This document describes the treatment and support that will be offered to people through our mental health and learning disabilities services and when they our leave our services. It includes the below key design features:

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. 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 below).

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.
- 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.

[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/

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 above)	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 above)	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* above.

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.

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:

- Depression
- Bipolar
- Autism
- Anxiety
- Eating Disorders
- ADHD
- Personality Difficulties
- Psychosis
- Perinatal

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 the transformation programme. 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

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.