All Age Transformation –Co-design Workshop for ACCESS to mental health and learning disability services

Week Summary

Highlights:

All of the notes and details from the first of our High Level Pathway design weeks are being typed up and will be brought together into a full document that will then be shared. This document provides a brief summary of the outputs of the week.

Not quite consensus…

There were over 20 service users, carers, staff and stakeholders involved in the workshop and many more that contributed through the feed-in sessions, and online feed-in, that ran on the Monday and Wednesday. Whilst the individuals involved in the workshop shaped and developed the model together, at the end of the week they were not all fully comfortable that aspects of the model would work well. Whilst there was a focus and attention within the workshop on building on existing good practice there were fears that some good practice could be lost. As the Transformation programme moves into the detailed phase (stage 3) the access model will be worked on further and tested to adjust and improve it so that there is confidence it will work well.

Features from the access workshop

Central Access Point - Direct Access through a single phone line and digital media (such as email, web-portal or an app)

A key design feature was the development of a central access point that professionals, partner services or members of the public could use to seek support or advice. The access point was being described as running 24 hours 7 days a week and would have skilled 'Care Navigators' that could support and direct people based on apparent urgency and need. Several streams were initially suggested:

- Immediate very urgent need – 999 call
- Urgent need – for a crisis service response
- Non-urgent need – clinical screening
- Advice
- Re-direct – warm handover to GP practice, IAPT, local authority services, voluntary sector services

The allowing of direct access for patients, carers, other services, advocates of patients (e.g. voluntary sector, etc) and professionals was one of the more controversial elements of the proposed access model. It was originally identified as a feature people wanted as part of the outputs of wide engagement of service users, carers, staff and stakeholders around *What excellent looks like* for accessing services that was undertaken through stage 1 of the Transformation programme that took place at the end of 2017 (the outputs from this are shown in the set of principles see http://www.leicspart.nhs.uk/Library/Principles.pdf). There were concerns that without a GP's involvement, physical health issues may be missed

and that demand for secondary care service may increase. Consideration of how physical health checks would happen was considered in the workshop. Potential demand increases could not be, however there are some examples of other mental health and learning disabilities services that offer direct access in other areas of the country. They will therefore be contacted to see the effect of such an approach has had on their demand.

Self Help and Self Navigation

There would be key information available to the general public on the website and/or an application to allow people to be able to help themselves as much as possible. This included an easily navigable compilation of self-help information around particular concerns that they may have and guidance on health, local authority and voluntary sector support that may be helpful, how to contact them and what they help with. The central access point would be available if people cannot find the help they need on the website or application. This information would be easy to use and provide people with alternatives to contacting the central access point.

GP

There are lots of people that go to their GP with concerns around their mental health and/or learning disability. The GP would be able to refer someone into a specialist service directly if they were confident what service would be able to help the individual. They would also be able to go to the *Central Access Point* to get connected with a professional for advice or to refer someone for help where they were not sure of the right service to meet a person's need. There was discussion that the *Central Access Point* could also book or direct people to their GP where it was seen as the best place to meet their need or where a particular tests or physical health assessments were required.

People That Are Not Likely To Access A Central Point

There was discussion that there are people living within Leicester, Leicestershire and Rutland that may not use a *Central Access Point* or a *GP*. They may not have access to power or phones such as individuals that are homeless or there may be cultural or other reasons that they may not make contact. Therefore there needed to be specific action to go to where people may be (rather than wait for them to access support) and supports them to get help where appropriate. There also needs to be work with groups, faith leaders and other people trusted in their community to promote and support access where needed.

Urgent Need - Crisis

The Care Navigator in the *Central Access Point* can direct people into a dedicated pathway when they seem to have an urgent need for support (commonly called crisis). There was discussion around how this crisis support would work and support people of any age. This had several features:

- People would be able to access it directly through the central access point (streamed as having an urgent need).
- People of any age's needs would be triaged by an up-skilled practitioner initially by phone (or face to face if the individual has come to the emergency department) and then face to face if needed.
- The up-skilled practitioner would undertake a physical health screening and if there were concerns of a physical health emergency would support them to attend urgent

care centre or emergency department for tests.

- Based on the needs of the individual the practitioner would support them to other services (similarly to Central Access Point) or to organise home support and/or short-term interventions.
- The home support and short term interventions would need to be more specialist and match the individuals needs

Non-Urgent Need

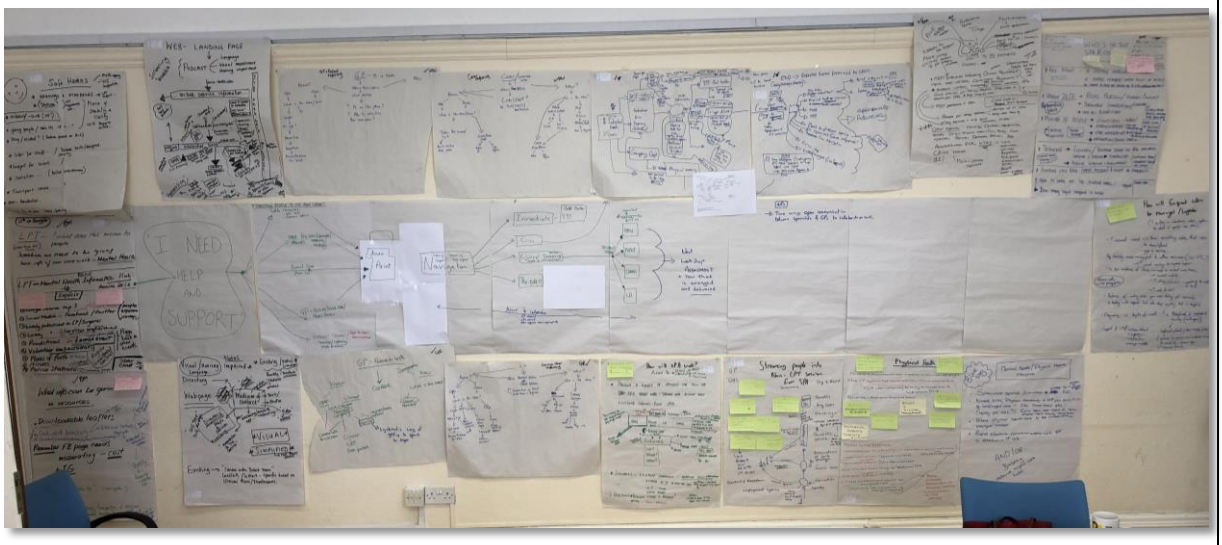
If someone is seen as likely to have some non-urgent needs that are likely to benefit from a specialist service then they are directed to a triage that can support people into getting the right place for a formal assessment. This was an area that was not fully formed from the workshop. There was consensus that this triage needed specialist expertise (e.g. expertise relating to young people, older people, adult and learning disabilities). It was discussed that this could be co-located or with close links together (in different locations) but needed to stream people to the right assessment first time. This triage concept will need to be developed further as the assessment element of the service is developed in the next workshop (19th-23rd March 2018).

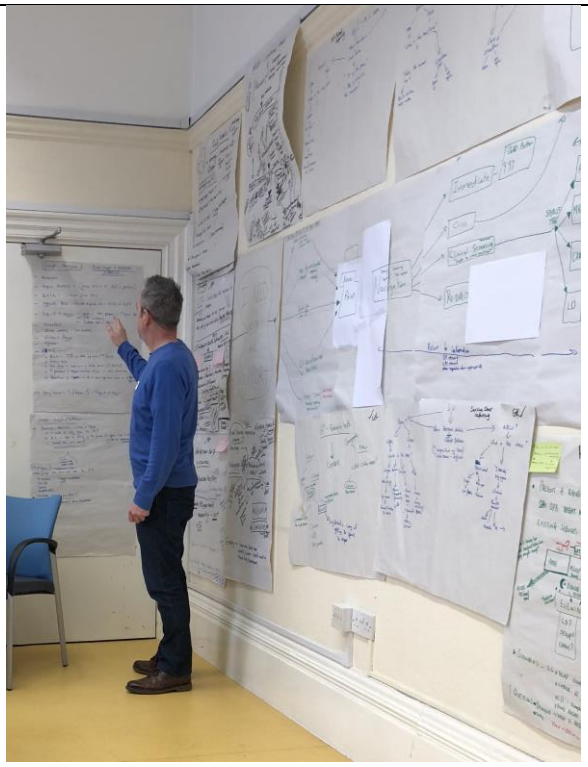
Frequent users of the Central Access Point

There was a discussion that there may be people who frequently contact the *Central Access Point*. The group considered that there should be a supportive approach to such individuals with the potential for a multi-agency meeting to consider how they could get better tailored targeted support.

Lots more…

There were lots more discussion and ideas developed across the week. These will be brought together in a more comprehensive document over the next few weeks.





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