



The THRIVE Framework for system change and Equality, Diversity and Inclusion

National i-THRIVE Programme

13th May 2021

“If we keep on doing what we have been doing, we are going to keep on getting what we have been getting”



Agenda



Time	Item	Presenter
10:30	Welcome and Housekeeping	Rachel James, National i-THRIVE Programme
10:40	Addressing inequalities in accessing mental health and wellbeing help and support through the lens of personalised care and personal health budgets	Tom Raines, NHSE&I Deborah McLean-Thorne & Dafna Bicaci, National Children's Bureau
11:20	THRIVE as the learning front end of an ICS addressing inequalities in mental health access and outcomes	Al Mulley, Dartmouth Institute
11:40	Co-production: reflections on a journey from theory to action	Georgina Fozard, Darzi Fellow
11:50	Feedback: Mentimeter	All
12:00	Close	All

Welcome and house keeping



- Welcome from Dr Rachel James, Clinical and Programme Director of the National i-THRIVE Programme.
- **Please note: this webinar will be recorded and uploaded online.** Please keep your camera turned off and mute yourselves unless you are asking a question.
- If you need to communicate a technical issue please use the chat function, this is monitored by one of the team and we can attend to this ASAP.
- If you have a question or reflection on the content of the presentations please submit this using the chat function, and indicate who you would like to address it to. You can select to submit anonymously if you do not want your name to be included.
- You will be sent the slides following the webinar, as well as a link of the recording to enable you to share with colleagues who may not have been able to join.
- If you have any questions or reflections you would like to share following the webinar please feel free to send them to the National i-THRIVE Programme team at ithriveinfo@tavi-port.nhs.uk

Our commitment to Equality, Diversity and Inclusion



- The National i-THRIVE Programme actively promote Equality, Diversity and Inclusion to all prospective sites to ensure collaboration across localities to reduce inequalities and actively promote equitable access for all.
- We celebrate and value difference and the benefits that diverse individuals and communities can contribute to the delivery of mental health and wellbeing provision.
- Our aspiration is that all mental health and wellbeing provision is accessible, welcoming and inclusive for all.



THRIVE Framework Key Principles

Common Language

- The conceptual framework, and its five needs based groupings, support a shared language and understanding across the system, which is easily available, accessible, and communicated.

Needs-Led

- Approach based on meeting need, not diagnosis nor severity. Explicit about the definition of need at any one point, what the plan is and everyone's role within that plan. Fundamental to this is a common understanding of the needs based groupings across the local system, taking into account the needs of different communities and populations.

Shared Decision Making

- Voice of children, young people and families is central, particularly for those who may have previously experienced being disempowered in decision-making processes about their care.

Proactive Prevention and Promotion

- Enabling the whole community in supporting mental health and wellbeing. Proactively working with the most vulnerable groups. Particular emphasis on how to help children, young people and their communities build on their own strengths, including safety planning where relevant.





THRIVE Framework Key Principles Continued...

Partnership Working

- Effective cross-sector working, including service user participation, with shared responsibility, accountability and mutual respect based on the five needs based groupings.

Outcome Informed

- Clarity and transparency from outset about children and young people's goals, measurement of progress movement and action plans, with explicit discussion if goals are not achieved. Consider full range of options including self or community approaches.

Reducing Stigma

- Ensuring mental health and wellbeing is everyone's business and supporting communities to access support with consideration of their beliefs, existing support systems and individual and cultural needs.

Accessibility

- Advice, help and risk support available in a timely way for the child, young person or family, where they are and in their community.



Addressing inequalities in accessing mental health and wellbeing help and support through the lens of personalised care and personal health budgets

Tom Raines, NHSE&I
Deborah McLean-Thorne & Dafna Bicaci, NCB

“If we keep on doing what we have been doing, we are going to keep on getting what we have been getting”



Changing Young People's Lives Through Personalised Care: Health Inequalities and Social Deprivation

May 2021

Background

Project built on:

- Looked After Children with Mental Health Support Needs Demonstrator Project (the LAC Project, 2016-19)
- Projects identified that personalised care provides a way of engaging with children, young people and their families who experience social deprivation.
- CAMHS PHB Development Programme (2019-20) and the Street Games project (2019-20)
- This project aims to take this work further, identifying how and why personalised care (specifically PHBs and Social Prescribing) can support children and young people experiencing poor mental health and social deprivation.
- Funded via the Personalised Care Group's Health Inequalities work stream.
- NHS England & Improvement's corporate approach to tackling health inequalities: [Long Term Plan](#) and [Operational Planning Guidance 2021/22](#)
- [Future NHS Collaboration Platform: https://future.nhs.uk/system/home](https://future.nhs.uk/system/home)

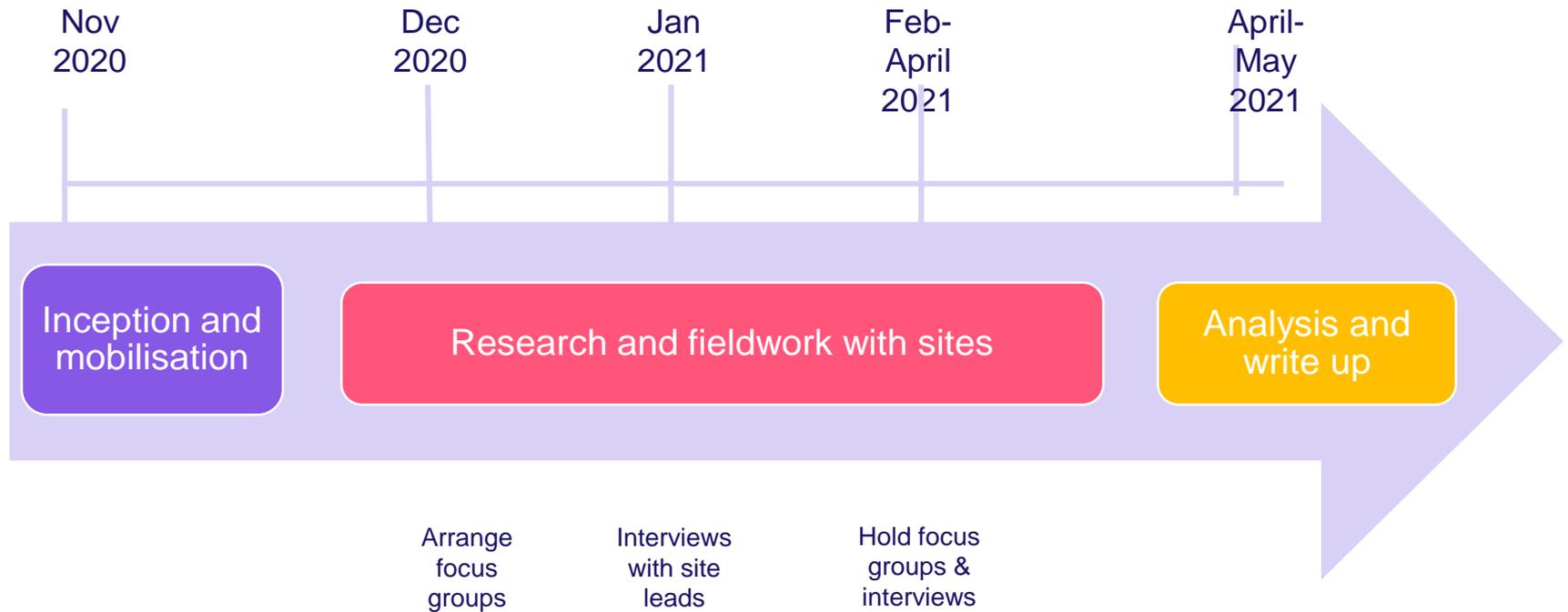
Background

NHS England & Improvement established a project to understand how personalised care interventions can better support children and young people who experience poor mental health and live in our most deprived communities.

NCB commissioned in the winter 2020

- work with selected local areas with high levels of social deprivation
- a mix of urban and rural with an existing offer covering personal health budgets, social prescribing and other elements of personalised care.
- They are at different levels of maturity in terms of their personalised care offer.
- focusing on best practice, facilitators and challenges.

Project Overview



The Local Sites

Nottinghamshire –
You Know Your Mind

Bristol – You're in
Control

Hull

Thurrock – Positive
Pathways

Social Deprivation Indices

7 domains of deprivation which combine to create the Index of Multiple Deprivation:

1. Income and poverty (Income deprivation affecting children index)
2. Employment (including NEET young people)
3. Education (attainment, attendance, exclusion, education post-16)
4. Health (including disability and learning disability)
5. Crime
6. Barriers to Housing and Services
7. Living Environment



Social deprivation and mental health inequalities

- **Poverty** - young people who live in poverty are three times more likely to have a mental health condition
- **BAME** young people, particularly boys and young men
- **Excluded children and young people/those at risk of exclusion**
- **Looked after children and care leavers**
- **Households with three or more children**
- **Parental mental illness**
- **Young people in youth justice settings** - a third of children in these settings have a mental health condition
- **Young people with physical disabilities**
- **Young people with ASD and/or learning disabilities**
- **Children exposed to ACEs**
- **LGBT children and young people, particularly BAME LGBT young people**

Thurrock - *positive pathways* development

Thurrock and Brentwood Mind - 2017

Service Design in Mind approach to identify young people's mental health service needs and co-design services for Thurrock.

- Young people, many of whom had mental health needs but had received **no formal mental health support**
- Young people reported that they weren't aware of resources available locally and **wanted reliable information and signposting,**
- Emotional Wellbeing and Mental Health Service (EWMHS) clinicians challenge was **hesitancy about discharging children and young EWMHS,** as there was a significant 'drop off' in support at moments of transition
 - Clinicians 'hold on' to young people, which had an impact on waiting times.

Thurrock - *Positive Pathways* process

The Positive Pathways project started on 1st November 2018.

The young person is supported by a clinician and the youth facilitator

When the clinical work finishes, the youth facilitator for positive pathways carries on **supporting the young person with support available in the community.**

A wellbeing plan designed by a young person is used as a tool to help the young person keep well.

Personalised care and support plan session is conducted with the Mind youth facilitator worker, young person and their family

The youth facilitator will **explore what is available in the community** that meets the young person's needs and interests

Where services are not available, **Personal Health Budgets are made available** but only 6 out of 40 young people have needed this.

Young people receiving positive pathways support formed a social group -'beYOUUnique'

Thurrock - *Positive Pathways* Cohort

- YP being discharged from EWMHS
- Initially set up for those **aged 16-18** but has been **expanded to 14-18** as some YP were being discharged by early intervention and psychosis teams at that point
- Focus on **transition from EWMHS** has been the focus for the pilot
- Exploring working with YP who are earlier in their journey as the project expands in the future
- Average of **40 referrals per year**
- Families are identified through conversation and postcode areas known for low income and deprivation
- YP can come back into the service later if any problems arise.

Thurrock - *Positive Pathways* Local Strengths

- Able to **respond quickly** which builds momentum
- **Gradual hand over** process between EWMHS and positive pathways youth facilitator
- Harnessing passion and engagement: working with people in the system as a **shared goal/vision**
- **Commitment, flexibility and availability** of Commissioning Team, including finance
- **Quick access** to funding for those who need it.



Bristol - '*You're In Control*' development

Concern about young people who had experienced trauma and eligible for MH services but not engaging with them.

The pilot:

- CYP in care and **care leavers age 14-21**
- Partnership between CCG, the local authority and Barnado's
- **Coproduction group of YP** who named the project *You're in Control I'm in Control* and who stayed involved throughout including at celebration event
- **Staff specifically trained up**, 1 full time post and 1 part time
- Started in January 2017 and got off the ground quickly

Bristol - 'You're In Control' Process & Cohort

- Referred through the PA
- Lots of **self-referrals**
- USAC and other organisations such as Off The Record who work with care leavers
- PA trained in **Different Conversation**
- Barnado's assesses and administers the budgets; give YP the budget
- PA work with YP to fill in a form, send it to Barnado's who process the request
- Barnado's check if YP has been **satisfactorily involved in form content**
- PAs help YP access the budget
- Run **alongside other services**, i.e. Loneliness and Isolation campaign

Bristol - *'You're In Control'* Cohort

- YP in Care & Care Leavers
- Parent Care leavers
- Refugee & Asylum Seekers
- Ages 14-21
- Mixed ethnic group



Bristol- *'You're In Control'* Strengths

- Word of mouth from YP has been effective as a result of positive experiences
- Being led by children and young people
- Running alongside the other services
- Enthusiasm of the dedicated team in the pilot
- An example of impact - 2 big PH budgets offered in the pilot (up to £10k) illustrates real impact on people in Tier 4 and inequalities



Nottingham - 'You Know Your Mind' development

Notts was a late joiner to the NHSE pilot. In 2018 Notts county joined first then City.

- Fits with **social work practice model** rather than through health
- Supporting **LAC**
- IPC trailblazer for personalised care and so systems in place
- Does not require a MH diagnosis
- Social worker, or PA if Care leaver, who advises if that person has unmet emotional health needs
- YP **self identifies a support** that can improve mental health

Uptake: up to Easter 2020,
360 Notts county and **120 Nott City**

Some Challenges Identified

- Digital poverty
- Identifying young people who are socially deprived (Thurrock)
- Reaching people, particularly the most disadvantaged and disaffected
- Had reached some very disadvantaged such as homeless, mixed heritage, and unaccompanied asylum seekers. But not African Caribbean young men. (Bristol)



Emerging Findings

Individual elements of the PC model

Impact on issues of social deprivation

Impact on engagement with MH services

Are PHBs /SP and personalised care making a difference?

We have included quotes from across the focus groups, interviews and site lead interviews but they are not exhaustive, many additional comments were made about each key theme. Please also note that the figures may change as we continue to interview young people.

Primary Data Sources

- Interviews with site leads
- Pilot reports, supporting documents including bids
- Focus groups with young people (using discussions, Miro boards and survey answers)
- Focus group with parents
- Parent Interview
- *Young people individual interviews*

Individual elements of the PC model

Choice & control

All young people valued how the support was tailored to them and their needs and interests, rather than getting them to fit into a rigid or prescriptive service

“I feel like we all get our own individual needs met, because my needs aren't the same as [his].”



“..when [support worker] sees things that make her think you'll particularly like it, she can share that with you because she knows you and what interests you”

“Other services see problems as if they are in a textbook, and when that doesn't help you, they pass you onto new services and you have to begin all over again”



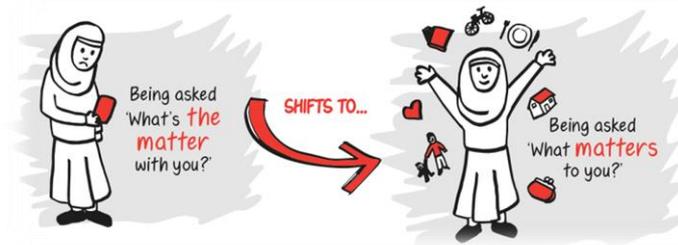
The best thing about it is “it is able to fit your needs and be unique to you”

YP talked about this in relation to their needs and interests, but also in terms of how mainstream services failed to understand ASD and ADHD, their physical health needs, their roles as young carers or young parents, and/or their backgrounds as care leavers, whereas the personalised support they had received understood this and adapted to meet their reality

Individual elements of the PC model

Social prescribing/PCSP/ PHB

- YP and parents valued the mixture of practical support e.g. **crafts activities, toys for young children, food parcels, bus pass, gym membership** and more focused mental health support e.g. **mindfulness activities, support to access mental health services** – and the impact *both* had on their mental health and wellbeing
- Young people report that they benefited from something to fill their time and mind
- YP in Thurrock did not see the intervention as a form of mental health support but holistic support that had an impact on all aspects of their life (mental health, physical health, confidence, loneliness etc.)

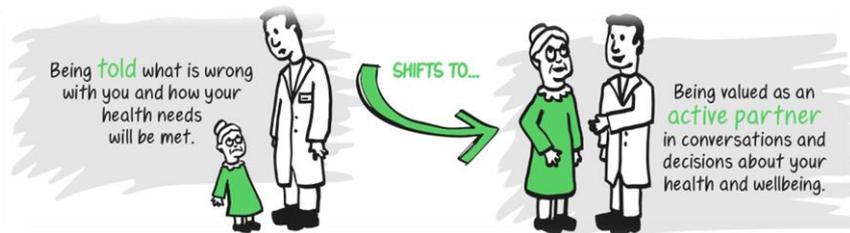


Individual elements of the PC model

Different Conversations and holistic approach

“It's almost enlightening, the questions that they ask you... Instead of asking what problems, they ask what the solution for this could be”

“The best thing about the support is 'different conversations' e.g. asking 'what happens on a good day?' rather than asking 'what would help your mental health' - the process worked really well”

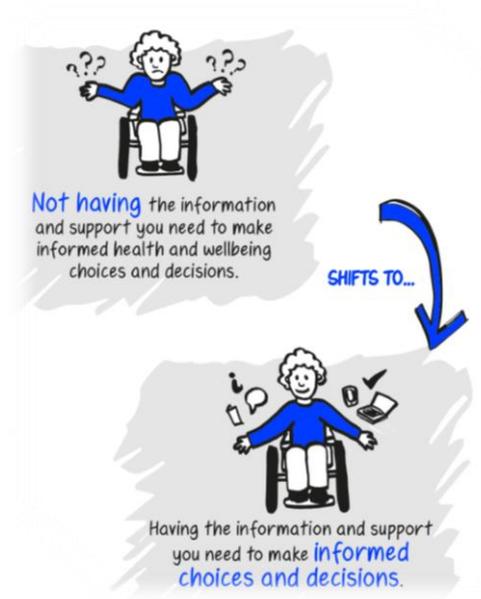


Recognition of the whole family and how that impacts young person's wellbeing

Individual elements of the PC model

Shared Decision Making / Supported Self Management

- All areas report strong methods of ensuring YP self identify support needed
- 84% agreed they felt “more able to make good decisions about my health”



What young people liked most about PC support

Personalised



“Able to fit to your needs and wants”, “meets our individual needs – our needs are not the same”, “individuality”

Feasible

“Super quick to get into”/ “no long waiting lists”

Holistic



“I feel accepted”

Reliable



“How warm and friendly the support worker is”

Solutions-focused

“Opened up opportunities like college and volunteering”

Flexible



“Different conversations process worked really well” – “enlightening questions”

“Can be referred into different services, support agencies and groups”

What young people liked least about PC support

All young people we spoke to highly valued the support they received. The most common response to the question of what they liked least or would change was “**nothing**,” with comments like “**there is nothing that should change – it is perfect.**” However, a few young people identified areas for improvement:

Awareness

- “I didn't know the options because I was the first person to take the pilot. Instead of gym membership, I might have got driving lessons to have more freedom but I didn't know the options I could have” (Bristol)
- “You don't know what the options and limits are. I am so used to sticking to a tight budget, I don't know what was available, having stories or examples might have helped or maybe having a budget limit so you know what you can do?” (Bristol)

Inability to meet in person

- “Covid stopping us from meeting in person and face-to-face”

Reduced worker support

- “Makes a big difference when you have a worker linked to a personal budget, it makes it more holistic and effective. Without a worker, people didn't know the what it was or its purpose.”

Impact on issues of inequality and social deprivation

“I feel like the personal health budget helped me a lot, because at first I wanted to go to the gym I could not afford it being on benefits, I couldn't afford £30-something a month to be able to go, and **also it helped me control a lot of my anger and a lot of my emotion...**’ Focus Group participant



“Having access to funding for my driving lessons and a laptop had helped massively,..... its given me something to look forward to and something to keep me focused... **I feel like freedom is so close** and I'll be able to go and see my family and actually be able to do things with my daughter..’ Focus Group participant



“Cuts out bureaucracy and red tape from the start - Can refer a YP on Monday, hold a ‘Different Conversation’ by Wednesday and money released by Friday, which makes a significant difference if income is an issue.” (site lead)



“We couldn't afford any art supplies at all after the benefits were cut so being able to get these again was huge as my daughter said it was the only thing keeping her going, the only thing that helped her not self-harm”
Parent Interview



Impact on Inequality and access to MH services

Barriers to accessing clinical MH services:

Insignificance

Feeling judged

Long waiting
lists

Unfitting

Too formal

Too
prescriptive/
clinical



"they said I wasn't unwell enough" "you have to get to crisis before someone actually listens"

"it's difficult for care leavers who are parents, you want to get involved with a service you can trust and that won't judge you"

"my mental health work all stopped, I was just expected to deal with it on my own" - "black hole between children and adults' services"

"black hole between children and adults' services"

Not trusting a clinical environment and support feeling overly formal - preferred the relationship-building and informality of PHB/social prescribing support

"It didn't understand me and my ADHD"

"Not many services are able to be shaped to your needs," "you can't see a full picture in a 20 minute appointment"

Inequality & engagement with MH services

Across all sites

- These interventions are often not badged as 'mental health support' and can help avoid stigma.
- **Helps engage groups** that have stigma attached to accessing MH support
 - *"The first time I ever saw a counsellor... it wasn't helping at all and I knew it wasn't. I was just kind of there just talking, I wasn't getting anything from it. There were no benefits. Then I left because it just made me feel worse in the end..."* [Focus Group participant]
- Some YP have then carried on accessing other mental health services within TB Mind, or were referred to additional services.
- the support worker, had been able **to understand and support them with their mental health and wellbeing in a way they did not trust other services and professionals to do**

Are personalised approaches making a difference?

Benefits to mental health and wellbeing



Young People:

“I feel less stressed, less anxious, feel able to join in with social activities”

“It has changed my life, I feel I can cope now”

Parent/carers:

“It completely changed our lives. It helped with [child’s] education, with their happiness, with my happiness... I don’t think I would be here without it.”

Are personalised approaches making a difference?

Skills and learning

84%



agreed they felt "more able to make good decisions about my health"

"[personalised approaches have] given me a wider opportunity of things to do, outings, meeting up with an individual worker or even zoom calls where we bake or do quizzes"



"I have learnt new skills like how to cook different meals"



Improved access to college education or employment that they wouldn't otherwise have done

Are personalised approaches making a difference?

Agency and formation of networks/services



Young People:

"it helped me access a lot of different things that you need professionals to access"

"I know who to contact if I need help with anything"

YP and families had been supported to access a wide range of other services including education support, carers grants, food parcels, youth groups, ASD referrals, parent support groups, and more

Are personalised approaches making a difference?

Wider Benefits



“It has helped me communicate more with my family and it has given me more determination to carry on”

Thank you!

- Final report due June 2021
- Any questions?
- Quick poll

- Please access the online poll and answer the questions *once*.
- To access the polling, **use your smart phone and search:**
www.PollEv.com/jazzeddew393
- You will be able to answer questions only when the speaker turns it on

Contact details:

Deborah Mclean-Thorne
dmclean-Thorne@ncb.org.uk





The THRIVE Framework as the learning front end of an ICS addressing inequalities in mental health access and outcomes

Al Mulley, Dartmouth Institute

*The THRIVE Framework, in the words of Benjamin Zander is:
“A possibility to live into”*



The THRIVE Framework as a Learning Front End for ICSs Addressing Inequalities in Mental Health Access and Outcomes

i-THRIVE CoP Webinar: Exclusion, Diversity and Inclusion
13 May 2021

Al Mulley, MD, MPP

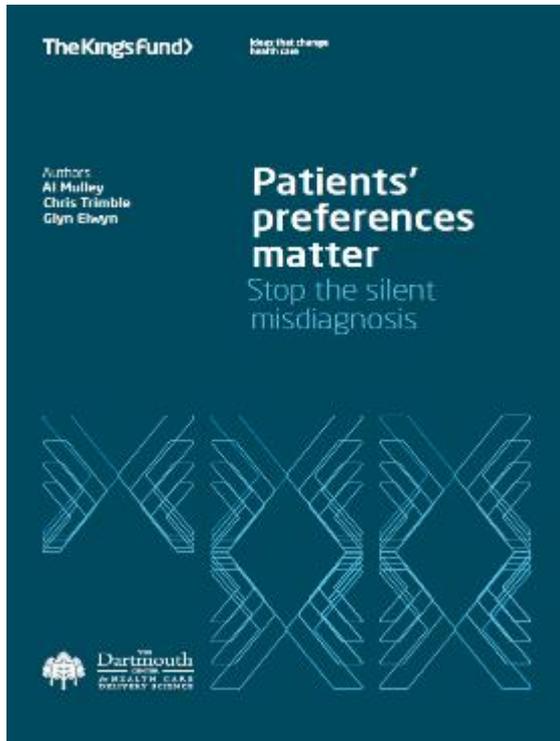
Professor of Medicine, The Dartmouth Institute for Health Policy and Clinical Practice

Visiting Professor, UCL



**The
Dartmouth
Institute**
for Health Policy
& Clinical Practice

Patient Preferences Matter: Stop the Silent Misdiagnosis



How much does keeping your breast matter?



How bothersome is urinary dysfunction?

Learning from Variation to Deliver What is Valued across Health Systems

2010 – 2017

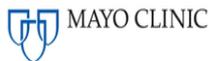


> 400 SGS Fellows from > 25 Nations on 5 Continents

- **The Greatest Untapped Resource in Health Care: Informing and Involving Patients in Decisions**
- **Innovating for Value in Health Care Delivery**
- **Realizing the Right to Health: A Rights-Based Approach to Strengthen Sustainability & Access**
- **Achieving Sustainable High Value Health Care by Maximizing Cross-Border Learning**
- **New Paradigms for Mental & Behavioural Health Care**
- **The Promise of Data – Will it Bring a Revolution in Health Care?**
- **Rethinking Care Toward the End of Life**
- **Changing Minds: Innovations in Dementia Care and Dementia-Friendly Communities**

Learning from Variation to Deliver What is Valued for Mental Health

2010 – 2017



Robert Bosch Stiftung Pat Deegan



'You think your job is to keep me from hearing voices. I think it is to keep me functional enough to have a job of my own.'

> 400 SGS Fellows from > 25 Nations on 5 Continents

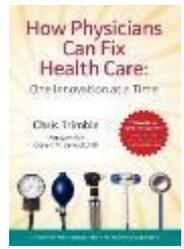
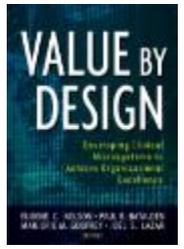
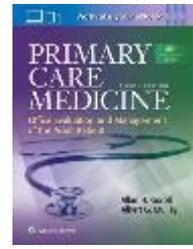
<https://www.commongroundprogram.com/blog/why-shared-decision-making-with-young-people-diagnosed-with-psychosis>

Making Choices Matter for Health & Wellbeing: New Roles, New Training



Category	Item	Value	Item	Value
Patient Care	Primary Care	100%	Specialty	95%
	Urgent Care	90%	Emergency	85%
	Maternity	80%	Pediatrics	75%
	Geriatrics	70%	Behavioral Health	65%
Operational	Quality Improvement	85%	Cost Management	80%
	Population Health	75%	Value-Based Care	70%
	Telemedicine	65%	Remote Patient Monitoring	60%
	Artificial Intelligence	55%	Big Data Analytics	50%

Dartmouth HEALTH CONNECT
 UMass Lowell Primary Care Practice



New approaches to measurement and management for high integrity health systems

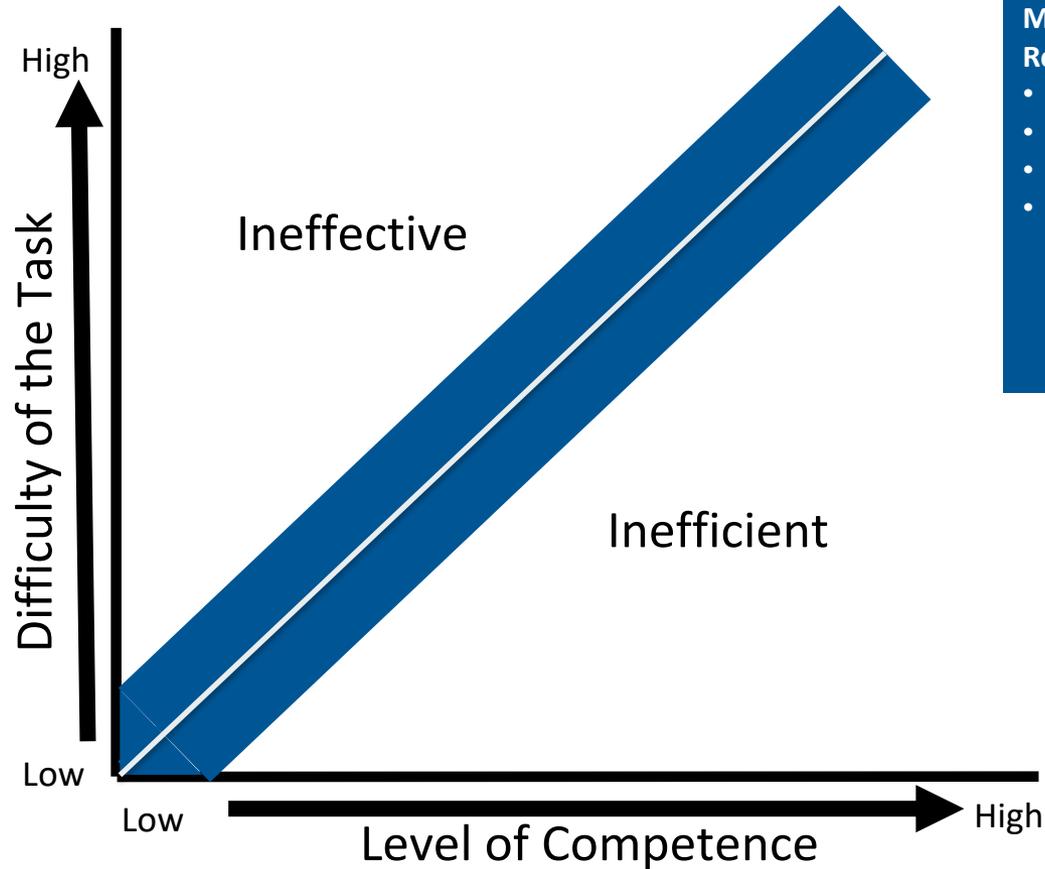
BMJ 2017;356:j1401 doi: 10.1136/bmj.j1401 (Published 2017 March 30)

Published in HFMA's Leadership magazine, Winter 2016 (hfma.org/leadership)

40 © Trustees of Dartmouth College



Technical and Relational Competencies for Integrated Care Teams



Measuring Teamwork as Relational Coordination (Gittel)

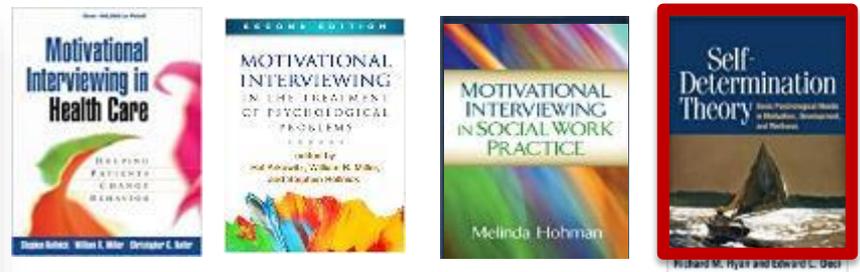
- Shared Goals
- Shared Knowledge
- Mutual Respect
- Communication that is...
 - Frequent
 - Timely
 - Problem- solving
 - Accurate

Making Choices Matter for Health & Wellbeing: New Roles, New Training



Category	Item	Value	Item	Value
Patient	1	100	2	100
	3	100	4	100
Physician	1	100	2	100
	3	100	4	100
Nurse	1	100	2	100
	3	100	4	100
Pharmacist	1	100	2	100
	3	100	4	100
Behavioral Health	1	100	2	100
	3	100	4	100

Dartmouth
HEALTH CONNECT
Urology Health Primary Care Practice



New approaches to measurement and management for high integrity health systems

BMJ 2017;356:j1401 doi: 10.1136/bmj.j1401 (Published 2017 March 30)

Published in HFMA's Leadership magazine, Winter 2016 (hfma.org/leadership)



Further Education Colleges as the Workforce Supply-Chain Innovators in the Black Country



Healthier Futures Academy

Black Country and West Birmingham

Making Choices Matter for the Health and Wellbeing of the People of the Black Country and West Birmingham

Choices as a **system** to ensure **high quality decision making** informed by the needs and wants of the people we serve, especially the most vulnerable, to support stakeholders to be mutually accountable for achieving strategic outcomes and priorities.

Choices at **place** to ensure **high quality decision making** in operationalising our strategies and designing effective interventions, collaborating with Health and Wellbeing Boards and strategic commissioners.

Choices at a **neighbourhood** level to ensure **high quality decision making** in implementing effective interventions and sharing intelligence with place and system.

Choices at an **individual** level to ensure **high quality decision making** by preventing avoidable ignorance for the patient about what is possible, and for the clinician about what is valued, thereby reducing harmful and wasteful overuse and underuse.



Co-production: reflections on a journey from theory to action

Georgina Fozard, Darzi Fellow

“If we keep on doing what we have been doing, we are going to keep on getting what we have been getting”



Co-production - Reflections on moving from theory to action

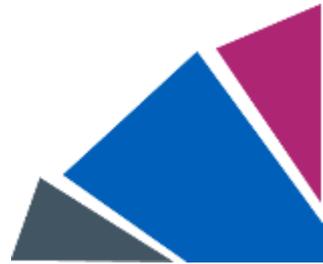
Dr Georgina Fozard, Darzi Fellow, Child and
Adolescent Psychiatry ST6, NCL Partners ICS and
Tavistock and Portman NHS Foundation Trust



“[co-production is] about broadening and deepening public services so that they are no longer the preserve of professionals or commissioners, but a shared responsibility [with communities], both building and using a multi-faceted network of mutual support”

(Stephens et al, 2012)

Boyle and Harris (2009) make a link with how badly equipped public services are to respond to demand as *“they have largely overlooked the underlying operating system they depend on: the social economy of family and neighbourhood.”*



The context

i) Addressing notions of value in society and ii) Sustainability of services

- 1. Recognising people as assets, because people themselves are the real wealth of society
- 2. Valuing work differently, to recognise everything as work that people do to raise families, look after people, maintain healthy communities, social justice and good governance

iii) Challenging professionalised and paternalistic organisational cultures

- 3. Promoting reciprocity, giving and receiving because it builds trust between people and fosters mutual respect

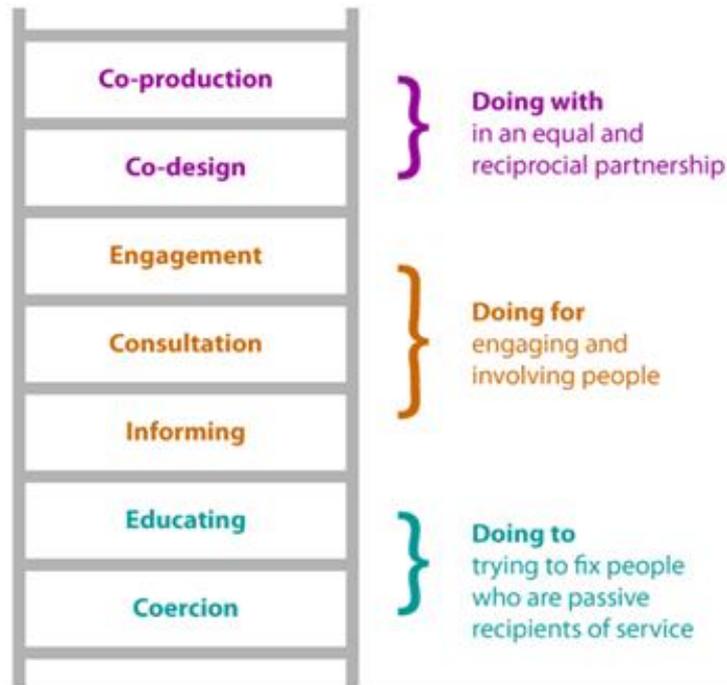
iv) Addressing individualism and loneliness

- 4. Building social networks, because people's physical and mental wellbeing depends on strong, enduring relationships

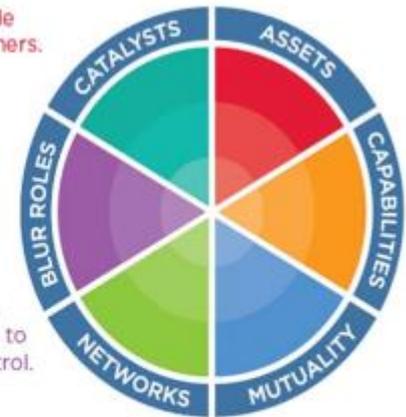
Figure 1: Why co-production is needed - author's own, adapted from Boyle and Harris (2009)



What is co-production?



- Assets:** Transforming the perception of people from passive recipients to equal partners.
- Capabilities:** Building on what people can do and supporting them to put this to work.
- Mutuality:** Reciprocal relationships with mutual responsibilities and expectations.
- Networks:** Engaging a range of networks, inside and outside 'services' including peer support, to transfer knowledge.
- Blur roles:** Removing tightly defined boundaries between professionals and recipients to enable shared responsibility and control.
- Catalysts:** Shifting from 'delivering' services to supporting things to happen and catalysing other action.



People Powered Health Coproduction Catalogue

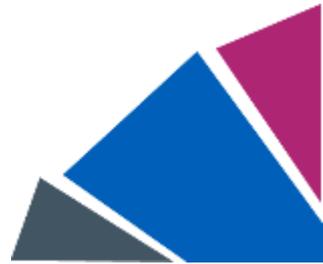
The NESTA Framework (NESTA, 2012)



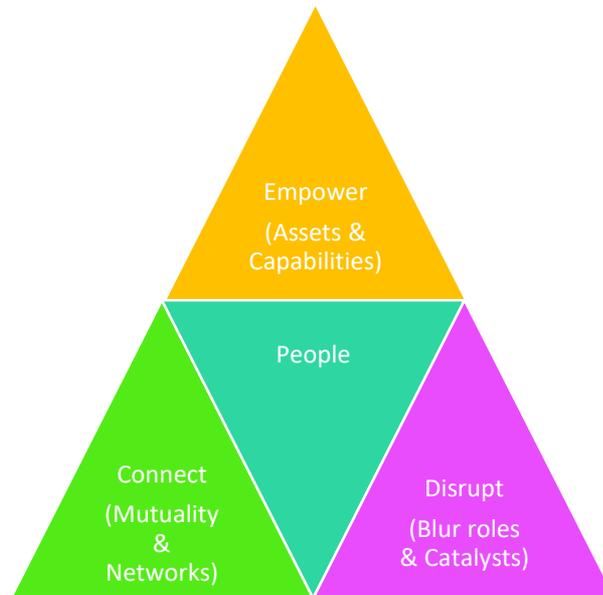
How to gain momentum amongst staff?

“Coproduction simultaneously promotes engagement with and autonomy from the state, and that this tension generates political struggle and change”.

- Zheng, R. (2018) explores the extent to which our social roles make moral claims on all of us to exercise our individual agency throughout the system to bring about the conditions for transformative change.
- Post COVID healthcare staff and communities may be triggered to disrupt and do things differently, looking beyond the bounds of their institutions for the way forward.

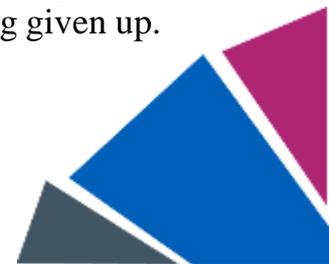


How to gain momentum amongst staff?



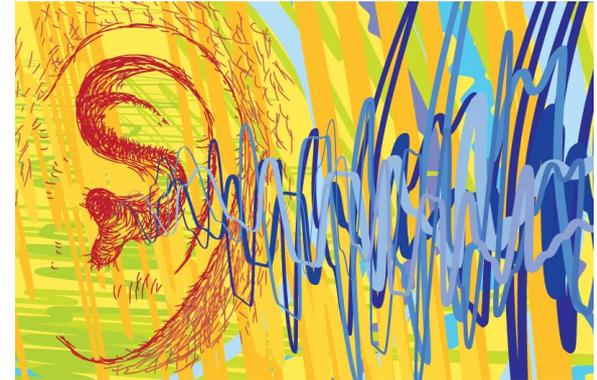
- Both William Halton (2004) and Otto Scharmer (2014) write about a need for something to be lost or destroyed in order for growth.
- Unless staff are able to ‘let go’ of their roles as they saw them, the space for them to become catalysts won’t occur.
- This creativity involves a process of mourning (Halton, 2004) something given up.

‘Disrupt, Connect, Empower’ (author’s own, adapted from NESTA, 2012)

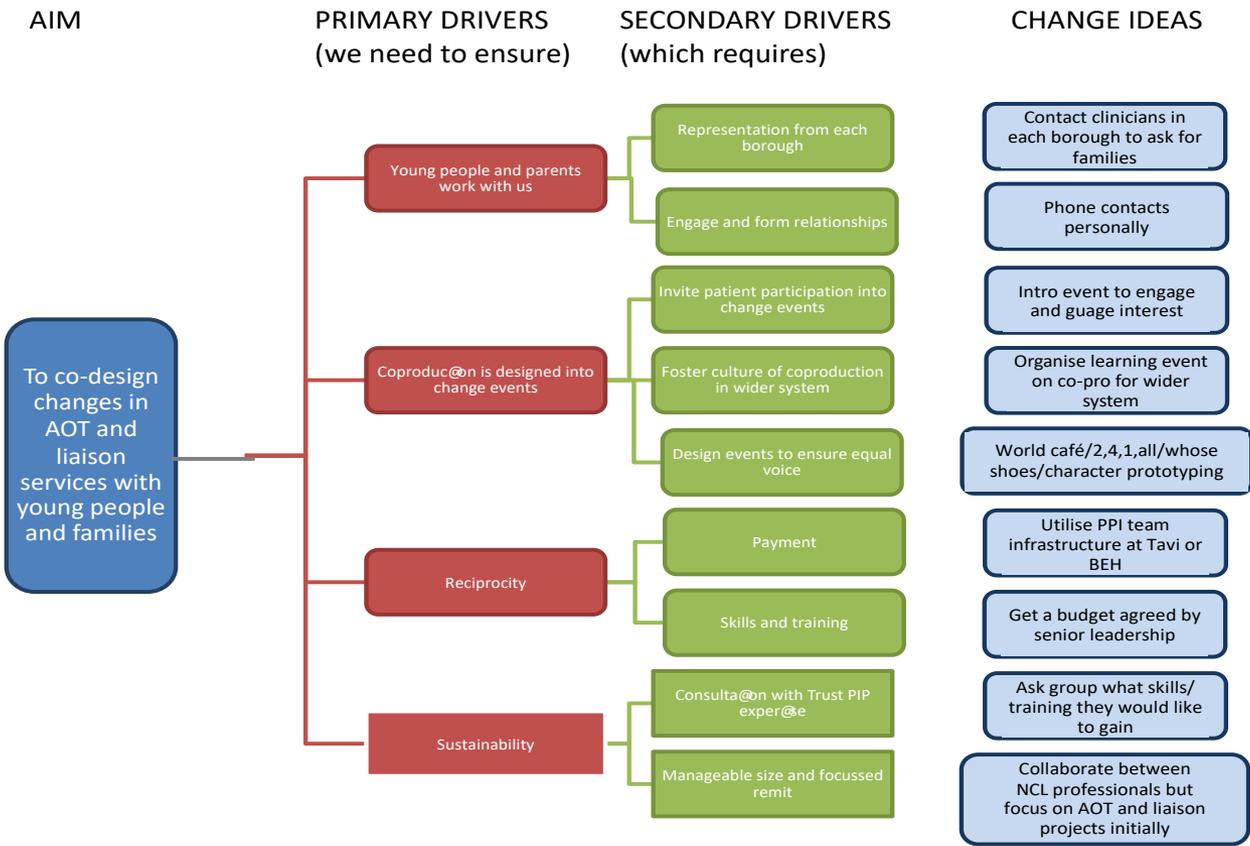


NCL CAMHS Lived Experience Group

- Collaborative group across North Central London, including 3 NHS Trusts
 - Barnet, Enfield and Haringey NHS Mental Health Trust
 - Tavistock and Portman NHS Foundation Trust
 - Whittington Health
- Involving young people, parents and carers who have accessed CAMHS and have experience of using the AOTs or A&E/liaison services.



Driver Diagram for NCL experts by experience group



What do you think is important when in Crisis?

Recap from intro session:

listening to yp
 medical support family support
 practical resolution care
 help from a professional
 not having to repeat
 listening support comfort
 consistency expectations
 planning support

If you had a magic wand...
 what would you do to make AOT/crisis/liaison services better?

A&E - ways of working

Proper triage - ask what OD you took

Training for ED triage staff

Lack of mental health support on physical ward

Consider trauma when arranging 1:1 - No more 10mins, if patient asks not to have one

No long waits

Not pep talks

Privacy - not disclosing reason for admission to receptionist

A&E location

Being turned away from A&E to the hubs can feel bad

Subsection of A&E for mental health

Private/separate space in A&E for mental health patients

A&E specialising in mental health conditions

Somewhere comfortable to sit

AOTs

Need at least one person who they may fully connected with the whole way

Parents perspective - please involve parents!

AOT - can pick up quickly, respond the next day

Consistent person to talk to

Be more like CAISS

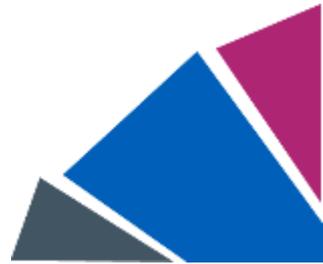
It is really difficult to learn to trust someone brand new and never see the old person again after it being so intense.

Put your ideas on post it notes or speak out and we will do them for you:



Challenges in the system

- Initial scepticism about **collaboration** from parts of the network.
- **Accessing patients**, takes constant asking and hassling, find allies, find people who see the value, ask!
- **Funding and payment** – managed to get funding for attendance but there are administrative barriers
- **Anxieties about safety and information governance** etc
-> took just try it approach
“don’t ask for permission, ask for forgiveness”



Learning how to run the group

- Culturally – **professionals not used to parents or patients in groups** – changes dynamic and can throw in curve balls. How to respond?
- Importance of looking after people contributing → **Briefing and debriefs important.**
- Experimenting with running the group – **parents and patients together** but some uncomfortable.
- **Large resource** initially
- **Equalities** – how can we get all communities involved?
- Equality with staff hard as budgets and power to enact change sit with a few professionals.



Lessons learned:

- Extremely rewarding.
- Level of passion, ideas and energy from group have been inspiring and the most enjoyable part of my Darzi year.
- Patient stories cut through work politics and focus minds.
- Resource heavy though, so needs concerted and systemic investment by Trusts or systems if they truly want to shift to this way of working.
- Reciprocity is essential, can't be exploitative, should be enjoyable and rewarding.
- We need to be brave – challenges faced by the healthcare system need radical shift towards prevention and a shift in power dynamics.
- Peer support, psychoeducation, shifting support into the community and groups need to be enabled.



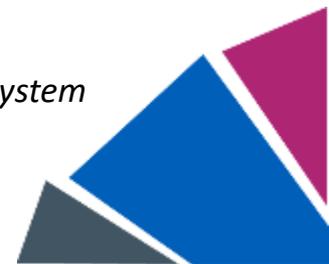
References:

Boyle, D., Clark, S. and Sarah Burns (2006) Co-production by people outside paid employment Available from: <https://www.jrf.org.uk/report/co-production-people-outside-paid-employment> [accessed on 15/2/21]

Boyle, D. & Harris, M. (2009) The challenge of co-production: How equal partnerships between professionals and the public are crucial to improving public services, London: National Endowment for Science, Technology and the Arts NEF model Available from: https://neweconomics.org/uploads/files/312ac8ce93a00d5973_3im6i6t0e.pdf [Accessed on 27/3/21]

Halton, W. (2004) By what authority? Psychoanalytical reflections on creativity and change in relation to organisational life. In Clare Huffington et al (eds) Chapter 6 of '*Working Below the Surface: The Emotional Life of Contemporary Organizations*'

Scharmer, C. O. & Kaufer, K. (2013). *Leading from the emerging future: from ego-system to eco-system economies*. San Francisco, Berrett-Koehler Publishers, Inc.



References:

Stephens, L., Ryan-Collins, J. & Boyle, D. (2008). Coproduction: A manifesto for growing the core economy. New Economics Foundation, London Available at: <https://neweconomics.org/2008/07/co-production> [Accessed on 5/1/2021]

Zheng, R. (2018) What is My Role in Changing the System? A New Model of Responsibility for Structural Injustice. *Ethic Theory Moral Prac* 21, 869–885



Upcoming National i-THRIVE Programme Webinars



Date	Title
Thursday 10 th June 10:30am-12pm	Approaches to enhance children, young people, and families' understanding of the THRIVE Framework. Register for your place here .
Thursday 8 th July 10:30am-12pm	Applying Quality Improvement methodology to support THRIVE Framework implementation. Register for your place here .

For more information: i-THRIVE



www.implementingthrive.org

Sign up to the National i-THRIVE Community of Practice and receive monthly updates. Email:

ithriveinfo@tavi-port.nhs.uk



@iTHRIVEinfo

LinkedIn

YouTube

National i-THRIVE Programme



The Tavistock and Portman
NHS Foundation Trust



Anna Freud
National Centre for
Children and Families



UCLPartners



The
Dartmouth
Institute
for Health Policy
& Clinical Practice