All Age Transformation
Transforming our mental health and learning disabilities services

NHS
Leicestershire Partnership
NHS Trust

All Age Transformation Co-design Workshop for Discharge from mental health and learning disability services

Wednesday 25th April 2018 – Mid-Week Summary

Highlights:

Focus of the week

The week was kicked off by Helen Thompson asking a group of staff, service users, carers and representatives from other agencies to focus on improving how we support service users when they leave our services.

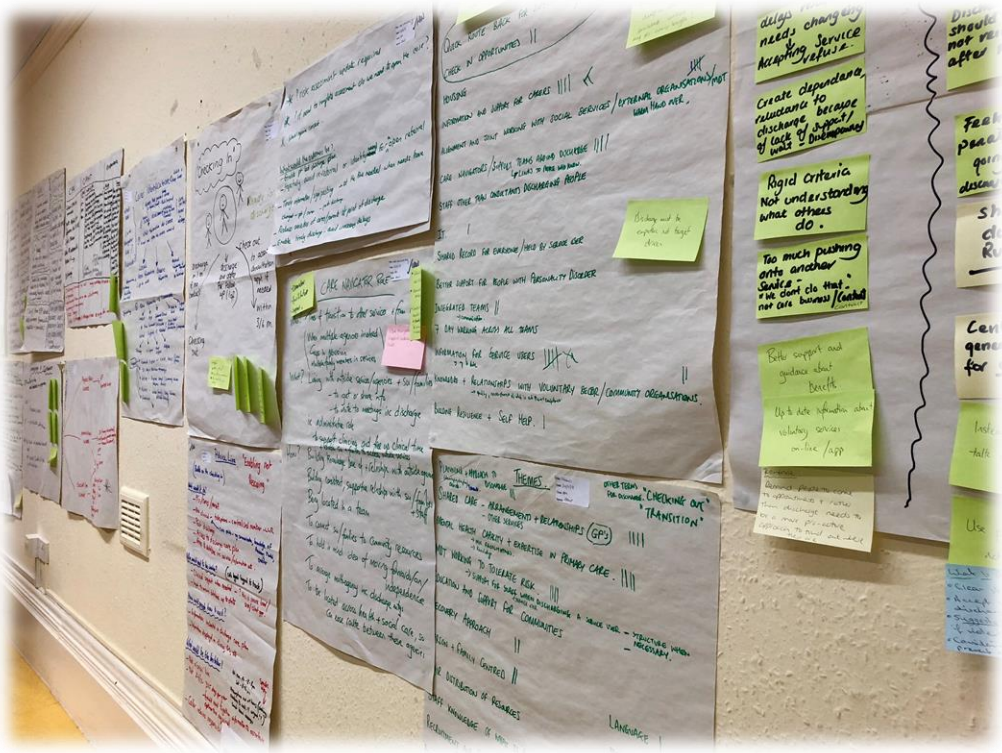
We started by identifying some of the things that need to change

These included:

- Some service users feel abandoned on discharge and anxious that they may not be able to re-access services if they need to. A point of contact/advice is needed.
- A lack of information about local groups and resources to support the recovery journey.
- A lack of communication sharing and partnership working between agencies.
- Discharges from services can be delayed due to concerns around escalating risk to the service user.
- Some difficulties in setting up shared care arrangements with GPs

Ideas to improve discharge

The group has considered these problems, the principles that were developed in stage 1 of the transformation and the suggestions received from people who have fed in their views this week. A number of ideas have been developed including:



Information around support outside LPT

A resource of trusted information and support (such as voluntary sector, local authority and wider community support), systematically updated, in multiple formats, that anyone can see and that has been rated as having a certain level of quality/assurance.

Connecting different agencies, services and non-LPT support around a service user

A non-clinical role could be introduced into each team to help connect service users and clinical staff with external support services that can help meet individual needs as part of their whole person / recovery planning. It was felt that the role could release clinical time to care and help connect the service user with multiple agencies.

Carer pathway

A carer pathway that creates a more consistent approach to identifying, supporting and connecting carers with help they need. The carer's needs would be continually reviewed throughout the patient journey and would also include a more detailed assessment on discharge to try to ensure that the carer has as much support as needed.

Improving shared care arrangements

There was a recognition that improvements could be made to shared care agreements between primary (e.g. GPs) and secondary care (specialist mental health services). Shared care agreements allow GPs to continue someone's specialist medication in the community

with some specific support from the specialist mental health team. This could include a review of all the medications subject to shared care. Also suggested was the offer of specific mental health expertise to be made available to GP practices. The group will explore what this expertise could look like.

Potential for 'check in' around discharge

When a service user is potentially ready to leave LPT services, a 'check-in' opportunity with the lead clinician could provide the service user/carer with further support to become independent of LPT services. This could be face-to-face contact or telephone. (Considerations need to be made to ensure this is in keeping with policies and procedures such as governance and managing risk). The proposed new direct access central contact point arrangements could provide an ongoing way that people can get advice or support.

Advice line

It was suggested that an advice and information line linked to the central contact point (described in Access design week) could be helpful to support and signpost people to services and information after discharge.

Joint working between social care and mental health/learning disabilities teams

The group considered how social care and health practitioners could collaborate better in discharge and the overall service user journey. The group are considering re-integration of the social care and health teams to improve joint working and how records could be shared securely between agencies.

Recovery approach

The group are considering how the service user's goals and aims can be collaboratively agreed and reviewed throughout their journey to help them prepare for leaving our services. Having this in place was felt to make it easier for the service users to prepare for leaving services at the appropriate point.

Next steps

There will be a showcase of the outputs from the week's workshop tomorrow from 2pm at Paget House, 2 West Street, LE16XP and a more detailed report will be shared by the end of next week.

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