CLEAR
Empowering staff to innovate care

CLEAR Mental Health 2022/23

Norfolk and Suffolk NHS Foundation Trust

Improving the care of older adults with mental health needs

AT A GLANCE

CLEAR CHALLENGE

Unclear criteria causing misaligned referrals for the Dementia Intensive Support Team. A need for improved care pathways tailored to older adults' needs

KEY CHANGES

A new hospital at home team to meet the needs of older people with dementia and mental health problems who are at risk of hospital admission and support hospital discharge

FORECAST BENEFITS

Reduced hospital admissions and lengths of stay - with potential productivity savings of £1.6m after investment

THE CHALLENGE

The project focused on the Dementia Intensive Support Team in East Suffolk (DISTe) which was facing an increased number of misaligned referrals from patients in crisis - as the criteria was unclear and open to misinterpretation.

There was a need for improved care pathways tailored to the needs of older adults to avoid increased hospital admissions and prolonged lengths of stay.

Disjointed communication within teams and a need for collaboration between specialist older people's mental health teams was causing some delays. With no physical working space, holding meetings to discuss cases was challenging for the DISTe team.

WHAT THEY DID

Staff within the trust embarked on clinical engagement to gain a clear picture of the challenges. This involved 17 multi-professional focus groups and one-to-one interviews. Participants included staff from NSFT, East Suffolk and North Essex NHS Foundation Trust, social services and primary care mental health practitioners. This insight was analysed alongside quantitative data from April 2018 to September 2021.

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CLEAR RECOMMENDATIONS

A new mental health hospital at home team could be created, building on the existing DISTe workforce. Its remit would be broader to include the care of older adults with mental health needs who are at imminent risk of hospital admission and patients needing support with hospital discharge.

It was recommended that the service has an additional 18 staff with the skill mix to provide specialist intensive support at home as a viable alternative to hospital admission for up to six weeks. Patients would then be discharged or transferred to an appropriate alternative service. The recommended working hours for the team were 8am-8pm, seven days a week.

The project team suggested the criteria for the new hospital at home team should be further developed with key stakeholders from the system and experts by experience. Where a patient did not meet the criteria of the new service, the team receiving the referral would handover to another service that would meet their needs.

Forecast admission avoidance and reduced length of stay could lead to projected productivity savings of £1.6m after investment

FORECAST IMPACT

The new model of care is forecast to reduce admissions by one third after a year, equating to around 30 a month, a saving of £2.4m.

With the new hospital at home team also supporting earlier discharge, it is projected that there would be a 30% reduction in length of stay, which would result in a further saving of £656,070. Together the potential productivity savings would be £2.8m. After investment in the new model, the overall projected savings would be around £1.6m.

Training and upskilling the workforce is likely to lead to improved staff morale, job satisfaction and staff retention.

A streamlined crisis pathway for older adults would result in reduced repetition of assessments and duplication of work.

For further information, visit clearprogramme.org.uk or contact the 33n team at info@33n.co.uk