Health and Wellbeing

Dementia Care Pathways

Redesigning care pathways through MDT working

Kate O'Brien and Russell Patton

Vision

- People will be supported to live well at home for as long as possible.
- When additional care and support is needed, it can be accessed as close to home as possible.
- Care homes will be supported to manage people with behaviours that can be challenging.
- Admission to MH hospital will be by exception

Mental Health- The vision for 2017/18/19

The Story: Mental Health and Learning Disabilities.

Northumberland vision is to have a integrated life span approach which encompasses support for the mental health condition alongside the persons physical health care and social care need.

Developing resilience in primary care will enable more people to be seen earlier and reduce demand in secondary and tertiary care. More effective integrated management of complex conditions will reduce admission (both to acute and mental health hospitals) and length of inpatient stay, supporting out of hospital treatment closer to home.

New models of care

To deliver MH5YF, a redesign of mental health services will: **Enable primary care to effectively manage**, with support most mental health conditions.**Reduce the reliance on secondary and tertiary** care, releasing savings to be reinvested in multi specialty community providers.**Allow most people to receive their care close to home,** avoiding unnecessary admission.

Key Milestones

Review and reduce current inpatient bed base.

Commission regional based eating disorder service

Multi agency approach to reducing suicide rate.

Reduce wait times in all CYPS services to local targets.

Increase rate of dementiadiagnosis and post diagnostic support pathway.

Deliver in full the implementation plan for the Mental Health Five Year Forward View for all ages, including:

o Additional psychological therapies so that at least 19% of people with anxiety and depression access treatment, with the majority of the increase from the baseline of 15% to be integrated with primary care;

o More high-quality mental health services for children and young people, so that at least 32% of children with a diagnosable condition are able to access evidence-based services by April 2019, including all areas being part of Children and Young People Improving Access to Psychological Therapies (CYP IAPT) by 2018;

o Expand capacity so that more than 53% of people experiencing a first episode of psychosis begin treatment with a NICE-recommended package of care within two weeks of referral;

o Increase access to individual placement support for people with severe mental illness in secondary care services by 25% by April 2019 against 2017/18 baseline;

o Commission community eating disorder teams so that 95% of children and young people receive treatment within four weeks of referral for routine cases; and one week for urgent cases; and

o Reduce suicide rates by 10% against the 2016/17 baseline.

Ensure delivery of the mental health access and quality standards including 24/7 access to community crisis resolution teams and home treatment teams and mental health liaison services in acute hospitals.

• Increase baseline spend on mental health to deliver the Mental Health Investment Standard.

• Maintain a dementia diagnosis rate of at least two thirds of estimated local prevalence, and have due regard to the forthcoming NHS implementation guidance on dementia focusing on post-diagnostic care and support.

• Eliminate out of area placements for non-specialist acute care by 2020/21.

CCG initiatives in 2017-18 /19

Reduce wait times in CYPs to local 9 week target for all routine cases.

Reduce admissions to hospital of people with dementia by 50%.

Review and reduce inpatient bed base via whole service redesign.

Work with primary and community providers to develop the multi specialty community provider model with mental health at the heart of delivery

Multi agency approach to reducing suicides by 10%

Roll out effective 27/7/crisis support across All localities in Northumberland

Background

- This approach is not totally new it builds on some strong foundations
  - High Risk Patient pathway
  - Local Integrated networks (Lins)
  - Role of Community Geriatricians
  - Better care Fund – Care homes work
  - Northumberland Vanguard and development of primary and Acute care systems (PACS)
  - ACO development

Introduction

- 2014/15- memory clinics established within community mental health teams.
- 2015/16- Review of health and social care Dementia pathways.
- 2015/16 Reductions made to Woodhorn ward from 22 to 14 beds.
- 2016 Risk of admission registers set up in each locality.
- 2017- Investment made in a Intensive Support team.

Principles

- To have a ‘Home first’ approach.
- To focus on the lowest level of care to meet people’s needs as well as maintain/improve independence
- To avoid unnecessary hospital admissions
- To reduce length of hospital stay
- To empower and support people to make decisions about how services can help them live as active and independent life as possible.

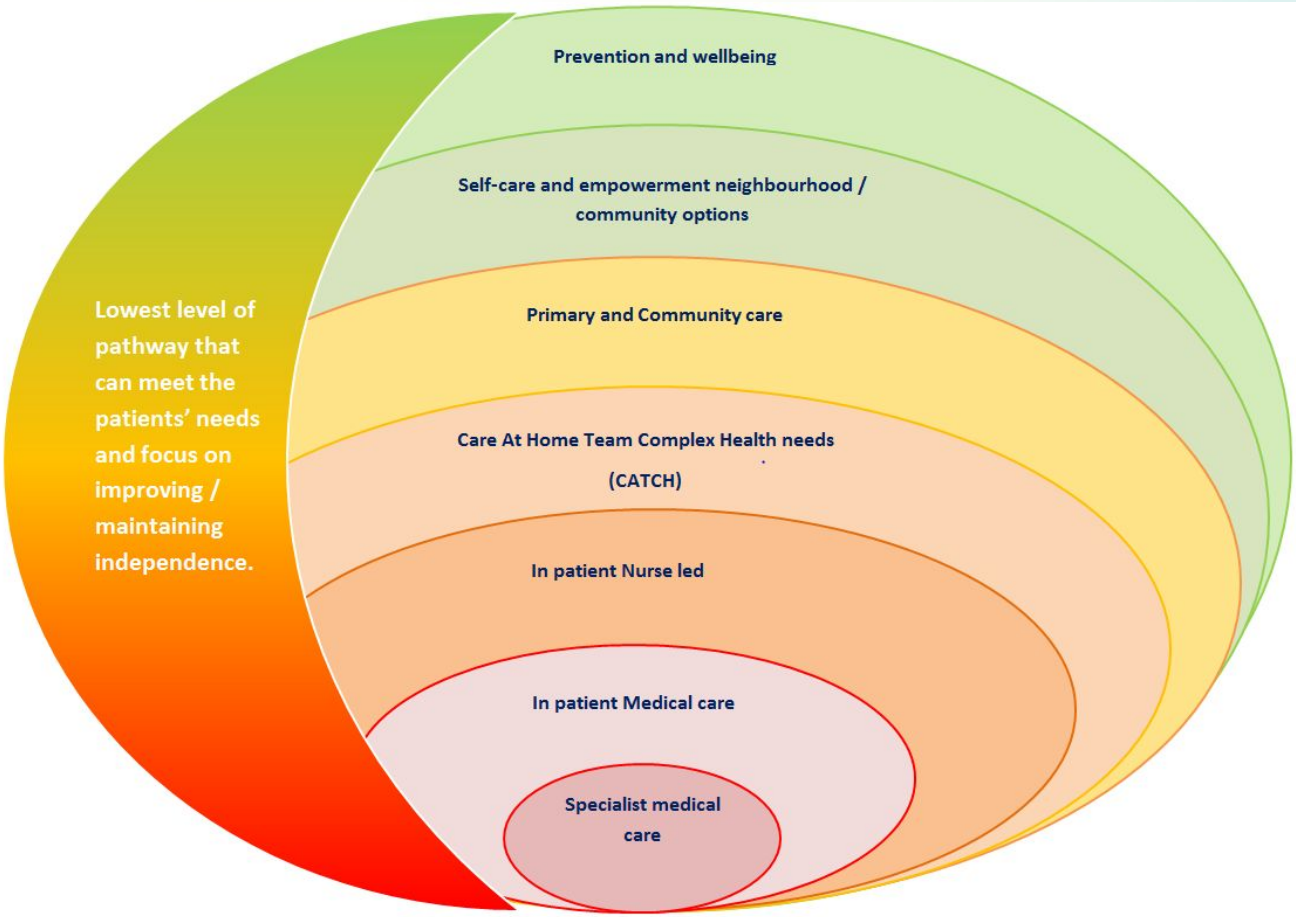
The model

Oversight

- For people at highest risk of health crisis and MH hospital admission.
- MDT decision making to avoid a crisis admissions / moves
- Coordination of current care and treatment
- Enhanced community offer in EMI Nursing homes.

Lowest level to meet need

Approach to integrated physical and mental health



Outcomes

- An improvement in quality of life / patient experience
- A reduction in avoidable hospital admissions.
- A reduction in hospital length of stay
- A reduction in medication costs
- An increase in the number of people whose preference to stay as close to home as possible is fulfilled