Leicestershire Partnership NHS Trust

All Age Transformation
Transforming our mental health and learning disabilities services

Draft – Key Design Features Document

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Introduction

The All Age Transformation Programme was set up in late 2017 with agreement across Leicestershire Partnership NHS Trust (LPT), the Clinical Commissioning Groups (CCGs) other NHS Trusts and local authorities within Leicester Leicestershire and Rutland. It was set up to focus on improving all mental health and learning disabilities services delivered by LPT. While some of these LPT services have been meeting demand and delivering a good quality of care, many consistently struggle with long waiting lists, difficulties in meeting the demand for services and not meeting service user expectations. This has been evident in previous Care Quality Commission (CQC) findings as well as service user and staff surveys.

The approach to the All Age Transformation Programme was inspired by how the outstanding Northumberland, Tyne and Wear NHS Foundation Trust (NTW) approached changing themselves. Their change methodology was adapted to suit LPT's local needs and priorities and the programme was set up to be undertaken over 5 years.

Across the duration of the programme the understanding of what to change, the design and ultimate implementation of changes is achieved using several key methodological approaches:

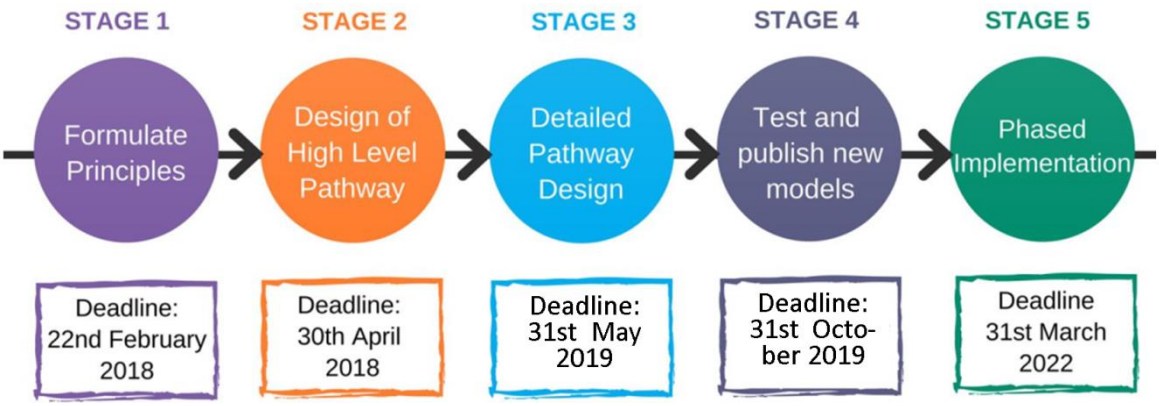
- Co-design — bringing the views of staff, service users, carers and other stakeholders together to understand and design (usually in workshops)
- Data analysis — analysing data and observation to understand where we can improve the areas of the work and ultimately the impact of changes made
- Quality Improvement cycles — when implementing change to use improvement cycles to refine the changes being made and ensure improvement is being achieved

All of the different aspects of the work have been focused primarily upon **Adding Value** to the people that use our services. To help achieve this there is focus on **removing the things that get in the way** of LPT staff adding that value and **improving the processes and systems** to work better for service users.

Adding value – Increasing the things that add value to the people that use our services	**Removing the things getting in the way –** enabling clinicians to have more time to spend with service users and creating a better working life for staff
	Making the processes and systems better – ensuring the best journey experience for service users throughout

Progress so far…

LPT sets out to support a wide diversity of needs through its array of mental health and learning disabilities services. There are too many different services to be able to meaningfully work through all of them in the time that the All Age Transformation Programme has been running. Therefore the programme has been organised into two waves (Wave One and Wave Two). The focus of the programme to date has been on community based services in ***Wave One,*** which has been set out in a series of layers of design leading to a published model and its implementation. These layers are described over 5 stages:



The first stage set out to understand what excellent looks like for staff, service users, carers and stakeholders (such as local authorities, GPs and the voluntary sector). Hundreds of views were received through surveys and workshops. These views were thematically analysed into a set of principles that describe what excellent looks like for how people access services, have their needs assessed, receive treatment and leave services. Follow the link to these principles.

The second stage brought together service users, carers, staff and stakeholders into four week long workshops (access, assessment, treatment and discharge) with many other staff and stakeholders feeding in during each week. Using the principles from stage 1, the attendees developed high level designs of how mental health and learning disabilities could work better. There were over 50 different elements to the designs that came from the four weeks. Follow the following links to those summaries (Access, assessment, treatment, discharge)

The third stage has taken forward the different design elements from stage 2 into many different workshop days (more than 60) with staff, service users, carers and stakeholders focused in creating detailed designs.

What is this document?

This document summarises the **key features** from the end of Stage 3. It has come together from the many months of co-design workshops that have brought together hundreds of LPT staff, service users, carers and stakeholders. It is also been informed from the extensive detailed analysis of LPT service data and hundreds of hours of observing and learning directly of what is working well and what isn't within LPT's mental health and learning disability teams.

The key features will be brought together with a draft workforce model and proposed set of service structures to form a complete draft model at the end of May 2019. See next steps section for more information.

Key Features from Transformation design

This section provides details of all of the key design features that have come out of the Transformation programme to date. The key features of the transformation design to date are described under three sections:

1. Design features and principles that go **across all** mental health and learning disabilities services
2. Specific aspects of design that **require all** mental health and learning disabilities to make changes and work together
3. Specific aspects of design that **effect specific parts** of the mental health and learning disabilities services but not all of them.

These sections are described in turn below.

Section 1: Design features and principles that go across all mental health and learning disabilities services

We will have a common *approach to our care* across all of our mental health and learning disabilities services. We will have *distinct specialties* within our mental health and learning disabilities services that provide specific expertise to groups of service users who, through particular life stages or other reasons, have commonality in their needs. However in recognition that everyone is different and people's needs change over time, we will also work together. We will *share expert knowledge*, collaborate across services, and bring expertise together around each service user. The majority of service users will receive care through *geographically organised teams that are* linked and aligned to the primary care networks (patches of GP practices) to help increase future joint working with GPs and other community services. Service users will always have an individual within LPT's mental health and learning disabilities services *coordinating* the care and support that is offered to them.

Key Feature: Our approach to care

That all LPT mental health and learning disabilities services promote and measure their compliance with the following approach to care:

- We are **Person Centred** in how we support a service user to ensure we meet their individual needs.
- We will help individuals' identify **their Goals** and describe what **Quality of Life** means to them, to shape the treatment and support we offer.
- We **Focus on People's Strengths** in the support we provide and look to build upon their capabilities when planning and delivering treatment and support.
- We will maintain a **Positive Perspective** free of judgement and prejudice and promote wherever possible individuals' making **Choices** and taking **Control.**
- We will help people to **Connect** and strengthen their **Social Networks** to increase the number of people they can turn to when they need support and assist them to develop a social identity.
- We will support people to **Identify** and **Use the Assets** available to them in and around their lives that can help them to stay well.
- We will help individuals to find **Hope**, **Aspirations** and **Motivation** in their health and life journey.
- We will help individuals to **Overcome Stigma** and form a **Positive Sense of Self** and **Identity** and not define themselves by their illness or diagnosis.
- We will support and encourage individuals to identify the things that give them **Meaning and Purpose** in their life.
- We will promote **Empowerment** of individuals to build on their strengths, take personal responsibility and control of their lives.
- We will **Collaborate** with individuals in decisions about their treatment and support.
- We will organise and deliver our services so that they are **Inclusive** and do not unduly exclude anyone.
- We will use **Language** that promotes collaboration, balance in power and creates equal understanding between service user and practitioners.
- We will work with other agencies supporting an individual to **Join Up** support wherever possible.

It is expected that Our Approach to Care will be incorporated into our ongoing quality measurement of services.

Key Feature: Distinct specialties that work together

There will be four broad and distinct specialties within our mental health and learning disabilities services focused on:

- Children's and Young People (CAMHS – Children's & Adolescent Mental Health Services)
- Adults (AMH – Adult Mental Health)
- Older People (MHSOP – Mental Health Services for Older People)
- Learning Disabilities (LD – Learning Disabilities)

The four specialties are designed mainly around life stages and commonality of needs and not by age alone. Each specialty will be made up of staff with specific expertise and training to offer tailored support and interventions. An individual starting an episode of care with our services will be streamed to a particular specialty based on their specific needs through the Central Access Point (described in section 2). All specialties will work together to support service users' individual needs irrespective of which specialty they are initially streamed into. Where individuals require expertise from more than one specialty or team, then this will be provided (described in additional support and expertise key feature).

Service users and carers have described that continuity and coordination of care is important and needed to be maintained wherever workable. However there may be a point or points in their care journey that their needs would overall be better supported within another specialty. In this case, there will then be a transition between specialties that will feel planned and seamless and will:

- be undertaken when it is in the best interests of the service user (determined in conjunction with the service user). This will be mostly informed by the different expertise offered by practitioners in an alternative specialty being more appropriate for the service user's needs.
- see practitioners between different specialties working together alongside the service user (and significant others to the service user) to continue and evolve the individual's care plan.
- not solely occur on an individual's birthday.

Common transition points

The following are common transition points between specialties:

- Children's and young people's specialty will initially[1] focus on childhood and adolescence. Any transition will commonly occur as individuals move into adulthood.

[1] Over the next 5-10 years it is expected that the children and young people's specialty will also focus on young adults as well as childhood and adolescence. This is part of the NHS long-term plan. https://www.england.nhs.uk/long-term-plan/

- A transition to older people specialty will commonly occur when individual's develop dementia and/or have developed both complex physical and mental illness and/or have a mental illness where aging in and of itself is influencing the needs of the individual.

It is expected that all service specifications and criteria will be altered to reflect the above approach.

Key Feature: Continuity and coordination through Professional Lead / Care Coordinator and 'team around the service user'

Continuity and coordination of care is important to service users and needs to be maintained wherever workable. Specialist mental health and learning disabilities services are delivered through multi-disciplinary teams.

Care coordinator / lead professional

Each service user will have a Care Coordinator (also referred to as Lead Professional) who will be part of the multi-disciplinary team (MDT) that is supporting that service user. On the majority occasions this team will be in a specific geographical area (described in geographical patches below). The Care Coordinator / Lead Professional is an individual who takes responsibility of coordinating the care that is provided by LPT and linking, where appropriate, with other services outside of LPT. Where an individual has a high degree of complex needs (as defined by the LPT CPA policy) the Care Coordinator will take on specific duties associated with enhanced CPA.

Team around the service user

The individual service user may require expertise and support that is not routinely part of the local MDT. This may be because there are a few LPT staff with that particular expertise and they need to support several different multi-disciplinary teams at once. These experts will be directly involved in planning and discussions with the local MDT relating to a service user and their individual needs.

This will help to maintain the continuity and coordination of support and be organised to efficiently use the experts' time.

Key Feature: Additional Support and Expertise Process

There will be occasions where the broad specialties and the local MDTs within those specialties do not have all of the expertise and skills to support a service user's individual needs. In such instances the service user's practitioners can seek additional expert support. To support both continuity and resources management there is a ladder of support for the practitioner involved in the service user's care. The level of support required is broadly described in the following basic framework:

• **Transition to another MDT**: (see distinct specialties that work together)	where majority of a service user's care requires expertise and skills that are not available in the local MDT
• **Additional**: (see Team around the service user)	where additional expert support is required to undertake specific tasks / interventions
• **Supported**:	where a practitioner can deliver specific tasks / interventions with the support of another expert
• **Independent**:	where a practitioner can deliver specific tasks / interventions without support

Supported capacity

When a practitioner requires expert support to deliver specific tasks / interventions or assess an individual, they can request expert support from anywhere in the mental health and learning disabilities services (including across the broad specialties). Different levels of support can then be offered to service users as required. The different levels of support are described by the expert (from outside or within Local MDT) to:

- Provide phone advice to practitioner **or**
- Provide case supervision, coaching and support practitioner's planning **or**
- Provide joint (practitioner and additional expert) contacts with the service user for a brief time **or**
- Provide specific interventions jointly with practitioner (where both practitioner and additional expert need to support each other)

Practitioner time will need to be made available to provide supported capacity[2].

[2] Local arrangements will need to be established to ensure that practitioner can access further expertise when required. This can include 'practitioner support slots' in practitioner diaries, electronic tasks and strong directory of different expertise within services. Some practitioners are more likely to provide expert support than others based on their role and these should have more structured arrangements to be accessed and offer support.

Combination of expertise

Combining expertise from across broad specialties to meet individuals' specific needs can occur from the point of access into services (see Central Access Point).

Key Feature: Community teams and geographical alignment

The majority of service users' care will be delivered through geographically aligned local teams. Those geographical patches will be set around groups of GP practices known as Primary Care Networks (PCN). This is to meet the National direction of greater integration between primary and secondary community care and increase joint working across physical, mental health and social care services.

There are likely to be around 26 PCNs in Leicester, Leicestershire and Rutland. Each geographically aligned local team will be organised around three or more of these PCNs. As each broad specialty differs in size, they may need to align to a different number of PCNs to maintain a critical mass of staff in each team. However to support joint working between the specialties they will also need to align well with each other.

The exact geographical alignment of each team will be mapped out after the transformation programme's structural design process in April and May 2019 and when confirmation of the boundaries of the PCNs has been received to LPT.

Geographically Aligned Teams

For each broad specialty it is expected that, wherever possible, the different expertise will be organised into geographically aligned teams. This is to strengthen local MDTs, support diverse service user needs and help teams to understand and manage flow and resources. Small groups of experts are likely to be too small to organise into community teams and will need to work as described in *Team around the service user*.

Section 2: Specific aspects of design that require all mental health and learning disabilities to make changes and work together

We will have a *Central Access Point* that all referrals and individual enquiries for mental health and learning disabilities can be made to. This will be available for health professionals, people involved in our services and people who have a General Practitioner (GP) within Leicester, Leicestershire or Rutland. It will support people's general enquiries and help navigate people to the right help both inside and outside of LPT services. If an individual being referred or referring themselves to the Central Access Point is in *crisis* or has urgent needs then their needs will be assessed promptly at any time of the day across 7 days a week.

When an individual's referral (self or through a health professional) for specialist mental health and/or learning disabilities is non-urgent, it will be reviewed within a working day (at least initially on weekdays). If there is a need for further assessment and treatment then an appointment with the right specialty (or combination of specialties) experts will be made there and then.

As part of the assessment phase of a service user's support needs, health professionals will collaborate on developing a care plan (or update one that they had already). This is a *shared plan* between the service and the service user. Any practitioner involved in a service user's care contributes to this one plan. It will also commonly be shared with the service user . This plan will help guide the GP on ways that they can support the service user, both whilst the individual is under the specialist LPT service and also when they leave LPT services. The clearer guidance and improved access arrangements are expected to help people transition between specialist mental health and learning disabilities services to primary care (GPs) easier.

Whilst individuals are receiving specialist services they are likely to have a wide array of other support needs alongside their mental ill health or challenges with their learning disabilities. There will be *improved navigation and connection* offered in our community services with groups, services, procedures and activities that could help their other needs. This will both improve service user's access to support available and release time of professionals to utilise their specialist skills. There will also be individuals who have lived experience of mental health or learning disabilities recruited to teams to support service users' care journey.

Key Feature: Central Access Point for Mental Health and Learning Disabilities

There are several different elements to the Central Access Point. Figure 1 shows the referral and triage process and a detailed description is provided below.

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Transforming our mental health and learning disabilities services

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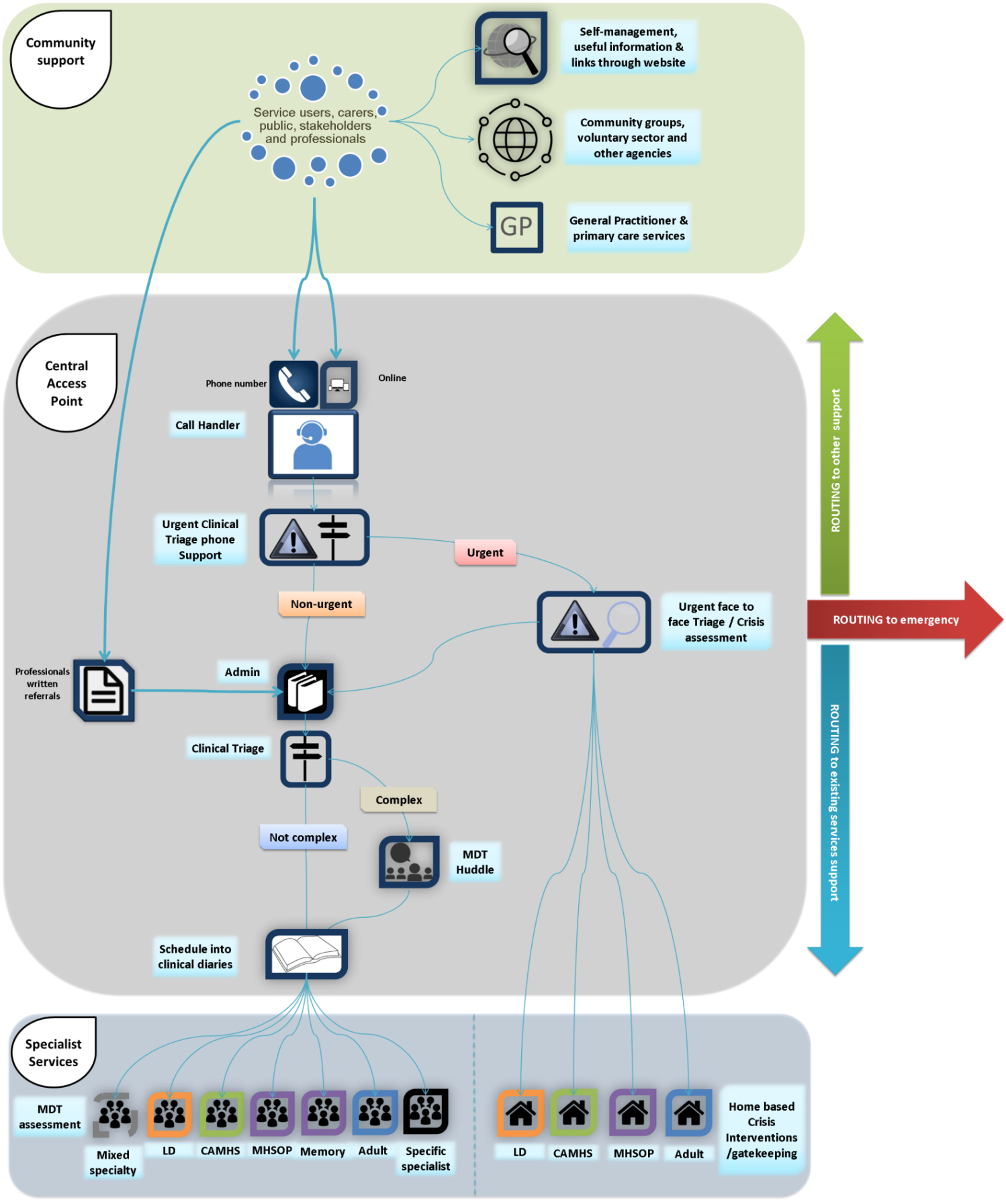


Central Point

The Central Access Point will be a central point for:

- All referrals for mental health and learning disabilities[3]
- All mental health crisis referrals
- All phone enquiries (e.g. general, advice, appointment related etc)

When assessments are required the Central Access Point will be aspiring to:

- Undertake urgent assessments within four hours of referral.
- Schedule non-urgent assessments within a working day of referral.

Community Support

There will be information for self-guidance and support available on LPT's website and advertised in different community venues. This is to help people to be aware of what support may be available to them in primary care (such as IAPT) and the community (such as services run in the voluntary sector). There will also be key contact information for them to self-navigate to these resources.

Contacting the Central Access Point

If service users, carers, stakeholders, public or professionals believe that they need to speak to and/or access specialist mental health services they will have initially three ways to do so.

Written referral from professional

Professionals, like GPs, will be able to make a written referral through the electronic system they use or through a letter. This will be received and logged by the Central Access Point Administrative Team and then reviewed by a clinician as part of clinical triage (this is described in more detail under 'clinical triage').

Phone call

Service users, carers, stakeholders, public or professionals will be able to ring the Central Access Point number. This will be answered by a call handler. The call handler determines the nature of the enquiry and some initial information. The call handler will manage the call if the nature of the call is not directly clinical such as general information, appointment changes (that the call handler can amend) or navigation advice. If the nature of the call is clinical then they will direct the call to

[3] There may be an alternative 'Triage and Navigation hub' commissioned specifically for children and adolescence referrals. If in place then processes will need to be established for two access points to seamlessly work together. This could work initially by referrals for CAMHS that are received directly to the Central Access Point being redirected to this new hub and referrals accepted. Any specialist CAMHS referrals agreed at the hub will be routed to the central access point for scheduling appointments.

either the individual's existing clinician (if the caller is known to services) or urgent triage practitioner (this is described in more detail under urgent clinical triage below).

Online enquiry

As an alternative to a phone call, service users, carers, stakeholders, public or professionals will be able to use a secure digital platform to make contact with the Central Access Point. This will be using LPT proven technology (Chat Health) and provide an alternative to phone contact for individuals. The online queries will be managed similarly to the phone call described above. It is recognised that clinical related queries may need to be transferred to phone contact to best support people's needs.

Urgent clinical triage phone support

The urgent clinical triage will be made up of practitioners with skills and knowledge from each of the broad specialties (see distinct specialties that work together key feature). There will be urgent clinical triage available 24 hours a day, 7 days a week. Additional analysis is planned to estimate the shift pattern and the number of practitioners required at given times of the day. The urgent clinical triage practitioner will undertake one or more of the following to support individuals:

- provide telephone advice to inform care and treatment, and advise on a range of clinical issues and/or
- provide telephone support to calm and de-escalate where there are difficult situations and/or
- organise or undertake a face to face triage (this will be undertaken by the same practitioner where achievable) and/or a face to face crisis assessment
- transfer (this can be directly or by tasking depending on practitioner availability) to non-urgent clinical triage to focus on identifying the right non-urgent service to support the individual (see non-urgent clinical triage)

In all instances the person taking the call is focused on ensuring the caller gets the right support for their query.

Urgent face to face triage and/or assessment

If the urgent clinical triage practitioner, in collaboration with the caller/referrer, identifies a need for crisis assessment then this will be organised. Again the practitioner with the right skills and knowledge of the relevant specialty will be allocated for this assessment. It is expected that the service will work towards this being undertaken **within 4 hours** of the initial contact with the Central Access Point.

The urgent clinical triage practitioner may need to see a caller face to face to help identify whether or not they need a crisis assessment and what support to offer. If the individual requires a full crisis assessment then the practitioner will move from triaging to undertaking the assessment.

From the assessment the practitioner with the service user (and carer wherever relevant) will identify the right support for their needs. This could include:

- self-management plan and/or routing to alternative services outside of LPT
- Home based crisis interventions (see Crisis support)
- Non-urgent additional assessment[4]

Admin

The non-urgent written referrals will be organised by the Administrative Team who will provide:

- Initial information gathering to support triage and future assessment
- Book and re-book appointments for service users' initial assessment appointments
- Scheduling and tracking to ensure service users are booked for an appropriate appointment, once they have been triaged and they are not "lost" within the system.

The Administrative Team will help support the clinical triage practitioners and also support the call handlers during periods of high phone traffic.

Clinical triage

The clinical triage clinicians will review every referral received. They will make a decision on the urgency of the referral and stream the referral for urgent assessment if required. If non-urgent they will make a decision on streaming the individual to the most appropriate specialty assessment (*see specialty streams and assessments below*), and/or whether the individuals' needs would be better met through other services or support (*see routing below*). If there is any missing information required to make these decisions the clinical triage clinician (supported by the Administrative Team when appropriate) will seek this information from the referrer or service user/carer.

If the referral is complex then the clinical triage clinician will take the referral to an MDT 'huddle' (which will involve a wider team including medical, therapists etc. and also draw together cross specialty discussions) to help decision making. See MDT huddle section below.

There will be some specific types of referrals which will be supported by very specific clinical triage (such as in-reach older people's team referrals from nursing homes and eating disorder referrals). These referrals will be directed to specific clinical

[4] The additional non-urgent assessment will be looking to build on (rather than repeat) the crisis core assessment with greater depth and/or additional elements. This will be taken into account in scheduling who is to be involved in the non-urgent assessment.

triage clinicians who will review the referral in the same timescale (within a working day). If the case is complex then this will also be taken to MDT huddle.

MDT huddle and Additional Support and Expertise

The clinical triage clinician may not be sure of the best plan for a referral due to complexity or other factors. In these circumstances they can contact specific expertise from the wider services for advice and/or take the referral to a planned MDT huddle (at least daily meeting with input from wider disciplines such as consultant, psychologist, occupational therapists and other professionals scheduled to support the triage clinicians). This meeting will be scheduled to minimise disruption to the wider MDT clinicians' days.

There may be some instances where physical health checks may be required prior to any mental health assessment. The clinical triage clinician would dictate a letter or electronic system task to go to the service user's GP and the service user/carer would be advised to make an appointment with their GP.

Schedule into clinical diaries

If an individual is triaged as requiring an assessment the clinical triage practitioner will provide the details to the Administrative Team including:

- target timescale to be seen
- the specialty stream for the service user
- specific requirements of individuals to be involved in the assessment

The Administrative Team will then agree suitable times with the service user and schedule the assessment directly into clinical diaries.

Specialty Streams and Assessments

If a service user requires further assessment from the clinical triage then they will be streamed into one of the following areas:

- Learning Disabilities (LD)
- Adult Mental Health Services (AMH)
- Children and Adolescence Mental Health Services (CAMHS)
- Mental Health Services for Older People (MHSOP)
- Mental Health Services for Older People (MHSOP) - Memory assessment
- Specialist services (e.g. Eating disorders, Forensic, Nursing home in-reach etc.)[5]
- Mixed specialty

Each stream has differences in either the specialist expertise of the practitioners and/or mix of different disciplines that will normally be involved in the assessment.

The clinical triage clinician/MDT huddle will identify any additional disciplines that are needed to support an individual's assessment based on their particular needs. The mixed specialty stream will be used where a mixture of specialist expertise is required from across the broad specialties (e.g. MHSOP, AMH, CAMHS, LD) to undertake an assessment together. See assessment key feature below for more information.

Routing

At any point during any element of the Central Access Point there will be a consideration of possible routing of the service user to other advice and support. This can include:

- Routing a service user/referrer to the emergency services (e.g. police, ambulance) if at any point there are concerns that an individual requires immediate service support
- Routing a service user/referrer to advice and support provided by external agency (including IAPT, voluntary sector, GP, community groups, website etc.) where this meets their specific needs better than LPT's specialist mental health and learning disabilities services
- Routing a service user/referrer to existing clinical team when known to services. Where there are clinical concerns or queries the existing clinical team will most likely be best placed to support the service user/referrer. Therefore the individual will be routed to the existing clinical team unless the urgency of the need required support sooner than the existing team can respond to. In those circumstances the urgent clinical triage will support the individual with liaison with the existing team wherever possible.

Key Feature: Crisis support

The urgent/crisis triage and assessment of the service user's needs is described in the Central Access Point key feature. The different specialty expertise that provides the urgent triage and crisis assessments will also deliver broad specialty specific home-based crisis interventions.

Home-based Crisis Interventions

There will be different home-based crisis interventions delivered by each broad specialty to best match the support offered to the presenting needs of the service user and their carers. The different specialties will work together where required to ensure that individual needs can be supported where needs require a combination of specialty expertise and interventions.

Facilitated Early Discharge Planning

An aspect of the crisis support services is in facilitating earlier discharge from specialist mental health inpatient settings. The model for facilitated discharge within adult services is currently under design in Wave 2. See next steps.

Increased local support within community services

There will be community 'step up' support offered within community services (initially described in adult services – see community step up) that is expected to reduce demand for ad-hoc crisis support for adults receiving community services.

Key Feature: Single Integrated Care Plan

There will be a single integrated care plan for each individual that uses LPT's specialist mental health and learning disabilities services. This plan will, wherever possible, be collaboratively created between the service user and the practitioners involved in their care and support. Any practitioner, team or service involved with the service user will contribute to this one plan. Within the plan there will be:

- Service user and carer goals
- Safety and crisis plan
- Wider advanced directives
- Care plan (including expectations on other external practitioners involved with the service user such as their GP)

The plan will be provided to the service user and where appropriate their carer. It will use language and have content that they understand and is meaningful to them. It will also reinforce our approach to care. It will be used as a key and consistent tool for communicating with GPs to help them support the service user.

Key Feature: Peer support workers

There will be a programme of preparing, training and equipping current or previous service users with knowledge, skills and confidence to become peer support workers. There will be peer support worker roles introduced across all the core community teams, with recruitment planned for the initial cohort to commence at the autumn of 2019. There will be a central support structure, ongoing supervision and specific safeguards for the health of individuals recruited into the roles.

The peer support workers will integrate within each wider team and become part of a mix of different skills within each area. They will have a distinct role of utilising their lived experience, sharing personal experiences to build trust and develop a sense of mutuality in a service user's journey. They will focus on building on service user's

strengths, promote increased self-management, engagement in services and connection with community activities amongst wider support and team tasks. They will also have an important role in supporting their wider team in continually improving their care delivery approaches to best support service users using experience insight.

Based on other mental health organisation experiences and published studies, the involvement of peer support workers in our teams will be expected to have multiple benefits. This includes releasing clinical time within a team, help improve service user experience, reduce likelihood of admission to hospital for some and help service user's to be ready for transition out of specialist services earlier. In many instances, based on the service user's circumstances, the peer support workers will focus on the wider family as well as the service user. This can include supporting connection and communication between specialties (where different individuals are involved in different members of a family unit).

Key Feature: Supporting Other Needs

Alongside mental health or learning disability related needs, individuals involved in services can commonly require support for a variety of other needs. These *other needs* can include areas such as benefits, housing, loneliness and isolation, addiction, relationships, healthy lifestyles and general community activity.

Supporting these other needs is a significant component of what mental health and learning disability practitioners do but the systems, processes, support and information to help them is often patchy. There will therefore be:

- Framework for Supporting Other Needs - three levels of support: Advice and information, needing help, needing more help.
- A clear and easily navigable system of guidance, services and activities to meet individual needs
- A helpline for staff to get advice, guidance and information
- Capacity in teams for helping individuals access support for other needs

Framework for supporting other needs

There will always need to be flexibility to support individual's other needs. There will be a broad framework to help organise the way we go about supporting these other needs. This will have three levels:

Category	Individual…	Expected actions
• **Advice and information**:	Understands their other support needs Is confident to address them.	• Provide information and contacts • Record in integrated care plan
• **Needing help**:	Needs help to identify and understand their other support needs Requires some assistance to identify support and make contact.	• Explore other support needs and coaching • Discuss options and help decision making on right support • Provide assistance on making contact with support service / group / activity • Record in integrated care plan
• **Needing more help**:	Needs help to identify and understand their other support needs Needs more help and assistance to locate and access support.	• Explore other support needs and coaching • Discuss options and help decision making on right support • Provide assistance on making contact with support service / group / activity • Organise or provide support to the individual to access support service / group / activity • Record in integrated care plan

'Supporting Other Needs' System: A clear and navigable system of guidance, services and activities

There will be a managed database of the wider community services, activities, groups and guidance available to individuals that use our services. This will provide:

- high quality and accurate information on support available to service users
- an efficient way to search and locate information based on an individual service users need

It will be developed in conjunction with the other 'social prescribing' databases that exist currently to ensure consistency of information and increase likelihood of being up to date. It will be managed through a new central Community Knowledge Officer, who will throughout be continually updating and adding to the database.

This will be available for service users' to self-navigate and for LPT staff to use.

Community Knowledge Service: A helpline for staff to get advice, guidance and information

If staff cannot find a suitable service to support a service user's other needs through the Supporting Other Needs system (or their local knowledge) then they will be able to ring a helpline. The helpline will be able to:

- support a staff member to find their information on the system (and learn about better ways to organise the system to make it easier for people to find the information)
- take the staff query and explore whether suitable services exist to meet the need. They will then provide the details to the staff member and update the 'Supporting Other Needs' system. If they cannot identify a suitable service then they will log an unmet need (which will then be provided to commissioners to inform future decision making)
- support a team to identify any roles (e.g. Local area coordinators, local social prescribing facilitators) in their area that can help support a service user getting access to advice, guidance and information.

Capacity in teams to help individuals access support

Individuals needing help and more help (see above framework), may require time and assistance in completing forms, identifying what might help their other needs and accessing services. There will be capacity identified both within the teams and around teams that could provide this support for individuals. Within a team there will be support workers and peer support workers that can help the wider clinical team provide some direct assistance (see peer support workers) to service users and their carers. A network of other support will also be created around each team of key roles in each area that can provide additional support to individuals. This network is likely to include volunteers, local area coordinators, local social prescribing facilitators and targeted local voluntary sector and charity workers. Teams will be supported in identifying and building these networks through a new Community Knowledge Officer role.

Section 3: Specific aspects of design that effect specific parts of the mental health and learning disabilities services but not all of them

From the Central Access Point the Administrative Team will schedule adults, older people and individuals with LD directly into appointments with the combination of practitioners that are viewed to best assess the individuals' needs. The *assessment* will be scheduled to efficiently bring together the support of different practitioners and

increase the likelihood of a good experience for service users. At this initial assessment the service user and practitioners will collaborate to formulate a good initial care plan. For adults and older people this will include a selection of interventions informed by new *intervention pathways*. These pathways describe the likely phases of treatment for individuals with specific mental health conditions and a range of interventions that could help the service users' depending on their specific needs. Alongside informing care, simplified pathways will be used to explain to service users and carers their likely journey through our services. This is expected to improve their understanding of what is likely to happen for them and be better informed in their collaboration around their care choices.

There will be times when service users will become unwell and require increased contact with practitioners in the community. Within adult and older people community teams there will be specific *'step up'* practitioners who have flexibility to add support to a service user's existing care team when needed. This will help support service user's through periods of increased need and risk without practitioners cancelling appointments with other service users.

Key Feature: Structured assessment

There will be a new approach to initial assessment for adults, older people and individuals with LD.

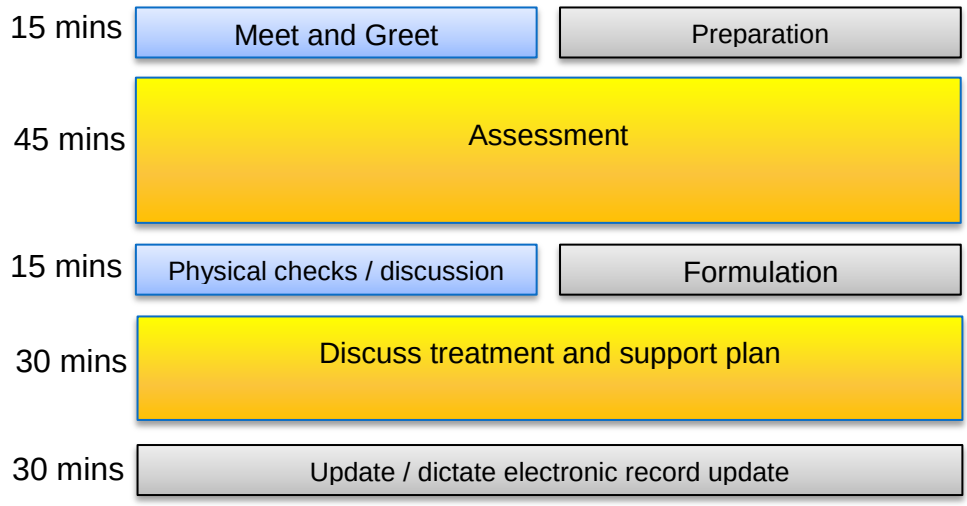
At the Central Access Point, a service user will be streamed into the most appropriate broad specialty for assessment (see specialty streams). At the Central Access Point, the clinical triage clinicians will determine the broad specialty that a service user should be streamed to and how quickly they should be assessed. They will also determine which specific disciplines (including where there needs to be additional expertise from a different specialty) need to be involved in the assessment. The assessment will be scheduled directly into clinical diaries and could be for home or clinic based contact. The service user will remain under the Central Access Point until the assessment has taken place to avoid the individual becoming lost in the system. The assessment will occur within the geographically aligned team that the service user has been streamed to.

The service user will be provided information explaining what to expect from their appointment when it is scheduled at the Central Access Point. This is intended to make sure they feel that there are no surprises in the assessment and can prepare themselves. They will also be provided with a form that they can use to generate any specific concerns, questions and queries that the can be addressed in the appointment.

For a clinic based contact, the service user will have a support worker meeting and greeting them. At the same time, the assessing practitioner will have time to prepare

well. The practitioner will then undertake a core assessment. The service user will then have time for physical checks and further discussion (e.g. on other support needs) whilst the assessing practitioner undertakes formulation. The assessing practitioner will be able to do this with the support of a senior practitioner, where required, to support the assessing practitioner think about their formulation and thoughts on treatment. The assessing practitioner and, if required, senior practitioner then both meet with the service user and carer to collaborate on developing a treatment and support plan that best suits the service user's needs. There is then allotted time for the assessor to dictate and record the assessment.

The following diagram and table describe how this is expected to work where a community nurse and consultant are required for the assessment (depending on the need of the service user this could be a combination of different practitioners). Please note: the timescales in the diagram represent a hypothetical example only.



Action:	Tasks:	By: (staff member)	Time allocated:
Meet & Greet	Meet service user, explain the format of the assessment, complete paperwork	Support worker	15mins prior to appointment starting
Preparation	Reading notes, familiarisation with referral & patient history	Nurse	15mins prior to appointment starting
Assessment	Complete assessment tasks	Nurse	45mins
Formulation	Discussion between nurse & consultant to formulate and agree treatment plan. Phone call to other clinicians	Nurse / Consultant	15mins
Physical checks/ further discussion	Physical checks as required. Discussion with support worker about other support needs/ social prescribing	Healthcare Support Worker/ Peer Support Worker	15mins
Discuss treatment & support plan	Clinician/s, service users and carers discuss and agree initial treatment & support plan	Nurse / Consultant	30mins
Update Electronic Patient Record	Clinician/s update the electronic patient record and perform other admin tasks regarding the assessment (e.g. contacts)	Nurse	30mins

This structured approach will be adapted for home-based assessments which can include joint visits or phone call slots allocated with senior practitioners, as required.

If the service user requires further assessment time then this will be offered which could include involvement of other practitioners (e.g. if a need is identified that requires alternative expertise to help assess). This would be scheduled directly from the local team.

Key Feature: Intervention Pathways

There will be intervention pathways across all mental health and learning disabilities. There are existing pathways that have been developed within Learning Disabilities and Children's and Adolescence Mental Health Services over time. There will now be additional new pathways, focusing predominantly on adult and older people with mental health illness. The pathways are designed to increase consistency of the treatment offered across teams and support the service user in being better informed around their likely journey with the services.

New intervention pathways

The new intervention pathways include:

- Attention Deficit Hyperactivity Disorder (ADHD)
- Autism Spectrum Disorder (ASD)
- Anxiety
- Bipolar disorder
- Depression
- Eating Disorders
- Personality Difficulties and Complex Trauma
- Psychosis

Each of these pathways can be viewed through following the embedded links above. There is a guide to the best way to read the pathways available here and an FAQ also available.

Work has also commenced to develop pathways for:

- Dementia
- Complex physical and mental health related illnesses

How pathways will be used

The new intervention pathways represent the way that we want to offer treatment to individuals presenting with specific conditions. They do not represent a proscriptive guide on how treatment should be undertaken and do not limit clinical judgment. As flexibility is required to ensure the treatment offered is developed in collaboration with the service user to best meet their individual needs. The pathways therefore represent the typical interventions that may be offered and the likely journey of a service user between them. Service users are not expected to use every part of a single pathway and may access parts of multiple pathways at the same time. It is recognised that individual service users may have multiple needs and diagnoses. The pathways will also support the ongoing planning of services in a way that can deliver best practice and evidence-based care that can be locally afforded. The pathways are therefore expected to be iteratively developed to keep up to date with best practice, changes to the wider system and the resources available.

Implementation of the pathways

The pathways are currently in draft form. They will not be finalised and/or implemented until the testing phase (Stage 4) of *Wave one* of the transformation programme has been completed (*see next steps*). Depending on the resources available and the total cost of the new model, the interventions in the pathways may need to be refined. After this point, the pathways will be expected to be reviewed on a regular basis to adjust to best practice, wider system and resource changes.

Key Feature: Community step up support

For community teams in adult and older people specialties there will be ‘step up’ capacity (LD services will continue to have outreach team support). This ‘step up’ capacity will:

- be located within local community teams
- be made up of practitioners who do not have a routine caseload and therefore have availability and flexibility to provide additional contact and support for service users when required
- work with service users’ existing care team to plan, coordinate and deliver additional support to service user’s when needed
- provide temporary additional support

‘Step up’ support will be considered if a service user’s needs change and they require a temporary increase in the frequency of support beyond what they have been receiving. The service user’s practitioners will have other service users that they will be routinely in contact with. The additional ‘step up’ support will allow these

contacts to continue whilst providing the increased support to the service user. The service user's existing care team will remain involved in the individual's care as before but with the additional help offered by the 'step up' practitioners. The 'step up' practitioners will also be involved in the care team's routine supervision and care management discussions whilst they are offering support to the service user.

When the temporary need has been resolved, the 'step up' practitioners will stop being involved in that specific service user's care. This will allow them to maintain flexibility and capacity to support other service user's if they need additional support.

Reasons to involve 'step up'

A service user's existing care team would consider involvement of their local 'step up' practitioners if a service user's needs required a temporary increase in support over and above the support that they could provide. This could include:

- Deterioration or relapse in a service user's mental health
- Increased risk of a service user harming themselves or others
- Carer burnout, carer resilience has been reduced or there is a breakdown in a care package
- Service user not engaging in services and is at 'high risk' of harming self or others
- Significant clinician or carer concerns

When will 'step up' support be provided

'Step up' practitioners will be able to provide support 7 days a week in daytime. They will be able to provide frequent contact (up to daily) for service users and carers as required for a temporary period (expected to be not more than 6 weeks). The 'step up' practitioners alongside the existing care team will establish contingency plans for if service users or carers need support out of hours (evening and night). This will commonly be the provision of telephone support through the crisis team (accessed through the Central Access Point).

What support will the 'Step up' practitioners provide

The 'step up' practitioners will provide an array of different interventions through phone and face to face contact, these include:

- Counselling
- Medication management and compliance
- Diet / eating support
- Sleeping advice and education
- Intensive psycho-education
- Supporting individual with other support needs
- Carer support
- Investigating safeguarding concerns

- Linking with other agencies

They will operate as part of the wider multi-disciplinary care team for the service user and will involve experts from the team where required in the support that they offer.

What are reasons not to involve 'step up' practitioners

'Step up' practitioners would not routinely be drawn into a service user's care in the following scenarios:

- If reported escalated needs of service user have not been assessed
- If a service user is not open to the service
- If the risks are assessed as 'too high' for the support that 'step up' can offer
- If increasing contacts or involving other practitioners is at odds with a service user's care plan or not felt by the care team to be helpful
- If 'step up' practitioner support has previously been tried and not worked (and the circumstances are not significantly different this time)
- If 'step up' is being used to compensate for planned and routine support not being done as expected

At what point will the 'step up' practitioners end their involvement in care

'Step up' practitioners are intended to provide temporary additional support to an existing care approach. They are envisaged to not provide support beyond 6 weeks and in many instances provide shorter periods of contact. The scenarios where the additional 'step up' support would stop include:

- When the service user has returned back to their baseline state (point prior to 'step up' involvement)
- When care package is in place (if care package was the main reason for 'step up' support)
- When specific issues or risks (that led to 'step up' support) are manageable for the individual or carer
- If the service user is developing dependency upon the additional 'step up' support that is unhelpful for their overall recovery/care journey
- If the service user wants to reduce the input they receive

Next Steps

A complete draft model from Wave One design will be produced for the end of May 2019. This will include:

The key design features	Described in this document
A draft workforce model	A detailed analysis has been undertaken alongside the co-design workshops. This is being used to develop a draft workforce model, which will provide a description of the staff estimated to be required to deliver these changed ways of working. A draft workforce model will be completed by the end of May 2019.
Proposed service structures	There is a process across April and May 2019 for LPT staff to look at the best ways to alter teams and service structures to help deliver these design features. Following an option appraisal on May 15 and May 23 to determine the best and safest workforce model and structure, there will be a preferred set of service structures described.

There will then be a period of testing and further engagement to have confidence that Wave One changes will be affordable, meet expected demand and deliver additional value (quality) to services users. This is expected to take until summer 2019 and there will be opportunities to trial changes across this period. The Wave One design will then be complete and a plan will be formed about how and when the changes will be put in place. The changes will then be made in phases (bit by bit) to make sure each change is working, learn and refine changes in practice and the right staff are in place. This will continue for the next two years until 2022.

Wave Two design and improvement work will start by June 2019 and work alongside the Wave One changes that all mental health and learning disabilities services are developing together. Wave Two will be made up of several different transformation and improvement schemes that each have a specific focus and build on existing improvement projects. The different focused areas of change within Wave Two are still to be mapped out but are likely to include severe and moderate Learning Disabilities (LD) pathways, core 24 (hospital based liaison services), children and young people services (CAMHS) and dementia services.

In most cases these are areas where there is existing improvement work planned or being undertaken. As part of Wave Two there will be some additional support offered to these projects from the All Age Transformation Programme team and a greater alignment of all the improvement work together. This is intended to build upon these existing improvement projects rather than replace or disrupt them. Each scheme will be expected to use co-design (involvement of service users, carers, staff

and stakeholders) and data to identify improvements and make changes incrementally (bit by bit) as they progress.

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