We want to improve the experience of hospital care
We want to help people with Dementia to experience a sense of wellbeing
We want people with memory problems to receive early diagnosis and the right on-going care and support
We want to make sure that people are cared for in the community wherever it is safe to do so and only admitted to hospital when necessary
We want to work with other teams, organisations and agencies to provide joined up care
We want to improve the care of people with Dementia in residential homes

We need to continue to develop Our Mental Health Services for Older People (MHSOP) to ensure that we deliver the best care for local people in the future.

This newsletter has been created to help staff working in MHSOP to understand and be involved in the changes ahead.

In this first edition we explain the proposed changes; what we aim to achieve; and how and when we’ll go about it. Future editions will keep you up to date as plans progress.

We also plan to publish frequently asked questions. If you have a question which you’d like to include, please call communications manager Lindsey Bond on 0116 2950801 or email Lindsey.bond@leicspart.nhs.uk

All editions of this newsletter and the frequently asked questions document will be published on a new Transforming MHSOP page on e-Source.

Why do services need to change?

We have hard working and dedicated staff who strive to do the best for their patients every day, but we’re not currently working as effectively as we could be. For example:

- There are lots of different points of contact for referrers, patients and carers, which makes it difficult for them to navigate the system and can lead to delays or breakdowns in communication and timely delivery of appropriate care.
• We have different processes and operate in different ways in different areas, which means we’re not delivering care consistently for all of our patients.

• Our referral, admission and discharge criteria and processes are not clear and are not always consistent, which means that patients sometimes stay in a particular part of the service for too long and/or are sometimes admitted to beds because we do not have the resources to care for them in their own home.

• Staff don’t always have confidence that other services/parts of the system can meet their patients’ needs and are therefore reluctant to refer them on when their condition and care needs change. Some of us hold on to patients with the best of intentions but this means we are putting extra pressure on ourselves and our teams.

• There are competing demands for planned and unplanned care. Staff have to manage both and responding to individuals with urgent care needs sometimes means that our care of other patients is interrupted.

“We’re re-designing our mental health services for older people to improve care quality and patient and carer expectations, and to make best use of resources to meet the needs of an increasing number of frail older people with complex mental health problems.”

The MHSOP model of care
The diagrams below show how the service is currently organised and how we propose to organise it in the future.
**Working together**

We want to deliver integrated mental health care for older people that promotes and prolongs independence, quality of life and psychological wellbeing.

We need to work more effectively and to do that we have to work together as one service. At the moment the roles and responsibilities of teams are not always clearly defined. As a result there is overlap and patients aren’t always receiving the most appropriate care and support in a timely way.

In future we’ll have clear criteria for stepping patients up and down between different parts of the care pathway, and the services provided within each part of the pathway will be more distinct. We recognise that mental health care is complex and every patient is different, however, staff will be expected to make sure that patients are being supported by the most appropriate part of the system.

Staff will be involved in the development of criteria for each element of the service over the coming weeks. As part of this we will define how we improve handover information and processes and how clinicians can stay involved in/informed about their patient’s care when they are being supported by a different part of the system. We will also define roles and responsibilities and how we work as part of the multi-disciplinary team, so that clinicians are clear about each other’s accountability.

**Improved access, management of referrals and coordination of care**

The time to care that most staff have available to them is reduced by inconsistent and onerous processes for managing referrals, managing beds, transferring patients and coordinating care arrangements. Some elements of this work are also too dependent on the right staff being available, and when they are not, things can break down, leading to more work or risks for patients. We are therefore looking at how to improve this through a more structured, coordinated and consistent approach. The first area we are considering is how to strengthen bed monitoring, management and admissions. Other parts of community services and the wider health system have already successfully improved referral and admission processes through use of a ‘Single Point of Access’ approach, so we are looking at how we might use similar principles to meet our needs.

**Care Home Service**

In October we launched a six-month pilot offering in-reach support to residential homes across Leicester, Leicestershire and Rutland. This followed on from a successful pilot with a small number of homes in Charnwood. Our new in-reach team includes a team manager, psychiatrist, psychologist, occupational therapist, community psychiatric nurses, healthcare support workers, a speech and language therapist and administrative support.

**What could be different**

- Dedicated specialist multi-disciplinary teams
- Emphasis on improving the patient and carer experience, including:
  - less patients on anti-psychotic medication
  - less unnecessary hospital admissions
  - more carefully planned transfer of patients in to care homes

**What will be different**

- Faster access
- Better coordination
- More time with patients
The team are helping to facilitate discharge from hospitals into care homes – so that transfers are more timely and carefully planned. They are also helping care home staff to develop their skills and confidence to manage residents with behavioural and psychological symptoms of dementia to prevent unnecessary admission to hospital. They will also help to reduce the prescribing of anti-psychotic medication and encourage greater use of drug-free approaches to dealing with this group of patients.

At the end of the pilot in Spring 2013 we hope that the results of the pilot convince the three Clinical Commissioning Groups to invest in this approach on an on-going basis.

There is a Frail Older People’s Advice and Liaison Service (FOPALS) within University Hospitals of Leicester NHS Trust (UHL). FOPALS is a team of clinicians – including consultant psychiatrists and mental health nurses - specialising in the care of frail older people. They assess patients presenting with psychiatric or psychological as well as physical symptoms to make sure they have the right care plan, not only during their stay in Leicester’s hospitals but also when they return home. The FOPAL team will help to ensure that patients who require ongoing care are transferred to the most appropriate part of the service with a robust care plan.

CMHTs will continue to be the first point of contact for most people who use our services. At the moment patients are not always stepped up from or back down to the CMHT when their condition and care needs change. Keeping patients on the caseload who could be managed by their GP and/or trying to manage patients with urgent and intensive care needs as well as those requiring complex case management puts additional pressure on CMHTs and individual staff and is not always best for the patient.

Urgent situations can’t always be planned for and we need to have the capacity to respond quickly and effectively without interrupting the routine, planned services.

In future we will enable CMHTs to have manageable caseloads, function more effectively and concentrate on complex but stable patients by:

- having clear criteria for stepping patients up and down to different parts of the care pathway, and
- having staff within the CMHT who concentrate on urgent assessment of patients who are reaching crisis point and at risk of hospital admission. These staff will have the capacity to respond quickly and determine what needs to be in place to prevent a vulnerable situation from breaking down. They will coordinate the involvement of appropriate teams and/or agencies.

**Memory services**
Memory services will continue to be part of the CMHTs because they are a planned service, with patients being seen in clinic by appointment in the main. In the future we will work in partnership with GPs to ensure that people with memory problems are diagnosed at the earliest opportunity. This is great news but it means that our assessment, diagnosis and prescribing work will increase. We are working with commissioners and GPs to introduce a ‘Shared Care Agreement’ for the diagnosis and management of Dementia. GPs will have a greater role in supporting people with Dementia on a day to day basis and we will focus on the assessment, diagnosis and prescribing element of the service.

Overlap between services, lack of clarity about roles and responsibilities and caseloads which aren’t proactively managed means that services have difficulty working effectively. In future we’ll have clear roles and responsibilities and criteria for stepping patients up and down between different and distinct parts of the care pathway.

In the future if the condition of a patient currently managed by a CMHT deteriorates or destabilises to the point where they need more support, there will be opportunity for the patient to be stepped up to the Intensive Service. Patients will also be stepped down to the Intensive Service from the Inpatient Service.

The Intensive Service will focus on supporting people to be cared for in their own homes instead of admission to hospital, and on preventing relapse by helping people who have been admitted to hospital to be discharged as soon as possible. It will provide up to 8 weeks of intensive support. This could include home-based interventions and/or day treatment services.

The Intensive Service will be managed in the same way that a hospital ward is. It will have admission criteria and a maximum capacity in the same way that a ward has a maximum number of beds, so that once it is full, staff will not be expected to take on additional patients for which they don’t have the resources to support safely.

**Day services**

The current arrangement for day services is not as efficient or effective as it could be. It is sometimes the case that there are just one or two patients at sessions and the input at them varies. It is proposed that we centralise the provision of day treatment in to one place so that capacity is fully utilised, care and support is consistent and delivered by specialist staff in an appropriate environment with good access to equipment and specialist services.

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**Intensive Service**

What will be different

- ICATs replaced by a new Intensive Service and dedicated urgent assessment element in CMHTs
- Staff with capacity to respond quickly
- Close links with social care so that all needs can be met
- Day services centralised to maximise effectiveness
We deliver good care on our wards and we’re continually making improvements. It is still the case, however, that our beds are almost always full, some patients are admitted inappropriately and some are staying longer than is necessary.

In future the Intensive Service and Urgent Assessment element of the pathway will focus on preventing people from being admitted to hospital and work closely with Inpatients to help those who have been admitted to be discharged as soon as possible.

We currently have inconsistent inpatient admission criteria and we don’t have a robust or efficient bed allocation process, which means clinicians spend a lot of time trying to manage the logistics of admission. In future we’ll have consistent admission criteria and a more effective admissions process.

At the moment when a patient is admitted the handover is often a piece of paper containing minimal medical information. We want to work out a better way of sharing information between different elements of our service. We’ll work to improve the information available when a patient is admitted so that we can care for them more effectively. That may simply involve a telephone conversation with the community clinician who has been caring for the patient for some time and knows the best ways to support them. In some circumstances it could involve the clinician accompanying them on to the ward to help settle them in.

**Other work supporting our plans**

In addition to the changes described in this newsletter, we will continue to constantly review our systems and processes to make sure that they are patient-centred, consistent and effective.

We will ensure that our plans align with the Trust’s strategy and take account of other plans in the pipeline or on the horizon. For example, you may already be aware that we’re introducing a better electronic patient record system into MHSOP next Summer. It’s called RiO. It will reduce the amount of paper records we keep, make it easier for different parts of the service to capture and share information and will eventually also support mobile working for community staff.

**Our workforce**

This first edition of the newsletter describes the future model of care for mental health services for older people. What you’ll no doubt be asking is ‘what does this mean for me?’ The answer is, right now it’s too early to say exactly.

What we can say is that we want to retain and develop staff and have a workforce which is flexible and able to adapt. Our aim is to drive up quality and deliver care in the most effective way. There will be changes for some staff. We need staff with the right skills in the right place. This may mean some staff working in a different geographical area or for a different part of the service. It may also mean there will be development opportunities – we would like to make better use of people’s skills and, for example, have more nurse-led memory clinics.
There are also changes taking place which are not as a direct result of the new model of care – that would have been happening anyway. We have, for example, increased the number of healthcare support workers and volunteers on the ward and are looking to standardise shift patterns on our wards to increase flexibility, make it easier to cover shifts, reduce bank usage and ensure that all staff have equal opportunity for flexible working.

We will help staff to understand all of the changes and what it expected of them. We will make sure that staff are treated fairly, consulted appropriately, and applicable human resources processes are followed.

**Making it all happen**

We are absolutely committed to transforming our mental health services for older people and involving staff in how we do it. Throughout November we have been defining the detail of how we are going to make this change happen and are now starting to prepare managers to inform, involve and support staff.

The transformation is being supported by a Project Board made up of senior clinicians and managers. There are a number of workstreams focusing on different areas in which frontline staff will be involved, including: the multi-disciplinary team approach; the patient journey; enablers and how we measure quality and improvement; the technology we need; people (including structures, job roles, training and development); culture and communication.

Band 6 and 7 staff have been invited to attend a workshop in January to provide them with information about the change programme and start to equip them to involve and engage frontline staff in the process.

We aim to publish a second edition of this newsletter by mid-January 2013 to provide all staff with further information. There will be opportunities for staff to be involved in shaping the new model of care. We are aiming for the new model to be operational by Spring/Summer 2013.

**Further information**

We hope you have found the first edition of *Transforming* Mental Health Services for Older People news useful.

We have created a [Transforming MHSOP](#) section on e-Source where we will post all latest information, including a frequently asked questions document which we are currently writing.

If you have questions please don’t hesitate to get in touch. Speak to your service lead in the first instance. If you don’t know who that is, or they aren’t able to answer your questions, contact communications manager Lindsey Bond on [Lindsey.bond@leicspart.nhs.uk](mailto:Lindsey.bond@leicspart.nhs.uk) or 0116 2950801.