

NHS Greater Glasgow and Clyde  
Multiagency Distress Collaborative  
April 2016 until March 2019  
Report on Outcomes

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“Together Delivering Care and  
Compassion”

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**NHS Greater Glasgow and Clyde  
Multiagency Distress Collaborative**

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## Foreword

### Programme Manager

“I was delighted and excited to be appointed Programme Manager for the Multiagency Distress Collaborative. I saw this as an opportunity to work in an area that was innovative, and that would hopefully lead to making a difference for people experiencing emotional distress.

The Collaborative was established to create the environment and conditions that would enable people in emotional distress to experience a response that validated their distress, where they were listened to and where the response had been compassionate. The response someone in emotional distress experiences may contribute to how that person might seek help in the future, if they seek help, and where they might seek that help from.

I gained so much insight through my meetings with local communities. They described what they thought a distress response should look like, and this was fundamental in the design of the programme. I have worked with people from many different areas/services and without exception each person has made a contribution to the overall achievements and outputs of the Collaborative. I would like to thank everyone who has been involved past and present in this important area of work. I would like to finish with a quote by Maya Angelou, the famous American poet and author. I think the quote encompasses the key message I would want people to take away from the work of the Multiagency Distress Collaborative Programme, and that is”:

**‘People will forget what you said, people will forget what you did, but people will never forget how you made them feel’**

***Maya Angelou, American Poet and Author***

**(Fiona McMahan, Multiagency Distress Collaborative)**

### Community Engagement Forum

“It was a delight to be part of the Multiagency Distress Collaborative as the lead team lived the principals. There was real collaboration, every attempt made to communicate and more importantly to listen. I always perceived that I was part of a dynamic project with key objectives that were being met. At no time did I feel that I was part of a talking shop.”

***(Betty Elliott, Glasgow Women’s Centre)***

## **Mental Health Network**

"It was clear to me that the work of the Collaborative, from its very beginning with the discussion and development of a definition of distress, was both innovative and important. Put simply this work redefined and changed the way I think about distress.

There was a dimension to this work which helped highlight the boundaries between experiencing an extreme emotional state and a mental illness. There was an aspect of this work which highlighted mental health attitudes and stigmas also. We could discuss both medical and social responses and the roles of 'professionals' and 'services' were felt to be important but different to the role of communities and non-statutory organisations who also responded to distress but frequently in different ways.

The community sub-group drew upon a varied range of organisations from the third and community sectors and this work explored the articulation of that often indefinable thing, an organisation's 'culture'. What does this service/community do that 'feels' right when responding to distress? How can we highlight this so that others can learn from it?

For Mental Health Network Greater Glasgow there is still a huge amount of learning to be gained from this work. Learning that could enable us to more effectively support and engage with people experiencing emotional distress and to enable them to move on from it. We have been happy to be a part of this work and hope to continue to carry on in this capacity."

***(Gordon McInnes, Capacity Building Worker, Mental Health Network)***

## **NHS 24**

"Being invited to be a part of this 'multiagency response to people in distress group' has been helpful to me to better understand the network of mental health services available throughout GG and C. This initiative has endeavoured to create the conditions and environment to support improvement around responding to distress and improve the patient/client experience of services.

The group has allowed me to share examples of how Breathing Space and NHS 24 Mental Health services recognise and respond to staff that may be experiencing distress. It has also allowed me to think about Breathing Space and consider potential areas for improvement/service development and how this might be taken forward.

The networking has also been key and I have enjoyed meeting with new people and share their interest in the development of mental health resources for GG and C. and being able to discuss good practice"

***(Tony McLaren, National Co-ordinator, Breathing Space/NHS Living Life (NHS24))***

## **Executive Summary**

The Multiagency Distress Collaborative was a three year programme funded by the Scottish Government Mental Health Innovation Funding. The theory was that establishing a Collaborative focused on responses to distress would create the conditions and environment to take forward a programme of consolidation and improvement work.

The Institute for Health Care Improvement Collaborative model was the frame of reference for this programme of work.

There were different phases over the three years. The first phase was the scoping phase during which the infrastructure to support the programme and final work streams were identified.

The work streams and objectives that were agreed following the scoping phase were:

- Communication - To create the opportunity for clear communication that would support knowledge and understanding across services in NHS GG&C about the Multiagency Distress Collaborative and the work of the programme
- Repeat Presentations to Emergency Departments - To support the implementation of a Standard Service Response Pathway for people repeatedly attending the Emergency Department known to the Community Mental Health Teams at the time of the presentation
- Alternative Distress Response Pathways – To design an alternative distress response pathway.
- Community Engagement Forum - To develop Key Service Principles that support services to provide a compassionate distress response and identify what resources communities have in place to provide support to people in distress.
- Training – To test the delivery of distress response training to a multiagency group.
- Staff Support - To scope out the current support structures available for staff that may experience distress and highlight areas of good practice.

The Collaborative was launched in January 2017, and during the second phase of the programme there were a number of themed learning sessions, periods of action/activity and tests of change.

This final phase was the development of a report describing the outcomes, findings, learning and key messages from the programme which could then be shared with the wider system.

## Chapter 1 - The Multiagency Distress Collaborative – Context and Method

The aim of this report is to provide a summary of the work of the collaborative. The report will include the achievements, findings and recommendations from the programme. The Multiagency Distress Collaborative was established to take forward a programme of work that would support the further development of existing areas of work and take forward new initiatives and improvement in the area of distress responses. The collaborative was developed in the context that response to distress was considered a priority from both a national and a NHS Greater Glasgow and Clyde perspective.

### National Context

Both the previous [Mental Health Strategy 2012-2015](#)<sup>1</sup> and the [Suicide Prevention Strategy 2013-2016](#)<sup>2</sup> identified distress as a national priority. The current [Mental Health Strategy 2017](#)<sup>3</sup> and the [Suicide Prevention Action Plan – Every Life Matters 2018](#)<sup>4</sup> also have key actions and commitments that will support people in distress being able to access services that are joined up, are accessible and have staff with the necessary knowledge, skills and experience to be able to respond to people in distress.

### NHS Greater Glasgow and Clyde Context

In 2015 the NHS Greater Glasgow and Clyde Mental Health and Acute Interface Group submitted a bid to Scottish Government for innovation funding to establish a Multiagency Distress Collaborative as there were areas of work that it felt needed further exploration and input.

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<sup>1</sup> Scottish Government - *The Mental Health Strategy for Scotland 2012-2015*.

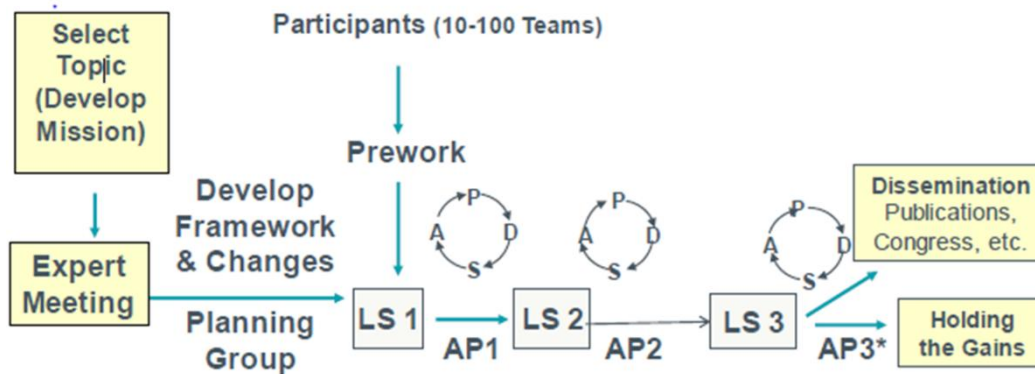
<sup>2</sup> Scottish Government - *The Suicide Prevention Strategy 2013-2016*.

<sup>3</sup> Scottish Government - *The Mental Health Strategy for Scotland 2017-2027*.

<sup>4</sup> Scottish Government - *Scotland's Suicide Prevention Action Plan Every Life Matters 2018*.

## The Method

The method chosen to deliver improvement in the area of distress was the [Institute for Healthcare Improvement \(IHI\) Breakthrough Series Collaborative model](#)<sup>5</sup>



This model describes the key steps and stages necessary to establish a Collaborative and to run a programme of work. There are themed learning sessions and periods of action. The model also includes a focus on sustaining any improvements/changes and how any learning/findings could be spread or shared. We were keen that the work was carried forward using this evidence based frame of reference and this was agreed through the Business Group, however as the work developed we had to design and draw on other improvement methods tools and techniques to support the level and quality of improvement work required for example the change theory, the driver diagram and distress response framework

Through this programme of work the focus was about creating the conditions and environment that would support someone receiving the right response to their distress at the right time.

<sup>5</sup> The Breakthrough Series: IHI's Collaborative Model for Achieving Breakthrough Improvement. IHI Innovation Series white paper. Boston: Institute for Healthcare Improvement; 2003

## Chapter 2 - Establishing the Collaborative

The three year programme commenced in April 2016 and the first 9 months focused on:

- Establishing the leadership and governance infrastructure.
- The scoping phase, including engaging with key stakeholders, local communities and reviewing the literature.
- Planning and designing the areas of work for the next 12 to 18 months
- Developing the Change Theory.

### Infrastructure

One of the first steps in establishing the Collaborative was to establish the governance and leadership infrastructure. The first key group to be established was the Business Group. This group provided senior leadership and governance for the Multiagency Distress Collaborative and the overall work of the three year programme and included the Lead Associate Medical Director, the Clinical Lead, Mental Health Service Redesign, the Head of Adult Services Northeast Glasgow and the Deputy Associate Medical Director as members. The Programme Manager was managed by the Clinical Lead, Mental Health Service Redesign.

The Expert Reference Group (ERG) was also established at the beginning of the programme, this had membership drawn from statutory and non-statutory services. The ERG contributed to the design and planning of the Collaborative, it helped identify key stakeholders to engage with and informed the scoping phase of the programme.

The group provided a significant contribution to the development of the following:

#### 1. Aim Statement:

*“Through Multiagency Collaboration, improvement and consolidation work we will confirm that existing services have a well functioning, compassionate distress response system for those people who are seeking help, and that prevention strategies are considered as part of the work”.*<sup>6</sup>

#### 2. Working Definition:

The ERG recognised that it was important for key stakeholders to have the same understanding of distress and the following working definition was agreed:

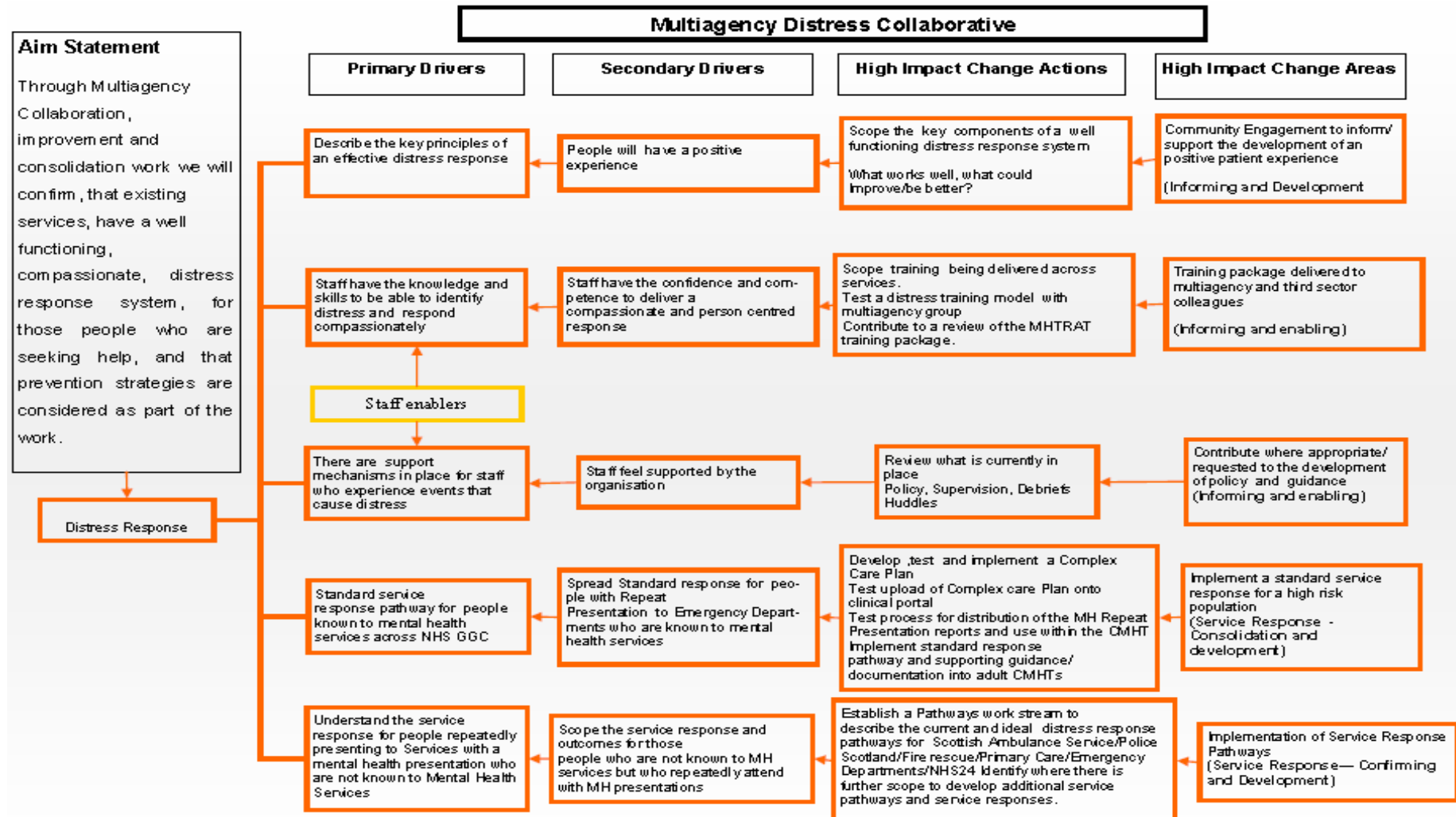
***“Distress is an emotional state, not an illness which is expressed and comes to our attention when a person’s internal capacities and external supports cannot contain something.” (Multiagency Distress Collaborative Expert Reference Group July 2016)***

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<sup>6</sup> Developed with input from the NHS GG&C Multiagency Distress Collaborative Expert Reference Group 2016

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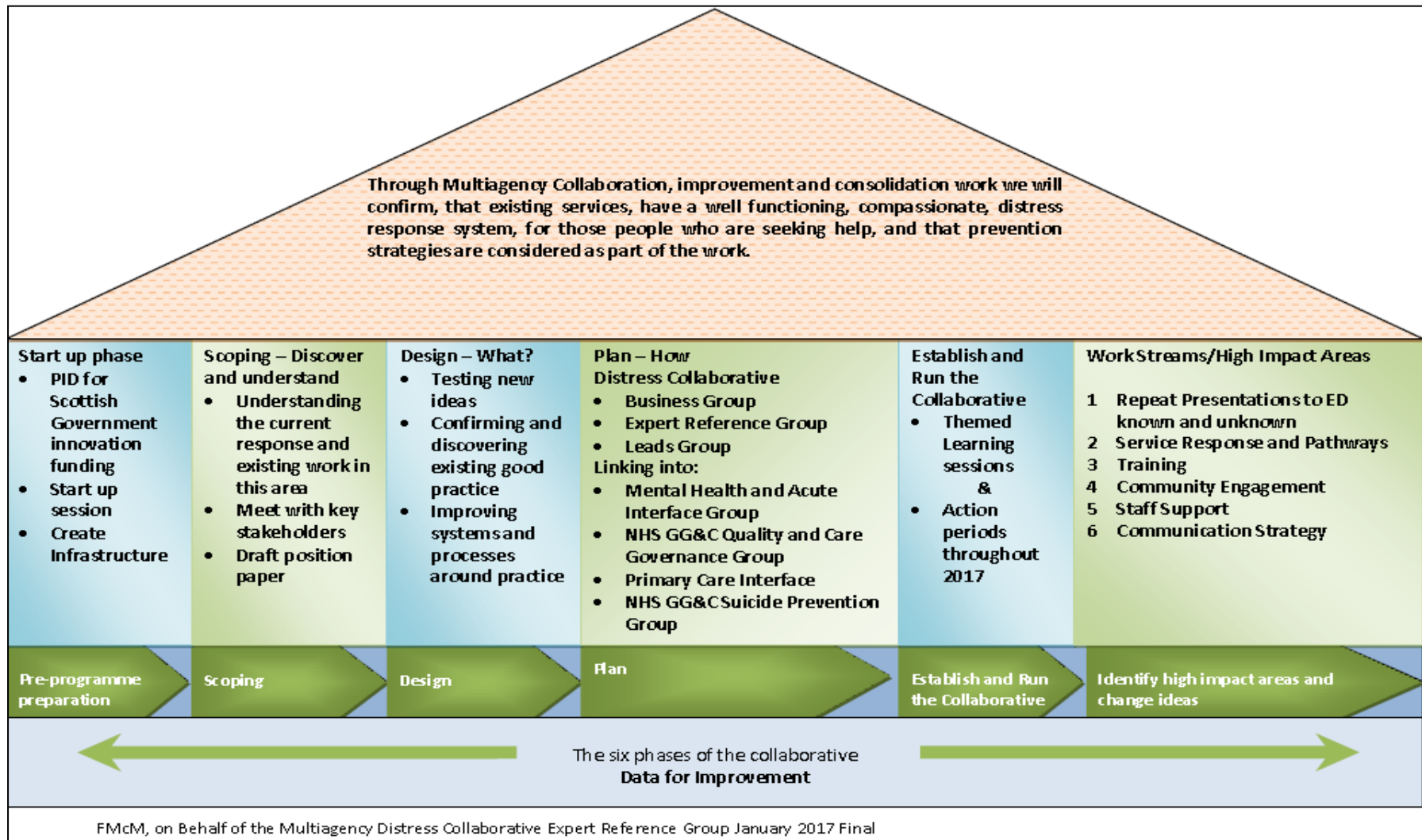
3. **Driver Diagram:** Identified the primary and secondary drivers and the change ideas/high impact areas.



**Distress Response Driver Diagram 08052017**  
Extract from the NHS GG&C Board Suicide Prevention Driver Diagram

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**4. Collaborative Diagram:** A pictorial representation of the key phases and stages of the Collaborative programme.

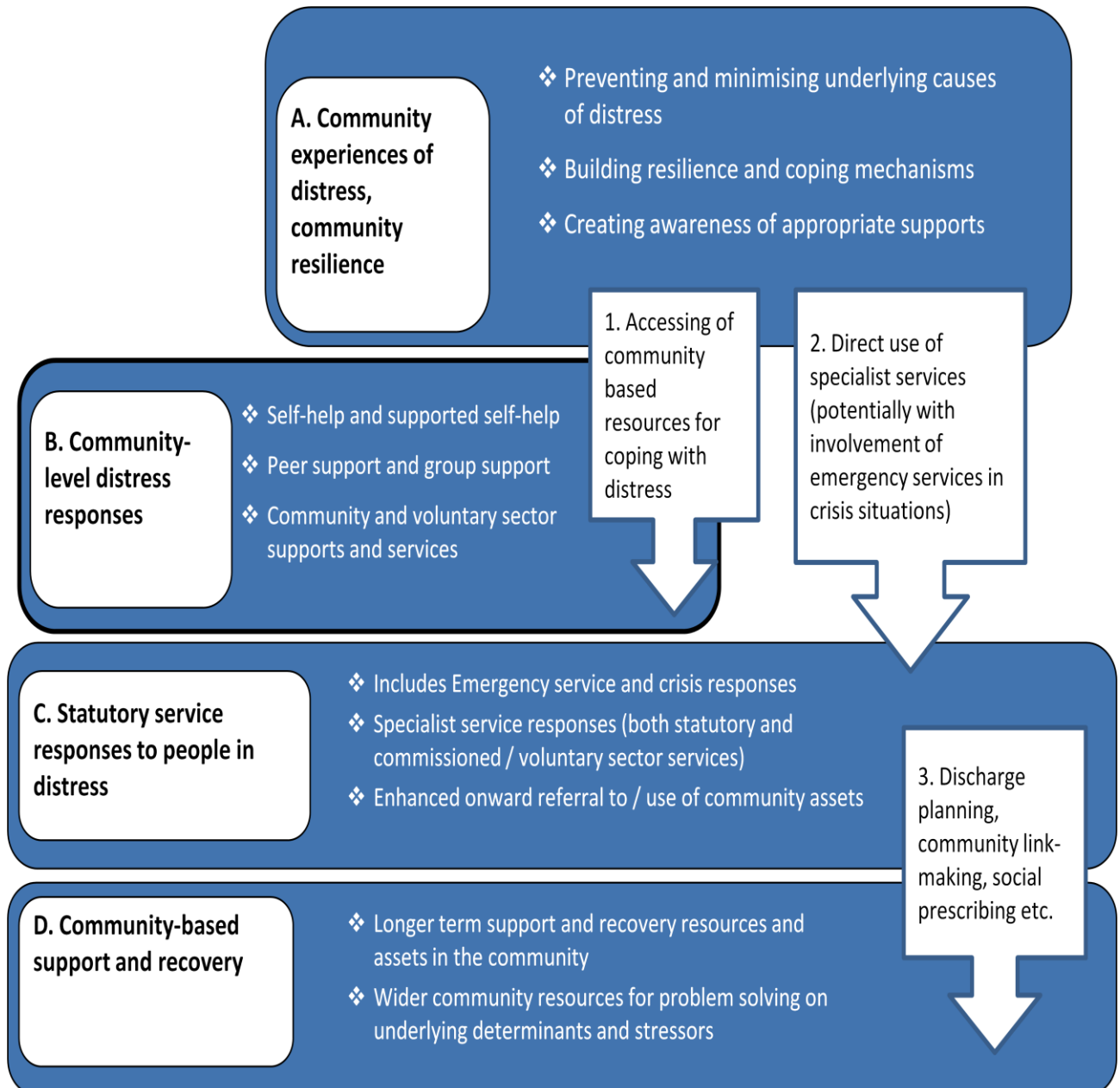


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The final group to be established as part of the infrastructure was the Leads Group; the remit of this group was to take a lead on relevant work streams, to provide regular updates on progress, and to raise any issues or risks to delivery of the work programme including slippage in timelines.

This group led on the development of one of the key outputs from the Collaborative and that was the development of the ***Distress Response Framework***.

**The Distress Response Framework**



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The Distress Response Framework describes the different levels of distress and where people in distress might seek help. It also describes the type of response or intervention they might expect. The Framework was an important development for the Collaborative as it has been fundamental in creating a better understanding of the types of responses that might be helpful at the different levels of distress. It has influenced and shaped the dialogue around our understanding of alternative or non clinical responses to distress and has supported the development of a proposal to develop an Alternative Distress Response.

## Scoping Phase

The scoping phase involved identifying and engaging with key stakeholders, consulting with local communities and reviewing the evidence.

## Key Stakeholders

The Collaborative has continued to grow throughout the three year programme. Key stakeholders have included both statutory and third sector partners. The Collaborative provided a mechanism for these stakeholders to come together to focus on understanding and improving responses to distress. They have been involved in every phase of the Collaborative including the programme design, contributing to work streams and supporting the learning sessions.

## Engaging With Local Communities

In trying to understand the key components of a compassionate distress response and what this would look like, the Glasgow City Mental Health Network facilitated three focus groups with local communities. The outputs from these focus groups have been significant in informing the final work streams. The local communities involved in the focus groups were asked to consider the following four questions:

- How would you define distress?
- What experiences might cause distress?
- What helps combat distress?
- What would a good distress response look like?

One of the key themes that emerged from this was that people wanted somewhere that they could go that was a **safe place** that provided an **alternative to a clinical response**, and that staff had the **time and the knowledge and skills** to respond to the distress. Staff support was also a theme that emerged from the focus groups, with recognition that staff experience distress and for them to be able to support someone in distress they should also be supported.

## Literature Review

A literature search was carried out using the following criteria; **prevention, responding to distress, measuring distress, the key components of compassionate care and service user experience, grey literature was also included.**

Articles were selected based on relevance to the topic area and these were reviewed by members of the Multiagency Distress Collaborative Expert Reference Group. The search yielded papers which focused on the context of distress e.g. health inequality, isolation,

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Adverse Childhood Experiences. One of the findings from the literature was that if people had an **understanding of the context** of someone's distress then this may then lead to a more compassionate response. In addition the **National Confidential Enquiry into Suicide and Homicide by People with Mental Illness**<sup>7</sup> identified the impact of life factors and contributory social factors on suicide; the report suggested that one of the improvement areas that services should focus on was **managing distress**.

The Care Commission also highlighted in their report '**Right Here Right Now**'<sup>8</sup> that it is important for organisations to strive to have pathways which support people getting the appropriate help, care and support and that this is one of the key factors in supporting a person **who is distressed** to stay well.

The availability of support for staff that may have experienced distress and how they then respond to distress was also a theme that emerged from the literature. Alys King-Cole and Paul Gilbert identified through their research two key areas which can promote a compassionate response:

1. Staff to be supported to deliver compassionate care.
2. The correct conditions are required within an organisation for care to be compassionate. One of the conditions is the culture, specifically how the organisation views the importance of compassionate care versus processes and systems.

The outcome of the scoping phase highlighted similar themes that then informed the final work stream choices and these were:

1. The importance of understanding the context of distress.
2. Clear and easily accessible pathways.
3. Non-clinical response and access to safe places.
4. Support for staff so that they can then provide a compassionate response including staff having the knowledge, skills and experience to respond to distress.

The Multiagency Distress Collaborative was launched in January 2017. The work streams were presented at this launch event. The scoping phase was a key phase of the programme and led to the development of the Change Theory. The Change Theory has been used to help describe the overall outcomes and achievements of the Collaborative programme.

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<sup>7</sup> Healthcare Improvement Scotland. 2017. *Briefing Paper for Community of Practice – Suicide Reporting and Learning System*. Reporting period 1 May 2016–31 October 20169 (<http://www.knowledge.scot.nhs.uk/media/CLT/ResourceUploads/4082178/91a25370-61fd-4db7-9702-fe34021173eb.pdf>)

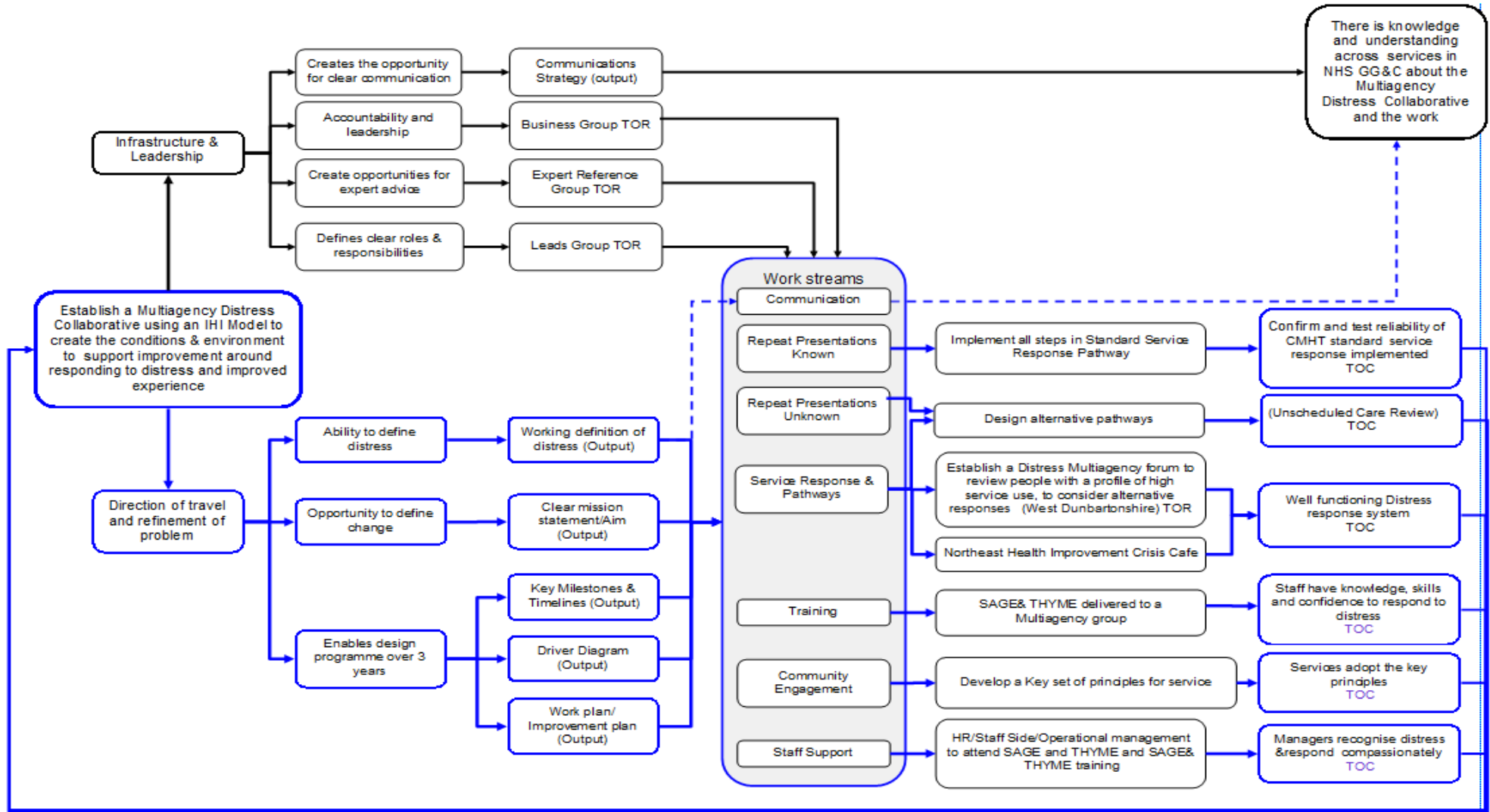
<sup>8</sup> Care Quality Commission. 2015. *Right Here, Right Now, Peoples experience of help, care and support during a mental health crisis*([http://www.cqc.org.uk/sites/default/files/20150611\\_righthere\\_mhcrisiscare\\_summary\\_3.pdf](http://www.cqc.org.uk/sites/default/files/20150611_righthere_mhcrisiscare_summary_3.pdf))

## Learning and Key Messages

- *Taking time at the start of the programme to carry out the scoping, planning and design phase allowed the work streams to emerge.*
- *Speaking with people from local communities about distress and distress response, using a focus group approach was very helpful; this type of approach is recommended.*
- *The development of the Distress Response Framework and how this helped conceptualise the levels of distress and the type of response at each level was a key output from this phase of the Collaborative.*

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## Chapter 3 - Change Theory



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The Change Theory<sup>9 10</sup> provided the improvement framework for the collaborative programme and was developed using the logic model and components of LEAN/improvement methodology, leadership and change management. The theory was that by establishing a Collaborative focused on responses to distress, this would create the conditions and environment to take forward a programme of consolidation and improvement work.

The work streams and the proposed tests of change/developments are described in the Change Theory. The following areas have been considered within each of the work streams in order for the outputs/learning and key messages to be captured:

1. The objective
2. What we did
3. Outcome
4. Learning and key messages

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<sup>9</sup> Coryn, C. L. S., Noakes, L. A., Westine, C. D., & Schröter, D. C. (2011). A systematic review of theory-driven evaluation practice from 1990 to 2009. *American Journal of Evaluation*, 32(2), 199-226. DOI: [10.1177/1098214010389321](https://doi.org/10.1177/1098214010389321)

<sup>10</sup> Taplin, D, Clark, H, Collins, E and Colby, D. (2013) [Technical Papers: A Series of Papers to support Development of Theories of Change Based on Practice in the Field](#). New York: Acknowledge and The Rockefeller Foundation.

## 3.1 Communication

### Objective

To create the opportunity for clear communication that would support knowledge and understanding across services in NHS GG&C about the Multiagency Distress Collaborative and the work of the programme.

### What We Did

A communication plan was developed to ensure that the work of the Multiagency Distress Collaborative, the key messages and any learning was shared with all stakeholders both internal and external to the organisation. A range of methods and approaches were identified in the plan to support effective communication and delivery of the anticipated outcome.

These included:

- Briefing Notes
- Social Media
- e-Mail
- Action Notes and Learning Session Reports
- Articles for inclusion in HSCPs communication materials
- Flash Reports
- Presentations delivered to a range of groups/services

### Outcome

A communication plan was developed and all of the methods identified in the plan were delivered with the exception of the use of social media. There were 8 learning and development sessions at each of which between 40 to 70 people attended. In the earlier stages of the Collaborative there was speculation about what it would actually be able to achieve, with some stakeholders holding the view that the remit was too broad. This view has changed over time, evidenced by the range and number of Key Stakeholders, services and organisations now engaged in this work and talking about distress.

### Learning and Key Messages

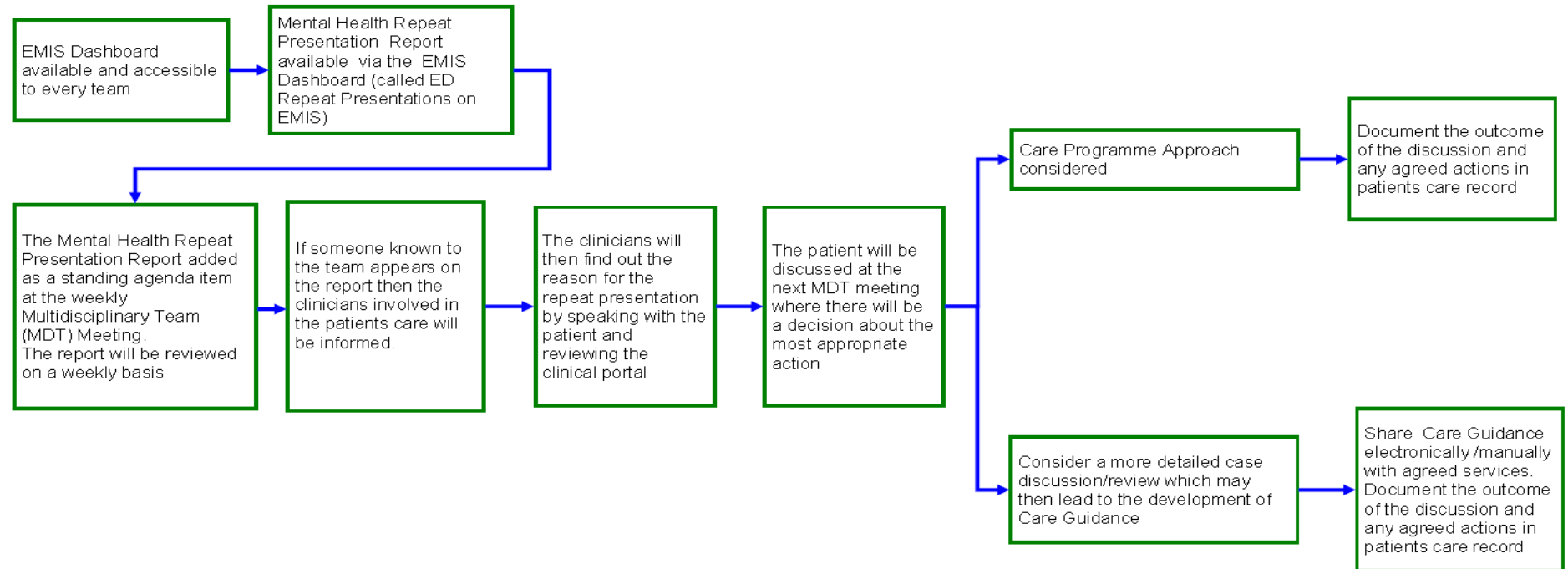
- *The Communication plan provided a structure, stating what should be communicated, how and when.*
- *Future improvement/development programmes should include regular briefing notes including the use of social media to ensure key messages and learning are reaching a wider/broader audience.*

## 3.2 Repeat Presentations

### Objective

Support the implementation of a Standard Service Response Pathway.

### Standard Service Response Pathway



## **What We Did**

The Distress Collaborative has supported the implementation and further development of a Standard Service Response Pathway across Adult and Older Adult Community Mental Health Teams (CMHTs).

This work has been taken forward in three phases:

### Phase 1

- Development of guidance to support the implementation of the Standard Service Response Pathway in practice.
- Development of a measurement framework and draft report
- Design and testing of a Care Guidance Template.
- Design and contribution to a test of change- uploading the Care Guidance document onto the Clinical Portal within one CMHT.

### Phase 2

- Confirmation of the Liaison response and the Out of Hours Community Psychiatric Nursing Service response to people who repeatedly present/call; and planning development of a Standard Service Response Pathway in partnership with these services.
- Confirmation of the interface between CMHTs and Primary Care for people repeatedly presenting to Emergency Departments (EDs) who are also known to the CMHTs.

### Phase 3

- To evidence the impact of the Standard Service Response Pathway on:
  - Patient experience
  - Number of ED attendances overall
- To establish the Care Guidance as part of routine practice and develop a process so that this can be shared with relevant others; this phase of the work is being taken forward in partnership with Clinical Effectiveness.

## **Outcome**

The Standard Service Response Pathway Guidance has been developed and shared with the Community Mental Health teams. A Care Guidance Document has been developed, tested and implemented. One CMHT has completed a test of change which involved the feasibility of uploading the Care Guidance onto the Clinical Portal and shared with relevant colleagues.

Each of the Community Mental Health Teams across Greater Glasgow and Clyde has confirmed via Service Managers that the Standard Service Response Pathway has been

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implemented. There is still one part of the pathway that requires further support/development which is the uploading and sharing the Care Guidance document via Clinical Portal across all CMHTs.

The impact of this work needs to be further assessed, however a repeat presentations quarterly trend report was developed and the report showed that the number of people presenting repeatedly to EDs known to mental health services at the time of the presentation was **1,956 (70%)** in a 12 month period, the number unknown to mental health services was **844 (30%)**. Overtime the trends have not shown any change, however when individual presentations to ED were reviewed there was a reduction of **108** presentations to EDs in a 12 month period. If this was translated into time using the ED 4 hour treatment target this would equate to **432** hours time saved. Further work is required to develop the data in relation to repeat presentations and this is being taken forward in collaboration with Business Intelligence

The Liaison and Out of Hours Community Psychiatric Nursing Service response has also been confirmed, and a Standard Service Response Pathway is being developed.

In Primary Care there is no standard service response for those people repeatedly presenting to EDs who are known to their practice.

### **Learning and Key Messages**

- *A range of methods were applied to confirm that the pathway was implemented in the CMHTs.*
- *Work with Liaison and OOH CPN services to describe a Standard Response Pathway will continue and could be included in the Unscheduled Care Response Framework*
- *Further work with Primary Care to identify what could be established between Primary Care and the CMHTs for Repeat Presentations.*
- *The Repeat Presentation Standard Service Response Pathway was noted in the NHS GG&C Clinical Governance Strategy as an example of success. It has also been identified as a priority area in the Glasgow City Health and Social Care Partnership Strategic plan.*

### 3.3 Alternative Distress Response

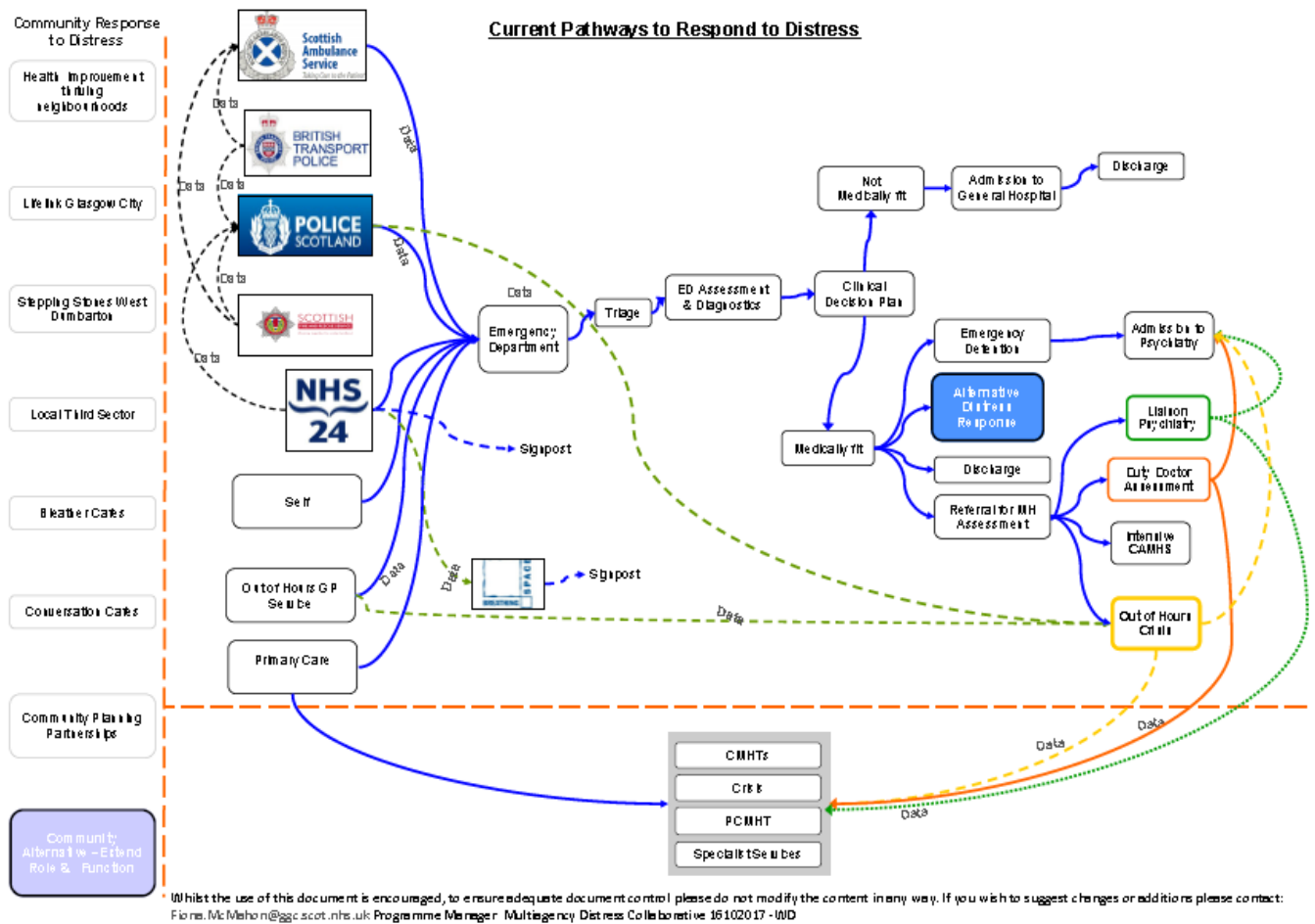
#### Objective

Design an alternative distress response pathway.

#### What We Did

##### Pathways

A series of pathway sessions were held to scope out and confirm current response pathways. The diagram below was shared with all services/agencies involved in the pathway session who confirmed that this reflected existing pathways.

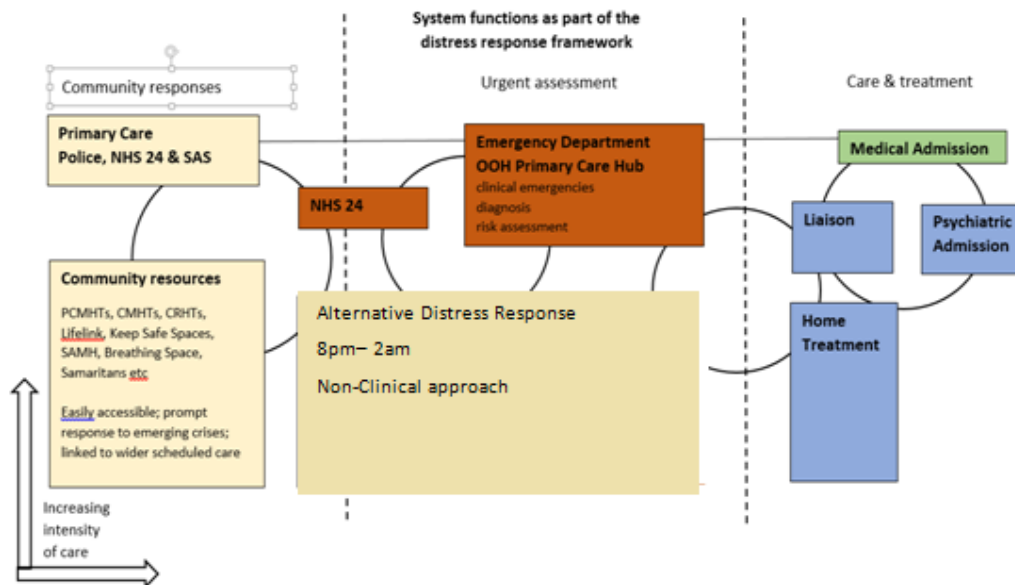


The pathway sessions and other development sessions helped inform the Distress Response Framework. This was subsequently used to start to describe what an Alternative Distress Response service would look like.

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This led to the development of a proposal paper that described further the key components and core functions of an Alternative Distress Response. A redesigned pathway that included an Alternative Distress Response was developed:

### A Distress response Pathway



The above pathway describes where Health and Social Care Partnerships might want to consider developing a non clinical Alternative Distress Response located in the community

**West Dunbartonshire Health and Social Care Partnership** tested the development of a Distress Multiagency Forum. The Forum was established to test an alternative multiagency community response for people who experience distress and who repeatedly use services.

The overall aim of the forum was to review people's contact with services and reflect on what could have been done differently across services for that individual. The learning from this would then be applied going forward with the individual.

The remit of the Forum was to:

- Identify people who frequently present or contact services in distress.
- Develop a timeline to reflect contacts, reasons for contact and outcomes.
- Reflect on what an alternative response might be in the future.
- Develop a local information sharing protocol.

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- Engage with individuals in order that the whole process is transparent and person centred.

In addition **West Dunbartonshire Primary Care Mental Health Team and Stepping Stones** developed a Distress Response Referral Pathway and a proposal to establish a Midnight Cafe.

### Outcome

Within each Health and Social Care Partnership there are a range of approaches being considered that could eventually lead to local approaches to delivering Alternative Distress Response models. It is important that these ideas are built upon, and that each HSCP continues to focus on how non-clinical Alternative Distress Responses are available within local communities.

### Learning and Key Messages

- *Local communities want access to a non-clinical response when they are in distress.*
- *Traditional pathways more often than not lead to a traditional response to distress.*
- *The development of an alternative distress response provides a choice for people.*
- *Access to an alternative distress response also provides choice for other services responding to people in distress.*
- *It is important that all HSCPs are considering what they can put in place to provide an alternative distress response model.*

### 3.4 Community Engagement Forum

#### Objectives

To develop Key Service Principles that support services to provide a compassionate distress response and identify what resources communities have in place to provide support to people in distress.

#### What We Did

##### *Key Service Principles*

The forum carried out a literature review that focused on examples of services that had taken forward development work in relation to identifying the components of a compassionate response. The forum favoured an evaluation report carried out by the University of Birmingham which was about a compassion recognition scheme<sup>11</sup>. It was felt that this was an example that fitted with the work the forum was trying to achieve. The compassionate recognition scheme identified 4 key elements to a compassionate response which were:

1. Meaningful connection – establishing personal connections; focusing on the most relevant needs for the patient and acting accordingly.
2. Patient expectations – pain control; careful listening; being respectful; offering clear explanations and giving timely assistance.
3. Caring attributes – providing hope, kindness and understanding; being empathetic; appreciating family /carers' needs.
4. Capable practitioner – competence, confidence and requisite knowledge and skill set for the role.

The forum considered the 4 key elements and, following further discussion and a period of consultation with local communities across Greater Glasgow and Clyde, the following 3 Key Principles were agreed:

1. We Care
2. We Listen
3. We Support

The Principles were tested within the Glasgow Women's Centre (GWC); they described how the principles would be applied and how they would be evidenced within their service.

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<sup>11</sup> Yvonne Sawbridge and Alistair Hewison (2017) - An Evaluation of the Leading with Compassion Recognition Scheme. University of Birmingham.

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The Principles were then tested further within Recovery Across Mental Health (Renfrewshire), Your Voice (Inverclyde), and the Mental Health Network (Glasgow City). Each service returned their interpretation of the Principles. This highlighted some variation in the interpretation of the Principles, for example, some of the returns were service driven i.e. what the service offered, opening times, groups etc. and some of the returns described the expected behaviours of the staff when responding to distress.

Data was also collected across these services to capture people's experience of the service in relation to the 3 Key Service Principles. A questionnaire was developed with 45 questionnaires returned. The responses provided examples of what people find important to them in terms of a compassionate response from services. Key words included:



### ***Information***

The group identified a number of areas where information would be available within local communities and to local communities. The group focused mainly on the ALISS data base which was under review at the time the forum was looking at it so there was missing information. The forum agreed that this was a good resource that could be helpful to communities; however there was acknowledgement that the data base needed the input of communities to provide the local information.

The forum contributed to the development of the Emergency Pocket Information Card (EPIC) by sharing their examples of similar cards developed for their local communities.

### ***Keep Safe Places***

At the NHS Greater Glasgow and Clyde Patient Focus and Public Involvement Forum, one member suggested that it would be helpful if there was a place people could go if they were in distress, where they would feel safe, that was easily identifiable and was within the local community, similar to the dementia-friendly communities' initiative.

The Community Engagement Forum became aware of the 'Keep Safe' initiative and 'I Am Me' charity. Contact was made with the charity and a presentation was then delivered to the Forum. It was agreed by the Forum and subsequently the wider Collaborative stakeholder

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group that there needed to be a greater awareness across HSCPs about this initiative. Representatives from the Charity were invited to present at an MDC Learning Session.

### **Outcomes**

1. Key Service Principles with method of evaluation tested and developed.
2. An increased awareness about the ALISS data base and information/services available.
3. The Emergency Pocket Information card (EPIC) is now available to order.
4. Raised awareness of Keep Safe and I Am Me across the Collaborative and across Glasgow City.

### **Learning and Key Messages**

- *The Community Engagement Forum was an effective model for engaging with the local communities and third sector partners.*
- *The learning from this approach could be applied to any future engagement with communities.*

### 3.5 Training

#### Objective

Test the delivery of distress response training to a multiagency group.

#### What We Did

As part of the overall work plan of the Multiagency Distress Collaborative, it was agreed that a consistent model of training be implemented for all multiagency partners. A scoping exercise was carried out to identify the most appropriate model. Various approaches to training were examined including NHS24, Police Scotland, Living Works and Macmillan Nurses. As part of this scoping phase, presentations were delivered at the launch of the Collaborative to afford stakeholders the opportunity to consider possibilities, and the SAGE and THYME model and structure was then chosen as the training to test and evaluate on a multiagency basis.

The SAGE & THYME model and foundation level workshop was developed to teach the core skills of dealing with people in distress. It was developed by members of staff at University Hospital of South Manchester NHS Foundation Trust (UHSM) in partnership with a patient in 2006. It was originally developed to meet the level 1 skills requirement described in the 2004 NICE guidance on 'Improving Supportive and Palliative Care for Adults with Cancer', however the principles are generic and can be used with anyone in distress.

Following discussions with the SAGE and THYME trainers (Macmillan Nurse Facilitators), it was agreed that a work shop would be delivered to a Multiagency Group; previously this training has just been available to Health Care Staff.

#### Outcome

The work shop was delivered in September 2017 and 26 staff attended from across a multiagency group. The training was evaluated using the [Kirkpatrick's Model of Evaluation](#)<sup>12</sup>. The evaluation showed that the training was an overwhelming success. The utilisation of the Kirkpatrick Model of Evaluation provided evidence that the training does assist in helping staff to provide support to those in distress.

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<sup>12</sup> Kirkpatrick, D. and Kirkpatrick, J. (2006). *Evaluating training programs*. San Francisco, CA: Berrett-Koehler.

### Learning and Key Messages

- *The training was viewed as relevant and helpful in supporting those that attended to respond to distress.*
- *This was evidenced in the follow-up evaluation. It was recognised that this foundation level training could benefit staff irrespective of position or the service they work in.*
- *Other types of training courses are available however this training is specifically about recognising and responding to distress and could be included in the suite of suicide prevention training currently available across the Board area to all partner agencies.*
- *Additional training resource/capacity would be required if this training was to be made available to a multiagency group.*

### 3.6 Staff Support

#### Objective

To scope out the current support structures available for staff who may experience distress and highlight areas of good practice.

#### What We Did

We carried out a scoping exercise to identify the support, either formal or informal, that is currently in place for staff working across NHS Greater Glasgow and Clyde. This included meeting with key stakeholders from a range of different service areas.

The findings were:

- One of the strategic priorities of the NHS GGC [Staff Health Strategy](#)<sup>13</sup> is the Health and Well Being of the work force, to support attendance at work. There are 4 key areas:
  1. Resilience
  2. Mindfulness
  3. Stress Risk Management
  4. Management Support and Training

The aim is to support staff to return to work and support on-going attendance at work.

The Staff Health Strategy is an on-going programme of work and is being led by the Director of Human Resources and Organisation Development.

- Following a meeting with a Senior Manager from HR it was agreed that operational/HR managers would be offered the opportunity to attend the SAGE and THYME training. The theory was that operational/HR managers would benefit from this type of training and that it would possibly equip them better to be able to identify and respond to distress.
- Staff support was also a theme of a learning session, “Recognising and Responding to distress in the work place”. The learning session was aimed at staff and managers working in statutory and third sector organisations. The learning session provided the staff who attended time and space to reflect on their own support structures, service structures to support staff, and it provided new information that could then be taken back to services.

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<sup>13</sup>NHS Greater Glasgow and Clyde Staff Health Strategy 2017-2020

## **Outcome**

A Mental Health and Wellbeing group has been established and this is being led by Occupational Health. Mental Health representatives are on this group. It is encouraging that this group has now been established and looking at what additional support can be made available to staff. Distress is one of the areas the group are interested to hear more about. Unfortunately no operational managers/HR managers were able to attend the SAGE and THYME training and for that reason the Collaborative cannot report on the outcome of this test of change.

With regards to support for staff, there is a range of support available including Occupational Health, Human Resources, and Healthy Working Lives. However some of the feedback from staff is that they don't always proactively access these services.

There are examples of innovative approaches to staff support, with a Practice Development Mental Health Nurse working within the acute setting providing supervision, general support and education for acute staff. In addition, the introduction of Reflective Practice Groups and Post-Incident Support within Forensic Services is an area that has been developed within that service in the last few years.

[Joy at Work](#)<sup>14</sup> is also a new IHI initiative, and this was included as one of the areas presented to delegates at the learning session.

## **Learning and Key Messages**

- *Scoping out current support structures within Statutory Health Services revealed that there is a range of support for staff if they are experiencing distress.*
- *How and when staff access this support is important.*
- *Most of the focus of this work stream has been on what support is available for staff working in statutory health. It is important going forward to understand better what other statutory and third sector services have in place for staff support.*

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<sup>14</sup> Perlo J, Balik B, Swensen S, Kabcenell A, Landsman J, Feeley D. *IHI Framework for Improving Joy in Work*. IHI White Paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2017. (Available at [ihi.org](http://ihi.org))

## **Chapter 4 - Recommendations and Conclusion**

The report on the outcomes of the Multiagency Distress Collaborative, including the key messages and learning, will be shared and disseminated via a range of meetings and community groups including the Health and Social Care Partnerships Senior Management Team meetings.

### **Recommendations**

Each of the Health and Social Care Partnership are asked to consider and agree the following recommendations

#### **Alternative Distress Response**

##### **Existing and development of new distress response work is supported across all HSCPs:**

1. Glasgow City Health and Social Care Partnership will support the development of an Alternative Distress Response for Glasgow City; and that this work will be managed through the MH Unscheduled Care Implementation Steering Group
2. West Dunbartonshire Health and Social Care Partnership agree to share any learning and key outputs from the West Dunbartonshire Multiagency Distress Forum, through the chair of the forum, with the Mental Health Unscheduled Care Review Steering group.
3. Each of the Health and Social Care Partnerships to agree to engage in a Board wide forum to share local developments/initiatives in relation to alternative distress response.

#### **Repeat Presentations**

##### **A period of consolidation and further development is taken forward in this work area across all HSCPs:**

4. To enable sustainability and ongoing development in this area, it is recommended that the Repeat Presentations work will be taken forward under the Effective and Efficient Work Stream (one of the work streams of the 5 Year Mental Health Strategy).
5. To support the further development of reports that would provide service managers/ teams with data about repeat presentation activity for their area and agree that this work is taken forward by the Data for Improvement Sub-group, a sub-group of the Mental Health and Acute Interface Group

## **Distress Response Training**

**HSCPs to consider how to increase the availability of SAGE and THYME, distress response training, to multiagency groups:**

6. Glasgow City Health and Social Care Partnership to agree to fund a 'training for trainers' model to increase training capacity to deliver the SAGE and THYME training to a wider stakeholder group of stakeholders.
7. Other HSCPs to consider how they would support this in their own areas.

## **Staff Support**

8. HSCPs to confirm what current support arrangements are in place for staff who may experience distress

## **Key Service Principles**

**All HSCPs support the consolidation and implementation of this development:**

9. Health and Social Care Partnership agree to the Key Service Principles (KSP) being included as part of any Alternative Distress Response models.
10. Health and Social Care Partnership to note and consider implementation of these principles in other service areas.

## **Emergency Pocket Information Card:**

11. All HSCPs to consider the implementation strategy for the Emergency Pocket Information Card Health across a range of settings

## **Keep Safe Places and I am me:**

12. Health and Social Care Partnerships continue to promote the Keep Safe initiative.
13. Glasgow City Health and Social Care Partnership agree to support the implementation of this initiative.

## **Conclusion**

The three year Multiagency Distress Collaborative programme brought together key stakeholders from across multiagency groups to focus on the topic of distress and responses to distress, to support people receiving the right response to distress at the right time by the right person.

The IHI Collaborative model was the frame of reference for this improvement work. Throughout the collaborative there has been significant engagement and collaboration which has resulted in:

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- **Discovery** of alternative distress response models.
- **Discovery** and **promotion** of the initiatives like the National Keep Safe initiative.
- **Contribution** to the development of the Emergency Pocket Information Card (EPIC).
- **Consolidation** and further **development** of existing practice around Repeat Presentations to Emergency Departments.
- **Tests of change:**
  - Care Guidance for people repeatedly presenting to ED.
  - West Dunbartonshire Distress Multiagency Forum.
  - The delivery of SAGE and THYME Distress Response Training to a multiagency group.

In conclusion we came together as a collaborative to focus on distress and there is still work to be done. Some of the work streams of the collaborative will continue to be taken forward as part of the 5 year Mental Health Strategy; this includes the Alternative Distress Response, a sub-group of the Mental Health Unscheduled Care Review and the Repeat Presentations work. There will be further work to develop Standard Service Response Pathways for Repeat Presentations for OOHs CPN, Liaison and Primary Care Services. The Repeat Presentation work will report to the NHS GG&C Effective and Efficient Work Stream. There is also potential to roll out SAGE and THYME distress response training to a wider multiagency group.

Throughout the Collaborative there has been a lot of shared learning and collaborative working and it is important to acknowledge the input from each and every one of the people who have contributed and led on specific areas of the work.

## Acknowledgements

Thanks to the following groups/organisations/services:

- **Business Group:**

- Dr Michael Smith - Lead Associate Medical Director
- Joan Blackwood - Clinical Lead, Mental Health Service Redesign
- Katrina Philips - Head of Adult Services Northeast Glasgow
- Dr Martin Culshaw - Deputy Associate Medical Director

- **Leads Group:**

Trevor Lakey - Health Improvement and Inequalities Manager

Ronnie Sharp - Patient Services Manager

Larry Callary - Senior Learning and Education Adviser

Marie Rooney - Intergrated ops manager West Dunbartonshire HSCP

I would also like to acknowledge the input and support from colleagues who were members of the Expert Reference Group, the Community Engagement Forum, the Repeat Presentation work Stream and all of those that attended and supported/contributed to each of the Learning and Development sessions, there are to many people and organisations to name individually, however without your continued engagement and collaboration we wouldn't have achieved the outputs we did, thank you!



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