3. The Service to be provided: Mental Health Intensive Enablement Accommodation

3.1 The Service will provide an Adult Mental Health Intensive Enablement and Crisis Bed Accommodation Service. This is a supported living service, and not residential or inpatient care. The Service will be operational 24 hours a day, 7 days a week, 52 weeks a year, The Service will have dedicated Staff members during operational hours. The Service will support service users to learn or re-learn daily living skills with intensive practical / therapeutic support (in line with the recovery model) in order to manage their mental health and acquire the learning needed to assist service users towards independence and social inclusion within the community.

3.2 The minimum requirement for this service is to offer 25-30 beds across either two or three sites (one being the current site in Higgins Walk, Stevenage, and at least one being in the East and North Herts CCG area and one in the Herts Valleys CCG area) for an intensive enablement service for people with a mental health diagnosis for up to 18 months. Some of these beds may be used for discharge to assess, step-up, step-down over a 4-8 week period, and crisis provision, subject to further discussions and agreement between commissioner and provider.

3.3 The rehabilitation beds will provide Service Users who suffer with severe and enduring mental illness up to a maximum of 12-18 month period of intervention and rehabilitation. The service will promote service user move on based on service user individual need to allow for service users to live more independently. In all cases an exit plan will be implemented at the start of the programme and reviewed every 3 months. Exit planning starts from day 1 with provider, commissioners and district and borough councils developing the move-on plan.

3.4 All service users will take part in the service's recovery programme, which is developed and reviewed in partnership with HCC and HPFT, and each service user follows a co-produced care and recovery plan developed with family member input where appropriate. Service users will be supported to attend one to one sessions and group work sessions regularly.
The service will adopt a recovery star programme, or other recovery programme as agreed with HCC and HPFT. The service will proactively support service users with meeting key agreed actions. The service will provide a proactive approach to promote physical activity, education and work progression to each service user.

3.5 Any beds allocated to step-down placements for 4-8 weeks will allow service users who are not ready to go straight home as they may be at risk of being admitted into hospital without a more intense understanding of their needs. The user of the bed would have had a mental health episode but their independent skills need little input or very low level support. It will offer intense emotional and practical support where they have accommodation in place to go to following the step-down placement. They will have weekly support plans

which target short term input towards the goal of returning to independent living in the community.
The period in the 'Step Down' bed allows for an intensive social assessment and opportunities to learn or re-learn daily living skills.

3.6 The Crisis Beds can be used as step-up or crisis beds for up to a maximum of 10 days are available for individuals who are experiencing a crisis and would benefit from an individually tailored period of support in a safe and supportive setting away from their current situation. The Crisis beds must help prevent admissions to hospital and attendance at A&E.

3.7 The Service must be provided in a safe environment with over-night stays in single accommodation arrangements allowing privacy and dignity.

3.8 Face to face support will be provided within the Adult Mental Health Intensive Enablement Accommodation Service. People can access one to one support, or can use the facilities knowing that Staff are nearby. Staff will be required to proactively promote the recovery model and rehabilitation approach to supporting service users 7 days a week, proactively promoting inclusive rehabilitation work plans and activities, and aligning this work with the connected lives approach and utilising community providers/vol Sector services to support achievement of service users' goals.

3.9 Staff must support Service Users with therapeutic approaches to manage their rehabilitation including techniques and skills to avert crisis, recognising their crisis trigger points and develop coping strategies for the future.

3.10 The Council also encourages the Service Provider to propose innovative approaches to delivering this Service in order to meet the overall aims and vision for the Service.

4 Overall aim of / vision for the Service

- To ensure equity of access to high quality Intensive Enablement, Step down and Crisis support across the County
- To ensure the Service is supportive of inclusion and integration and delivered in a culture which embraces diversity and difference
- To ensure that the Service is responsive and flexible to meet the ever changing and emerging needs of Service Users
- A therapeutic approach that is person-centred and recovery-oriented
- Staff providing support will demonstrate empathy, congruence and unconditional positive regard towards the Service User
- Service Users are empowered to find the resources within themselves, and with support, to find their own solutions
- Working with Service Users will mean work is Service User led in a fully co-produced environment
- The Service will complement and be aligned with statutory services and their clinical and procedural pathways including access and advice systems and ensure that it does not duplicate any of these

- Recovery Star principles, or other models agreed as appropriate to the needs of the individual, are applied and outcomes measured on individual tailored basis using the recovery tools, with 3 monthly reviews/ as individually required
- Service Users engaging in community activities and independent living
- Service users supported with mental health and wellbeing via daily group work sessions
- Service Users supported to access mainstream sports, social, leisure, education, training to support recovery process
- Service Users supported to access employment related activities
- Improvements to quality of life, confidence building, and self esteem of Service Users
- Improvements in physical wellbeing of Service Users
- Service proactively engage with third party organisations to ensure joined up approach to support service users are implemented
- Service Users supported to avoid the need for hospital admission
- Service Users supported with mental health and wellbeing which will enable move on to more independent accommodation
- Service Users assisted with mental health issues ,finance issues, housing related concerns, medication concerns
- Carers and families (when appropriate) supported and involved in care planning
- Service Users and Carers involved and consulted regarding service delivery and planning, and are encouraged to be fully engaged in co-production of the service
- Social inclusion is emphasised particularly in relation to BME issues

4.1 Overall aim of / vision for the Service User

The six mental health objectives set out in the NHS Five Year Forward View for Mental Health (2016-21) are as follow:

A seven day NHS – right care, right time, right quality:

- more people of all ages and backgrounds will have better wellbeing and good mental health
- Fewer people will develop mental health problems - by starting well, developing well, working well, living well and ageing well.

Promoting good mental health, preventing poor mental health and supporting recovery:

- more people who develop mental health problems will have a good quality of life
- increased size and range of social networks for people with mental health problems

- More people engaging with or participating in local community activities.

An integrated mental and physical health care approach to improve quality of life

- Fewer people with mental health problems will die prematurely, and more people with physical ill health will have better mental health.

People will have positive experiences of good quality care and support services

- Care and support should offer access to timely, evidence-based interventions and approaches that give people the greatest choice and control over their own lives.

Prevention of avoidable harm

- People receiving care and support should have confidence that the services they use are of the highest quality and at least as safe as any other public service.

Fewer people will experience stigma and discrimination

- Public understanding of mental health will improve and, as a result, negative attitudes and behaviours to people with mental health problems will decrease.

When using this Service, the Service User should have an appropriate and effective exit plan, which should fit in with any existing coping strategies plan and be:

- Person centred
- Recovery orientated
- Promote and build independence, personal resilience and self-management skills
- Provide strategies for coping with a crisis
- Prevent reliance on the Service

4.2 Partnership Working

The Service will link with other organisations and develop and implement pathways and protocols between stakeholders, and statutory services.

The Service is required to have a developed and robust communication and marketing strategy to ensure the Service, what it can offer and referral routes are known throughout the County to providers and Service Users alike. Referrals for rehabilitation beds will come through HPFT bed placement, and crisis beds may be referred into through RAID and CATT teams. Links must be developed with other service providers to enable enhanced Service User pathways.

The Service will accommodate service users moving into and out from the sites on a county-wide basis. Through partnership working to develop appropriate pathways and protocols with other services for the residents of Hertfordshire including but not limited to:

- NHS Trusts such as HPFT and their community mental health teams
- Hospital Emergency Departments, local and in bordering counties
- First Response Services
- Police and criminal justice services
- HCC Adult Social Care Services teams
- Approved Mental Health Professionals (AMHPs)
- 111
- Ambulance services
- Third Sector providers including local Service User and Carer organisations
- Primary NHS Care
- Statutory sector partners
- Local transport providers.
- Housing providers
- District councils
- Local drug & alcohol services including CGL Drug and Alcohol Recovery Services
- Pharmacists
- Further Education providers
- Jobcentre Plus

Links must be further developed during the duration of the contract. Confidentiality agreements and referral protocols to and from services will be in place between the Service and other providers.

4.3 Staffing and Resourcing

Appropriately skilled Staff, will work with and support Service Users in a way that recognises the importance of the quality of the relationship and interaction between them including:

- Respect and treating seriously the Service Users' concerns.
- A warm, caring, compassionate response
- Understanding, empathy, person centred
- Ability to support a Service User to build skills and strengths to enable them to manage their needs
- Co-production approach

All Staff and volunteers must have an enhanced DBS check before starting work at the Service, have the right to work in the UK and be registered with

any relevant professional body and, where necessary, are allowed to work by that body. Supervision should be an integral part of the culture of the Service and a part of everyday practice. Staff and volunteers' own emotional wellbeing should be supported as a Service User's crisis may have an adverse impact on the Staff member.

Peer support workers will be utilised and/or employed within the service and peer support from people who have been on similar recovery journeys will be accessible to service users.

The Service will be staffed to meet the demands so individuals can access the Service without delays.

The Service is expected to be staffed by a combination of paid and volunteer workers to meet the demands of the Service.

4.4 Physical Environment of the Service

The service must be located across 2 or 3 sites (Higgins Walk in Stevenage, plus 1 or 2 additional sites) in Hertfordshire, with suitable public transport routes available to all sites.

The sites will include single en-suite rooms for residents, communal kitchens, communal lounge and activity areas, and communal laundry facilities and outdoor space. Sites will also include secure office and staff rooms and facilities. The current service at Higgins Walk operates on an assured shorthold tenancy basis, and it is envisaged that a similar arrangement would be adopted for the additional site(s).

Repairs, maintenance, provision of utilities, and tenancy management will be carried out by the provider.

4.5 Web based information and HertsHelp

The Service Provider will work with the Council's Communications team to ensure that Hertfordshire's Community Directory is kept up to date and works to develop online tools for residents that will enable independence as far as possible and reduce the need for telephone support services.

The Service Provider is also required to be part of the HertsHelp network. As part of this network, their staff will be trained to access the administrative tools of the Community Directory and work with the Council to maintain the integrity of the information held. It will also involve signposting and referring Service Users to the HertsHelp service where they have needs that the Service Provider cannot meet.

4.6 Social and local economic value

The Council recognises that there is additional social value[1] that can be obtained from contracts of this nature and size and that Service Providers are often well-placed to offer innovation and added value. The Council encourages bidders to propose innovative approaches to delivering this service that provide additional social value. Examples could include use of volunteers to support/enhance delivery of the service or use of an apprenticeships scheme, or employment of people living locally to the scheme.

Providers are encouraged to identify ways that the scheme can add value to the local community by participating in community initiatives.

The schemes will also have an impact on the environment, and providers are encouraged to identify ways that this impact can be minimized or positive value added.

5 Volume of Service

It is envisaged the Service should aim to support approximately 40-60 individuals per year (in total across existing and additional site(s)), depending on their recovery progress and move-on planning.

6 Accessing the Service, Assessments, Pathway & Referrals

6.1 Service Users identified for the rehabilitation beds will be identified through the HPFT Bed Placement Team, while referrals for any crisis beds will come via channels such as RAID and CATT teams.

6.2 Service Users can be considered for admission if they are subject of an order under the 1983 (amended 2007) Mental Health Act. For example, a supervised community order or a person on Section 17 leave will be accepted for trial assessment prior to the discharge of the order. Admission whilst on an order of the Mental Health Act would only be considered following comprehensive assessment and planning with the care co-ordinator and consultant. The service is not a designated Place of Safety under the Mental Health Act

7 Eligibility

[1] 'Social value' refers to a way of thinking about how resources are used and services delivered. It involves looking beyond the price of each individual contract to consider the collective benefit to a community

7.1 The Service is aimed at people 18 years old or over who live in Hertfordshire and / or who are registered with a GP in Hertfordshire and or the Royston area of Cambridge and Peterborough CCG, and who are experiencing a long term enduring mental health illness, requiring long or short term rehabilitation, including those with a form of mental health crisis and those with complex mental health issues.

7.2 The Service will be suitable for males and females, people with physical disabilities and be culturally sensitive to diversity of needs. The service will not offer physical health care support, but will support service users to access physical healthcare where necessary. Where diverse groups are under using the Service the Service Provider will promote the Service to raise awareness.

7.3 The Service will offer appropriate support to Carers and the family of Service Users where this is necessary while ensuring the safeguarding of Service Users and confidentiality agreements.

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7.4 No referrals should be accepted for Service Users from outside this area unless by specific agreement with the Authorised Officer.

7.5 Exclusion Criteria:

- People who are not experiencing mental ill-health
- People behaving in a violent and / or disruptive way
- Children and young people up to 18 years, however any young person accessing the service will be offered immediate support according to operational protocols and signposted to appropriate CAMHS using a no 'wrong door' approach to access

7.6 The Service Provider will work with and actively support commissioners and partner agencies to create and develop a clear integrated care and support pathway and co-ordinated provision for all Service Users. All services will be delivered in a coordinated way and offer a whole system approach to Service Users and their Families

7.7 The Service Provider will coordinate all services so that Service Users can move from one part of the care and support pathway to another without barriers or delays

7.8 The delivery model must be flexible and responsive to future requirements, changing service needs and resources. The model must have the capacity to be flexible and responsive within available resources