

MHDLDA Mental Health Inpatient Strategy 3 Year Vision

Lincolnshire 2024 – 2027



Supporting people to live well in their communities

Working together



Supporting people to live well in their communities

Vision

Aim

To ensure that inpatient services are local, inclusive and deliver safe, effective and compassionate care to all.

To ensure our local inpatient offer will have the conditions in which people (patients, families, carers and staff) can flourish.

To ensure our inpatient provision meets the needs of the population, makes effective use of resources and enables people to live well in their community.

To ensure that co-production and the voice of lived experience are at the centre of all decisions we make.

Scope

Whilst the focus of this programme is on inpatient provision, we know that creating improved models and pathways will be dependent on the capacity and capability of the local community and system partnerships.

As with all sustainable improvement, strong relationships and collaboration across the organisations and system partners will be vital to establish and maintain effective joined up pathways and to share learning, knowledge, skills and support.

It is essential that the scope of this three-year strategy is not seen in isolation.

Working Commitment

System working:

- We will work with respect, recognising achieving system change can be difficult
- We will use improvement methodology and data to guide and structure our approach
- We will focus on improvement and outcomes and experience
- Properly implement co-production ladder

Our patient pathway approach will reflect:

- No wrong door
- 'Together we will' approach
- Citizenship
- A personalised care approach
- Patients and their family carers are at the centre of everything we do



Our Journey

What we've done

Mental Health diagnostic, self-assessment, gap analysis work (181 conversations with staff and 111 conversations with current inpatients)

Dementia diagnostic rate achievement

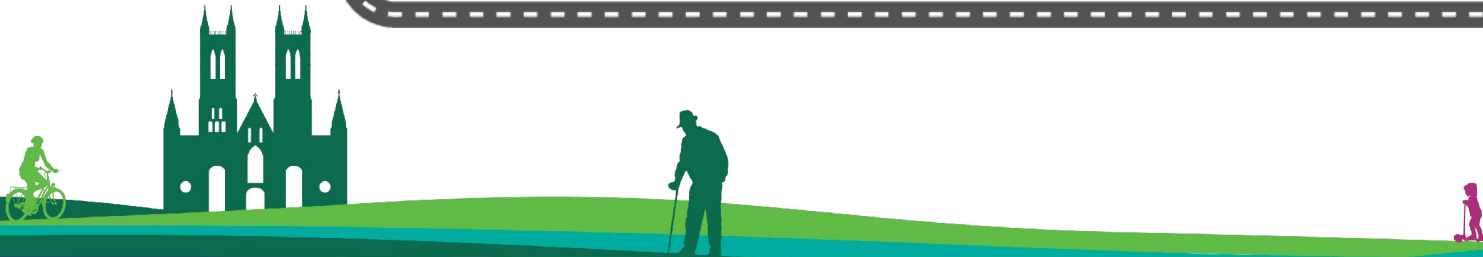
NHSE Community Transformation Roadmap

LDA – LDA roadmap, benefits realisation, community CTRs, DSRs, LPFT Transforming Care Team and LDA forensic team, Autism virtual hub (all age)

NHSE host commissioner

No OOA placements for 65+ acute or dementia

No moderate or severe LD admissions to assessment and treatment units have occurred for a number of years for our citizens



Our Journey..

Work that is in progress

Quality Improvement
Inpatient Programme
(LPFT)

Eradication of
Dormitories – East
Coast (LPFT)

National programme
Bed Reduction
(LDA) rate per
million

Right Care
Right Person

Community Mental
Health Transformation
(Community Rehab
team, PD team, Crisis
Alts)

OOA reduction

Female
pathway
review
(LPFT)

HACT housing
strategy

Lincolnshire
S117 Aftercare
policy

Culture of Care

Enhancing
Health in Care
Homes

Benefits of the
Frailty Strategy
(enhancement
to the home
treatment team
model and falls
prevention)

Rehab
maturity
index, PD
maturity
index

LPFT Crisis and
Home Treatment
Pathway review

24/7 Community
Pilot

TAA: Team
Around the
Adult approach

LCC/ Section
75 Social Care

Virtual
Frailty Ward

What will come next?
3 Year Inpatient Strategy



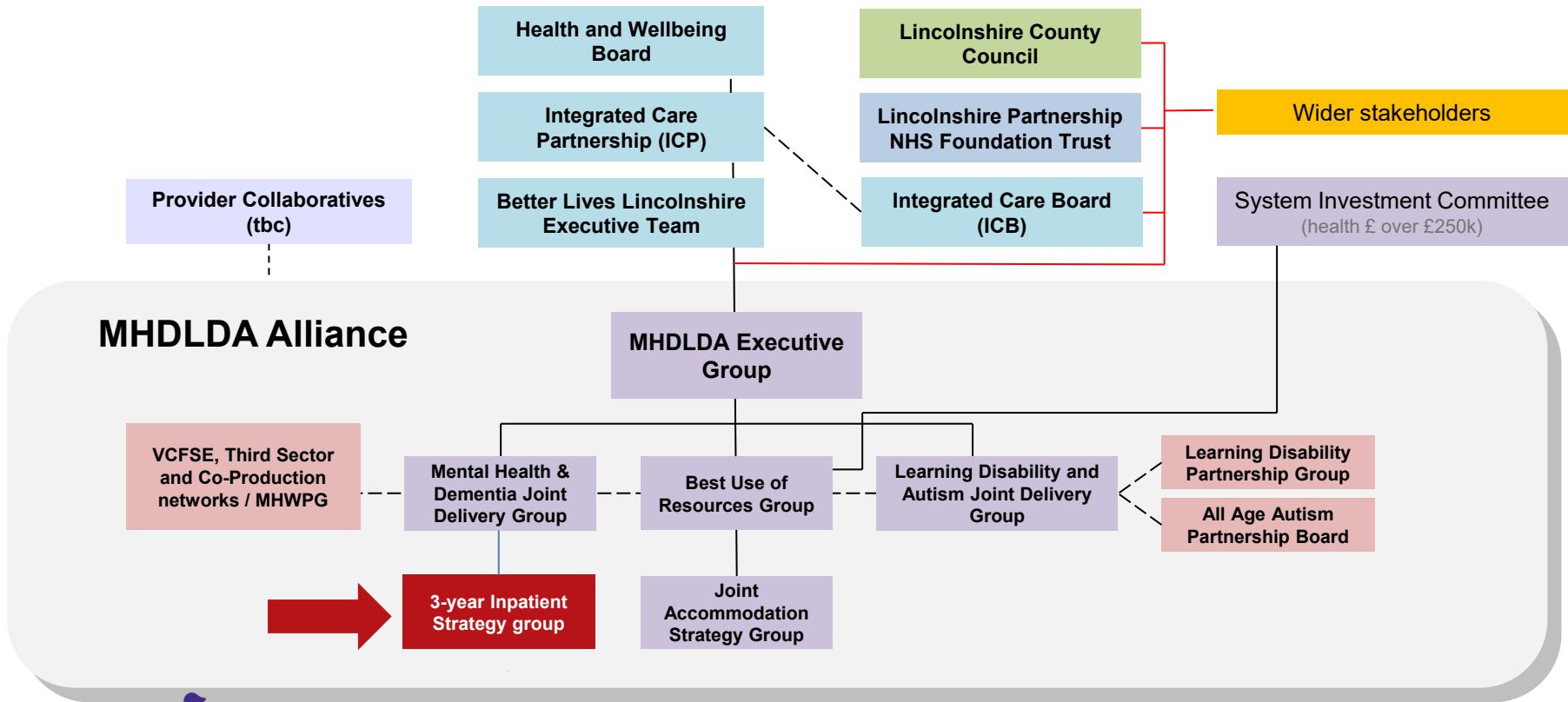
Working Principles

- A Model of Care (agreed to take the approach of reasonable adjustments (LD, autism and Positive Approach to Care – PAC)
- We will achieve the top rung of the co-production ladder and a model of citizenship
- To improve and ensure consistent involvement and application with the health inequalities and population health management agenda, to better equip the system, to ensure that validated data is the cornerstone of decision making
- Commissioning principles are to ensure we can evidence quality, parity and lived experience across the provider landscape
- We will seek to implement the model of care required, through the best use of resources and/or invest to save principles



Governance

Mental Health, Dementia, Learning Disability, and Autism (MHDLDA) Alliance Governance Arrangements £ year Inpatient strategy task and finish structure



Strategic approach

Six strategic pillars have been identified to ascertain the workstreams needed to implement change to achieve the three-year vision. Guided by achieving 'what good looks like,' each strategic pillar is underpinned by the model of care.

Pillars

Workforce

Environment

System achievement of the patient pathway

Procurement/contracting

Improving system interface

Improving Data

What good looks like

- Governance
- Valuing
- Accessible
- Humane
- Equitable
- Therapeutic
- Collaborative
- Citizenship

Model of Care



How the national and local picture align

| | | Strategic Pillars | | | | | |
|----------------------|---------------|-------------------|-------------|---|--------------------------|----------------------------|----------------|
| | | Workforce | Environment | System achievement of the patient pathway | Procurement/ Contracting | Improving system interface | Improving data |
| What good looks like | Governance | | | ✓ | | | |
| | Valuing | | ✓ | ✓ | | ✓ | ✓ |
| | Accessible | | ✓ | | ✓ | | |
| | Humane | | | ✓ | ✓ | ✓ | ✓ |
| | Equitable | ✓ | ✓ | | | | |
| | Therapeutic | ✓ | | ✓ | ✓ | | |
| | Collaborative | ✓ | | | ✓ | | ✓ |
| | Citizenship | ✓ | | ✓ | | ✓ | |

Model of Care

Listed below, are the **areas of focus** resulting from the self-assessment commissioning framework process

| Admission avoidance/ Alternatives to admission | Purposeful admission | Therapeutic Model of Care | Timely Discharge | Re-admission avoidance/ purposeful readmission |
|--|---|--|--|--|
| <i>Achieving 85% occupancy Reducing LoS Zero inappropriate OOA placement</i> | <i>Achieving 85% occupancy Reducing LoS Zero inappropriate OOA placement</i> | <i>Achieving 85% occupancy Reducing LoS Zero inappropriate OOA placement</i> | <i>Achieving 85% occupancy Reducing LoS Zero inappropriate OOA placement</i> | <i>Achieving 85% occupancy Reducing LoS Zero inappropriate OOA placement</i> |
| Use and bolster system escalation call: <ul style="list-style-type: none"> • LPFT to Commissioner • Commissioner to System • Commissioner to Region | Crisis and Home Treatment Review | QI methodology to draw a distinction between actions and approaches that require: <ul style="list-style-type: none"> • Quick win process implementation actions • Longer term cultural change implementation actions | Remove / improve existing care package barriers (pace): <ul style="list-style-type: none"> • procurement pinch points • 117 aftercare support arrangements • Parity of discharge status (MH inpatient to be as high a priority as ULHT inpatient discharge). | Community Rehabilitation Team (exemplar site) |
| Define and formalise system interface escalation for solution | Clive Treacey IR Principles: When not placed in a setting that can meet needs robustly monitor the quality of care provided. Doing the right of thing but not the right environment and managing patients who are waiting for specialist provision. | Process implementation actions: <ul style="list-style-type: none"> • GIRFT • Life planning and individual service funds • Patient requested activities daily | Accommodation improvements: <ul style="list-style-type: none"> • Development of a mental health housing strategies • Embed housing/accommodation needs into the care pathways • Conclude pilot of housing needs triage assessment • Achieve second stage - recruit system housing lead | Achieve Personality disorder maturity index |

Model of Care..

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| Admission avoidance/ Alternatives to admission | Purposeful admission | Therapeutic Model of Care | Timely Discharge | Re-admission avoidance/ purposeful readmission |
|---|---------------------------------------|---|---|--|
| Crisis and Home Treatment Review 'Lock in to' Community Mental Health Transformation better and work alongside Mental Health Prevention Concordat | Better use of system escalation call. | Effective clinical care: <ul style="list-style-type: none"> • Trauma and autism informed • Therapeutic support that gives people hope. • Relevant NICE guidance • Behaviour change: individual approaches (addressing health damaging behaviours). | Process implementation actions: <ul style="list-style-type: none"> • GIRFT • Ten high impact interventions | Continue systemwide Personality Disorder Pathway work. |
| Clive Treacey IR Principles: When not placed in a setting that can meet needs robustly monitor the quality of care provided. (doing the right thing but not the right environment and managing patients who are waiting for specialist provision. | | Commit to delivering the intentions within the guidance for: Commissioning Acute MH Inpatient Services for Adults with LD and Autism. Commit to safer staffing to achieve therapeutic model of care and addressing harm metrics | Effective clinical care: Social Network Model? (CofC) | Effective Home Treatment Therapeutic continuation of care |
| | | A Reasonable Adjustments approach to care delivery connected to the Personalisation Agenda: <ul style="list-style-type: none"> • Communication methods • Accessible information • Additional support • Changes to standard clinical activity. • Changes to physical environment. | Improve data collection and definition understanding of: <ul style="list-style-type: none"> • DToC • Clinically ready for discharge • LoS on discharge • True LoS since initial admission • Long stay discharges | |

Timeline

| Pillars | What 'Good Looks Like' | Year 1 | Year 2 | Year 3 | Strategic Outcome |
|--|---|--|---|---|--|
| Workforce | Therapeutic Humane Citizenship Collaborative | <ul style="list-style-type: none"> Finalise the therapeutic model of care Review staffing levels and skill mix | <ul style="list-style-type: none"> Analysis of resource implications Submit business case/case for change | <ul style="list-style-type: none"> Processes to secure funding | We will have a resilient workforce who are able to deliver the therapeutic model of care and address safety/harm metrics |
| Environment | Accessible Valuing Equitable | <ul style="list-style-type: none"> Stocktake of inpatient environment Review of reasonable adjustments data capture (see implementation of digital flag) | <ul style="list-style-type: none"> Analysis of resource implications Submit business case/case for change | <ul style="list-style-type: none"> Processes to secure funding | We will have achieved reasonably adjusted trauma informed spaces and services that meet therapeutic need |
| System Achievement of patient pathway | Governance Valuing Humane Citizenship Therapeutic | <ul style="list-style-type: none"> Recruit accommodation lead for the system strategy Interdependency with the Improving Data workstream to understand the needs of our citizens Expand on our existing co-production approach and implement the co-production ladder | <ul style="list-style-type: none"> Develop and finalise strategy for accommodation for the system Analysis of resource implications To develop a model of citizenship and co-production grounded in the lived experience of our citizens | <ul style="list-style-type: none"> Support the system to identify recommendations and develop a delivery plan Embed the model of citizenship and co-production as BAU in all areas of service provision | We will reduce reliance on all OOA placements, shorten lengths of stay through improved patient flow ensuring citizens are cared for close to home |



Timeline..

| Pillars | What 'Good Looks Like' | Year 1 | Year 2 | Year 3 | Strategic Outcome |
|-----------------------------------|--|---|--|---|---|
| Procurement/ Contracting | Accessible Humane Collaborative Therapeutic | <ul style="list-style-type: none"> Depending on outcomes of Improving data workstream in Year 1 Creation of Bed Strategy Task and Finish group Embed the Model of Care escalation process for alternatives to admission Engage with regional colleagues to adopt an approach to regional footprint commissioning in light of new priorities and population health needs | <ul style="list-style-type: none"> Bed Strategy Task and Finish group to share findings with the system through system governance Understand and implement any contracting and procurement implications from the delegated functions Participate in the regional commissioning frameworks as identified in Year 1 | <ul style="list-style-type: none"> Bed Strategy Task and Finish group to report on recommendations To ensure that the model of care is incorporated into any regional commissioning framework | We will adopt agreed commissioning principles and implement the contracting and procuring methodology to ensure that there is quality and parity of provision across the provider landscape for both in and out of area |
| Improving system interface | Valuing Humane Citizenship | <ul style="list-style-type: none"> Development of the Target Operating Model Development of OOA admissions as a virtual ward Pilot site for NHSE mental health host commissioner | <ul style="list-style-type: none"> Complete transfer of the delegated functions and resources identified to ensure improved integration Improve quality oversight (provider/commissioner/ local system) for both in and out of area Embed the new host commissioner framework into BAU | <ul style="list-style-type: none"> Embedding new processes around the delegated functions Further exploration of opportunities for wider integration | We will have improved our quality assurance and ensured parity across organisations as commissioners and both independent sector and NHS in county and out of area providers |
| Improving Data | Equitable Valuing Collaborative | <ul style="list-style-type: none"> Population data level review Review of system data capture Capacity and demand modelling Engage with the RA digital flag programme of work | <ul style="list-style-type: none"> Ensuring population health management and access to accurate data informs the planning and delivery of services Implement changes into data systems | <ul style="list-style-type: none"> Validated data is being used in service pathways redesign and new business case development | We will ensure all our strategic decisions are informed by transformed data |



Risks and Issues

- Existing capital infrastructure
- Financial benefits will not be realised in time for reinvestment in order to achieve the vision
- Financial benefits will not be released in order to be invested
- Workforce recruitment challenge
- Time required to deliver the data improvements needed to realise our plan
- Community capacity to support individuals with complex, challenging and emotional need, requires significant market stimulation
- Delivery of the strategy will require significant integrated working across the ICS (this includes the allocation of programme and project management resources in addition to procurement professionals) – this would potentially affect achievement of the bed strategy task and finish forum
- Uncertainty regarding priorities nationally and locally due to the change of government and the Target Operating Model



Immediate next steps

- The vision/strategy needs a detailed implementation plan to be created
- Finalise programme support and project structures
- Undertake wider service users and stakeholder engagement
- Familiarise co-production networks with this vision
- Ensure overlap and inclusion with wider system reporting and planning processes and deadlines

