NHS
East and North Hertfordshire
Clinical Commissioning Group

NHS
Herts Valleys
Clinical Commissioning Group

Hertfordshire
Hertfordshire County Council

Appendix b

Transforming Care Plan

Hertfordshire

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Contents

1. Introduction

The Fast Track areas are five selected sites across the North of England and Midlands and East to help achieve the ambitions of the Learning Disability Transforming Care programme, which aims to significantly re-shape services for people with learning disabilities and/or autism with a mental health problem, or behaviour that challenges, to ensure that more services are provided in the community and closer to home, rather than in hospital settings.

The five Fast-Track areas will bring together organisations across health and care that will have access to a £10 million transformation fund and technical support, to accelerate service re-design in their areas.

The Fast Track guidance set out the principles and timetables for the development of local plans. Within this guidance was a timetable for submission and an indication that plans would be reviewed thereafter to test both the quality and overall deliverability. The process of planning review will involve two groups of stakeholders in order to ensure local ownership of plans whilst supporting consistent improvement at a national level.

The sites, that are located in Greater Manchester and Lancashire; Cumbria and the North East; Arden, Herefordshire and Worcestershire; Nottinghamshire; and Hertfordshire, bring together a large number of commissioners – each with different challenges – so a number of approaches can be tested and new models of service delivery created to effect the biggest change.

The Fast-Tracks will help shape the transformation of learning disability services more widely across England, including:

- the future model of care for people with learning disabilities and/or autism – a new Service Model – that will describe what good services look like, with clear outcomes for individuals;
- national planning assumptions for re-designing services to be reflected in planning guidance for 2016/17;
- more flexible ways of using funding to get the best outcomes for individuals.

2. Background and scope

This plan concerns the needs and services for individuals in Hertfordshire with learning disabilities and/or autism. This includes children or adults with a learning disability and/or autism who have or display:

- A mental health condition, including but not limited to severe anxiety, depression or a psychotic illness
- Self-injurious or aggressive behaviour, not related to severe mental ill-health
- A specific neurodevelopmental syndrome, with complex life-long health needs
- Behaviour which may put themselves or others at risk (this could include fire-setting, abusive, aggressive or sexually inappropriate behaviour) and which could, but might not necessarily, lead to contact with the criminal justice system
- Other health or social care needs and disadvantaged backgrounds (e.g. social disadvantage, substance abuse, troubled family background), who display behaviour that challenges
- Been in inpatient care for a significant period of time (often decades), having not been discharged when NHS campuses or long-stay hospitals were closed

However, improving services for these groups involves a wider system change. In Hertfordshire, our new services will be part of a whole-system transformation to improve care for all with learning disabilities.

Hertfordshire has a strong track record in working collaboratively to drive better outcomes for people with complex support needs. From 2009 to 2012 the number of Assessment and Treatment (A&T) / Learning Disabilities rehab inpatient beds was reduced from 46 to 10. During that time the Positive Moves programme resettled 22 people with long histories of inpatient care and the label of behaviour that challenges; commissioners worked with HPFT in order to reinvest into the Specialist Learning Disability Service Community Assessment and Treatment Service.

The 2014 Joint Commissioning Strategy for people with learning disabilities sets clear principles for how services will be improved and **personalised** for the people of Hertfordshire. In particular services will promote:

- Choice and control – adapting what we do to suit people, by working with people and their families as partners
- Living in the community as a full citizen – with local support, leading to a meaningful and safe life
- Better health – supporting people to be healthy as possible
- A capable workforce – working in partnership with providers to employ and develop the right people in their workforce

In addition, as part of Hertfordshire's joint commissioning intentions for 2015/16, the contract with HPFT is being reviewed.

As a result, this is a timely opportunity to develop a plan that brings together these various drivers for change into a collaborative model that will transform the lives of people in Hertfordshire. This plan describes the collaborative approach that Hertfordshire is taking to move towards a radical new model of care that is built around a lifelong pathway that brings all services and teams together in a single integrated model of care and pathway.

3. Governance and planning arrangements

Hertfordshire's collaborative governance arrangements are detailed in the diagram below. Key features of this include:

- A multi-agency Transforming Care Board to provide a single place for collaborative decision-making by commissioners, clinicians and relevant professionals and experts
- The representation of parents and carers on the Implementation Steering Group to ensure service user/carer involvement and participation
- An Implementation Steering Group to drive and manage progress in developing and implementing this plan

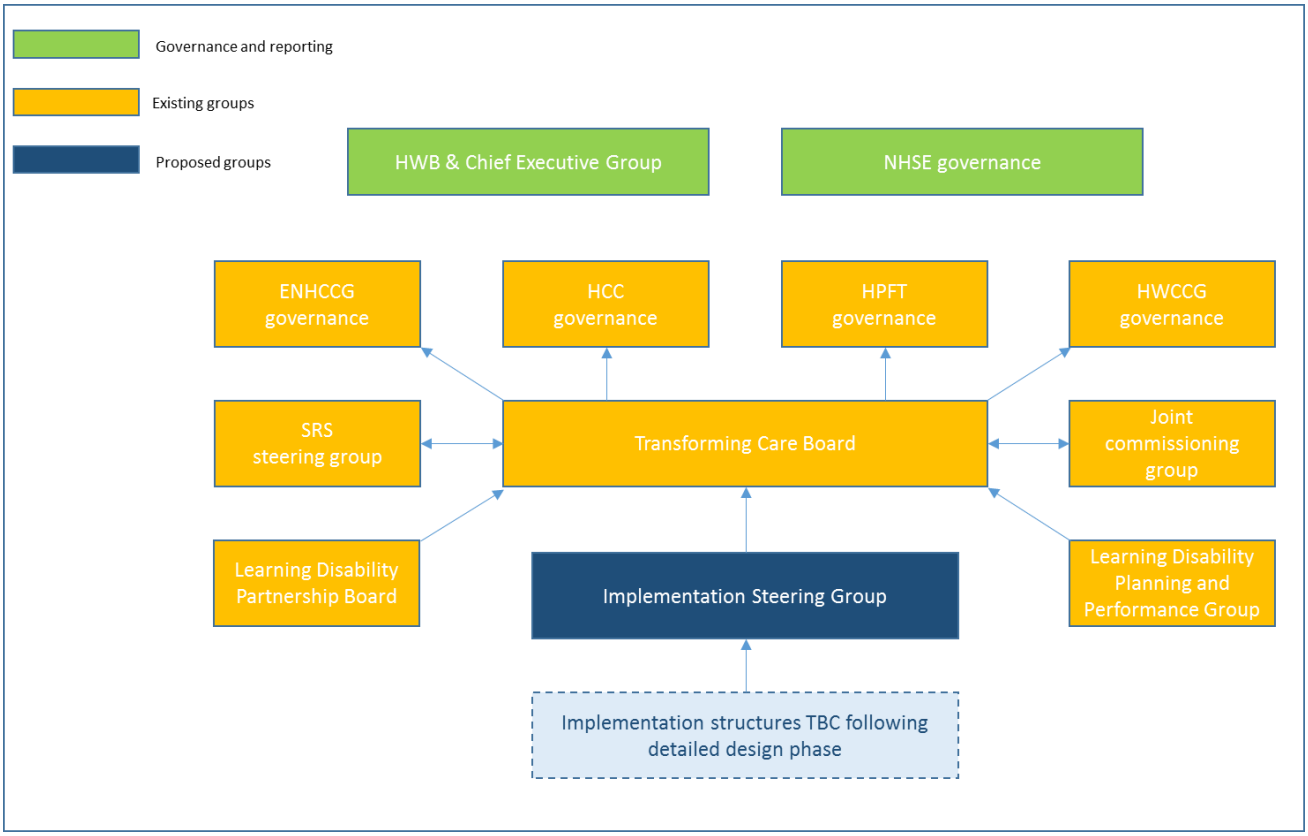


Fig.1 Governance structure for the Fast Track Implementation
NB –Additional link to County-wide Workforce Group

Transforming Care Board

This is a senior multi-agency leadership and oversight of work stream to ensure effectiveness of systems/proposals; quality and assurance check control and escalation for decision making. Members of the Boards are:

- Chair/Co Chair from the CCGs and the Local authority
- Experts representatives (e.g. Inclusion East Lead)
- Directors of Nursing CCGs
- Integrated Commissioning Team
- Hertfordshire Partnership Foundation Mental Health/specialist LDTrust (HPFT)/Community Learning Disability Service (CLDs)
- NHS England

- Children's representatives from Health and Social Care

Implementation Steering Group and proposed working groups

The Fast Track Implementation Steering group will lead on the development of the service model and the implementation plan for delivering it. Following submission of this plan, further work will be taken to develop the detailed service model design and the core enabling work streams to deliver it.

The detail of these governance arrangements is to be determined but will include coverage of the following key issues:

- Finance, joint commissioning and pooled funding arrangements
- Workforce development
- Systems and data
- Provider development
- Clinical and care professional assurance.
- Market shaping

4. How we are currently serving the needs of our population

4.1. Who we are serving

What are learning disabilities?

The White Paper, *Valuing People*, defined a learning disability as: a significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence); along with a reduced ability to cope independently (impaired social functioning).

Certain conditions such as dyslexia are not considered to be learning disabilities, as while they make tasks such as reading or writing difficult they do not affect intellect; instead they are considered to be learning difficulties. Similarly, while learning disabilities are linked to mental health issues, poor mental health is not considered to be a learning disability in itself, as it can affect anyone, at any time and can usually be overcome with treatment and support (Department of Health, 2001).

Learning Disabilities can be grouped into four main levels of severity:

- Likely to result in some learning difficulties at school. At this level, many adults will be able to work, maintain good relationships and contribute to society.
- Likely to result in marked developmental delays in childhood but most can learn to develop some degree of independence in self-care and acquire adequate communication and academic skills. Adults are likely to require varying degrees of support in order to live and work in the community.
- Likely to result in severe developmental delays and a continuous need for support throughout the life course.
- Likely to result in severe limitations in self-care, continence, communication and mobility. Requires a high level of constant care and support.

(Department of Health, 2001)

At a national level there is no definitive record of the number of people with learning disabilities in England. The Improving Health and Lives (IHAL) profiles produced by the North East Public Health Observatory estimates that approximately 2.5% of the total population have some form of learning disability, resulting in an estimated 1,191,000 people in England with a learning disability This population is predominantly (60%) male and unknown to services; of the estimated 905,000 adults with a learning disability in England, only 189,000 (21%) are known to local authority or health services. Around 24% of the estimated population with learning disabilities are believed to be children and 76% are believed to be adults. (IHAL, 2011).

How do we define this in Hertfordshire?

At a local level there are two main methods for estimating the population of adults with learning disabilities within Hertfordshire:

- Information (POPPI) estimates – These use the national prevalence estimates for the 18-64 (PANSI) and 65+ (POPPI) age groups and apply it to the Hertfordshire population to provide projected number of people with learning disabilities.

- These use the number of pupils receiving support at school action plus or statement level with a primary need associated with learning disabilities in later life (Moderate Learning Difficulties (MLD), Severe Learning Difficulties (SLD) or Profound and Multiple Learning Difficulties (PMLD)) to estimate the population of adults with learning disabilities.

Based on the estimated national prevalence of 2.5%, Hertfordshire has an estimated population of approximately 20,400 adults with learning disabilities, while projections based on children in Hertfordshire schools with special educational needs associated with learning disabilities (as outlined above) suggest a population of around 15,100 adults with learning disabilities (a prevalence of 1.7%). While neither method is perfect, it is likely that the Hertfordshire population of adults with learning disabilities would fall between these two values.

As of June 2015 there were 3,660 adults with learning disabilities known to adult social care services, representing between 15% and 21% of the total estimated population, equating to between 12,000 and 17,000 people with learning disabilities who are not currently known to services.

In relation to children and young people if we apply the mean percentage of disabled children in English local authorities estimated to be between 3% and 5.4%, for the population of Hertfordshire this would equate to between 7,133 and 12,840 children experiencing some form of disability. This is based on the JSNA Profile of children and young people aged 0-25 SEND agenda.

People with learning disabilities who are known to services

Learning disability support for social care within Hertfordshire is provided by Community Learning Disability service (CLDs). CLDs clients represent all the adults with learning disabilities that are known to Hertfordshire County Council support services; as a result, all commissioning decisions are made based on the needs of this group, which represents between 15% and 21% of the total estimated learning disabled population in Hertfordshire. As at June 2015 there were 3660 adults with learning disabilities known to services.

This means that only a relatively small proportion of the estimated population with learning disabilities that currently receive support could indicate potential unmet need; however it could also indicate that the majority of adults with learning disabilities are able to live fully independent lives without local authority support.

By comparison, there are 2,928 children in Hertfordshire schools that currently receive support for a special educational need associated with learning disabilities in later life (School Action Plus and Statement only). Due to differing approaches between children's and adult services there is no definitive number of children known to have a learning disability, as special educational needs can be short term and as a result services are provided in accordance with an individual's specific need set, with specific services being provided for each specific need. Children identified with SEN whose primary need is associated with learning disabilities make up 1.7% of the child population while adults with learning disabilities who are known to services make up 0.3% of the population aged 16+.

16-24 year olds are significantly more likely to be receiving local authority support, with 610 per 100,000 16-24 year olds in Hertfordshire currently receiving CLDT support. People aged over 65

are least likely to be receiving support (167 per 100,000). This difference is most likely due to a number of factors, including the reduced life expectancy associated with learning disabilities (people with LD are 58 times more likely to die before their 50 birthday) changing social values regarding people with learning disabilities resulting in increased service uptake in the younger generations. A higher prevalence is reflected in 16-24 year olds being significantly over-represented when compared to the general population distribution for Hertfordshire, while over 65's are significantly under-represented. As learning disabilities are a lifetime condition, it would be expected that the age distribution will level out over time, particularly if the reduced life expectancy is addressed, resulting in additional strain on services in future years.

At school level, secondary school pupils are significantly over-represented in the population of children with special educational needs associated with learning disabilities in later life, and display a significantly higher prevalence when compared to the average, while pre-school pupils are significantly under-represented with a significantly lower prevalence.

The disparity is most likely due to new diagnoses at each school stage being added to the existing cohort due to the lifelong nature of the condition, while most of the cohort would be identified during primary school, those identified in secondary school will increase the size of the existing cohort and therefore increase the prevalence. Given the definition of learning difficulties requires the disability to have been diagnosed by the age of 18, we can expect the prevalence to peak at secondary school level and remain fairly stable until mid to late adulthood when it would be expected to drop as a result of reduced life expectancy.

Hertfordshire experiences an increasing prevalence up until the age of 16, with a sharp and significant decline between the 11-16 and 16-24 age groups, followed by a smaller decline between 16-24 years and 25-34 years. The sudden drop at the 16 years age mark suggests that a significant number of children who receive support at school level do not continue support into adult life, although it is not clear if this is due to them being "lost to services" or not reaching the threshold for support into adulthood. In the event that the latter is the case, it would suggest that around four out of every five children diagnosed with moderate, severe or profound learning difficulties do not qualify for continuing support after school, equivalent to the proportion represented by children diagnosed with "moderate learning difficulties" in the SEN associated with LD cohort

Between 25 and 54 years of age there is no significant change in prevalence, suggesting that the higher prevalence seen at 16-24 years may herald the start of an increased demand for services as a result of factors including changing attitudes towards learning disabilities and lower infant and premature baby mortality rates. Based on the high relative prevalence of special educational needs associated with LD and the higher prevalence of supported people with LD in the 16-24 age groups, it is likely that demand for services will continue to increase, particularly if the reduced life expectancy for people with learning disabilities is addressed.

Within Hertfordshire, Watford has a significantly higher prevalence of adults accessing learning disability services while Dacorum, East Hertfordshire, North Hertfordshire and Three Rivers all display a significantly lower prevalence. A similar pattern is seen for children with special educational needs associated with learning disabilities; the prevalence seen in Stevenage and Watford is significantly higher than the county average while that seen in Dacorum and St Albans is significantly lower. This is supported by data taken from CLDs Client List as of February 2012, Hertfordshire School Census (Spring 2011) and ONS population estimates for Hertfordshire (2010).

Children from a Gypsy/Roma or Irish Traveller background are four times more likely to be in receipt of support for special educational needs associated with learning disabilities than the average Hertfordshire pupil. While the other ethnic groups show no significant variation overall, pupils from an Asian background are significantly more likely to receive support at school for Severe or Profound and Multiple Learning Difficulties than the average Hertfordshire pupil.

When adult prevalence is examined in terms of ethnic background, some key differences compared to the school level analysis are evident. Unlike the school level analysis, people from Asian, Black and Chinese backgrounds are significantly less likely to access support for learning disabilities. Other ethnic groups showed no significant variation from the Hertfordshire average. No data relating to the Gypsy/Roma or Irish Traveller population was available for adult service users.

When compared to the pattern shown at school level, the ethnic breakdown of CLDT clients suggests a significant under-engagement with services by people from Asian, Black or Chinese backgrounds. This is of particular concern in those from Asian backgrounds given the significantly higher prevalence of severe and profound learning difficulties in school pupils from this background.

Demographic Changes affecting our population

The population of Hertfordshire has increased across the last decade and this increase is forecast to continue over the period of this plan. This is demonstrated by summarised population statistics from the Hertfordshire Joint Strategic Needs Assessment (JSNA). Therefore there has been and will continue to be, an associated increase in the prevalence of mental health disorders across the plan period to 2016. The average annual demographic movement based on JSNA statistics is set out below:

Per annum average	
Under 18	0.84%
18-65	0.69%
65+	2.57%

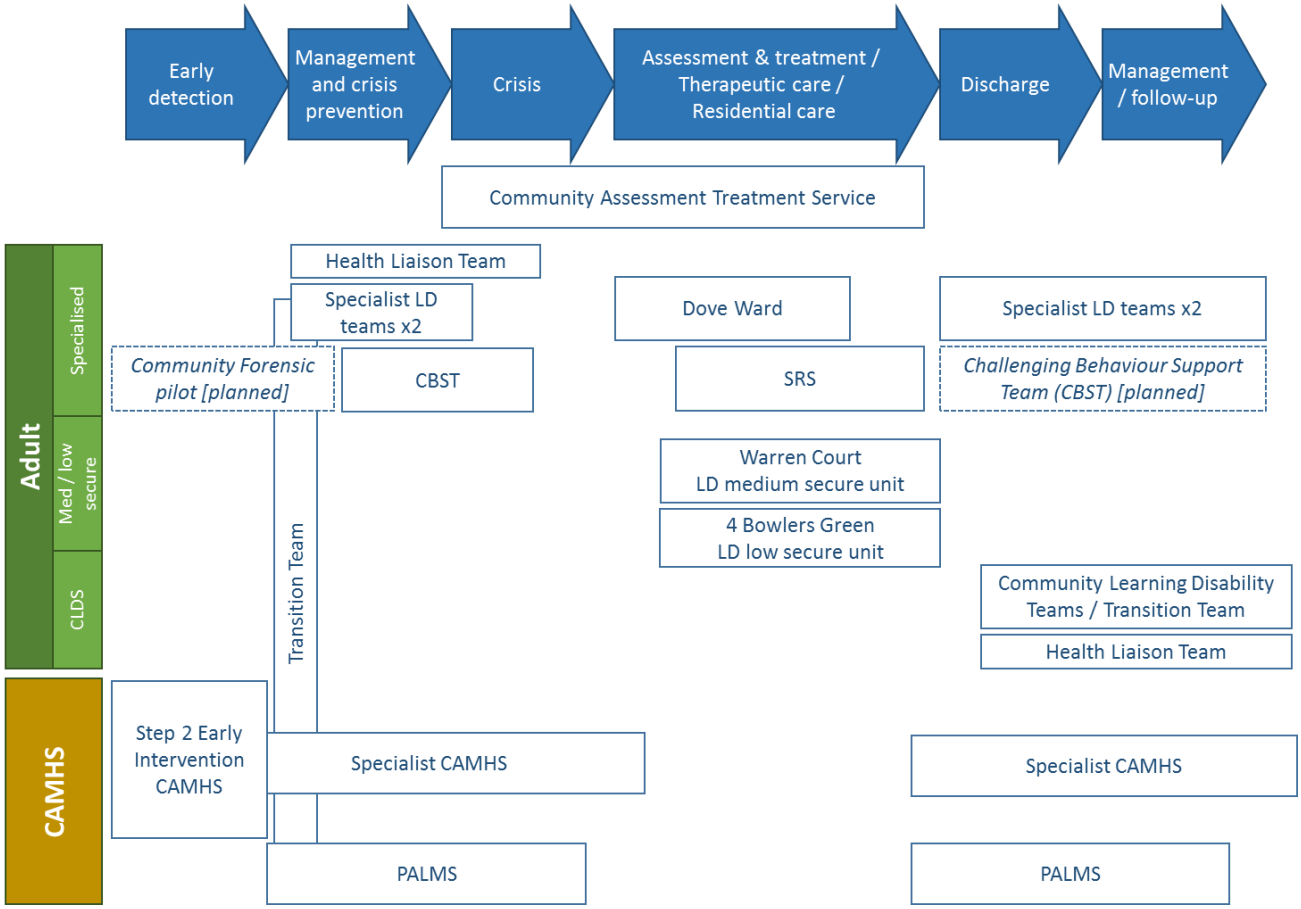
The number of people with a learning disability is forecast to grow. It is estimated that there will be an overall growth of 14% over the two decades 2001-2021 (Emerson and Hatton 2004)

Whilst a useful guide, these population projections do not always directly translate into the patterns of demand experienced by our services. In particular, there has been a significantly higher increase in demand amongst the older population over the last 24 months and we anticipate that this level increased demand will continue. For example, demand for Continuing Healthcare (CHC) placements has seen a sustained increased of c.10% over the last 6 – 12 months.

4.2. How we currently serve them

Services can be simply viewed by the age cohort (children / young people and adults) and the type of service. However, this simplified view does not capture the complexity of the way on which services are currently provided. There are multiple experts and specialist professionals who can

affect an individual at any point on the journey from initial occurrence of an issue through their receipt of services to their on-going management.



As can be seen above, there are multiple providers and multiple points of entry. The model is geared around the services and the provider, rather than the individual's journey through their lifecycle.

Further detail of these services and providers is provided below.

Adult services

Hertfordshire currently spends £126.9m on services for adults covered within this plan:

- £118.1m is spent on the Community Learning Disability service (CLDs) provided by HCC
- £8.8m is spent on HPFT's Specialist Learning Disability services in Hertfordshire – this includes Community Teams and Dove Ward (10 assessment and treatment beds)

HPFT Specialist LD Services

Hertfordshire currently reports to NHS England on 29 people. This includes people from the original cohort, 10 people within the Specialist Residential Service and new admissions to the local Assessment & Treatment Unit. In addition, NHS Specialised Commissioning report on 20 people, this includes 3 CAMHS cases. There is a Transforming Care Team in place which has responsibility for the care management for the majority of the individuals. Care management for people admitted to the Assessment and Treatment unit remains with the local Community Learning Disability Team with support/oversight from the Transforming Care Team as appropriate. The team also has a Person Centred Planner, a Service Finder to support with finding housing and support options and a

psychologist. All cases have input from the CAT team as appropriate and there is good partnership working in place to support people to be discharged evidenced by the 22 people that have moved since the end of 2013.

One of the challenges for Herts to resolve locally is the pathway for people, particularly for people with Aspergers. Work is already in progress around this cohort and will continue under the Fast Track work.

- Hertfordshire has two Specialist Learning Disability Community Assessment and Treatment Teams (which incorporates an Intensive Support Team function); the service works with people who have specialist health needs that cannot be met in mainstream services. The team is a person centred service, which focuses on supporting people to develop and maintain independence through holistic assessment of needs, working with service users to understand their goals and delivering interventions that focus on these outcomes. The team specialises in positive behaviour support and works with people with additional mental ill health needs; complex behaviours; complex health conditions; communication difficulties and dysphagia. The Intensive Support Team act as gatekeepers for the assessment and treatment service.

- Dove Ward (Kingfisher Court)
  Dove ward is an assessment and treatment service for adults with learning disabilities who also have a mental health condition, whose assessment and treatment needs are best met within a specialist service. Dove ward has a multidisciplinary team, which works in partnership with HCC and HPFT Community Learning Disability staff to facilitate a safe discharge for people in a timely way. Dove ward is in year two of working towards QNLD AIMS accreditation.

- Specialist Residential Service
  SRS provides care and support on a hospital site for 29 adults with LD; the service opened in 2001, in response to the closure of long stay hospitals for service users who were not resettled in the community. 10 of these are Hertfordshire patients.

- Community Forensic team (Pilot)
  This small team will be made up of three clinicians (Clinical Psychologist, Registered Nurse and OT or SW, with dedicated sessional time from a Psychiatrist) who will be managed by Community Forensic Team. Their focus is people with previous offending behaviour or who are at risk of offending, and those who are considered ‘high risk’ in the generic LD services. There will be a mix of early intervention and preventative work; a monitoring and support role; as well as providing advice and support to other services.

- Challenging Behaviour Support Team (Pilot)
  This is a larger team of clinicians; the primary focus is working with community support providers who are struggling to meet the needs of people with complex behaviours, building skill and capacity in the workforce and, over time, the wider community with the aim of increasing community engagement and involvement. The team will complement the existing Specialist Community LD Teams and have expertise in the delivery of Positive Behaviour Support as a framework for working with people with complex behaviours that can challenge services. The team will also have capacity to work with identified individuals for a longer period than is currently commissioned.

- Therapeutic psychiatry services
  Medium and low secure services include a therapeutic psychiatry services for individuals with a learning disabilities and/or autism with a mental health problem, or behaviour that challenges who present a significant risk of self-harm or harm to others. These services are delivered at the following locations:
    - Warren Court (medium secure),
    - 4 Bowlers Green (low secure)

Medium and Low Secure

The table below illustrates the numbers of Hertfordshire residents in receipt of medium and low secure services in Hertfordshire as of September 2015, classed by commissioner in Hertfordshire and the section under which these patients are held.

East & North Herts	**Total 3**
HPFT -	**1**
Section 3 (Treatment)	1
PiC	**1**
Section 3 (Treatment)	1
SEPT	**1**
Section 3 (Treatment)	1
Herts	**Total 19**
HPFT	**7**
Other	1
Section 3 (Treatment)	2
Section 37 (Hospital Order)	1
Section 37/41 (Hospital Order with restrictions)	2
Section 47/49 (transfer from prison to hospital with restrictions)	1
Huntercombe	**1**
Section 37/41 (Hospital Order with restrictions)	1
PiC	**8**
Section 3 (Treatment)	4
Section 37 (Hospital Order)	2
Section 47/49 (transfer from prison to hospital with restrictions)	1
(blank)	1
SEPT	**3**
Section 3 (Treatment)	1
Section 37 (Hospital Order)	1
Section 47/49 (transfer from prison to hospital with restrictions)	1
Herts Valleys	**Total 6**
Danshell	**1**
Section 3 (Treatment)	1
HPFT	**3**
Section 3 (Treatment)	3
PiC	**1**
Section 3 (Treatment)	1
SAH	**1**

Section 3 (Treatment)	1
North Hertfordshire	**1**
Cygnet Hospital, Godden Green, Sevenoaks, Kent, TN15 0JR	**1**
Section 2	1
Grand Total	**29**

Community Learning Disability Services (CLDS) (HCC)

This service is provided by Hertfordshire County Council and comprises of:

- 7 Community Learning Disability Teams and a Transforming Care Team
- 2 Transition Teams
- a Health Liaison Team
- an Aspergers social care team

Community Learning Disability Teams work with adults aged 18 and over who have a learning disability and are often not able to manage without the appropriate levels of support. The teams consist of social workers, other social care staff and the community learning disability nursing service. This means they can offer a person centred service and can help, support and advise on health, benefits, rights, housing, finances, family issues, education, legal and social issues. They also assess the needs of family carers and help them to support the person they care for.

The Health Liaison Team, which is part of the nursing service work in primary and secondary health settings to ensure that people with a learning disability receive the same health services as other Hertfordshire residents.

The Transition Teams, in partnership with Children's Services, work with young people with learning and physical disabilities from the age of 16 through their transitional years into adulthood.

Children

Hertfordshire currently spends £10.3m on tier 2 and 3 Children and Adolescent Mental Health Services (CAMHS) services covered within this plan:

- £2.4m is spent on pooled tier 2 CAMHS services
- £7.9m is spent on HPFT tier 3 CAMHS services

- Child and Adolescent Mental Health Services (CAMHS) for learning disabilities
  In Hertfordshire, child and adolescent mental health services (CAMHS) operate a four-tiered model.
  1. Tier 1 represents universal services to promote good mental health (e.g. Health visiting or social and emotional learning in schools);
  2. Tier 2 is for children who need early support to regain good mental health (e.g. school based counselling and community based youth Counselling as well as targeted parenting interventions); This includes Step 2 (Hertfordshire Community Trust) Early Intervention CAMHS Service for 0-19 year olds.
  3. Tier 3 provides specialist multi-disciplinary support in the community;
  4. Tier 4 Outpatient provides further specialism and is access via a tertiary referral from tier 3
  5. Tier 4 Inpatient - inpatient care commissioned by NHS England

The majority of learning disabilities support covered in this plan falls within tier 3 services. Tier 3 services are delivered by specialist multi-disciplinary teams of child and adolescent mental health professionals who deal with the more complex and persistent mental health difficulties. Tier 3 services are for Children and Young People with severe, complex and/or persistent disorders that may require the involvement of a psychiatrist and/or multi-disciplinary team for individual or family work.

Specialist CAMHS (delivered by HPFT) deliver assessment and interventions in the community for Children and Young People with Mental health problems which are:

- Persistent
- Complex
- Severe
- Present in all environments – school, community, with peers
- Where intervention at Tier 1 and 2 has not been successful

  - CAMHS Crisis and Assessment Team (CCATT)
    The CAMHS Crisis, Assessment and Treatment team (CCATT) works with children and young people with complex and challenging mental health problems who are at high risk of harm to themselves or others. Crisis interventions are delivered by HPFT Specialist CAMHS.
    The team provides assessments for children and adolescents with high risk mental health needs presenting at Emergency Departments (A&E) or on paediatric wards (including those from outside of Hertfordshire) at the Lister and Watford Hospitals. The team also provides a range of short-term community based assessment and treatment options for this group of children and adolescents and provide advice and support to parents/carers.

  - Positive behaviour, Autism, Learning disability and Mental health Service) (PALMS)
    PALMS works across the county providing a specialist multi-disciplinary approach to children and young people aged 0-19 who have a global learning disability and/or autistic spectrum disorder and their families.
    PALMS provides intervention where necessary and intensive support to families reaching crisis with a step up and step down approach throughout their care journey including workshops, group, learning, therapeutic work with children and young people, parents, carers and siblings, second opinions and intensive support to families in or reaching crisis with a step up and step down approach throughout their care journey.

    A child or young person meets PALMS criteria if they:
    - are aged 0-19 and registered with a Hertfordshire GP
    - have a diagnosis of autistic spectrum disorder (ASD) and/or a global learning disability, or are waiting for a diagnosis

    and
    - show additional behavioural difficulties, including challenging behaviour towards self, others and environment and sleeping, feeding and toileting difficulties which have not improved following standard community and paediatric interventions and advice

    and/or
    - show an emotional or mental health need that cannot be met by mainstream services including local CAMHS clinics with reasonable adjustments

5. Case for change

5.1. What is working well to date?

As described in section 2, Hertfordshire has a strong history of services and partners working together to drive improvements in the service it delivers for its population. It is important that this plan builds on these strengths, including:

- A history of reducing the dependency on inpatient beds as the default service
- Conducting a Care and Treatment Review (CTR) for the full Transforming Care cohort, with plans in place for every individual in that cohort
- An excellent partnership working, embodied in joint governance arrangements and joint plans involving health and social care and professional, provider and service user engagement
- Strong support in the community through the Specialist Learning Disability Community Assessment and Treatment Service (incorporating the Intensive Support Team function)
- An average length of stay in inpatient Assessment and Treatment of approximately three months, with robust care pathways in place

These strengths are illustrated below:

"DM is an 18 year old male with a history of autism. He lives in the family home with his parents. He is reported to have had difficulties every time there is break from college. **Both parents felt that they needed help around community support, education about autism. This support was provided by the Psychologist and the CATTS nurses.**
More recently, DM had expressed a fear that the neighbour was planning to harm him. A couple of days before being admitted to hospital he crossed the road and hit the neighbour. Before the incident, it was felt that he was also having experiencing the start of a psychotic illness and anti-psychotic medication was started in small doses. It was decided to detain him under section (MHA) as his behaviour was unpredictable and his parents were concerned that he would go after the neighbour again. During the admission it was noted that there were lots of High Expressed Emotions within the family. Both parents were struggling to support him and other children who were also going through a difficult time. There was no evidence of psychosis and his symptoms could be explained in relation to his autism. His medication was gradually reduced and then stopped. **Extra support was provided by CATTS nurses and psychologist. Parents also agreed for some respite care for DM. His admission was only for a few weeks.**"

5.2. Where can the service improve?

However, whilst there are examples of good practice in a system that has made great strides, there are still significant opportunities for improvement.

In particular the model suffers from the following characteristics:

It is a service-led model – the model is built around the services with people being offered individual services in isolation. This creates multiple handoffs and greater opportunities to lose knowledge and intelligence.

"JM is 48 years old with a history of Bipolar Affective Disorder. **He had a history of previous admissions but had been well for over 10 years with minimal support and had recently been discharged from Psychiatric follow-up**. He lived in his own flat. His Lithium was being managed by his GP. **Over the 6 weeks period he stopped taking his medication and started to become unwell**. He threw all his clothes outside, stopped eating and drinking. The Community learning disability team were contacted and after a mental health act assessment he was admitted to an acute assessment and treatment unit, initially to a mainstream general adult psychiatric ward where he was supported on one to one basis. He injured himself repeatedly by trying to get into cupboards and trying to swim on the floor. It was noted that he was not eating or drinking because of his paranoid beliefs. He was transferred to a specialist Learning disability unit. With the help of continuous nursing support and restart of his medication, he improved enough to go back to his flat. He is being supported in the community by the CATTS nurses and extra support from the personal budget"

It is a point in time model – because the model is not a holistic one, but rather service led, there is no management of individuals across their life course. This can create a number of challenges:

- Failure to identify early and prevent crisis
- Difficulties in managing transitions

It is a model that struggles to join up information – whilst there is a strong willingness to collaborate; there are not the mechanisms or processes to chare joint clinical information. This is especially the case as individuals move across the transition from child to adult or when an adult receives multiple services and the outcomes are not tracked or reported to other agencies.

"A recent example was a young person admitted to a cubicle in Children's Assessment unit for 4 days, due to challenging behaviour and carer breakdown; **admission could have been avoidable** if there was an accelerated support plan, that included a lead professional from either psychology/psychiatry and communication for local police/paramedics"

It is a model that can place people a long way from home - A high number of cases that get referred to us are of those who were placed outside the county for their special education needs and then come back to the family at 18 years. This group has particular challenges in relation to their families, education, support needs and health and many do not have any diagnostic formulations so their needs have not been clearly identified or met when they come back to the county.

It is a model that struggles to handle end of life care – there is a growing older population with early onset memory loss with increasing health needs and end of life care. There is a growing population of adults who have life limiting conditions, who would benefit from improved nursing care.

It is a model that is facing new demand pressures that it did not foresee –

- Due to better survival rates at birth, number of people with hearing, visual and other complex physical disabilities are also being referred to our services with milder learning disabilities.
- There is a very high demand and need for diagnostic assessments in relation to autism, its co-morbid diagnosis (dyspraxia, dyslexia, Mental health, epilepsy etc). This population is poorly served due to their complex needs, limited resources, high volume and inadequate training. Hence there is limited support available of specialist staff.
- Patients with complex behaviour who have complex needs and need longer term support which can create resource pressures in trying to meet these needs.

- Patients with high forensic needs in the community are often poorly served and may enter the criminal justice system as there is no community learning disabilities forensic support and treatment.

It is a model that struggles to provide joined-up packages of care when they are needed – there are on-going challenges in ensuring CCG and Local Authority liaison to ensure the right community packages are secured in a timely manner (including funding and placement), so that patients do not stay in hospitals longer than necessary and do not return to secure care.

"Mr AB is a 76 year old man who lived with his two brothers in a council house. One brother had learning disability and other brother (main career) was without disability. His brother without disability was admitted to a nursing home after a diagnosis of dementia. AB's other brother was moved to a supported living accommodation and NK was on his own in the house. NK had two admissions to Watford general hospital with a Urinary tract infection. During the second admission he was found to be confused in time and place and person even after his urinary tract infection cleared. His mood was labile with pressure of speech. He was admitted to a learning disability acute assessment and treatment unit as there was no other community placement available. He had previously lived independently, was well known and supported in the community. **He did occasional work for the local publican and was fed and supported by the publican. During the admission, it was noted that he was not sleeping or eating and his behaviour was disinhibited**. Second opinion was sought and he commenced treatment on anti-psychotic medication. His mental state improved over 6 weeks**. He stayed another 2 months as there was no appropriate community placement available**."

It is a model that struggles to optimise its scarce resources - because the resources are limited and placed across a number of services in a number of teams, it is hard to coordinate these resources most effectively. This can create squeezes in the system on key roles such as care coordination / case management, with a shortage of these available to attend CTRs, CPAs and other professional meetings relating to the person's future care and pathway.

5.3. Performance data for the system

The challenges identified above suggest specific challenges in the up-front identification and prevention, the availability of alternatives at the point of crisis and the opportunities to improve transfers of care. This is supported by the data below which shows:

- Lengths of stay are relatively short
- There are Delayed Transfers of Care which are attributed to difficulties in sourcing robust community social care placements

Occupancy

<u>Assessment & Treatment (Dove Ward)</u>

Hertfordshire commissions 10 assessment and treatments beds which are located on Dove Ward, Kingfisher Court. Over the past 12 months, average bed occupancy is 90%. An inpatient care pathway model is in place which ensures that people are assessed and allocated to a care pathway to meet their needs within 72 hours of admission, with a predicted date of discharge set. There are three cohorts of people that are admitted into Dove Ward:

1. People detained under the Mental Health Act

2. People who may be admitted informally for a period of assessment and treatment who have been assessed as having capacity to consent to admission and treatment under the Mental Capacity Act.

3. There are more people now on Dove ward who are either detained or under the Deprivation of liberty safeguards. This pattern is a change from what was

previously the case of high number of informal patients. Increasingly, the number of readmission has decreased and most patients are new to the services or have been recently referred.

Low and Medium Secure

Forensic secure beds at Warren Court and 4 Bowlers Green are commissioned by NHS England. Specialised commissioning determine the unit placement based on need and availability. Every effort is made to place people close to home but their type of need and availability at the time may prevent this from happening.

Referrals for both Warren Court and Bowlers Green exceed discharge rates. Not all people within these inpatient facilities are from Hertfordshire – several are from London boroughs and the wider East of England region.

		April	**May**	**June**	**Q1**
4 Bowlers Green	Referrals	1	0	0	1
	Admissions	0	0	0	0
	Discharges	0	0	0	0
	Bed Occupancy	9	9	9	-
Warren Court	Referrals	4	1	3	8
	Admissions	1	2	0	3
	Discharges	0	2	0	2
	Bed Occupancy	30	30	30	-

Lengths of stay are relatively low

Assessment and Treatment Unit

Average length of stay is between 6 and 12 weeks and average A&T bed use described below:

30-40 % of beds	**50 % of beds**	**10 % of beds**
Patients with behaviour that challenges Average length of stay: 12 weeks	Patients under section 2 (depression, psychotic relapse and suicide) Average length of stay: 6 weeks	Placement breakdown/failure Average length of stay: depending on social care assessment

Low and Medium Secure

Average length of stay within the units is detailed below (data for winter 2014 average length of stay):

4 Bowlers Green – low secure unit **(**calculated Q3 2013/14)		**Warren Court** – medium secure unit Calculated July 2015	
Average number of days of stay for Service Users currently detained at 4 Bowlers Green	614.9	Total number of days of stay, for service users discharged [calculated winter 2014 for that financial year to that date]: **4729.0**	
Average number of days of stay for Services Users discharged from 4 Bowlers Green	576	Average number of days of stay, for service users discharged [calculated winter 2014 for that financial year to that date]: **945.8**	

Average bed usage in low and medium secure services is described below:

	Section	**Numbers**
Warren Court medium secure unit current MHA sections	3	1
	37	1 (1 x Herts Patient)
	47	1 (1 x Herts Patient)

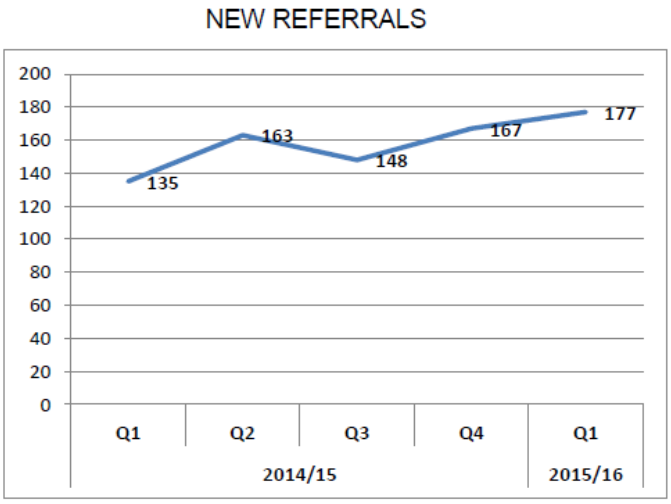
	48	1
	37/41	19 (2 x Herts Patients)
	47/49	6
	48/49	1
Warren Court medium secure unit total = 30 **Herts Patients total = 4**		
4 Bowlers Green low secure current MHA sections	3	3 (1 x Herts Patient)
	37	2
	37/41	2 (1 x Herts Patient)
	47/49	2
4 Bowlers Green low secure current MHA sections total = 9 **Herts Patients total = 2**		

There are opportunities for improvement in delayed transfer of care (DTOCs) within inpatient assessment and treatment services

Delayed Transfers of Care (DTOC) occur due to the lack of robust social care packages within the community, due to poor provider resource and support, or lack of appropriate accommodation. DTOCs can arise following admission to an assessment and treatment unit when a provider issues notice to cease a tenancy agreement or no longer is able to meet a person's changing complex behaviour needs.

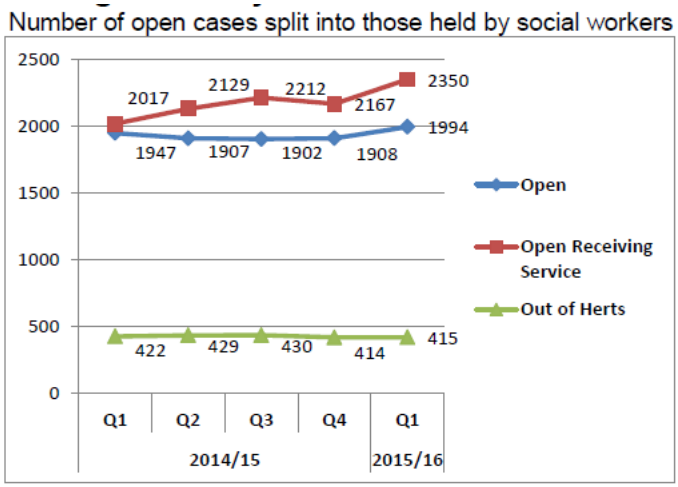
Community Learning Disabilities service (CLDs) are facing increasing demand

In community services there has been an upward pressure on CLDs referrals in the past 12 months.



Approximately a 25% increase from Q1 2014/15

There has also been a rise in the number of cases held by social workers.



A 15% increase for Open Receiving Service from previous Q1 2014/15

This shows that focus on early identification and prevention can lead to reduced community caseload and have an impact on the wider system. This could potentially prevent people from entering the criminal justice system.

6. Vision, Strategy and Outcomes

6.1. The vision for services in Hertfordshire

The vision for services in Hertfordshire described in this document has been developed from the 2014 Joint Commissioning Strategy.

Personalisation is the overarching principle of the Joint Commissioning Strategy. Key areas are:

- Choice and control – adapting what we do to suit people, by working with people and their families as partners
- Living in the community as a full citizen – with local support, leading to a meaningful and safe life
- Better health – supporting people to be healthy as possible
- A capable workforce – working in partnership with providers to employ and develop the right people in their workforce

1. Choice and control

This means people with learning disabilities and their families are involved and in control of decisions made about their lives; maximising choice within the resources available. Working with providers to ensure a strong commitment to providing services in a person centred way; finding creative and flexible solutions to get the best outcomes for people.

What this looks like:

- People with a learning disability have access to good information about their entitlements and know what options exist for meeting their needs
- People with a learning disability, together with their families and carers, are involved in the design and delivery of their support and services
- Good independent advocacy and self-advocacy is available
- People with a learning disability have a personal budget, with more people having their personal budget as a direct payment
- Services work with people with a learning disability to anticipate their future needs and plan accordingly
- Every service user with complex needs has a named care coordinator or keyworker.

The Joint Commissioning Partnership expectations are:

- Service users have clear financial information to support personal budgets

  This means that people have clear information about what they are buying, what they get for the money e.g. support hours and that it is best value for the person and the local authority or health funder (personal health budgets)

- Person-centred practice is integral to all roles in services, providers and practitioners:
  - Working with individuals, their families/carers
  - Open and honest conversations
  - Continual listening with commitment to actions
  - Accurate and respectful recording
- Every service user has a person-centred care and support plan

- There are clear outcomes for people and these can be evidenced
- Children's services and adult services work together with families to plan the transition of children with a learning disability.

2. Living in the community as a full citizen

Everything should be done to allow service users to lead a purposeful life in a meaningful way and be a valued member of the community; to live in the community with access to housing, employment, leisure, training, learning, friendships and relationships.

What this looks like:

- Living in local communities in Hertfordshire
- Having support to build skills to live as independently as possible
- Support to move through the different transitions in life
- Individuals know their rights and responsibilities and are supported appropriately
- Leading a purposeful life that makes sense to the individual
- If it becomes necessary to admit someone into hospital, everything is done to ensure that the hospital stay is as short as possible and that the person returns to a safe and fulfilling life in the community.

The Joint Commissioning Partnership expectations are:

- That there is a range of housing and support and personalised short break services available
- With choice of day, evening and weekend opportunities and support and accessible information about services for people with learning disabilities and their families, including employment options for some.
- People living in restricted environments (locked places, or places without tenancy rights) are continually reviewed with move on plans to community settings in Hertfordshire, with support that is right for them
- That we commission safe services and take prompt action as required where there are concerns
- That there is meaningful progression in people's lives, support for skill building with individual expectations raised and aims identified and met; with good transitions through life
- Innovative thinking with and for people who have complex needs
- A workforce that promotes and supports a balanced approach to risk taking and safeguarding and combating hate crime
- If a person's needs change there is a seamless transfer of care from one service to another
- There is a strong emphasis on prevention of behaviour that challenges and early intervention to avoid and resolve crises where possible
- A register is maintained of service users who are risk of needing a hospital admission, and person-centred contingency plans are devised to reduce these risks.

3. Better health

People with learning disabilities getting the healthcare, support and information they need to live healthy lives.

What this looks like:

- Improved life expectancy
- Reasonable adjustments routinely made as required for individuals by all health services
- Good management of existing health conditions
- High uptake by, and support for, people with learning disabilities to receive quality health checks
- Social care workforce who understand and robustly support the health needs of people with learning disabilities
- High quality, evidence based specialist health services

The Joint Commissioning Partnership expectations are:

- That social care contracts are changed to include clauses on supporting health needs
- All partners, health and social care, sign up to the Joint Strategic Plan for Challenging Behaviour and associated pathway That there will be an increase in uptake of Annual Health Checks, with good health action plans and appropriate follow up
- All health services embrace and act on the recommendations of CIPOLD (2013) and the Mencap Charter for Clinical Commissioning Groups (2013)
- Health services, public and private, embrace the Purple Strategy and sign up to the Purple Promise
- Health and social care partners and providers contribute to the annual Joint Health and Social Care Assessment Framework and take on actions from the improvement plan
- Improved awareness, by the health workforce, of individual communication needs and reasonable adjustments required.

4. A capable workforce

This is about employing the right people with skills, knowledge (or ability to develop them) attitudes and behaviours, who are well supported in their practice. This applies across all providers and includes befrienders and Personal Assistants.

What this looks like:

- A work force that is adaptable and flexible, multi-skilled and confident in their role
- Respects dignity, choice and control and is compassionate
- Enabling people with learning disabilities to live their lives around their aspirations and aims
- Services are designed and resourced around people not service led

The Joint Commissioning Partnerships expectations are:

- The workforce is signed up to this strategy
- Employers will ensure that their workforce has the right attitudes and behaviours and that they are able to ‘stick with’ people following episodes of crisis.
- Person specific learning and development needs are identified and are not limited to mandatory training
- Commissioners and contract managers will robustly monitor performance management and development processes and support in provider services
- People with learning disabilities and their families are always involved in the recruitment of staff and trained and well supported to do this

- People with learning disabilities and their families are active in learning and training of the workforce in health, social care and community services
- There is a skilled and confident workforce to work with people with the most complex needs and people whose behaviour challenges.

6.2. The outcomes this will deliver

The outcomes that Hertfordshire aim to deliver through this vision are:

- More people with learning disabilities will be supported to live in the community / at home
- Fewer people will develop behaviours that challenge and those who do will be kept safe in their communities
- Fewer people will be admitted to secure hospitals
- Any hospital stays will be as short as possible.
- Any hospital stays will be as close to the individual's home and support networks as possible
- There will be fewer inpatient beds in Hertfordshire.

The planned trajectories (submitted to NHSE as per Fast Track requirements) for improvement in these key metrics are identified below:

Assessment &Treatment (A &T) beds

A and T beds	2014/15	2015/16		2016/17		2020		Total Change over the period	
	Baseline	Number	% Change	Number	% Change	Number	% Change	Number	% Change
Reduction in admissions									
Total number of adimissions (all beds):	10	10	0.0%	10	0.0%	10	0.0%	0	0.0%
Reduction in length of stay									
Average length of stay:	n/a	90		85		75		#VALUE!	
Increase in number of discharges									
Total number of discharges (all beds):	0	30		32		40		-40	
Number of beds to be closed (Forecast 6.8% of total admissions):	0	0		0		0			
Number of beds actually closed:		0	#DIV/0!	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!
difference:		0	#DIV/0!	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!

Specialised Commissioning (Hertfordshire population)

Total number of beds (including Specialised medium & low secure)	2014/15	2015/16		2016/17		2020		Total Change over the period	
	Baseline	Number	% Change	Number	% Change	Number	% Change	Number	% Change
Reduction in admissions									
Total number of adimissions (based on patient numbers not beds):	28	3	89.3%	3	89.3%	2	92.9%	26	92.9%
Reduction in length of stay									
Average length of stay:	827	600	27.4%	500	39.5%	300	63.7%	527	63.7%
Increase in number of discharges									
Total number of discharges (patients):	7	4	42.9%	5	28.6%	1	85.7%	6	85.7%
*Number of beds to be closed (Forecast 6.8% of total admissions):	8	3	37.5%	3	37.5%	2	25.0%		
Number of beds actually closed:			0.0%		0.0%		0.0%	0	0.0%
difference:		-3	-37.5%	-3	-37.5%	-2	-25.0%	-2	-25.0%

	Baseline	8*
NOTE:	17 LSU 9 MSU 2 CAMHS	*Illustrates a reduction in patient numbers, as beds are commissioned for Herts population across a variety of secure care providers. We would not suggest that HPFT (Hertfordshire) close a total of 7 beds. Within these Low / Medium secure service, futher work throughout the Fast Track may however result in a number of secure beds with Low / Meduium in HPFT closing*

NB – secure provision is managed by specialist commissioning. There is a procurement pending led by NHSE.

SRS (Specialist Residential Services) services

Total number of beds SRS beds (Herts patients)	2014/15	2015/16		2016/17		2020		Total Change over the period	
	Baseline	Number	% Change	Number	% Change	Number	% Change	Number	% Change
Reduction in admissions									
Total number of adimissions (all beds):	0	0		0		0		0	
Reduction in length of stay									
Average length of stay:	n/a	na		n/a		n/a		#VALUE!	
Increase in number of discharges									
Total number of discharges (all beds):	0	2		2		3		-3	
Number of beds to be closed (Forecast 6.8% of total admissions):	0	2		2		3			
Number of beds actually closed:		0	#DIV/0!	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!
difference:		-2	#DIV/0!	-2	#DIV/0!	-3	#DIV/0!	-3	#DIV/0!

NB: In relation to the SRS beds , of the 10 beds commissioned on behalf of the Hertfordshire population work with the families to date including detailed CTR's suggests that 7 could be supported to move in their best interests to accommodation that could meet their changing needs more appropriately. Commissioners will not make any plans or proposals to move any residents however unless it is in the best interests of the residents concerned to do so. Plans put forward are currently subject to approval by the Official Solicitor/Court of Protection. The trajectories submitted take into account that over the next 2/3 years there may be some movement with expected bed closure as and when residents can be appropriately moved. There have been no new admissions to the SRS since the provision opened.

7. The new model of Care

7.1. An integrated model of care

Hertfordshire is proposing a radical new model of care that is:

☑ **Integrated and person-centred**

This means services will not be delivered sequentially with multiple hand-offs / referrals but rather through a single referral to an integrated team of experts who consider the person in whole.

☑ **Intelligent**

This means knowledge will be used across communities, public services professionals and providers to deliver what people need, when they need it.

☑ **Preventative**

This means more activity will brought upstream reducing the likelihood of crisis.

☑ **Life-long**

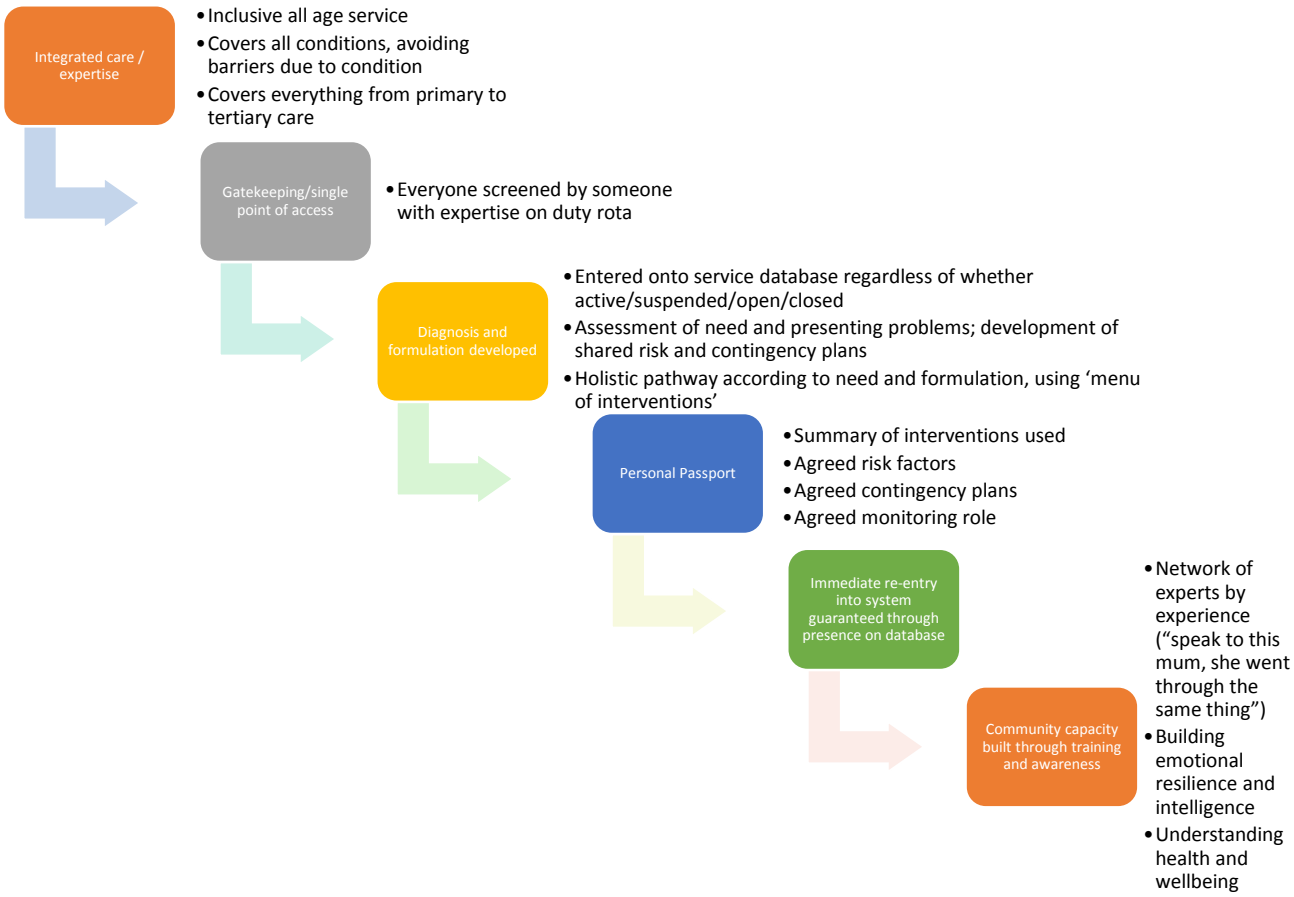
This means patients will be managed by a single team across their life, beginning as soon as they are identified.

☑ **Inclusive**

This means a wide-range of conditions and challenges will be covered to provide greater opportunity for pooled expertise and learning.

This model is built around a **common life-long pathway** and **capable communities** that support the individual through their life. This pathway is illustrated overleaf and is built around 6 key elements:

1. Integrated care and expertise
2. Gatekeeping with a single point of access
3. A single diagnosis and formulation
4. A personal passport
5. Immediate re-entry into the system guaranteed through presence on a database
6. Community capacity



7.2. The benefits of this model

This proposed model is built around the principles of the Joint Commissioning Strategy:

1. It is a person-centred model, in support of the principles of Personalisation.
2. It provides choice and control through a single team and a personal passport.
3. It promotes living in the community as a full citizen through the management of the personal passport with an agreed monitor in the community, and through earlier identification to reduce the likelihood of crisis and inpatient treatment.
4. It promotes better health through earlier intervention.
5. It supports a capable workforce through the pooling of expertise and the breaking down of organisational and professional boundaries.

Through using a single integrated team acting to common and shared processes, this model will also drive the changes recommended in the 2015 CAMHS review in providing:

- More accessible support
- Stopping a trend towards crisis management and being more proactive
- Providing essential data
- Actively involving a range of local agencies.

7.3. Critical success factors for this model

This model is a radical development on the current model of care and hinges upon the following key changes:

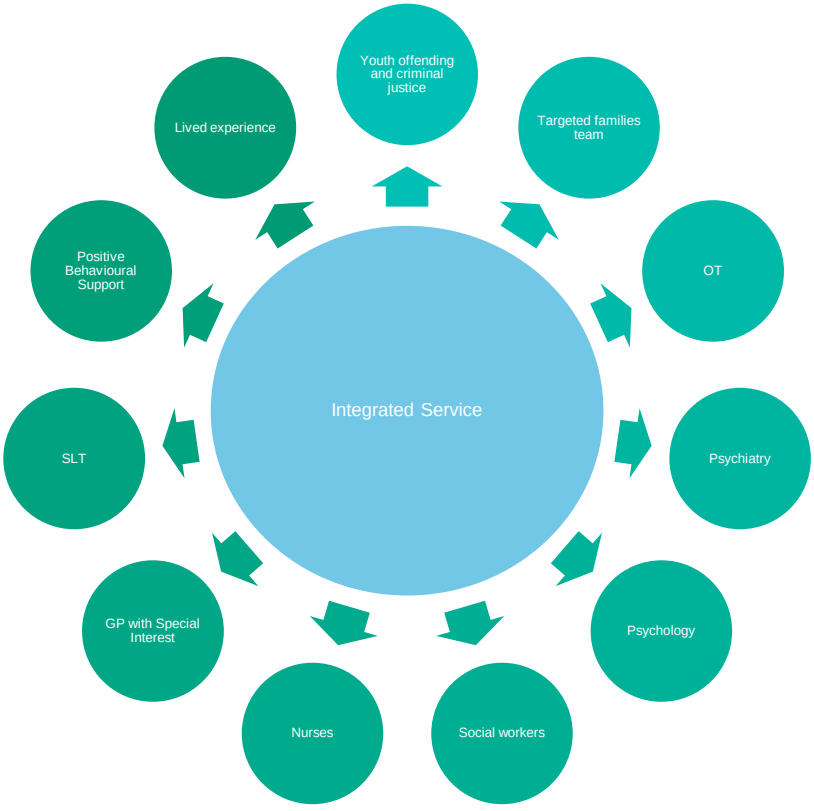
☑ **Early detection, prevention and intervention**

- Identification of individuals at risks – children in particular – at an early stage and prevention of behaviour that challenges[1], including the use of a "Risk Register" of all ages to early identify individuals at risk of admission and provide early intervention alternatives to avoid hospital admission (when possible).
- Crisis prevention and risk management. Identification of individuals at risk of break down, monitoring of individuals needs in order to prevent crisis, provide support to allow individuals a stable, meaningful and safe life.
- Advocacy

☑ An **integrated team**, working in a new way, including:

- Integrated referrals meeting (lack of cross over, breaking down silo) with case discussion (people at risk of admission/breakdown)
- Joint paper work (eg. patient passport)
- Joint and social care assessment need document
- Operating entirely separate
- Joint database (separate IT system but have access to both IT systems)
- A new care and treatment review policy

☑ A **patient passport** that identifies the trigger points and wrap around care that each person will receive.



[1] There is a missed opportunities with adults at a younger age and difficulties in making any changes in later life and benefits of very early intervention by age 7 to have better results.

☑ The coordination of services around the person through the community. There is **no discharge** from the integrated service, but rather lifelong management to a plan that will draw on various services managed, wherever appropriate, in the community.

☑ A **culture of personalised care**
- Understanding the person needs in order to provide the right support
- Family support and engagement across the whole pathway
- Embed a person centred care culture in the organisation and workforce

☑ **Workforce planning** and **workforce development**
- Multi agency / multi-disciplinary workforce planning to determine the scale and form of the workforce required for Transforming Care (e.g. Skills for Care fund)
- A multi-agency/multi-disciplinary workforce to support the specific needs of individuals who have complex needs or who may display challenging behaviour
- Ensure the workforce support is person centred, preventative; strength based and enable people to lead full and meaningful lives whilst ensuring that they and their communities remain safe.

☑ **Housing and support** to individuals/families
- Innovative solutions in designing housing and support packages (e.g. supported living, shared life scheme) to meet individuals needs and enable them to live a fulfilling life in their community
- Solutions to help families of those identified to be nearing or in crisis
- Involve families in the co-production of care
- Flexible respite care support
- Balance community safety whilst ensuring individuals safeguarding

☑ **Step down and crisis prevention** options available in social care to avoid admission to hospital.

☑ Private sector **partnership working** with independent and private hospitals

☑ **Better understanding** of certain key groups, including:
- People with learning disabilities and dementia
- Women with complex needs (learning disabilities and mental health, including Personality Disorders)
- Young people with autism and in transition
- People in low/medium secure units

These critical success factors will be enabled by the following:

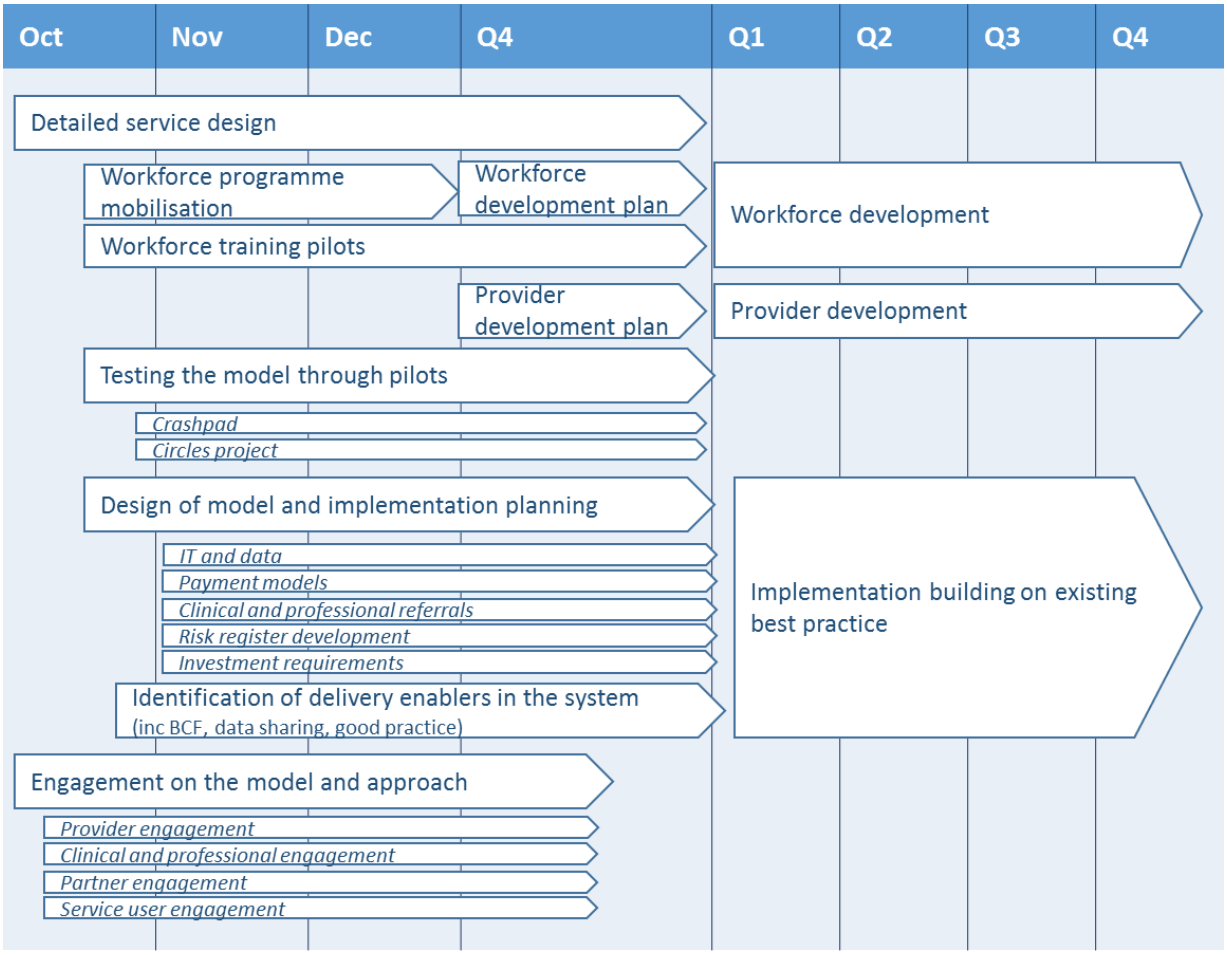
- **Time** – taking the time to build this model over several years.
- **Incentives** – ensuring commissioners create the right collective incentives for providers.
- **Processes** – creating processes that are common and facilitate the model.
- **Capability and capacity** – building the capability of the workforce to recognise needs and putting capacity where can have the greatest impact earliest.
- **Shared systems** – interoperable systems, shared patient records and the means of pushing intelligence to where it is needed, when it is needed.
- **Cultural change** – a common culture that cuts across organisational boundaries.

8. Plan for success

8.1. Our plan of action

We recognise that this model will not be implemented overnight and will require significant further engagement and detailed design followed by incremental changes to ensure the continuity of services as changes are implemented.

Our roadmap for the next 12-18 months is detailed below:



This plan contains the following key elements:

- Detailed service design to further understand what good looks like (Oct 15 to Mar 16)
- Further engagement on the model with providers, service users, workforce and operational delivery teams to support design work (Oct 15 to Mar 16). This will need to include engagement with social care and housing colleagues to address DTOCs challenges in securing placements and support packages in the community.
- Mobilising a workforce development and training programme to understand the workforce constraints, opportunities and requirements for the model (Jan 16 to Jun 16). This will need to include working closely with HEE to understand the gaps in our current workforce model and where new training will be required.

- Provider development to build the community capacity to deliver this model (on-going programme of engagement and development through FY16/17 and beyond)

- Running pilots to understand key elements of the model (Dec 15 on-going). These would include:
    - piloting the Crash pad/Crisis House model to provide respite / alternatives to A&T in crisis
    - piloting the Circles project for managing transitions out of prison

- Working with other system enablers and changes to support the design of the model and the moves towards implementing it. (On-going). This includes:
    - Identifying, celebrating and expanding on current good practice in delivering person-centred care in Hertfordshire
    - Using the BCF to drive pooled commissioning and joint risk sharing for these services
    - Using existing data sharing / inter-operability programmes as a vehicle for delivering the needs of the future model
    - Using joint agency working to support intelligence development (eg with the Police, education and justice).

- Developing detailed requirements and options for transition for the following key components:
    - IT and data
    - Payment models,
    - Clinical and professional referral protocols
    - Risk register development
    - Understanding of investment requirements

- Continuing to manage the immediate caseload, including developing the SRS plan and providing crisis support for the young and elderly.

8.2. Our investment plan

As detailed in the separate funding bid, Hertfordshire has already invested significantly in improving the services for its people. It has invested / committed to more than £7.5m since 2013. The bid seeks further funding to the total of £1,643,500 to support this development further. Further information can be found in the attached bid.

Appendices

Service specification – Main Mental Health Contract which includes Learning Disability Service and Child and Adolescent Mental Health Services (CAMHS) Services

Service specs (MHC).doc

Service specification – Child and Adolescent Mental Health Services (CAMHS) Tier 1,2,3

CAMHS Specs (FINAL CONTRACT VI

Service specification – PALMS Services

SCHEDULE 2 - PALMS Service spec.