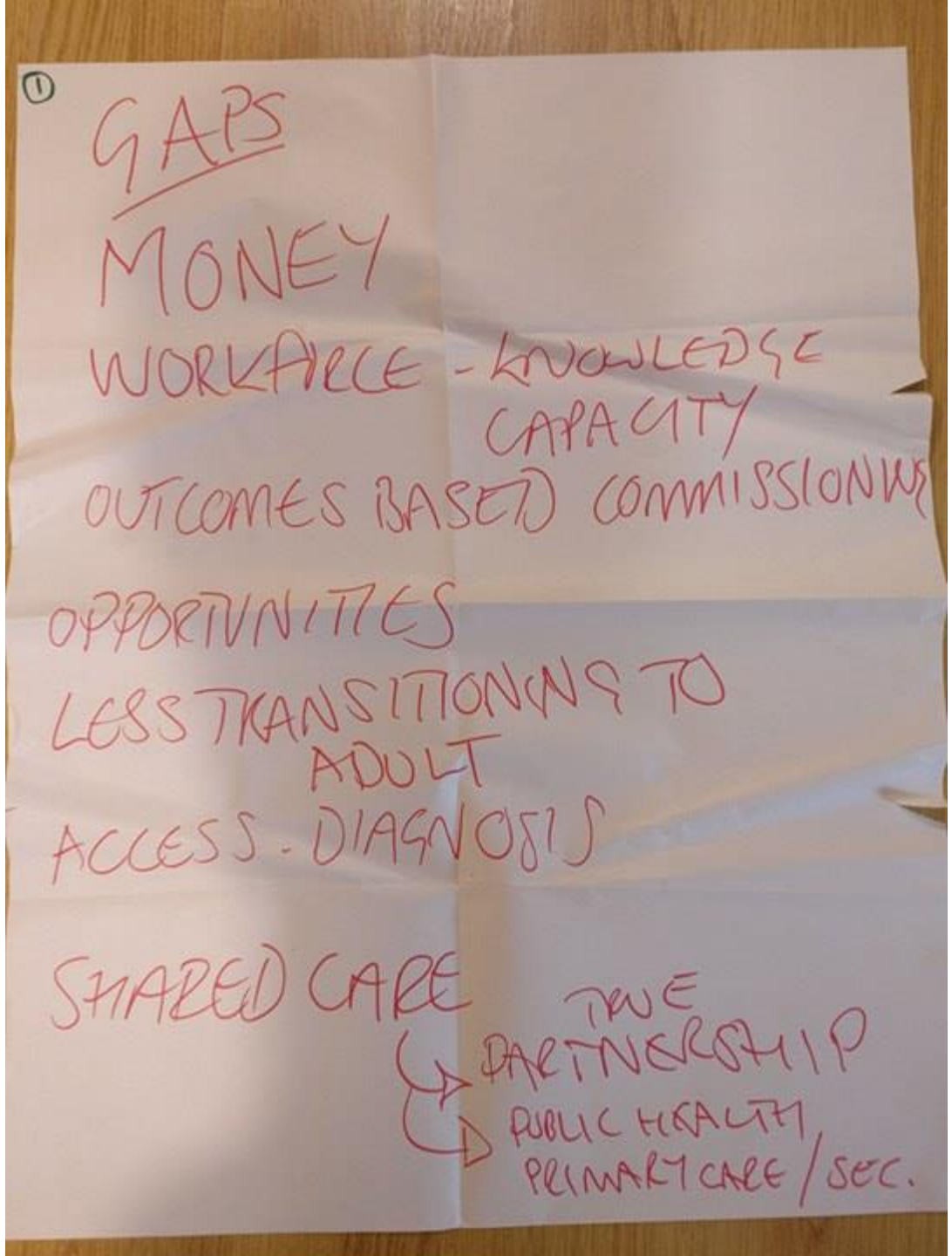
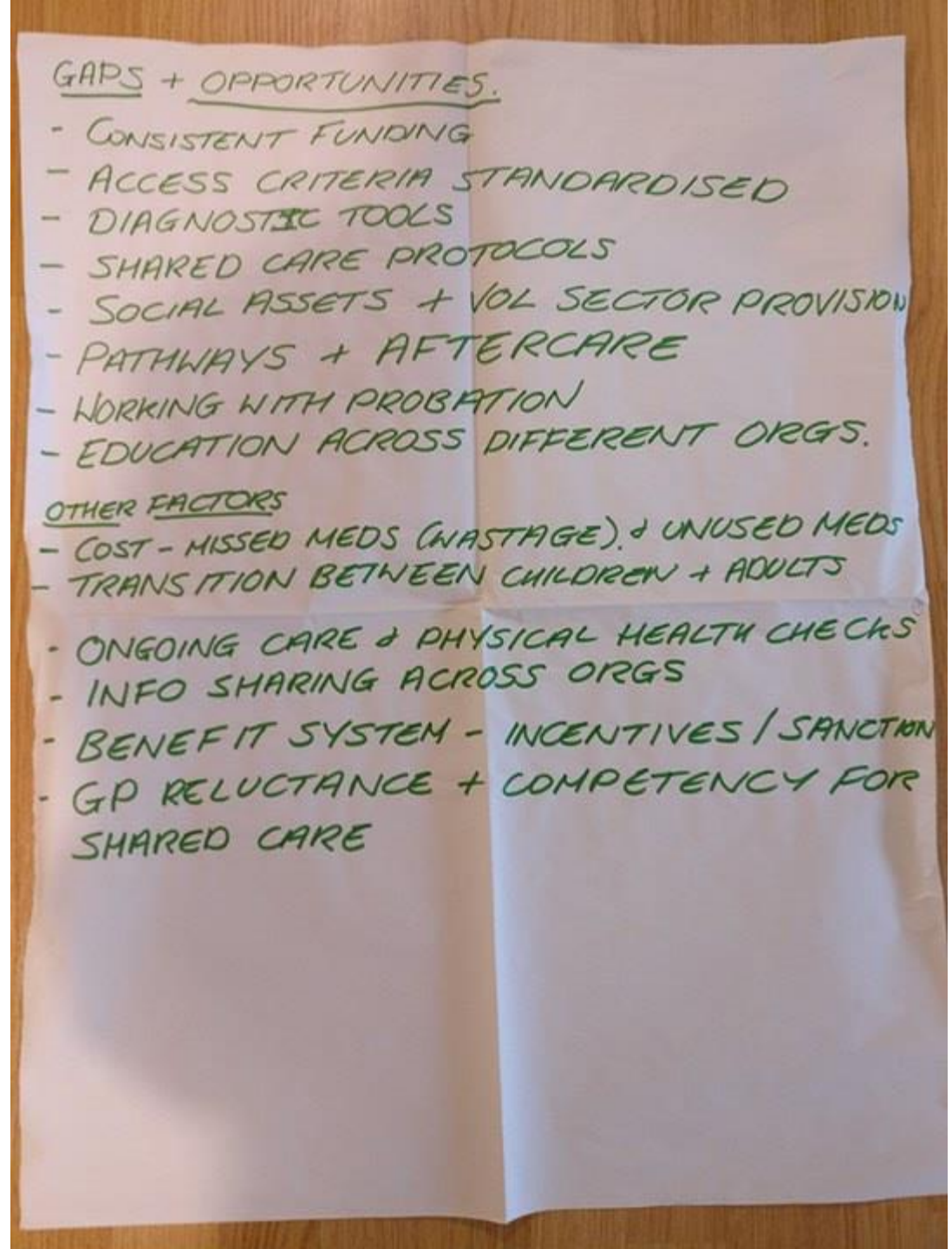
Wilmington Healthcare

EMMHTSN 20th September 2017

Table discussion notes


1
GAPS
MONEY
WORKFORCE - KNOWLEDGE
CAPACITY
OUTCOMES BASED COMMISSIONING
OPPORTUNITIES
LESS TRANSITIONING TO
ADULT
ACCESS - DIAGNOSIS
SHARED CARE
TRUE
PARTNERSHIP
PUBLIC HEALTH,
PRIMARY CARE / SEC.


GAPS + OPPORTUNITIES.
- CONSISTENT FUNDING
- ACCESS CRITERIA STANDARDISED
- DIAGNOSTIC TOOLS
- SHARED CARE PROTOCOLS
- SOCIAL ASSETS + VOL SECTOR PROVISION
- PATHWAYS + AFTERCARE
- WORKING WITH PROBATION
- EDUCATION ACROSS DIFFERENT ORGS.
OTHER FACTORS
- COST - MISSED MEDS (WASTAGE) & UNUSED MEDS
- TRANSITION BETWEEN CHILDREN + ADULTS
- ONGOING CARE & PHYSICAL HEALTH CHECKS
- INFO SHARING ACROSS ORGS
- BENEFIT SYSTEM - INCENTIVES / SANCTION
- GP RELUCTANCE + COMPETENCY FOR SHARED CARE

Nottm (2)

3 GAPS

Geographicle differences (City & County) within services

1. Not enough beds which means the ones we have are not used efficiently/effectively
2. POOR STAFF Nos. + RETENTION IN ACUTE
3. Lack of money in the system

MOT.

3 TRANSFORMATION OPPORTUNITIES

1. Own version of STP
2. Trying to have a consistent care pathway model - consistent use/pair to maintain services
3. Means Support staff to work across the different plways to have a seamless sector to relay to commissioners & get them on board.

LLR②

Physical health of people with mental illness. (LLR)

(Part of estem)

(1) Active lifestyle approaches may not be high priority for pts or for some practitioners

(2) Skill mix - mental health facilitators, practice nurses, community liaison nurses — follow up = better maybe for AD pts.

(3) Early access - probably better in Secondary care inpatient settings, but depends on patients - psychiatric intensive care pts probably not interested.

LLR STP③

↓ INPATIENT PSYCHOSIS

* WEEKLY MEETINGS RE S.S. RE DELAYED DISCHARGES / HOUSING
* ONE STOP PSYCHOSIS SERVICE
* REORGANISE INPATIENT TO LOCALITY/ SPECIALIST SERVICES - BETTER PATIENT OUTCOMES - NICE COMPLIANT TREATMENTS
* IMPROVED DAY SERVICES
* REVAMPED CRISIS SERVICE - SERVICE EXCLUSION CRITERIA. ? SELF REFERRAL?
  - ↳ CONSENT!
  - ↳ INSIGHT!

WHAT IS NEEDED LCR STB (3)

AUDIT current state of service
- PREVERIANCE - Public health
- NICE GUIDELINES
- OUTCOMES
- AIMS / OBJECTIVES

HOW - training for all staff
Robust ASS
- REF TO *SPECIALIST TEAM

CLEAR PATHWAY

* STAND ALONE ?? ACROSS CHILD / ADULT
(NOT VIA CMHT'S)

REF - ALL INC: -GP
-CAMHS
-ADULT
-SSERVICES
-Educational

? who manages other co-morbidities

FUNDING - ? FROM current budget

(need for them to be in other services.)

SHARED CARE = MONITORING = PRESCRIPTION

Nottinghamshire (2)

Various ADHD Courses Available

Management of co-morbility can take over the ADHD diagnosis

GP's & CCG's refuse to describe

County refer to City - no follow ups after diagnosis

Inputs from 'areas' across board but nothing cohesive

No comprehensive or consistent offer
- not seen @ a consistent area.

How to
Spread confidence
Spread knowledge

How to get a CONSISTANT service?

PROACTIVE APPROACHES TO UNCOVERING DEPRESSION + TACKLING STIGMA:- NOTTS OT P (1+2)

(1) COHORT / GENERATIONAL FACTORS
→ IN STAFF + PATIENTS

⇒ IMPLIES A NEED FOR A RANGE OF OPTIONS
⇒ NEEDS + SKILLS + CONFIDENCE OF STAFF + SERVICE USERS NEED TO BE SURVEYED + PLANNED FOR

(2) STIGMA:- ARGUABLY
" THERE IS NO SUCH THING AS AN "UNSTIGMATISING" CONTACT "
⇒ ITS ABOUT DELIVERY THAT IS VALUED + VALUABLE TO THE SERVICE USER
⇒ SOLUTIONS NEED TO BE DEVELOPED IN PARTNERSHIP

(3) INDIVIDUAL NEEDS + PREFERENCES NEED TO BE INCORPORATED INTO THE SERVICE DELIVERY MODELS ON OFFER
→ F 2 F MAY BE IMPORTANT FOR SOME
→ DIGITAL METHODS MAY BE CONVENIENT FOR OTHERS
" MIXED ECONOMY "
⇒ DEVELOPING A HOLISTIC MODEL OF SERVICE DELIVERY

02

LINCOLNSHIRE

- Now - Focus on hitting the target - miss the point
- Value the work done by the team NOT on the price
  So able to deliver what is needed
- ↑ Community Team Investment
- Dual diagnosis Gap.

LINCOLNSHIRE

- Identify the cost of doing nothing + Risks
- Information sharing between ALL organisations to gain size of ~~issue~~ need
- Centre on the patient Journey
- Focus on quality + Experience
- Develop 'borrow' best model that works for Lincolnshire that is ALL AGE. NO TRANSITION

TOP 3 GAPS.

1. PSYCHO/SOCIAL INTERVENTIONS - AFTER CARE
2. PARTNERSHIP WORKING ACROSS ORGS.
3. DATA + UNDERSTANDING

TOP 3 OPPORTUNITIES

1 CONSISTENT PATHWAY
2. ASSESSMENT/ACCESS CRITERIA
3 POOLED RESOURCES.

GAPS

1. uncertainty over rates / prevalence
   e.g. undiagnosed in children

2. issues re: prescribing in 1°/2°
   graduates vs new cases
   transition

3. new cases diagnosis
   delays / creating
   expectancy.

4. ? over-reliance on meds.
   spectrum

5. fragmentation →

OPPORTUNITY:

→ lots.
→ parenting interventions
→ better case finding in childhood
→ better transition arrangements
→ non-medical approaches
   e.g. wkle on w/e
→ shared CARE