All Age Transformation
Transforming our mental health and learning disabilities services

NHS
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Stage 2: Co-design Feed-in to the High Level Pathway for 'Discharge' after planned support ends and you leave services...

All-Age Mental Health and Learning Disability Transformation Discharge Week (23 - 27 April 2018)

A big thank you to everyone who contributed to last week's all-age mental health and learning disability transformation which focused on improving the support we offer our service users and their carers as they leave our services. Here's a summary of the key proposals resulting from the co-design week.

Summary

The workshop drew together discussions from previous co-design workshops and described a discharge approach that starts at the very beginning of a service user's journey with our service. The group expressed the need to jointly agree clear goals and expectations with the service user early in their journey with us. We would need to build a structure that enables us to monitor progress of these goals and that helps the individual to work on the many things (inside and outside of LPT services) that may help meet those goals. The group described features of service aimed at maintaining clarity on what the end of the service input looks like throughout their journey and increased structure in supporting an individual to have a good safe discharge. There were lots of elements discussed across the week and these are summarised below.

Information and support outside LPT services

The group described a need for a resource of trusted information and support available outside of LPT (such as voluntary sector, local authority and wider community support) that anyone can see and that has been rated as having a certain level of quality/assurance. A number of different agencies within Leicester, Leicestershire and Rutland (LLR) have previously developed directories (e.g. LAMP, local authorities etc.). It was suggested that there could be collaboration across these agencies to keep information up to date and work through how the services are quality assured. The information will be available in multiple formats. The group started to explore a potential role for peer workers to support service users and practitioners' trust and awareness of the support outside of LPT and to help make relationships and connections with them.

Recovery approach

It was described in the workshop that it was important to have a 'recovery' approach to the support and interventions provided. This had several features:

- An understanding of the goals the service user is aiming for with help from their clinical team. This is to build hope in the individual whilst also being

realistic about what can be achieved clinically. This may not be 'symptom free'.

- Focused on the whole person and may include areas where the service user needs support outside of health services. We can link the individual to other support available.
- Wherever possible, the service user will own the recovery plan, supported by professionals, carers and services.
- Jointly agreed success criteria of the recovery plan between service user and professionals, with a target date for the recovery and the intervention plans (described in previous workshop)

This approach was viewed as being different from many aspects of the current mental health and learning disabilities services and therefore would need careful implementation. This included:

- A clearly described model for recovery that can be used across LPT, social care and other agencies
- Education on the approach across all services and for service users that are currently being seen within LPT services.
- Student training
- Monitoring the use of the approach and re-enforcing its use in supervision

Carer pathway

There was recognition that carers don't always get supported sufficiently and this can make it harder for service users to leave services well. The group considered a carer pathway that creates a more consistent approach to identifying, supporting and connecting carers with help they need. This would need to be continually reviewed throughout the service user's journey, would work with the local authority led carers assessment and the service user's care. This may also include an additional, more detailed assessment on discharge to try to ensure that the carer has as much support as possible to enable them to care for the service user.

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

The group suggested that a non-clinical role could be introduced into each team to help connect service users and clinical staff with support services outside LPT that can help meet individual needs (as part of their whole person/recovery planning). This role would work alongside MDTs, multi-agency joint working and wider administrative work to release clinical time and ensure that these connections were timely and effective. This person would also provide information, advice and support to the service user throughout their recovery journey and prepare them for leaving our services. There was a recognition in the group that some teams have

staff that currently undertake some aspects of this work and that this could be built on.

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

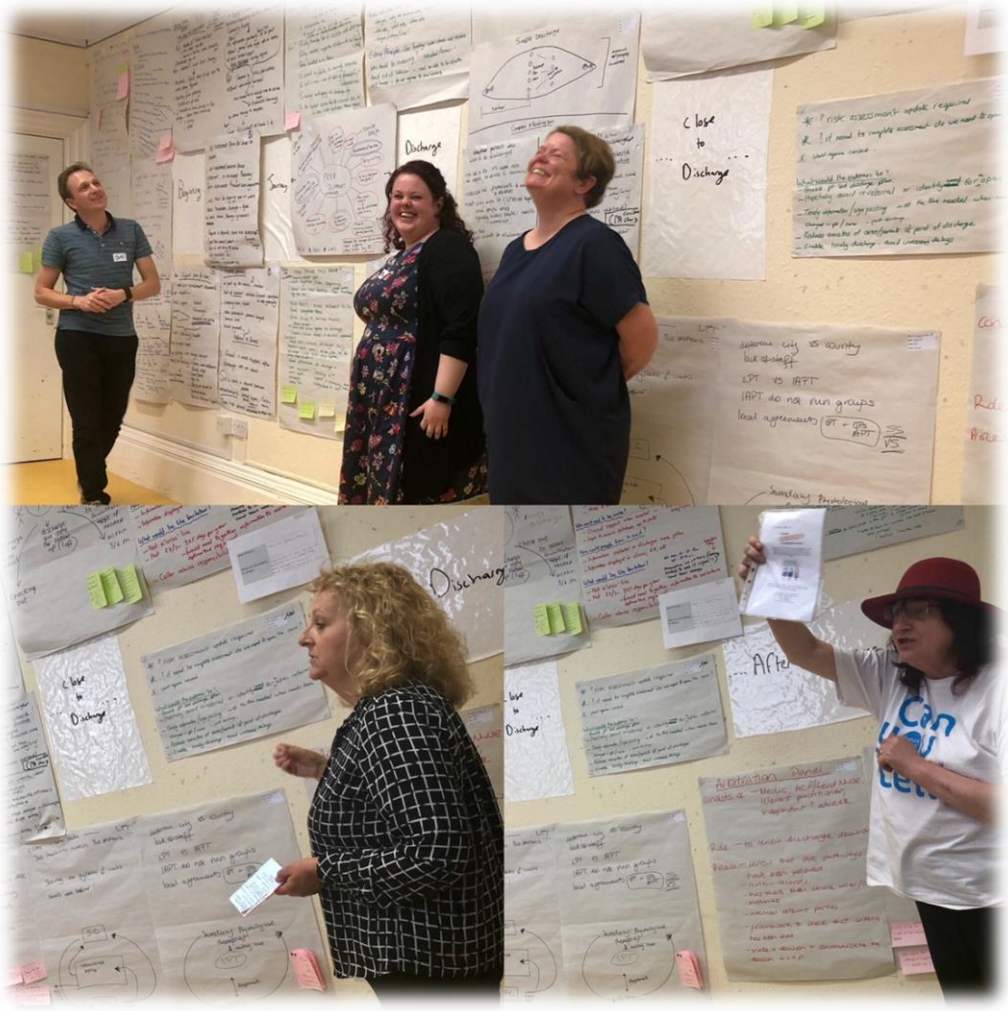
The group considered how social care and health practitioners could collaborate better throughout the overall service user journey and also in discharge. They felt that this worked well when social care staff worked alongside health practitioners in teams and that it has become harder as they have separated over time. The group suggested exploring re-integration of the social care and health teams to improve joint working. They also considered how records could be shared between agencies, with the appropriate consent, to improve information flow.

Peer Support Workers

The group discussed introducing Peer Support Workers into teams. These are individuals, who have lived experience of services and who could provide service users with peer support, help them connect with a wide range of services and groups to aid recovery. The group described this role as doing potentially different things in different services to best meet the needs of service users. They felt the role could also be helpful in supporting service users in their recovery journey and would release some clinical time.

Peer Reviews

There was a discussion around the importance of having regular opportunities for all clinical staff to review their cases with peers and the wider multi-disciplinary team. There were many examples of this working well in different areas of LPT that could be maintained or built on and some areas where this does not systematically happen. A peer review approach was felt to be important to take place at particular milestones along the service user journey to ensure that the services have provided the expected interventions/support and help support discharge planning. Other clinical staff in the MDT could adopt a role of 'critical friend' to challenge thinking, support reflection, help with complexity and share responsibility for risk to help support people to move on from services.



Red to Green

The group considered that the 'red to green' conceptual framework, which is being adopted in in-patient services could be useful across all services. This framework is focused on providing purposeful and value-adding work with a service user each

day, appointment or interaction that a service is involved. When a day/appointment is purposeful and value adding then it is described as ‘green’ when it’s not it’s seen as ‘red’. This framework was felt to be helpful in keeping track of progressing the things that would support an individual’s recovery, help identify when there should be a peer review and when someone might be ready for discharge or transition to other support.

Discharge Decision Tool

There was recognition that some individuals have relatively clear structured interventions and people can move on and be discharged relatively simply. However there are individuals with far more complexity, with potentially several different intervention pathways and individuals supporting them. This complexity, and concerns around risk, can make it difficult to move individuals on from services. The group discussed the use of a discharge decision tool that is based around the recovery plan for an individual. This tool would be able to help structure discharge, help communicate the process to the service user/carer, help to consider the risk and ensure anything has not been missed that could lead to an unsafe discharge.

Check-in Process

There was a recognition that some service users/carers feel anxious when coming up to discharge and worried about leaving services. It was felt that this anxiety may be reduced by the direct access that was described in the access week but the group also suggested that there could also be value in a having a ‘check-in’ process just before an individual is discharged. This process would offer a staged discharge whereby a service user or carer had direct ways of making face-to-face contact or

telephone support with the lead professional if they need advice or have worries after their last routine appointment (and prior to official discharge). After a set time the individual would then be discharged but could directly access services again through the central access point (described in access week) if they needed help. It was described in the group that this approach would need to be considered on an individual basis to ensure it is effective and helpful for the service user to transition out of services.

Primary Care Collaboration

It was described in the workshop that good collaboration and communication between GPs (primary care) and LPT (mental health and learning disabilities secondary care services) was important throughout the service user journey and especially to support discharge. The group identified a number of ways of improving this collaboration which included:

- Attendance and alignment of services with new GP regional patches (collections of GP practices in localities that meet and work together) to create a systematic place for supporting transition out of services
- Sharing of contact information between GPs and psychiatrists and building of relationships within the patches
- Shared electronic record system to allow quicker systematic sharing of information

Shared Care

There were ongoing issues described around how the ‘shared care process’ worked. This process is a formal agreement between GPs and secondary care around certain medications and allows a service user to be supported in primary care. These agreements did not work very well in some specific instances and it was not universally agreed across GP practices. The group felt that it was important to review the overall approach adopted within the region and look at how it could be improved to make them more meaningful and better adopted across all of GP practices.

Intermediate support between GPs and secondary care mental health and learning disabilities services.

The group suggested that there would be value in mental health and learning disabilities expertise being available directly to GPs to enable them to support service users outside of secondary care services. This included capacity and expertise for advice, low level psychological support, signposting and specific interventions such as ‘depot’ injections. Roles within primary care such as mental

health facilitators and IAPT (Improved Access to Psychological Therapies) could be built on.

Telephone Advice Line

It was suggested that a telephone advice line be put in place that linked to the central contact point (described in Access design week). This was described as offering practical information and support to respond to queries and signpost people to services and information at any point but particularly after discharge.

Arbitration Panel

It was recognised that as mental health and learning disabilities services change as part of the transformation there is likely to be an increased number of individuals, who have been within services for a long time, leaving services. The group recognised that this transition may be difficult for some individuals and a pro-active approach to explaining and preparing would help prepare and support these individuals for discharge. This type of approach was felt to have worked well in other services that have transformed within LPT. There may be service users/carers who don't agree that they are ready for discharge during this transformation and going forward. Disagreements can then get raised through LPT's complaint process and these may not easily be resolved so there would need to be a standard review process put in place. This was described as a panel that brought together clinical experts, wider agency expertise, legal experts and advocates for the service user to review the decision and support the service and service user agree a way forward.

Next steps

The outputs from the four weeks will be brought together and communicated widely to show how the entire high level pathway comes together. This will be circulated in

the next two weeks and will also outline how the detailed design work will be shaped moving forward.

A big thank you for everyone’s involvement and input so far.

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