

Appendix a

Transforming Care Fast Track – Briefing to Health and Wellbeing Board

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Transforming Care

- Individuals in Hertfordshire with learning disabilities and/or autism who may have:
 - A mental health condition but not limited to severe anxiety, depression or a psychotic illness
 - Self-injurious or aggressive behaviour
 - A specific neurodevelopmental syndrome, with complex life-long health needs
- Behaviour which may put themselves or others at risk Other health or social care needs and disadvantaged backgrounds
- 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

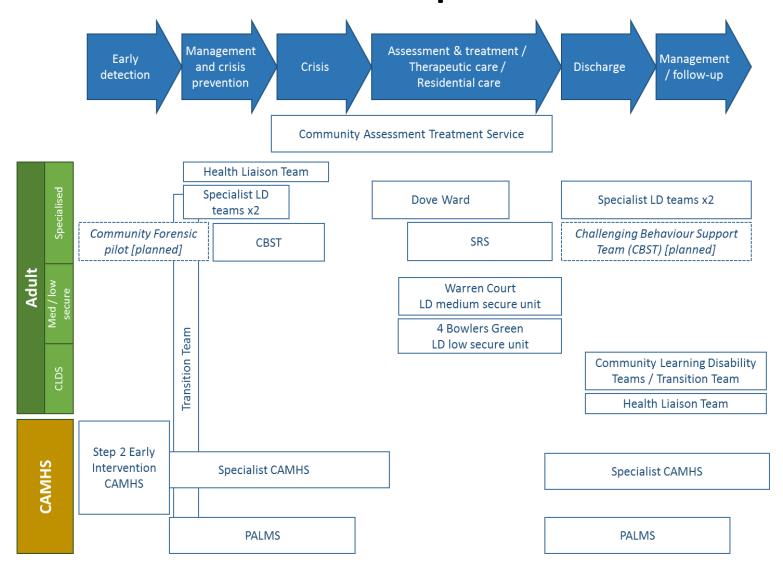
Fast Track Pilot

- The Fast Track areas are six selected sites across the North of England and Midlands and East to help achieve the ambition set out in the Learning and Disability Transforming Care programme
- 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.
- Hertfordshire awarded £1.2m to accelerate service redesign and pilot new projects

Hertfordshire Background

- Low bed base
 - Reduced inpatient beds LD rehab beds from 46 to 10, but this makes savings more challenging
 - Monies invested in Specialist Learning Disability Service
 Community Assessment and Treatment Service.
 - Resettlement of 22 people with long history of inpatient care through Positive Moves teams
 - Care and Treatment Reviews carried out for all Transforming Care cohort, with plans in place for every individual in that cohort
 - System for Pre-admission CTR's in place

Current provision



LD Service Redesign – Hertfordshire Vision

- Integrated and person-centred
- Inclusive
- Preventative
- Intelligent
- Lifelong, all age pathway

Model of Care – Common Lifelong Pathway

•Inclusive all age service Covers all conditions, avoiding Integrated care / barriers due to condition expertise •Covers everything from primary to tertiary care Gatekeeping/singl • Everyone screened by someone with expertise on duty rota e point of access **Personal Passport**

- •Entered onto service database regardless of whether active/suspended/open/closed
- Assessment of need and presenting problems; development of shared risk and contingency plans
- Holistic pathway according to need and formulation, using 'menu of interventions'

Summary of interventions used

- Agreed risk factors
- Agreed contingency plans
- Agreed monitoring role

Immediate reentry into system guaranteed through presence on database

> Community capacity built through training and awareness

- Network of experts by experience ("speak to this mum, she went through the same thing")
- Building emotional resilience and intelligence
- Understanding health and wellbeing

Pilots

- £1.27m secured (non-recurrent) for Hertfordshire
- Circles of Support to support people with LD and a Forensic history in the community
- Crash pad preventative, avoidance of inappropriate hospital admissions
- Crisis Support team similar model to Home
 Treatment teams
- Workforce development/training
- Creative Rehab for inpatient/community

High-level Plan

Oct	Nov	Dec	Q4	Q1		Q2	Q3	Q4		
Detailed service design										
Workforce programme Workforce development plan Workforce training pilots					Workforce development					
	Provider development plan					Provider development				
Testing the model through pilots Crashpad Circles project Design of model and implementation planning IT and data Payment models Clinical and professional referrals Risk register development Investment requirements Identification of delivery enablers in the system (inc BCF, data sharing, good practice) Engagement on the model and approach Provider engagement Clinical and professional engagement Partner engagement Service user engagement				Implementation building on existing best practice						

Governance

