All Age Transformation

Transforming our mental health
and learning disabilities services

John Edwards

We're on a five-year journey to transform care in all our mental health and learning disabilities services, through improvements co-designed with service users, carers, staff and other stakeholders

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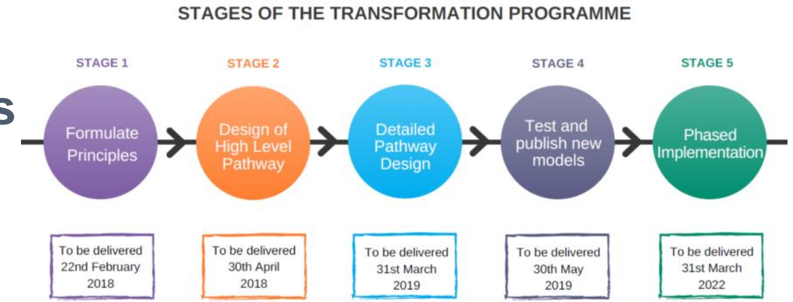
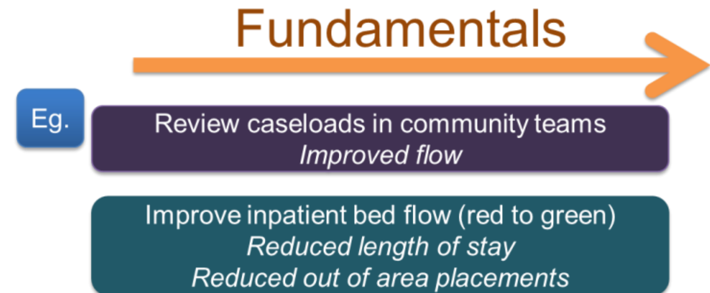
Summary

- LPT has embarked on a 5 year Transformation programme to redesign its entire mental health and learning disabilities services. This is described in 5 key stages.



- This is focused on: Increasing value to service users (and reducing activities that doesn't add value), releasing clinical time to care, creating increased flow through services.

- This will involve both radical changes (requiring time and significant redesign) and small scale changes that happens concurrently to the radical redesign such as improving inpatient flow in the Bradgate unit.



- The redesign is being undertaking through co-design with service users, carers, staff and stakeholders working together to redesign services.

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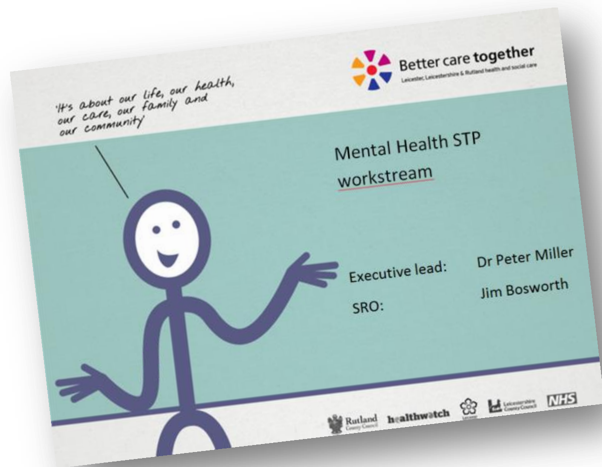
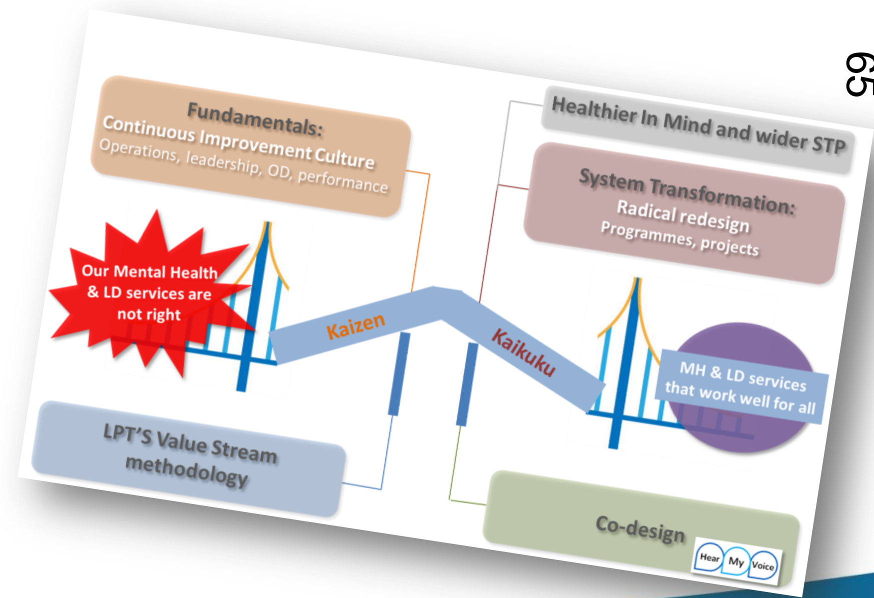
5 year Programme





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The challenges.

Gaps in services

Disproportionate amount of resource in inpatient services than community

Patients bounced around between services

Long waiting times

Our services are not right

Unequal services based on location, age etc.

Many NICE approved treatments not provided or provided with enormous waits

Location of services not always convenient and parking often hard

One of the highest community caseloads in country

One of the longest length of stay in adult mental health services

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System configuration

Creating seamless flow

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Outcome

Adding value to service users

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Resource change

Releasing time to care in front line staff

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All Age Transformation

Transforming our mental health and learning disabilities services

STAGES OF THE TRANSFORMATION PROGRAMME

STAGE 1	STAGE 2	STAGE 3	STAGE 4	STAGE 5
Formulate Principles	Design of High Level Pathway	Detailed Pathway Design	Test and publish new models	Phased Implementation
To be delivered 22nd February 2018	To be delivered 30th April 2018	To be delivered 31st March 2019	To be delivered 30th May 2019	To be delivered 31st March 2022

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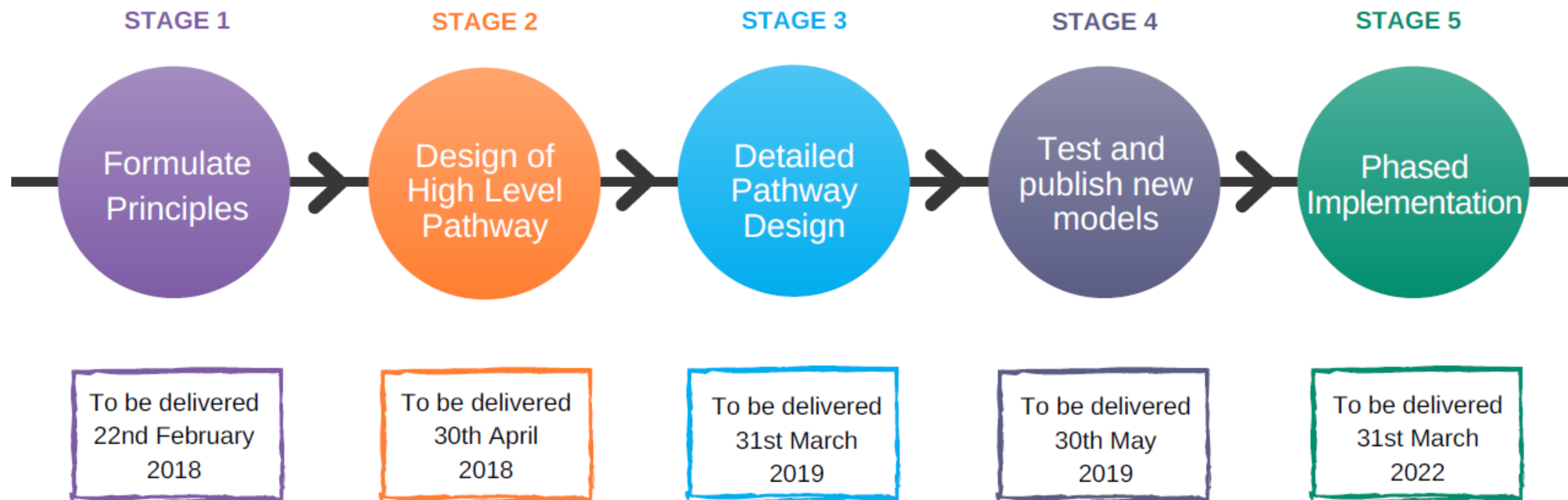

Eg.

Review caseloads in community teams
Improved flow

Improve inpatient bed flow (red to green)
Reduced length of stay
Reduced out of area placements

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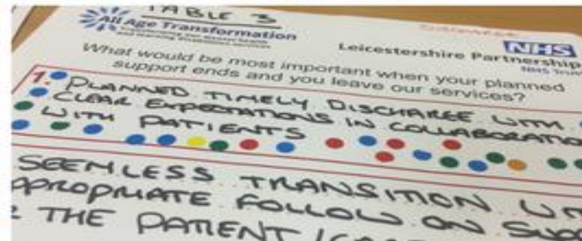
Stage 1: Principles



Service users, carers, staff and stakeholders views

The Patient Journey
Four common stages…

Access | Assessment | Treatment | Discharge

Views themed to form a set of principles

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Stage 2: High Level Pathway Development – Co-design

- 4 x Week long Workshops
- 20+ staff, service users, carers and stakeholders in the room each week
- Twice each week there were 7 Feed-in sessions and online forms supported by VAL to get wider involvement of service users, carers, staff, local authority, VCS, other stakeholders and wider public.

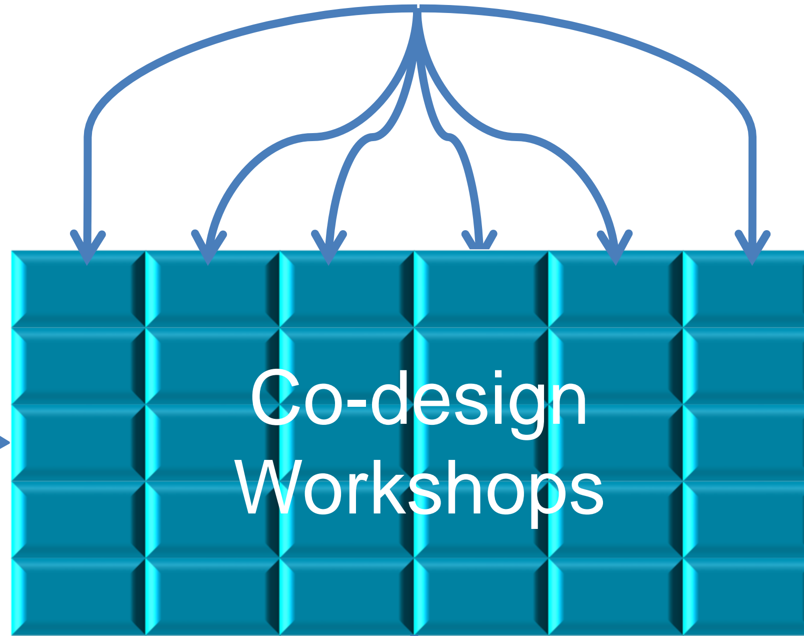
Access | Assessment | Treatment | Discharge

NEXT… Stage 3: Detailed Pathway Design (June to March 2019)

Stage 2: High Level Pathway Development – Co-design

Data

- Workforce mapping
- Cohort mapping
- Service performance
- Locality Mapping
- Inpatient Audit
- Stakeholder views on services
- Service mapping
- Shadowing
- Clinical pathway mapping



Strengthen 'best practice' clinical pathways

Workforce model, clinical pathways and organisational structure

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Summary outputs from stage 1 and 2

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Stage 1: Principles

Principles: Access - When people need help they get…

- Timely access that is immediate when required and available 24 hours and 7 days a week
- Simple and clear information that is understandable on where to go and what to expect.
- Easy and flexible access through various mediums including telephone, digital and face to face
- No bouncing between services - the access point has the right individuals and knowledge to be able to support individuals and/or signpost appropriately
- Interacting with staff from the beginning who are non-judgemental, compassionate, empathetic, friendly and supportive
- Contact with skilled, well trained and experienced staff
- Help is located in an accessible and local place that provides good, tidy, comfortable, and accessible environment
- Individuals can access services directly
- Joined up cohesive working across agencies (particularly health and social care) to support individual needs

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Principles: Assessment – What would be most important when staff are assessing and understanding your need

- There is a clear and transparent assessment process which the service users feel fully involved in, have an equal say in their assessment which is centred around their needs.
- Assessed once and not passed about. First assessment is undertaken by a member of staff who has the right skills, knowledge and experience and the time to understand the needs of the individual.
- When being assessed the service user needs to be treated with respect, not judged and feels listened to and understood.
- Assessment process avoids repetition and involves the multi-disciplinary team with the right skills and knowledge
- An Electronic system is used that provides access to all the relevant information for all staff involved with the service user
- Assessments undertaken when needed (timely and not delayed)
- Joined up cohesive working across agencies (particularly health and social care) to support individual needs

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Principles: Treatment – What would be most important when getting the support or treatment that you need?

- Service users understand their choices, have options and create a clear realistic individualised plan.
- Service users are involved in creating a plan which they agree and continue to collaborate on through regular reviews and that provides clear expectations on what will be provided and when.
- There is a support network for the service users through different people (e.g. peer, GP, staff, friends and family) in a variety of ways when they need it.
- Service users want consistency in who they see for their therapeutic interventions
- Treatment and support is provided without delay and in a timely manner.
- The care is provided by appropriately skilled and competent staff who are kind and welcoming.
- Services delivered at the times and locations that are convenient for service users to avoid them missing school or work.
- Joined up cohesive working across agencies (particularly health and social care) to support individual needs

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Principles: Discharge – What would be most important when your planned support ends and you leave our services?

- Individuals want to be signposted and aided in building support locally from peers and/or groups and community activities.
- Individuals want to have a service contact point for when they need it
- individuals want clear information on ways to stay well and how to re-access service support when unwell
- Discharge from service is planned early, is developed with service users, carers and other agencies (e.g. GPs, social care) to be at the right time and provide a seamless transition from the service.
- Leaving services should be built around individuals recovery and the achievement of goals that the service user has agreed
- Joined up cohesive working across agencies (particularly health and social care) to support individual needs

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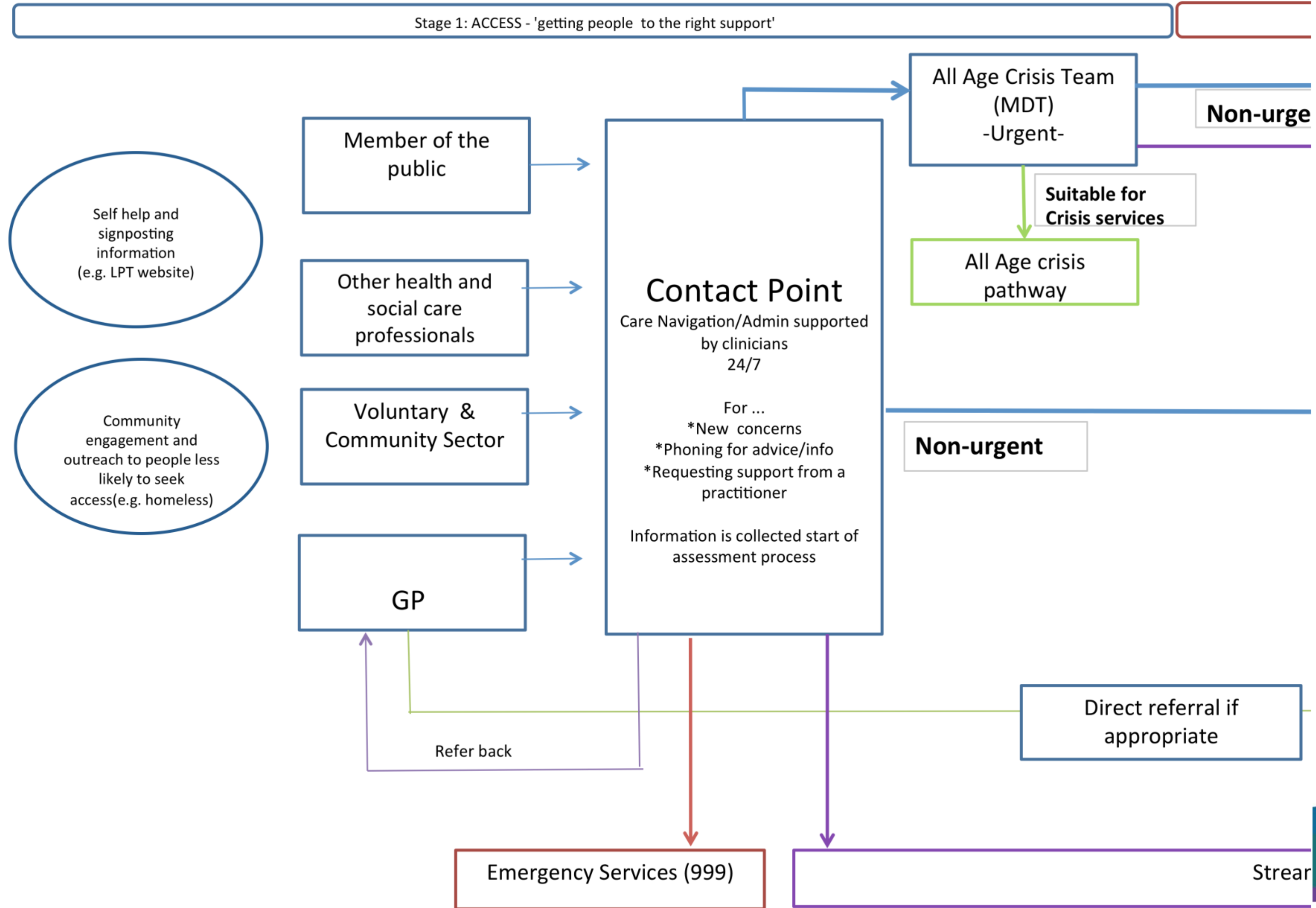
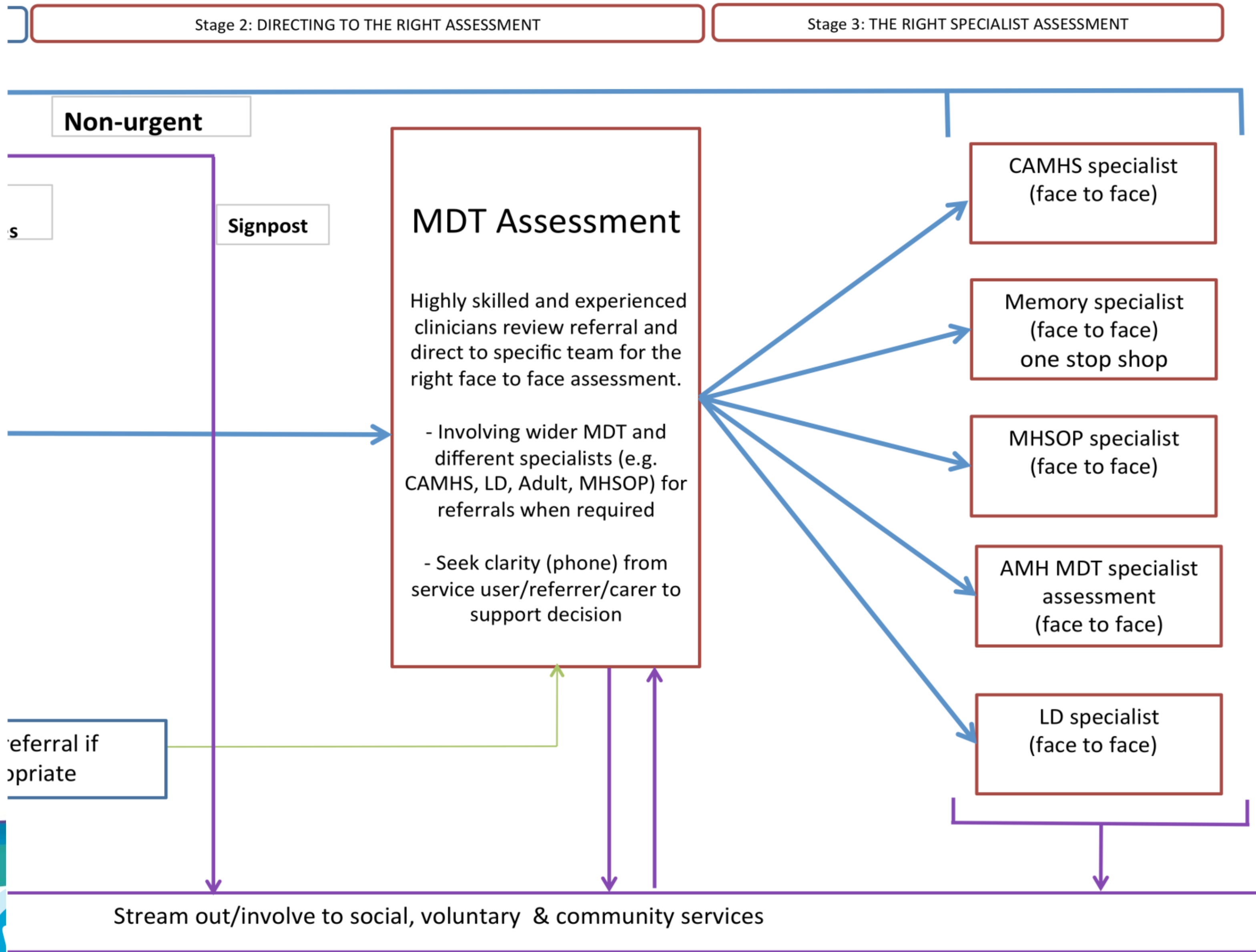
Stage 2: High Level Pathway - Access



Stage 2: High Level Pathway - Assessment



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Stage 2: High Level Pathway - Treatment

Multi-agency working and care navigation

Whole Person Approach to assessment

Continuity and lead professional

Intervention pathways

Choice and collaboration

MDT working

Inpatient & community working

Enabling changes: IM&T, buildings, focused around population needs, directory of services

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Stage 2: High Level Pathway - Discharge

Information & support available outside of LPT services

Peer support workers

Recovery Approach

Joint working with social care and mental health/learning disabilities

Coordination and connection of all support (in and outside of LPT) for service user

Carer Pathway

Red to green in community

Peer reviews

Discharge decision tool

Check-in process

Telephone advice line

Arbitration panel

Primary care collaboration

Shared Care

Intermediate support between GPs and secondary care mental health

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