positive

Nottinghamshire Healthcare NHS
NHS Trust

Positive about integrated healthcare

Mental Health Services For Older People

Mental Health Intermediate Care Team

Tony Wilde

Why ?

- Aging populations (in the next 20 years the elderly population will go up by 40%)
- First time ever there are more >65 than <18
- Hospital beds (70% over age 65)
- Cost of an NHS bed ~ £250 – 300 a day
- “Bed blockers” £4M a week!
- Dementia time-bomb
- Home is best ….

What is it ?

- Intensive & time limited
- Functional and organic
- Multidisciplinary
- Open referral system
- Needs led
- Comprehensive assessment
- Robust discharge plan

Aims

1) Prevent Hospital admission
2) Prevent entry into short term care
3) Prevent entry into long term care
4) Facilitate early discharge

Plus – enable a much better standard of home living

Partnership working - the way out …

- An accurate referral !
- Discharge planned from day one
- True joint working
- Setting up good working relationships
- Consistency of approach
- The ‘real stuff’ that matters

And the way in ….

- Homecare agencies can refer
- Advice / information sharing
- Early identification, (you will be the ones that see things first)
- Linked up working between all community services, local authority, NHS and the independent sector

The future

- Joint visits if it helps with transition
- Training / education
- Breaking down the barriers between services
- MHICT is a new service, great opportunity to shape the way it works

- And YOUR ideas …

Mr Bob Smith

72 year old gentleman, lives alone, no known family or close friends. In recent months neighbours have become worried about him, he has become more withdrawn and they see him less. His house is becoming messy and he is seen by his G.P. at home who says he is neglecting himself, diagnoses anxiety and depression and suggests a hospital admission. Bob does not want to go into hospital, has the capacity to make this decision, but will accept input at home.

MHICT see him on a basis of three visits a day for 9 weeks, he needs help with self care and with meal prep and meds prompts. On discharge he can manage with a package of two daily visits, to meet his needs.

Referred on to on-going community care agency.

If we don't do something we are asked to do, this should lead to asking why, not automatically dismissing an idea or request.

Thank you for your time and attention and fire away ……