All Age Transformation
Transforming our mental health and learning disabilities services

NHS
Leicestershire Partnership
NHS Trust

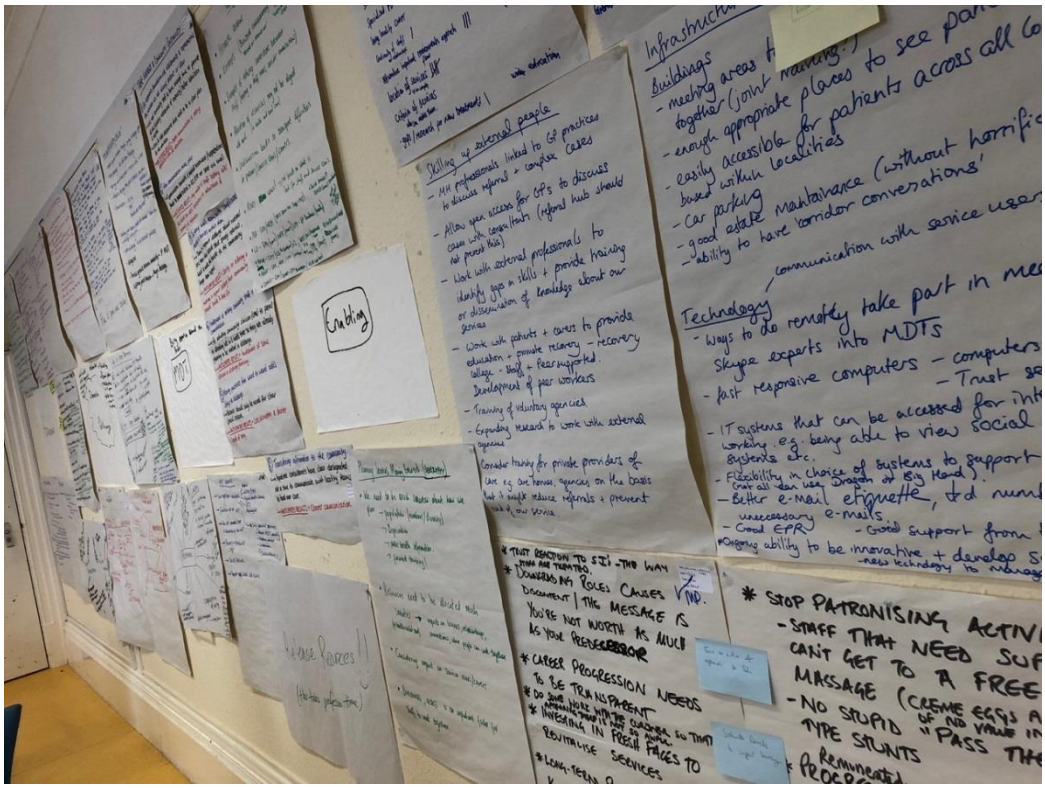
Stage 2: Co-design
Feed-in to the High Level Pathway for 'Treatment' when getting the support or treatment you need...

All-Age Mental Health and Learning Disability Transformation: Treatment Week (9 – 13 April 2018)

Thank you to everyone who contributed to last week's all-age mental health and learning disability transformation week focusing on improving the way we plan and provide treatment and support for our service users. Here's a brief summary of the key proposals resulting from the co-design week.

Summary

The approach will focus on the whole person and their family, provide continuity across their journey within LPT services and help coordinate the other agencies involved. The interventions will be delivered through 'intervention pathways' (see description further below) in collaboration with service users and promote choice wherever possible. There were lots of wider elements discussed across the week and these are summarised below.



Whole Person Approach to assessment and meeting individual's needs

There was recognition that in most areas there is currently a focus on the whole person rather than just their illness or health concern. The outputs of the workshop described that this should be continued, made easier and built upon to ensure the focus on the whole person and their family/carers is throughout a service user's journey from initial assessment through to treatment, and as they leave services. Alongside their presenting health issues, this would include wherever possible and relevant:

- An understanding of the service user's goals and hopes for the future alongside their current issues, their motivations and beliefs.
- Considerations of their social circumstances, their employment/daily activities, lifestyle housing and financial circumstances.
- The identification of main carers and significant others in the service user's lives early on and consideration of support for those individuals.

Continuity was described as important and would need to be supported through easily available and easily updated key information around the whole person and there being a lead professional for every service user.

Choice and collaboration

The group considered how there was genuine choice and collaboration between a service user and practitioner in identifying and undertaking interventions. There were several ways that were felt to help this collaboration which included:

- The practitioner needed to have access to information around what can and is appropriate to be offered.

- There needed to be realistic and honest appraisal of options that would be appropriate for a service user that is understandable to the service user (including meeting the diverse language and learning needs of individuals).
- There needed to be a clear description of interventions and their likely journey through services.
- That a service user needed to have the right to disagree and not fear that this will automatically lead to being discharged.
- That a service user has a way of changing lead professional if they have a breakdown in their relationship that cannot be worked through.

It was recognised that the approach may differ for individuals depending on the level of capacity they have to make decisions but there should be efforts to collaborate with all service users to the extent that can be achieved.

Multi-agency working and care navigation

It was recognised that in consideration of the 'whole person' there can be multiple agencies, voluntary sector and others that are either involved or needed to support a service user and their family. This can often be complicated with a need for coordination and/or collaboration of these agencies to best support a service user that can either use large amounts of clinical practitioner time or in some instances not occur well. It was proposed in the workshop that there would be care navigators (support workers) within teams to work alongside lead professionals to support this coordination alongside other pieces of work for patients and clinical staff (e.g. information gathering, form filling, liaison work etc.).

Continuity and Lead professional

There would be a focus on providing continuity for service users in their journey through LPT services and this continuity would be supported by a lead professional. This person is a qualified staff member who would support people through the intervention pathways that have been collaboratively chosen to meet their needs and goals. If a service user's 'intervention pathways' (see below for more details) shifted to a completely different specialty team then there would be careful and collaborative transition to a new lead professional who works within a team that are delivering the new intervention pathways (e.g. from children's and adolescent intervention pathways to adult focused pathways).

'Intervention Pathways'

The workshop considered ways of balancing the variation in individuals' needs with reducing variation across areas, supporting the distribution of resources and increasing the use of evidence based approaches in care. The approach described was for interventions for a service user to be undertaken under 'intervention pathways'. The features of these pathways included:

- That a service user may be on more than one pathway due to their multiple needs, which would make up their treatment plan.

- Each pathway was described as needing to be broad enough to meet the complexity and differences with people but have specificity to describe evidence based approaches.
- That the pathways would not be constrained by the existing clustering framework.
- The pathways would describe support that can be offered by both LPT and other organisations.

The description of what pathways are needed and the details within them need to be developed in the detailed design phase of the transformation programme.

Multi-disciplinary working

There was recognition that service users often need input from different expertise at different times. Therefore a multi-disciplinary team (MDT) approach to interventions was emphasised with expertise being drawn around the service user rather than the service user going from one expert to the next. There was a description that this MDT working should mean that the right individual, with the right skills is being matched with a service user's needs at the right time. The right expertise to support an individual may not be held within one 'team' and therefore there would be increased ways for experts who work outside of a team to take part in MDT discussions. Where it is rare for a team to work with a particular expert then there would be efforts for the lead professional to discuss individual cases with that expert prior to referral (thus reducing the risk of a referral being 'bounced' due to the expert not being suitable or able to get involved with the service user).

Inpatient and community working

There was recognition that there was significant pressure on beds in inpatient units across LPT. There were various approaches described around ways to support flow within inpatient settings. These largely focused on ways of increasing the connection between community and inpatient services and the individual's intervention pathways. Specific ideas included:

- To increase the continuity of knowledge and approach from community to inpatient with greater dedicated time for community staff to increase planning around and on admission for individuals already known to community services.
- Increased consistency and clarity through the electronic patient records for the inpatient team to see the intervention approach and whole person assessment undertaken in the community.
- Rationalise teams that support discharge to better support people back into community settings.
- Increased time for inpatient teams to communicate with community teams and share information.
- Service users only moved between wards for clear clinical reasons.
- Dedicated time for community staff to support discharge planning within inpatient settings.

Enabling changes

There were various areas that were considered to enable teams to work better and service users to get improved experience. These included:

- Matching the distribution of resource across the geographical areas to match population needs.
- Improve the location and facilities in the buildings where interventions are provided to be fit for purpose, in good condition and have available parking and transport links.
- Develop the Information Technology systems to be easy to use, relevant and informative for the treatment and interventions that clinical staff provide.
- To have ongoing innovation in use of apps and other technologies to try new ways of working and communicating with service users.
- Providing an improved directory of both external services and staff and teams across LPT to make it easier to know who to contact and make that contact.

There was also a focus on ways to improve the culture within LPT to have an increased focus on being fair, supportive and learning. This included specific examples of having a greater learning approach when things do not go well (such as serious incidents) and always supporting staff if they go to coroner's court. There was also a focus on ways to value staff more through providing improved career structures and training/development. This included having greater career development that keeps experienced clinical staff delivering service user care.

Next steps

These ideas will now feed into the final high level pathway co-design week (23 - 27 April) which will focus on 'discharge' and the support people need when they leave our services. Here is a link to the on-line survey where you can share your views:

www.surveymonkey.co.uk/r/AllAgeTransformation_Discharge_Monday23rdApril

The survey is live now until 10pm on 23 April. Please see below for details of the feed-in sessions for staff on 23 and 25 April:

Feed-in sessions for staff and stakeholders

Co-design Week	Monday (4-5pm)	Wednesday (4-5pm)	Feed-In Venues on 23rd April If you do not know the specific room, then report to reception for directions
Access	5th March	7th March	**Glenfield Hospital** (Porta-cabins 123, Mappa Training Rooms) **Evington Centre** (Room 149 Gwendolen House) **Artemis House - Tanglewood** (Conservatory) **Agnes Unit** (Meeting Room) **Stewart House** (Meeting Room) **Bridge Park Plaza** (Meeting Room 1, Suites 2 & 3)
Assessment	19th March	21st March	
Treatment	9th April	11th April	
Discharge	23rd April	25th April	

Co-design Week	Monday (4-5pm)	Wednesday (4-5pm)	Feed-In Venues on 25th April If you do not know the specific room, then report to reception for directions
Access	5th March	7th March	**Glenfield Hospital** (Porta-cabins 123, Mappa Training Rooms) **Evington Centre** (Swithland Room) **Artemis House - Tanglewood** (Conservatory) **Agnes Unit** (Meeting Room) **Stewart House** (Meeting Room) **Bridge Park Plaza** (Meeting Room 3)
Assessment	19th March	21st March	
Treatment	9th April	11th April	
Discharge	23rd April	25th April	

The showcase event to summarise the results for discharge week will be on Friday 27 April from 2pm-3pm and will take place at Paget House, 2 West Street, Leicester, LE1 6XP. Book your place by emailing mhldtransformationteam@leicspart.nhs.uk

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