact details for the service, including emergency and out of hours details. **Guidance:** This information is co-produced with patients.
4 [1]	Confidentiality and its limits are explained to the patient and their family/carer at the initial assessment, both verbally and in writing. The patient's preferences for sharing information with third parties are respected and reviewed regularly.
14 [2]	Services are developed in partnership with appropriately experienced patients and family/carers, who have an active role in decision making.
20 [2]	The team provides patients and family/carers with information about expected waiting times for assessment and treatment.
36 [1]	The patient and their family/carers are involved in discharge planning from acute inpatient services to the home treatment team.
46 [2]	The team actively encourage patients and carers to be involved in quality improvement initiatives.
47 [1]	The service asks patients and carers for their feedback about their experiences of using the service and this is used to improve the service. **Guidance:** Written information is offered to patients and family/carers about how to give feedback to the team, including compliments, comments, concerns and complaints.
Staffing and Training	
54 [2]	Appropriately experienced patient or family/carer representatives are involved in the interview process for recruiting staff members.
63 [2]	The team has access to peer support worker(s). **Guidance:** A patient or carer representative employed by the team to support other patients and/or carers.

84 [2]	All staff have received training in carer awareness, family inclusive practice and social systems, including carers' rights in relation to confidentiality.
90 [2]	Patients and family/carers are involved in delivering staff training face-to-face.
	Assessment, Care Planning and Treatment.
96 [2]	The team ensure that the patient and their family/carers understand the purpose of the assessment.
97 [2]	The patient is informed at the assessment that home treatment is a brief intervention, the expected length of time they would be involved with the team and the nature of the team approach.
113 [2]	Family/carers are routinely offered the opportunity to meet separately from the patient to discuss risk management, where appropriate.
119 [1]	The patient and their family/carer (with patient consent) are offered a copy of the care plan and the opportunity to review this.
121 [1]	Patients are actively involved in shared decision-making about their mental and physical health care, treatment and discharge planning and supported in self-management.
134[1]	Patients (and their family/carers, with patient consent) are helped to understand the purpose, expected outcomes, interactions, limitations and side effects of their medications and to enable them to make informed choices and to self-manage as far as possible.
135 [1]	Patients, family/carers and prescribers are able to contact a specialist pharmacist and/or pharmacy technician to discuss medications.
136 [1]	When a patient is discharged from the home treatment team, a detailed account of the medicines prescribed is provided to their community mental health team, GP and the patient. This should include with reasons for all new medicines started, doses increased or reduced, and all medicines stopped.
138 [1]	Patients and their families/carers can be signposted to gender-specific services. **Guidance:** For example, women- or men-only groups.

139 [2]	The team is able to provide a range of therapies to patients and their family/carers based on need. **Guidance:** Interventions could be drawn from the following approaches: 1. Cognitive Behavioural Therapy (CBT) approaches including Dialectical Behaviour Therapy (DBT) and Mindfulness-Based Cognitive Therapy (MBCT) 2. Psychodynamic approaches including Interpersonal Psychotherapy (IPT) and Cognitive Analytic Therapy (CAT) 3. Psycho-educational approaches 4. Solution-Focused Brief Therapy (SFBT) 5. Problem-Solving approaches 6. Family Interventions for Psychosis 7. Motivational Interviewing 8. Person-Centred approaches 9. Systemic approaches 10. Stress management 11. Supportive counselling 12. Relapse prevention.
141 [2]	The team supports patients to undertake structured activities such as work, education and volunteering. **Guidance:** For patients who wish to find or return to work, this could include supporting them to access pre-vocational training or employment programmes. This is managed through the care plan.
142 [2]	The team supports patients to continue to attend community resources where this has been assessed for risk, such as faith communities and Alcoholics Anonymous.
146 [2]	The patient and their family/carers (where appropriate) are informed as early as possible of when their care is going to be transferred from the team.
148 [2]	Families/carers are informed and involved when discharge is planned, if consent has been given by the patient. **Guidance:** This includes what contact they can expect and how to plan themselves for the event.
Patient and Family/Carer Experience	
151 [1]	The team contacts the patient and their family/carers to agree on contact times, frequency and duration of contact, and ensures they are informed about unavoidable delays.
152 [2]	The patient reaches an agreement with the team about where they would like their assessment to take place and the team is able to conduct visits remotely. **Guidance:** Visits could be conducted via, for example, Skype or FaceTime.
153 [1]	Patients and their families/carers are given a direct contact number to access help, 24 hours a day.

155 [1]	Patients feel treated with compassion, dignity and respect, listened to and not stigmatised by staff. **Guidance:** This includes respect of a patient’s age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation.
156 [1]	Patients are given accessible written information which staff members talk through with them as soon as is practically possible. This includes: • Their rights regarding consent to care and • Treatment. • How to access advocacy services (including • independent mental capacity advocate and • independent mental health advocate). • How to access a second opinion. • How to access interpreting services. • How to raise concerns, complaints and compliments. • How to access their own health records.
157 [1]	Patients are given verbal and written information on their rights under the Mental Health Act if under a community treatment order (or equivalent) and this is documented in their notes.
158 [1]	Patients are asked if they and their family/carers wish to have copies of letters about their health and treatment. **Guidance:** This should be achieved in line with the national policy or the NHS trust guidance about copying letters to patients and family/carers.
159 [1]	The team provides information and encouragement to patients to access local organisations for peer support and social engagement. This is documented in the patient's care plan and includes access to: • Voluntary organisations. • Community centres. • Local religious/cultural groups. • Peer support networks. • Recovery colleges.
160 [2]	Written information is offered to patients and their families/carers about transitional support services. **Guidance:** This includes mentoring, befriending, mediation and advocacy.
161 [1]	Patients are offered personalised healthy lifestyle interventions, such as advice on healthy eating, physical activity and access to smoking cessation services. This is documented in the patient's care plan.
163 [1]	The team supports patients to access: • Housing support. • Support with finances, benefits and debt management. • Social services.

165 [1]	There is a designated staff member to support carers.
166 [1]	Family/carers (with patient consent) are involved in discussions and decisions about the patient's care, treatment and discharge planning.
167 [2]	Family/carers are offered individual time with staff members to discuss concerns, family history and their own needs.
169 [2]	The team creates a plan around the whole family/group of carers, so that responsibilities of care are divided fairly.
170 [1]	Carers are supported to access a statutory carers' assessment, provided by an appropriate agency. **Guidance:** This advice is offered at the time of the patient's initial assessment, or at the first opportunity.
171 [3]	The service actively encourages carers to attend carer support networks or groups.
172 [1]	If the carer is 25 or under, contact with Young Carer, or Young Adult Carer services is facilitated.
174 [1]	Families/carers are given information on mental health problems, what they can do to help, their rights as carers and an up-to-date directory of local services they can access.