Joint transformation planning template- Leicester, Leicestershire and Rutland (LLR)

1. Mobilise communities

Governance and stakeholder arrangements

Describe the health and care economy covered by the plan

PROVIDER MARKET:
Social care:
Social Care commissions a range of independent and voluntary sector providers through block contract and Framework agreements. These include residential care, supported living, day time activities and more enabling services such as employment and volunteering services for people with learning disabilities and or autism. An increasing number of services/providers are commissioned directly by individuals and or their families through the use of direct payments.

Healthcare :
The majority of LLR healthcare services are provided by NHS Leicestershire Partnership Trust (LPT) including through block contract arrangements**:**

- Primary care Liaison Nurses
- Community Learning Disability Teams
- LD Outreach Team (Adults)
- Learning Disabilities Service for Families, Young People and Children (CAMHS LD Team)
- Autism assessment and support services
- Agnes Assessment and Treatment Unit
- Health residential Short-breaks provision
- Liaison and Diversion services (L&D)
- Forensic Mental Health Services
- Community, rehabilitation and inpatient mental Health services

Inpatient services:

NHS provision:
Children & Young people – LPT provide a NHS England funded (Tier 4) inpatient unit at Coalville hospital which admits up to 10 children and young people between the ages of 11 - 18 who have mental health issues. This includes support for those with a Learning Disability associated with mental health. Young people from LLR may be placed there or at another unit across the Midlands and East region. There are no specialist units in the region for young people with eating disorders or requiring a Psychiatric Intensive Care Unit (PICU).

Adults - LPT provides the main geographical facility called the Agnes Unit. This unit has 20 beds but only 16 are currently commissioned- four individual pods each with four en-suite bedrooms. 8 beds are people who need longer term support and who are either on the forensic care pathway or have been repatriated to Leicester from out-of-county placements. The other 8 beds are for patients who need shorter term admission for assessment and treatment. This is either planned or as an emergency due to crisis situations that may arise in the community. There will also at any one point be undiagnosed people with autism within the LPT main acute mental health Bradgate Unit.

Independent sector:
There are no specific adult independent sector LD inpatient facilities in LLR geographical area. There was a former Castlebeck Learning Disabilities inpatient facility in Melton Mowbray called Croxton Lodge (and

was little used by local commissioners in its previous role). However this site is now owned by Partnerships in Care and is now an acquired Brain Injury facility.

In relation to Mental Health, a private provider (Inmind) run Sturdee Community Hospital based on the southern outskirts of the city. This is a 38 service providing inpatient recovery based treatments to male and female service users who suffer with complex mental health needs. The hospital comprises of locked rehabilitation bed and semi-independent apartments. There is currently one locally funded placement for an individual with Autism at this unit.

Where treatment and rehabilitation needs cannot be met by NHS Leicestershire Partnership Trust, some placements are made in regional and national facilities run by providers such as Cambian Healthcare and St. Andrews. These are classed as 'Alternative Hospital Placements (AHPs)

Rehabilitation services
Apart from the Agnes Unit, LPT have 2 mental health inpatient rehabilitation units (Willows and Stewart House) which provide support to people with Autism and learning disabilities where the primary need is Mental Health. There are currently 2 local placements for individuals with autism and mental health needs.

'Step Through' supported living
A Grant from the Department of Health to support Transforming Care has been used to develop a step through provision in the community and secure properties to provide long term tenancies. Working with Affinity Trust 2 flats have been developed to provide short term tenancies with comprehensive, person centred support for people who are either at risk of being admitted to an inpatient setting following a breakdown in accommodation, are clinically fit for discharge and would benefit from a transitional period to support discharge or would benefit from a short period of intensive support away from their long term accommodation.

Acute Hospital liaison workers
Three nurses are employed by the main acute hospital (UHL) to provide support and advice on good practice to staff, young people and adults with mild to profound learning disabilities (this will include prisoners with learning disabilities who are accessing UHL hospitals) and/or their families whilst the person is an inpatient or out patient at UHL's three hospital sites

COMMISSIONING ARRANGEMENTS:
Adults
The three CCG's collaboratively commission community and inpatient Learning disabilities healthcare services from both Leicestershire Partnership Trust and University Hospitals Leicester.

Arden and GEM Commissioning Support Unit are commissioning by CCG's to manage the eligibility framework for CHC, S117 and AHP and case management of patients eligible for 100% healthcare funding.

The 3 CCG's are part of a regional collaborative commissioning framework for the provision of locked and unlocked mental health and learning disabilities rehabilitation services. LPT is the only provider from Leicestershire on this framework

In 2014 the Better Care Together (BCT) Learning Disabilities programme was developed. BCT is a significant programme of work which will transform the health and social care system in LLR by 2019. This work stream was developed as a direct response to expectations of the Winterbourne Action Plan and Transforming care Programme.

The development of Personal Health Budgets (PHB's) is being undertaken jointly by the 3 CCG's in collaboration with local Councils. East Leicestershire and Rutland CCG host a PHB Team.

Leicestershire County Council, Rutland County Council, WLCCG and ELRCCG have pooled budgets arrangements for the commissioning of packages of care, with Social care leading on Case management or those who are either joint funded or 100% social care funded. 100% health funded cases are managed through the local are CSU.

Leicester City CCG and Leicester City Council do not currently have any pooled arrangements but are exploring options to minimise discharge delays related to determination of health and social care funding eligibility. A memorandum of understanding is in development that will underpin any current and future joint commissioning processes and arrangements.

The finance work stream has been tasked to support this work by scoping the likely effects financially, including the shifts from specialist to each CCG and secondary to each LA and a detailed risk assessment and advice on how we will consider either pool or co-manage budgets.

We have jointly developed a Leicester, Leicestershire and Rutland Autism Strategy 2014 to 2019.

WHAT ARE KEY COMMISSIONING BLOCKS?

- Majority of existing healthcare provision by local NHS Trust (LPT) is currently block funded, meaning development of more flexible commissioning arrangements will require some double funding during transformation periods.
- A high cost and inflexible PFI on local Assessment and Treatment which is a significant financial implication on redesigning services.
- Historical intuitional approaches to services for patients and carers including dominance of Health and county building based short breaks services.
- Separate approved provider framework models in health and Social care making market management and driving up quality more difficult.
- Underdeveloped provider market for people with high levels of challenging or risky behaviour.
- Separate NHS England and CCG commissioning arrangements can cause delays in stepping down individuals from low secure inpatients facilities.
- Current arrangements to determine CHC and social care funding eligibility can cause delays in discharge.

Describe governance arrangements for this transformation programme

The Transforming Care partnership footprint replicates an existing partnership Better Care Together (BCT) programme developed in 2014. BCT is a significant programme of work which will transform the health and social care system in LLR by 2019

Key partners

CCGs:
Leicester City CCG
East Leicestershire and Rutland CCG
West Leicestershire CCG

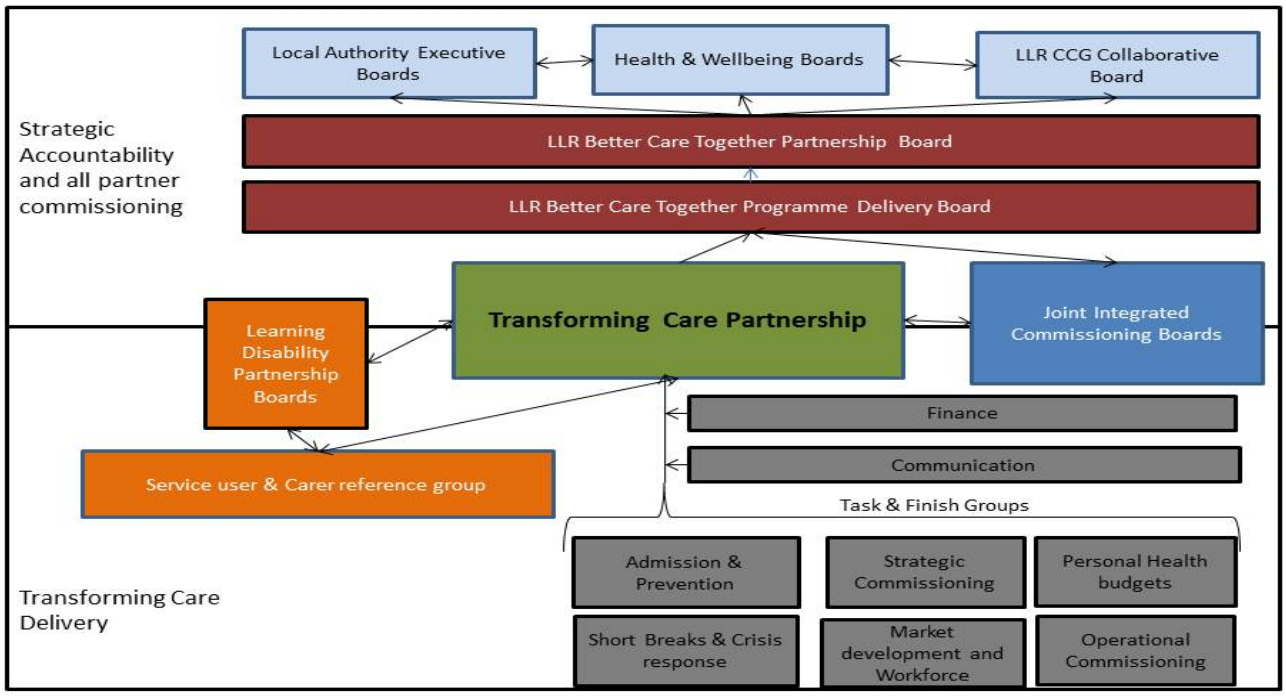
Councils:
Leicester City Council
Leicestershire County Council
Rutland County Council

NHS England:
Specialised commissioning

CSU:
Arden/ GEM Commissioning Support Unit

Service user and Carers representatives

LLR Transforming Care Governance Chart



MEMBERSHIP
It is envisaged membership of the Transforming Care Partnership Board will evolve as the programme develops, however core membership will include from:

- People with Learning Disabilities and/or Autism and carers* (see note below)

- Family Carer
- The 3 Local Authorities (adults and children)
- The 3 Clinical Commissioning Groups (adults and children)
- Leicestershire Partnership NHS Trust
- University Hospitals of Leicester NHS Trust
- Leicestershire Constabulary
- Health Education East Midlands
- NHS Specialised Commissioning
- NHSE Transforming Care
- Any other groups or individuals identified by the Board

*There will be a direct mechanism to ensure co-production and full engagement with People with Learning Disabilities and/or Autism through the Service User and Carer Reference Group. There will also be a place for a family carer representative to sit on the board.

The Transforming Care Partnership Board and the Service User and Carer Reference Group will regularly attend the 3 Learning Disability Partnership Boards and other forums/events to ensure engagement with the wider service user and carer population.

The primary purpose of the Transforming Care Partnership Board is to:

- Provide a partnership approach and oversight for the delivery of the local Transforming Care Programme to radically transform care for people with learning disabilities and/or autism who display behaviours that challenge across LLR;
- Build on the work already being undertaken locally through Better Care Together to reduce the focus of care from bed based care to community care;
- Lead and manage the successful implementation of the new model of care by March 2019 which focuses on simplifying the system and enhancing support to people in the community in order to prevent hospital admissions;
- Report to NHS England, Scrutiny and Health and Well Being Boards on progress on the delivery of the Transforming Care agenda;
- Ensure that the outcomes of the programme are delivered and evaluated;
- Provide a partnership approach to the programme and to provide a route for escalation of issues and risks in relation to the delivery of the programme.

The TCP Board is aligned to the Mental Health Better Care Together Work stream and will also work very closely with the LLR Children's and Young People Better Care Together work stream to ensure their plans support the Transforming care agenda with a view to achieving the following outcomes:

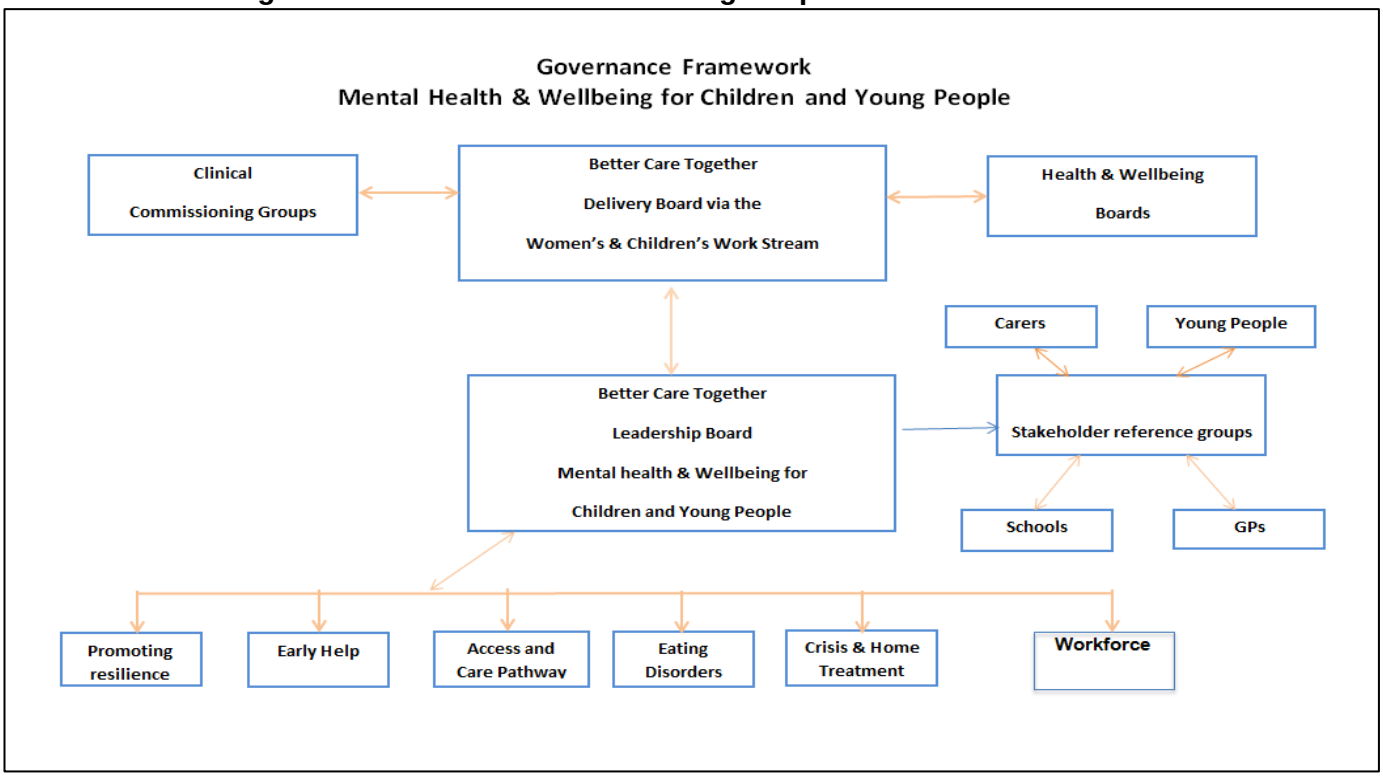
- Improved health and wellbeing for children supported into adulthood
- Improved life expectancy throughout their lives for the children we support
- Integrated working across secondary , primary and community to reduce duplication of structure and maximise productivity
- Age appropriate service across LLR
- More children and young people who have coordinated care.

To do this we will:

- Review what CAMHS capacity is required
- Develop options to facilitate greater integrated working between all sectors
- Develop a strategy around optimising children's life changes through public health interventions,

Health and Wellbeing

Governance Arrangements for Children's and Young People



Describe stakeholder engagement arrangements

Adults

The TCP plans align with the Better Care Together Plans for Learning Disabilities and Mental Health in LLR as a result of which people with lived experience specifically have been engaged in influencing and agreeing local planning on this agenda since August 2014 through:

- The Better Care Together Learning Disability Service User and Carer Reference Group.
- We Think – self advocate group
- The Partnership Board Carers Group

These include individuals who previously lived in an NHS setting and family carers who have experience of supporting a loved one with learning disabilities, autism and mental health who may also display behaviours that challenge.

In addition to this the implementation lead, supported by members of the reference group regularly attends the Learning Disability Partnership Boards, The LLR Autism Partnership Board and other forums/events to provide updates on progress and to ensure an ongoing opportunity to input and influence local planning. A family carer has been an active member of the Better Care LD Steering Group since 2014, an arrangement that will continue under the auspices of TCP.

Public engagement has been to be through a series of events, social media activity and newsletters under the existing Better Care Together structures that have been in place since 2014.

As with public engagement, there is an existing mechanism of engagement with both adults and children's providers and commissioners of services that support people with learning disabilities and family carers. A

series of clinical summits, co designed and delivered with people with lived experience family carer were held in the autumn of 2015 to enable any staff member of any of these organisations to learn more about the plans ask questions and provide their input via focussed workshops. Providers and commissioners also continue to be involved through bespoke meetings and via their representation on the 3 Learning Disability Partnership Boards and the LLR Autism Partnership Board.

People with lived experience, family carers, providers and commissioners will be further engaged through the development of a Market Position Statement to provide an understanding about how services need to change or be developed in order to support greater community inclusion and support.

Children and Young People
There is a strong commitment to collaborative working with young people and families which has resulted in long established forums that directly feed into local planning and development, for example :

- The Leicestershire Family Voice which represents parents and carers of children with disabilities, as well as specific support groups for parents of children on the autism spectrum.
- The Big Mouth Forum which represents disabled young people with a range of needs
- The Parent and Carers Forum

The voice of young people with lived experience of mental health problems contributed directly to the Transformational Plan for children and young people's mental health through strengthening elements on tackling stigma, and engagement with schools. Looked after children raised specific issues about being placed in residential or hospital units outside the region and difficulties in accessing mental health support. There will be specific reference groups for parent/ carers and for young people so that they can continue to influence the implementation of the transformational plan, and hold organisations to account.

A detailed Communications and Engagement Plan is being developed to ensure the ongoing involvement of all stakeholders and will include:

- People with lived experience, carers and families being involved throughout the programme
- Continued to support & engage individuals, carers and the general public
- Continuous engagement with hard to reach groups such as BME communities
- Continuous engagement with stakeholders including health and social care professionals providers and other stakeholders
- Events bringing stakeholders together to inform and further develop and deliver the plan

Describe how the plan has been co-produced with children, young people and adults with a learning disability and/or autism and families/carers

The We Think Self Advocates Group, the Partnership Board Carers Group, the Speaking up for Health Group and the Communication Network have been involved in co designing the plan as have the 3 Learning Disability Partnership Boards who receive regular updates and vice versa.

There is an established a service user group for children and young people, which includes learning disabilities sand autism, who are accessing or have accessed support from the CAMHS service. Called "Evolving Minds". The group has been involved in the co-design of crisis and home treatment services for C&YP and contributed at the launch event for the Child Mental Health Transformational Plan.

Further events are being planned to ensure ongoing engagement as the plans unfold. These will consider the plans in the whole as well bespoke elements of the plan, for example developing the models for short breaks provision.

2.Understanding the status quo

Baseline assessment of needs and services

Provide detail of the population / demographics

The local Transforming Care Partnership covers the geographical area of Leicestershire and Rutland. Based on the 2011 Census the total population was just over a million (1,017,697). The GP registered adult population (18 plus) is just over 853,000.

LD and Autism population forecast for Leicester. Leicestershire and Rutland (LLR)

We have detailed learning disabilities population information, broken down to district council and CCG boundaries in a core dataset developed by Leicestershire County Public Health Department in October 2015.

The tables below have been taken from PANSI data projections for adult needs and service information, population projections aged 18-64 predicted to have a learning disability, by age, projected to 2030 for LLR. The data highlights a steady increase in the overall LD population, but the numbers displaying challenging behaviour remaining fairly static.

LD Baseline Estimates for LLR

Table produced on 22/02/16 15:32 from www.pansi.org.uk version 8.0

People aged 18-64 predicted to have a learning disability, by age	**2014**	**2015**	**2020**	**2025**	**2030**
People aged 18-24 predicted to have a learning disability	3,004	2,988	2,828	2,808	3,072
People aged 25-34 predicted to have a learning disability	3,292	3,309	3,372	3,331	3,185
People aged 35-44 predicted to have a learning disability	3,189	3,171	3,159	3,314	3,398
People aged 45-54 predicted to have a learning disability	3,385	3,398	3,268	3,023	3,025
People aged 55-64 predicted to have a learning disability	2,697	2,726	3,007	3,197	3,066
Total population aged 18-64 predicted to have a learning disability	15,567	15,592	15,634	15,673	15,746

LIVING WITH A PARENT LLR

Table produced on 22/02/16 15:32 from www.pansi.org.uk version 8.0

People aged 18-64 predicted to have a moderate or severe learning disability and be living with a parent, by age	**2014**	**2015**	**2020**	**2025**	**2030**
People aged 18-24 predicted to be living with a parent	458	456	433	438	482
People aged 25-34 predicted to be living with a parent	364	366	373	368	352
People aged 35-44 predicted to be living with a parent	311	309	310	324	333

People aged 45-54 predicted to be living with a parent	174	174	166	154	158
People aged 55-64 predicted to be living with a parent	53	54	60	62	58
Total population aged 18-64 predicted to be living with a parent	1360	1359	1342	1346	1383

MODERATE OR SEVERE LD LLR

Table produced on 22/02/16 15:32 from www.pansi.org.uk version 8.0

People aged 18-64 predicted to have a moderate or severe learning disability, and hence likely to be in receipt of services, by age	**2014**	**2015**	**2020**	**2025**	**2030**
People aged 18-24 predicted to have a moderate or severe learning disability	693	690	657	661	728
People aged 25-34 predicted to have a moderate or severe learning disability	708	711	724	717	685
People aged 35-44 predicted to have a moderate or severe learning disability	801	797	794	834	856
People aged 45-54 predicted to have a moderate or severe learning disability	760	762	733	682	690
People aged 55-64 predicted to have a moderate or severe learning disability	585	592	654	690	659
Total population aged 18-64 predicted to have a moderate or severe learning disability	3,547	3,552	3,562	3,584	3,618

CHALLENGING BEHAVIOUR LLR

Table produced on 22/02/16 15:33 from www.pansi.org.uk version 8.0

People aged 18-64 with a learning disability, predicted to display challenging behaviour, by age, projected to 2030	**2014**	**2015**	**2020**	**2025**	**2030**
People aged 18-24 with a learning disability, predicted to display challenging behaviour	50	50	48	48	52
People aged 25-34 with a learning disability, predicted to display challenging behaviour	60	60	61	60	57
People aged 35-44 with a learning disability, predicted to display challenging behaviour	59	58	58	60	62
People aged 45-54 with a learning disability, predicted to display challenging behaviour	65	65	62	58	57
People aged 55-64 with a learning disability, predicted to display challenging behaviour	53	54	59	64	61

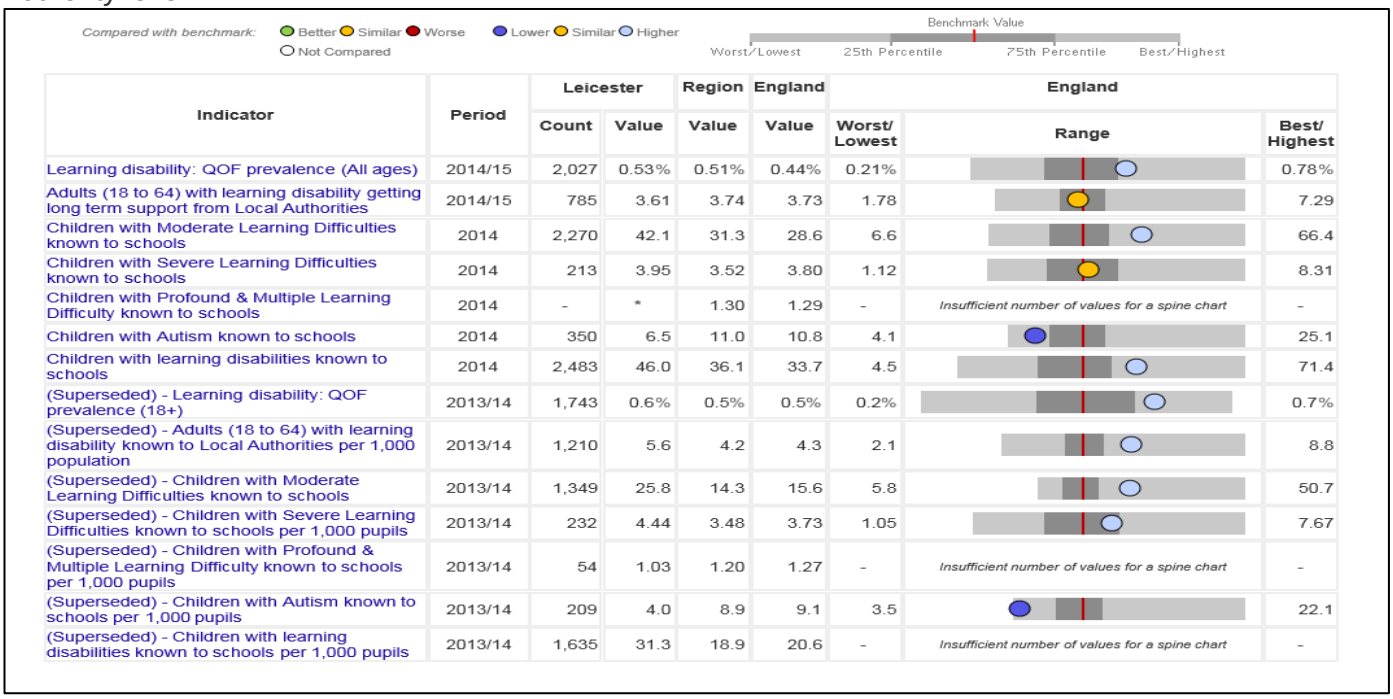
Total population aged 18-64 with a learning disability, predicted to display challenging behaviour	287	287	288	290	289

The prevalence rate for people with a learning disability displaying challenging behaviour is 0.045% of the population aged 5 and over.

AUTISTIC SPECTRUM FOR LLR					
Table produced on 22/02/16 15:33 from www.pansi.org.uk version 8.0					
People aged 18-64 predicted to have autistic spectrum disorders, by age and gender, projected to 2030	**2014**	**2015**	**2020**	**2025**	**2030**
People aged 18-24 predicted to have autistic spectrum disorders	1134	1131	1074	1069	1169
People aged 25-34 predicted to have autistic spectrum disorders	1314	1320	1359	1356	1296
People aged 35-44 predicted to have autistic spectrum disorders	1291	1285	1275	1329	1377
People aged 45-54 predicted to have autistic spectrum disorders	1443	1441	1375	1272	1265
People aged 55-64 predicted to have autistic spectrum disorders	1188	1198	1316	1390	1331
Total population aged 18-64 predicted to have autistic spectrum disorders	6370	6375	6399	6416	6438

Learning Disabilities profiles

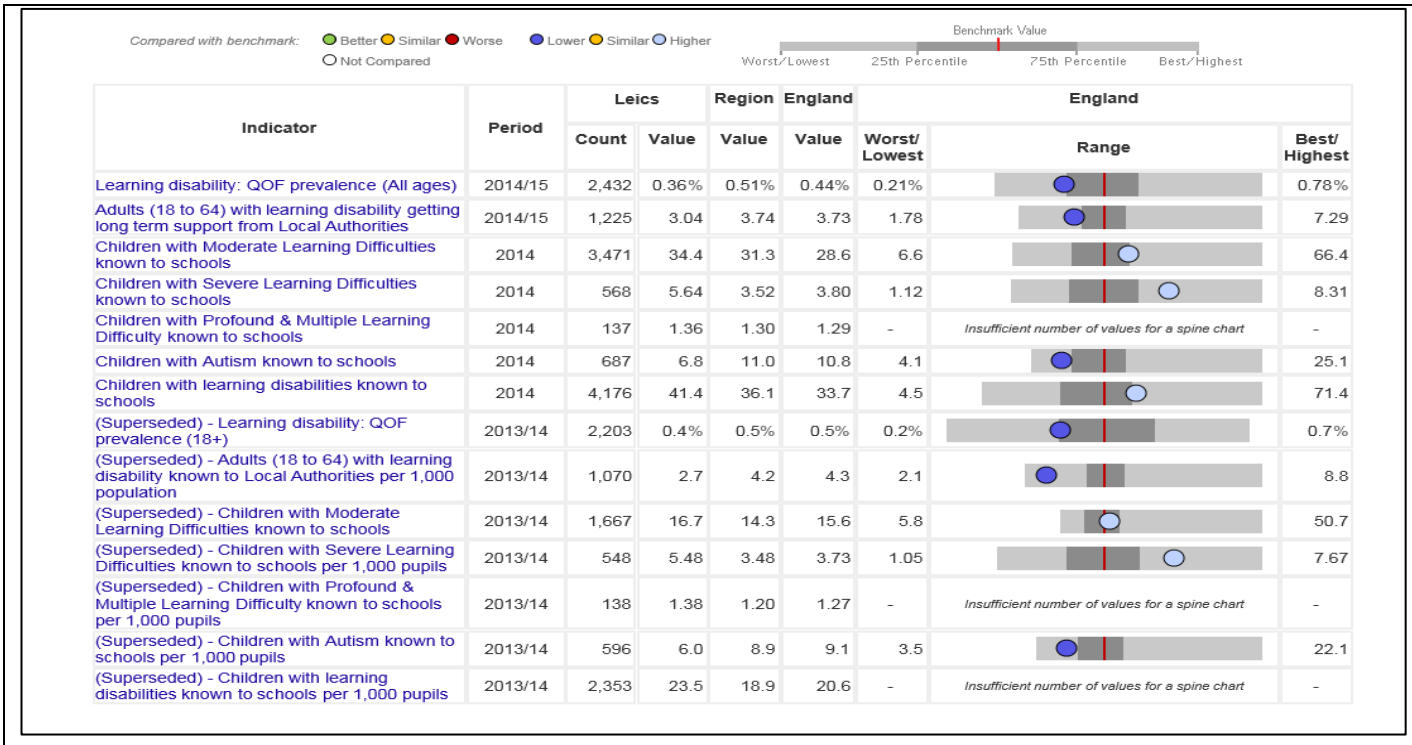
Public Health England have also produced a range of data about people with learning disabilities at Local Authority level:



Compared with benchmark: Better / Similar / Worse; Lower / Similar / Higher; Not Compared

Benchmark Value: Worst/Lowest | 25th Percentile | 75th Percentile | Best/Highest

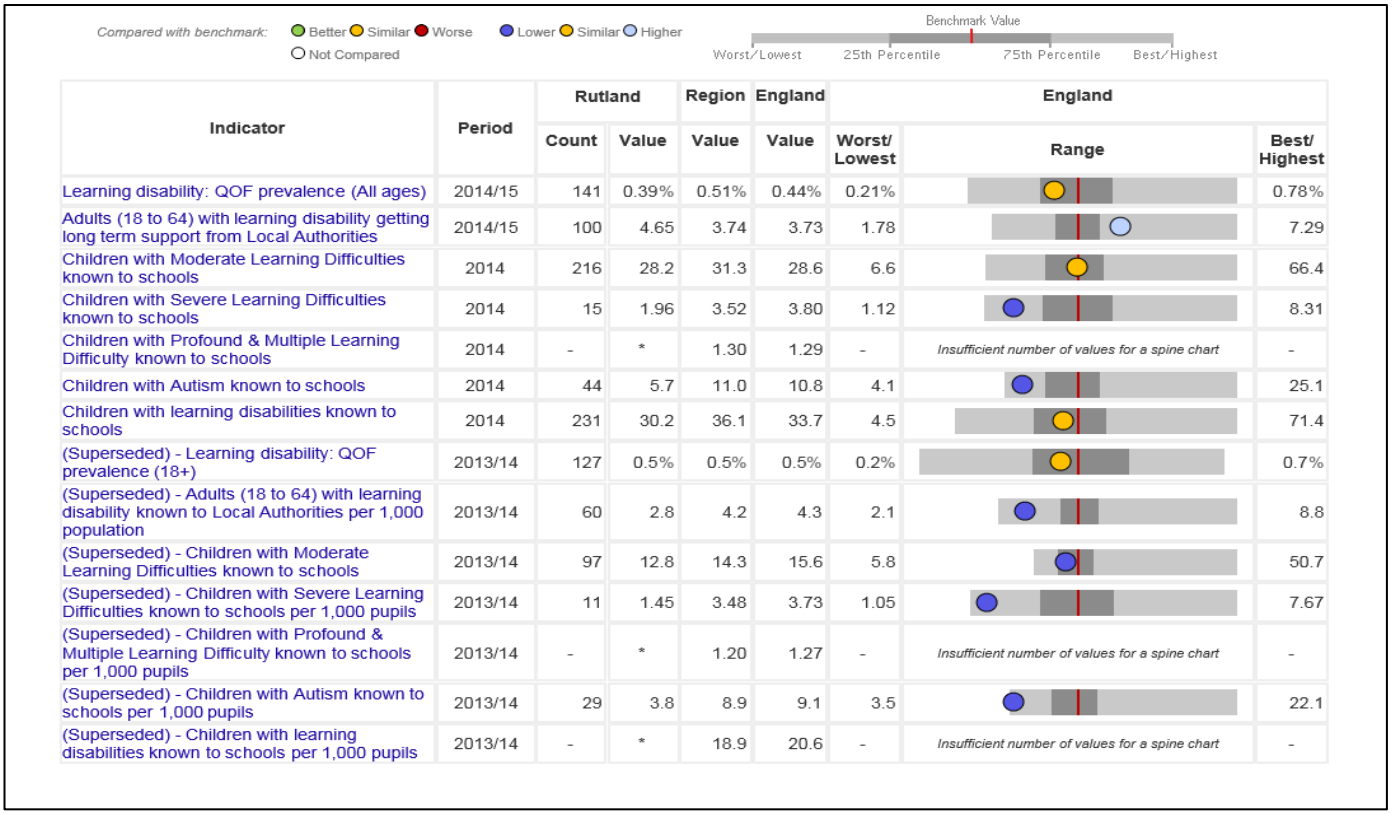
Indicator	Period	Leicester		Region	England	England		
		Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Learning disability: QOF prevalence (All ages)	2014/15	2,027	0.53%	0.51%	0.44%	0.21%		0.78%
Adults (18 to 64) with learning disability getting long term support from Local Authorities	2014/15	785	3.61	3.74	3.73	1.78		7.29
Children with Moderate Learning Difficulties known to schools	2014	2,270	42.1	31.3	28.6	6.6		66.4
Children with Severe Learning Difficulties known to schools	2014	213	3.95	3.52	3.80	1.12		8.31
Children with Profound & Multiple Learning Difficulty known to schools	2014	-	*	1.30	1.29	-	*Insufficient number of values for a spine chart*	-
Children with Autism known to schools	2014	350	6.5	11.0	10.8	4.1		25.1
Children with learning disabilities known to schools	2014	2,483	46.0	36.1	33.7	4.5		71.4
(Superseded) - Learning disability: QOF prevalence (18+)	2013/14	1,743	0.6%	0.5%	0.5%	0.2%		0.7%
(Superseded) - Adults (18 to 64) with learning disability known to Local Authorities per 1,000 population	2013/14	1,210	5.6	4.2	4.3	2.1		8.8
(Superseded) - Children with Moderate Learning Difficulties known to schools	2013/14	1,349	25.8	14.3	15.6	5.8		50.7
(Superseded) - Children with Severe Learning Difficulties known to schools per 1,000 pupils	2013/14	232	4.44	3.48	3.73	1.05		7.67
(Superseded) - Children with Profound & Multiple Learning Difficulty known to schools per 1,000 pupils	2013/14	54	1.03	1.20	1.27	-	*Insufficient number of values for a spine chart*	-
(Superseded) - Children with Autism known to schools per 1,000 pupils	2013/14	209	4.0	8.9	9.1	3.5		22.1
(Superseded) - Children with learning disabilities known to schools per 1,000 pupils	2013/14	1,635	31.3	18.9	20.6	-	*Insufficient number of values for a spine chart*	-



Compared with benchmark: Better Similar Worse | Lower Similar Higher | Not Compared

Benchmark Value: Worst/Lowest | 25th Percentile | 75th Percentile | Best/Highest

Indicator	Period	Leics		Region	England	England		
		Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Learning disability: QOF prevalence (All ages)	2014/15	2,432	0.36%	0.51%	0.44%	0.21%		0.78%
Adults (18 to 64) with learning disability getting long term support from Local Authorities	2014/15	1,225	3.04	3.74	3.73	1.78		7.29
Children with Moderate Learning Difficulties known to schools	2014	3,471	34.4	31.3	28.6	6.6		66.4
Children with Severe Learning Difficulties known to schools	2014	568	5.64	3.52	3.80	1.12		8.31
Children with Profound & Multiple Learning Difficulty known to schools	2014	137	1.36	1.30	1.29	-	*Insufficient number of values for a spine chart*	-
Children with Autism known to schools	2014	687	6.8	11.0	10.8	4.1		25.1
Children with learning disabilities known to schools	2014	4,176	41.4	36.1	33.7	4.5		71.4
(Superseded) - Learning disability: QOF prevalence (18+)	2013/14	2,203	0.4%	0.5%	0.5%	0.2%		0.7%
(Superseded) - Adults (18 to 64) with learning disability known to Local Authorities per 1,000 population	2013/14	1,070	2.7	4.2	4.3	2.1		8.8
(Superseded) - Children with Moderate Learning Difficulties known to schools	2013/14	1,667	16.7	14.3	15.6	5.8		50.7
(Superseded) - Children with Severe Learning Difficulties known to schools per 1,000 pupils	2013/14	548	5.48	3.48	3.73	1.05		7.67
(Superseded) - Children with Profound & Multiple Learning Difficulty known to schools per 1,000 pupils	2013/14	138	1.38	1.20	1.27	-	*Insufficient number of values for a spine chart*	-
(Superseded) - Children with Autism known to schools per 1,000 pupils	2013/14	596	6.0	8.9	9.1	3.5		22.1
(Superseded) - Children with learning disabilities known to schools per 1,000 pupils	2013/14	2,353	23.5	18.9	20.6	-	*Insufficient number of values for a spine chart*	-



Compared with benchmark: Better Similar Worse | Lower Similar Higher | Not Compared

Benchmark Value: Worst/Lowest | 25th Percentile | 75th Percentile | Best/Highest

Indicator	Period	Rutland		Region	England	England		
		Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Learning disability: QOF prevalence (All ages)	2014/15	141	0.39%	0.51%	0.44%	0.21%		0.78%
Adults (18 to 64) with learning disability getting long term support from Local Authorities	2014/15	100	4.65	3.74	3.73	1.78		7.29
Children with Moderate Learning Difficulties known to schools	2014	216	28.2	31.3	28.6	6.6		66.4
Children with Severe Learning Difficulties known to schools	2014	15	1.96	3.52	3.80	1.12		8.31
Children with Profound & Multiple Learning Difficulty known to schools	2014	-	*	1.30	1.29	-	*Insufficient number of values for a spine chart*	-
Children with Autism known to schools	2014	44	5.7	11.0	10.8	4.1		25.1
Children with learning disabilities known to schools	2014	231	30.2	36.1	33.7	4.5		71.4
(Superseded) - Learning disability: QOF prevalence (18+)	2013/14	127	0.5%	0.5%	0.5%	0.2%		0.7%
(Superseded) - Adults (18 to 64) with learning disability known to Local Authorities per 1,000 population	2013/14	60	2.8	4.2	4.3	2.1		8.8
(Superseded) - Children with Moderate Learning Difficulties known to schools	2013/14	97	12.8	14.3	15.6	5.8		50.7
(Superseded) - Children with Severe Learning Difficulties known to schools per 1,000 pupils	2013/14	11	1.45	3.48	3.73	1.05		7.67
(Superseded) - Children with Profound & Multiple Learning Difficulty known to schools per 1,000 pupils	2013/14	-	*	1.20	1.27	-	*Insufficient number of values for a spine chart*	-
(Superseded) - Children with Autism known to schools per 1,000 pupils	2013/14	29	3.8	8.9	9.1	3.5		22.1
(Superseded) - Children with learning disabilities known to schools per 1,000 pupils	2013/14	-	*	18.9	20.6	-	*Insufficient number of values for a spine chart*	-

These indicate some variation across the Partnership. Compared to the national average:

Leicester- there is a higher prevalence of people with learning disabilities and a higher than average number of adults getting support for the local authority. There is a higher than average number of children with moderate learning disabilities supported by school, but lower than average number of children with

Autism.

Leicestershire- There is lower prevalence of people with learning disabilities but a higher than average number of children with severe learning disabilities known to schools.

Rutland- Prevalence is lower than average but a higher than average numbers are supported by the local authority. The number of children with learning disabilities and autism known to schools is below the national average.

In line with the national service model (Annex c) we recognise the starting point should be a focus on those who are most at risk of inappropriate responses by services. We have therefore scoped number fitting into this categories, as indicated in the national service plans as at **31st January 2016**:

Service area	Unit type	City	County	Rutland	Totals
Hospital setting	NHS England funded specialised commissioning (adults)	5	6	0	**11**
	NHS England specialised commissioning (Children's)	0	0	0	**2**
	CCG funded Specialist LD Units	8	3	0	**11**
	CCG funded generic acute MH bed admissions	1	1	0	**2**
	CCG funded complex care and rehabilitation beds	0	3	3	**3**
	CCG funded Out of LLR alternative hospital placements (AHP's)	3	7	0	**10**
Out of area Care Homes (Adults)	LA or Joint funded out of LLR placements (Adults)	23	42	11	**76**
	CHC funded out of area placements	4	1	1	**6**
Out of area placements (Children)	Children in 52 week educational placements	6	2	0	**8**
	Looked after children's on other establishments	4	0	1	**5**
Specialist Community support challenging Behaviour from LD Outreach Team (2015) Adults)	Urgent Referral *	46	33	3	**82**
	Community Team referrals**	74	62	3	**139**
	Community Team referrals**	74	62	3	**139**

** leading to 14 admissions*
***leading to 13 admissions*

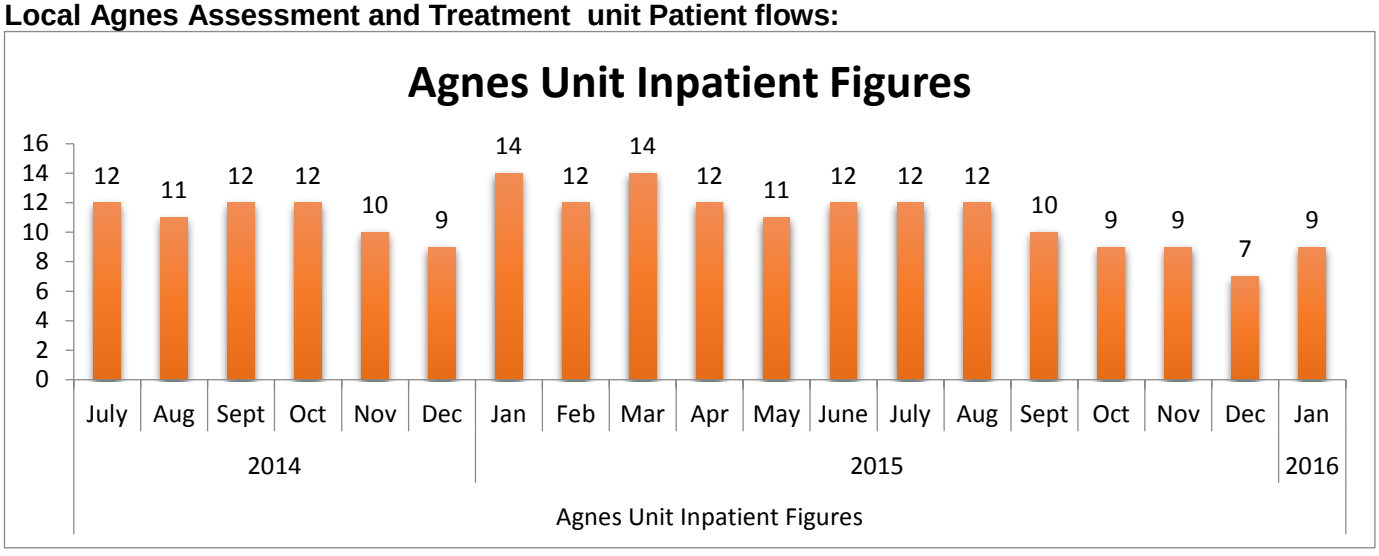
Analysis of inpatient usage by people from Transforming Care Partnership

NHSE specialised commissioning inpatients
Information provided by NHSE Specialised Commissioning at 9th March 2016 suggested there were 13 inpatients assigned to the three CCG's. However there have been several iterations of data therefore the **data must be validated**.

Responsible CCG	Unit Name	Level of Security
NHS LEICESTER CITY CCG	Hazelwood House	Low
NHS LEICESTER CITY CCG	Alpha Hospital, Bury	Low
NHS LEICESTER CITY CCG	Beech House - Huntercombe	Low
NHS LEICESTER CITY CCG	St Andrews - Nottinghamshire	Low
NHS LEICESTER CITY CCG	Oaktree Manor	Low
NHS EAST LEICESTERSHIRE AND RUTLAND CCG	Cheswold Park	Medium
NHS EAST LEICESTERSHIRE AND RUTLAND CCG	Broadland Clinic	Medium
NHS WEST LEICESTERSHIRE CCG	St Andrews - Nottinghamshire	Low
NHS WEST LEICESTERSHIRE CCG	Broadland Clinic	Medium
NHS WEST LEICESTERSHIRE CCG	Calverton Hill	Medium
NHS WEST LEICESTERSHIRE CCG	St Andrews - Northampton	Low
NHS Leicester City CCG	St Andrews – Northampton (CAMHS)	low secure beds
NHS Leicester City CCG	St Andrews – Northampton (CAMHS)	low secure beds

Six adults are in low secure units and will be potentially suitable for discharge over the next 3 years.
Joint CTR's are now being undertaken with NHSE Specialised Commissioning Team to profile and understand the needs of patient's considered ready for discharge. This will help ensure the provider market is shaped to enable the sustainable transfer of individuals.

Local Agnes Assessment and Treatment unit Patient flows:



Based on data of all discharges and transfers from the Agnes Unit in the past 17 months the length of stay was as follows:

Length of Stay	Number of Patients
1 month or less	21
Between 1-3 months	13
Between 3- 6 months	12
Between 6-12 months	2
Over 12 months	6

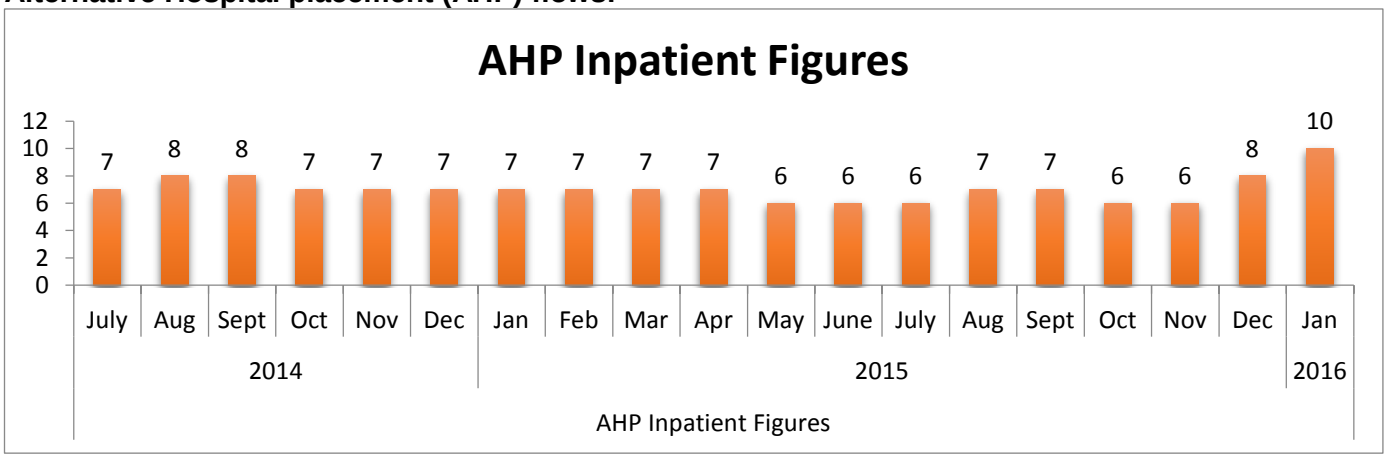
For current inpatients as at 01/03/16

Length of Stay	Number of Patients
1 month or less	3
Between 1-3 months	4
Between 3- 6 months	1
Between 6-12 months	2
Over 12 months	2

The unit currently has two long stay patients undergoing rehabilitation. The remainder have been short to medium stay patients. In 2015 a significant number of short stay admissions have been made despite the intervention of the LD outreach team, indicating current service arrangements are not effective.

Two individuals have been identified as 'revolving door' in last 12 months. One was due to poor management by a residential care home, which has been addressed and the second relates to the individuals personality disorder.

Alternative Hospital placement (AHP) flows:



Below is a summary of placement if current placements:

Provider	Location	Admission Date
Brookdale	Milton Park Independent Hospital ,Bedford	01/10/2009
Cambian	Sherwood Lodge, Notts	20/09/2011
Danshell	Newbus Grange Hospital, Darlington	08/05/2012
Cambian	Oak Court, Fairview Hospital, Essex	14/06/2013
Inmind	Sturdee Hospital, Leicester	21/08/2014

Cambian	Sherwood Lodge, Mansfield, Notts	29/06/2015
Huntercombe	Ashley House, Market Drayton, Staffordshire	16/12/2015
Cambian	Sherwood Lodge, Shire brook, Notts	16/12/2015
Cambian	Cambian Cedars, Birmingham	18/01/2016
St Andrew's	Thornton Ward, Northampton	18/01/2016

Five AHP placements have been made within the last year. These have all been patients stepping down from specialised commissioning low secure units to CCG funded locked facilities. The decision to step down these patients to locked facilities has primarily been made by specialised commissioning and current providers, with it appears limited exploration of local facilities. Some of this step down has been to a locked unit run by the same provider on the basis they will be able to provide some continuity of care.

Net importer or exporter?
Given there are limited independent inpatient facilities within the Partnerships geographical boundary, overall we consider ourselves a small net exporter.

Describe the current system

1. **People with a mental health problem which may result in them displaying behaviours that challenge:**

Adults: Assessment services are provided by NHS Leicestershire Partnership Trust LPT. Those with an intellectual disability and autism are supported by community learning disabilities services. Those with Autism and no intellectual disability do not receive dedicated ongoing support from healthcare but some social work support.

Children & Young People: Those with Autism and Asperger's without an intellectual disability are primarily supported the generic LPT CAMHS team.

2. **People with a severe learning disability who display self-injurious or aggressive behaviour :**

Adults: Primarily supported by LPT services including:
- Primary care Liaison Nurses
- Community Learning Disability Teams
- LD Outreach Team (Adults)
- Agnes Assessment and Treatment Unit
- Health Short-breaks provision

Children and Young People: those with a moderate or profound learning disability and representing with mental health problems are supported by a dedicated CAMHS LD Team. They provide input through an outpatient service which can be supplemented to if necessary using our outreach team. They also respond to crisis situations requiring intense intervention within the home and / or inpatient admission.

3. **People who display risky behaviours which may put themselves or others at risk (e.g. fire setting, abusive, aggressive or sexually inappropriate behaviour:**

Adults: supported either by LPT Agnes Assessment and Treatment Unit (particularly as part of a step down from secure services) or by LPT community and inpatient Forensic Mental Health services:

Children and Young People: supported by LPT specialist CAMHS community and inpatient services

4. **People who display behaviour which may lead to contact with the criminal justice system- often with lower support needs, from disadvantaged backgrounds, personality disorder:**

Adults: supported by LPT Community Mental Health and liaison/diversion services. This includes a Triage Car staffed by Leicestershire Police and a mental health nurse to ensure a quick response and the most effective treatment for the individuals concerned, thus avoiding the Criminal Justice Route wherever possible.

Children: Local Youth Offending Teams (YOTs) have CAMHS worker embedded within them.

5. **People who have been inpatient care for a very long time, having not been discharged when NHS Campus or long stay hospitals were closed:**

We do not have any individual in this category to our knowledge.

What does the current estate look like? What are the key estates challenges, including in relation to housing for individuals?

Local NHS Trust Assessment and Treatment Unit
The inpatient provision for People with Learning disabilities is delivered from a 20 bedded unit called the Agnes Unit. We have been advised by NHS Partnership Trust that it is a PFI building so does not have a CGA attached to it.

Currently, 16 out of the 20 beds are commissioned towards the assessment and treatment of individuals with Learning disabilities presenting with Challenging behaviour and/or Mental health problems. As part of the BCT planning, clinical models have been developed with an objective on reducing the reliance on inpatient units by intensive care and Crisis management in the Community. This will lead to a reduction in a reduction of 4 beds over 2017/18.

It is recognised that a high cost and inflexible PFI on local Assessment and Treatment is a significant challenge on our current ability to redesigning services. During 2016/17 the partnership will need to detailed consideration to the ability to further reduce the local assessment and treatment bed base over the next 3 year and whether it is viable to continue provision at the Agnes Unit?

Independent sector inpatient facilities:
There are no specific adult independent sector LD inpatient facilities in LLR geographical area so no specific estate challenges have been identified.

Where treatment and rehabilitation needs cannot be met by NHS Leicestershire Partnership Trust, some placements are made in regional and national facilities run by providers such as Cambian Healthcare and St. Andrews. Therefore there will be a need to work with regional partnership to understand the impact of their plans for independent sector provision on our patients in these facilities.

Short Breaks provision
Short breaks bed based provision currently includes:

- 15 health beds in three unit run by NHS Leicestershire Partnership Trust
- 28 social care beds in the county across 4 sites based in: Melton (6 beds), Wigston (6 beds), Hinckley (10 beds), Coalville (6 beds)

As part of BCT planning, various models of short break provision are being scoped with a view to improving the offer, choice and access of more local, community based person centred short break provision responsive to Service user/carer needs, including for those directly purchasing through the use of their Health, Social Care or Integrated Personal Budget. This includes those who need crisis support in the community as a result of a deterioration in mental health which does not require an inpatient stay and emergency provision in the event that the carer is unable to provide care for a short period of time.

Future models will be determined further to consultation stake holders, including people with learning disabilities and family carers. This is planned for the autumn of 2016.

Housing in the community
There is a particular challenge to develop appropriate long term accommodation for people with significant challenging behaviour or behaviour that poses a risk to others and develop or identify suitable long term housing.

The TCP includes two unitary Local Authorities (Leicester City and Rutland) and a 2 tier Local Authority (Leicestershire) which means innovative solutions are needed working in partnership with Local Housing Providers, Registered Social Landlords, Independent Sector Providers and the 6 district councils who are responsible for housing within the area alongside the City and Rutland.

Our planned market position statement will also support this challenge ensuring the availability of high quality support to compliment the development of a range of accommodation models to meet identified local needs.

What is the case for change? How can the current model of care be improved?
Taking into account key legislative and practice changes which have implications for all people with a Learning Disability, in response to the Winterbourne View Reports in 2012, partners across LLR started a journey to transform care for people with Learning Disabilities and or autism who display behaviour that challenges through the Better Care Together program work.

Services and plans for Transforming Care/ Better Care Together Learning Disability Work Stream

Our existing service	What are we going to do?	Our outcomes in 5 years
• High use of specialist services and under - developed offer from universal and preventative services • Too many people accessing long-term inpatient and residential services • Carer support and short breaks are inconsistent and not sufficiently integrated • Poorly developed market leading to over-priced package provision - we need to work together to manage and develop the learning disabilities market	• Joint market management and development • Develop integrated personal budgets to match support better to needs • Develop local community services • Consider the pooling of health & social care budgets • More consistent whole life approach across children and adult services • Better support for universal and primary care services • Develop more integrated pathways and short break provision	• All individuals will have the opportunity for a health and social care assessment • Fewerr people in institutional care • All individuals eligible will have a health & social care personal budget • More people will live in their own homes / individualised accommodation • More people will opportunities to access employment, education and social support • More people will be able to live in their locality

However it is recognised much more work is needed to further develop services, embed processes, shape the provider market and to ensure that services are sustainable for the future. The model of care for adults is in its early stages and it is recognised through our engagement work, that much more work is needed to:

- Reduce the reliance on inpatient care through person centred flexible care
- Transfer care into a community setting that offers high quality and safe services
- Develop community support models to focus on prevention, integration, care planning, crisis plans, places of safety and further develop housing and services to ensure that high quality services and capacity are available when needed
- Develop and retain the right workforce who have the necessary skills and knowledge across patient pathways to support clients in the community
- Improve integration and communication across the system and for organisations, professionals and teams to work better together to ensure that the care that is commissioned and provided is centred around the individual but also that consideration is given to the

families and carers who provide a vital service to support people keeping and staying well.

- Improve pathways to reduce delays and preventable escalations of needs, including admissions.

In relation the specific cohorts:

1. **People with a mental health problem which may result in them displaying behaviours that challenge:**
   - A need for an overall a 'whole life' preventative approach is with a much greater emphasis of addressing or reducing the impact of challenging behaviours from a young age.
   - In relation to the Autism Care Pathway a need to develop ongoing specialist support to individuals with Autism without an intellectual disability
   - In relation to Children a need to improve early detection services and improve crisis response and home treatment services when crisis situation arise.

2. **People with a severe learning disability who display self-injurious or aggressive behaviour :**
   - A need to refocus and enhance the LD Outreach team to ensure it is better able provides appropriate crisis and community support to support admissions avoidance.
   - A need to review the care pathway into Agnes Unit given the variation to the access, with admissions directly from the Community Teams & LD Outreach Team with neither maintaining patient responsibility following admission. The latter does not support early discharge.
   - A need to review and transform our short breaks health and social care provision from a one size fits all building based model to person centred and flexible support model, which young people and carers are increasingly requesting.
   - A need to develop individual and personalised services through increasing the number of individuals local Personal Health and Integrated Budgets offer for people identified at risk of admission and build on our baseline of 4 people with LD currently on a PHB.
   - A need to review local health and social care funding arrangements, to ensure they support early discharge from assessment and treatment units.
   - A need to strengthen links between children's, transition and adult services to support planning for accommodation need in adulthood.

3. **People who display risky behaviours which may put themselves or others at risk (e.g. fire setting, abusive, aggressive or sexually inappropriate behaviour**
   - A need to review community forensic support services to ensure the needs of this cohort can be met.
   - A need to further develop accommodation and the provider market for people with high support needs arising from challenging or risky behaviour – both step through and longer term community based provision
   - The opportunity to consider the role of the Agnes Unit in 'resettling' people who have been in hospital for many years and need to be stepped down from low secure units

4. **People who display behaviour which may lead to contact with the criminal justice system- often**

with lower support needs, from disadvantaged backgrounds, personality disorder

- A need to strengthen community based crisis response and home treatment services for both adults and children.
- A need to explore the feasibility of developing a 'Crisis House' facility for 'revolving door' inpatients with lower support need as an alternative to hospital admission.
- A need to develop the local Personal Health and Integrated Budgets offer for this group as some individuals will be able to develop approaches to manage their own care.

3.Develop your vision for the future

Vision, strategy and outcomes

Describe your aspirations for 2018/19.

Vision

Our overall vision is that all people with a learning disability and/or autism should have a good life that meets their needs, aspirations, respects their rights, and keeps them independent in their local communities.

We will deliver our vision by:

1. Providing more proactive, preventative care, with better identification of people at risk and early intervention
2. Empowering people with a learning disability and/or autism to manage their own care through the expansion of personal budgets, integrated budgets and personal health budgets and through independent advocacy
3. Supporting family members of children with a learning disability (under 18 year olds) to care for them home, and the provision of high-quality social care with appropriate skills
4. Providing greater choice and security in appropriate housing.
5. Ensuring access to activities and services that enable people with a learning disability and/or autism to lead a fulfilling, purposeful life (such as education, leisure)
6. Ensuring people with a learning disability and/or autism whose behaviour challenges are able to access mainstream health services (including mainstream mental health services in the community)
7. Providing specialist multi-disciplinary support in the community, including intensively when necessary to avoid admission to hospital
8. Ensuring that services aimed at keeping people out of trouble with the criminal justice system are able to address the needs of people with learning disabilities and/or autism, and that the right specialist services are in place in the community to support people with a learning disability and/or autism who pose a risk to others
9. Providing local hospital services that are high-quality and assess, treat and discharge people with a learning disability as quickly as possible.

This will be supported by our wider Children and Young People ' Futures in Mind ' strategy, who's vision is that by 2020, every child and young person in Leicester, Leicestershire and Rutland will be able to affirm

the following:

Self- care and prevention	*Early help and primary care*	*Specialist care*
My family and I are able to look after my emotional and mental wellbeing and development day to day. *I learn about mental health and how to protect myself at school or college.* *We can access trusted self-care advice when and where we like including websites, education settings, GPs and children's centres* *My parents / carers have access to support and guidance* *I am confident in talking about issues which affect my mental health*	*We can get high quality support to help me overcome emotional and mental health challenges quickly and locally, without being stigmatised.* *I will be able to make informed choices about the kind of help I would like.* *I and those who care for me will be listened to.* *I will be supported to become resilient and independent.* *I and my carers will be helped to navigate the system and services.* *I am involved in peer support groups and community networks in my area.*	*I will be helped by a specialist team quickly if my mental health problems are serious* *I will receive support which is safe, reliable and tested.* *I will be involved in setting my own treatment goals and deciding if I am getting better.* *With my consent, services will work together with me and my family to give us the best support.* *I will be involved in decisions to transfer or reduce my care.*

How will improvement against each of these domains be measured?
We plan use all the indicators in Appendix A , the LD SAF outcomes measures for people and the impact of changes to service models on the wider population to monitor progress.

In addition we identified the following key outcomes as markers of progress:

Adults:

- Increase in number of people with learning disabilities on integrated or Personal Health Budgets
- Reduction in the number of patients needing hospital admission, (measured by monitoring outcomes of blue light/pre-admission/ post admission Care and Treatment Reviews)
- Reduction on DTOC levels
- Use of and the evaluation of the effectiveness of the Step Through facility

Children and Young People:

- The number of children and young people assessed by the specialist CAMH service.
- Hospital admission rates for children for self-harm and attempted suicide

Describe any principles you are adopting in how you offer care and support to people with a learning disability and/or autism who display behaviour that challenges.
In terms of describing what good looks like, partners have adopted the "Driving Up Quality" standards and the service model is structured on nine core principles:

1. I have a good and meaningful everyday life
2. My care and support is person-centred, planned, proactive and coordinated
3. I have choice and control over how my health and care needs are met

4. My family and paid support and care staff get the help they need to support me to live in the community
5. I have a choice about where I live and who I live with
6. I get good care and support from mainstream health services
7. I can access specialist health and social care support in the community
8. If I need it, I get support to stay out of trouble
9. I am admitted for assessment and treatment in a hospital setting because my health needs can't be met in the community, it is high quality and I don't stay there longer than I need to

'Golden threads' which run consistently through the principles which are expected to be reflected in commissioning strategies are:

Quality of life – people should be treated with dignity and respect. Care and support should be personalised, enabling the person to achieve their hopes, goals and aspirations; it should be about maximising the person's quality of life regardless of the nature of their behaviours that challenge. There should be a focus on supporting people to live in their own homes within the community, supported by local services.

Keeping people safe – people should be supported to take positive risks whilst ensuring that they are protected from potential harm, remembering that abuse and neglect can take place in a range of different environments and settings. There should be a culture of transparent and open reporting, ensuring lessons are learned and acted upon.

Choice and control – people should have choice and control over their own health and care services; it is they who should make decisions about every aspect of their life. There is a need to 'shift the balance of power' away from more paternalistic services which are 'doing to' rather than 'working with' people, to a recognition that individuals, their families and carers are experts in their own lives and are able to make informed decisions about the support they receive. Any decisions about care and support should be in line with the Mental Capacity Act. People should be supported to make their own decisions and, for those who lack capacity, any decision must be made in their best interests involving them as much as possible and those who know them well.

Support and interventions should always be provided in the least restrictive manner. Where an individual needs to be restrained in any way – either for their own protection or the protection of others, restrictive interventions should be for the shortest time possible and using the least restrictive means possible, in line with Positive and Proactive Care.

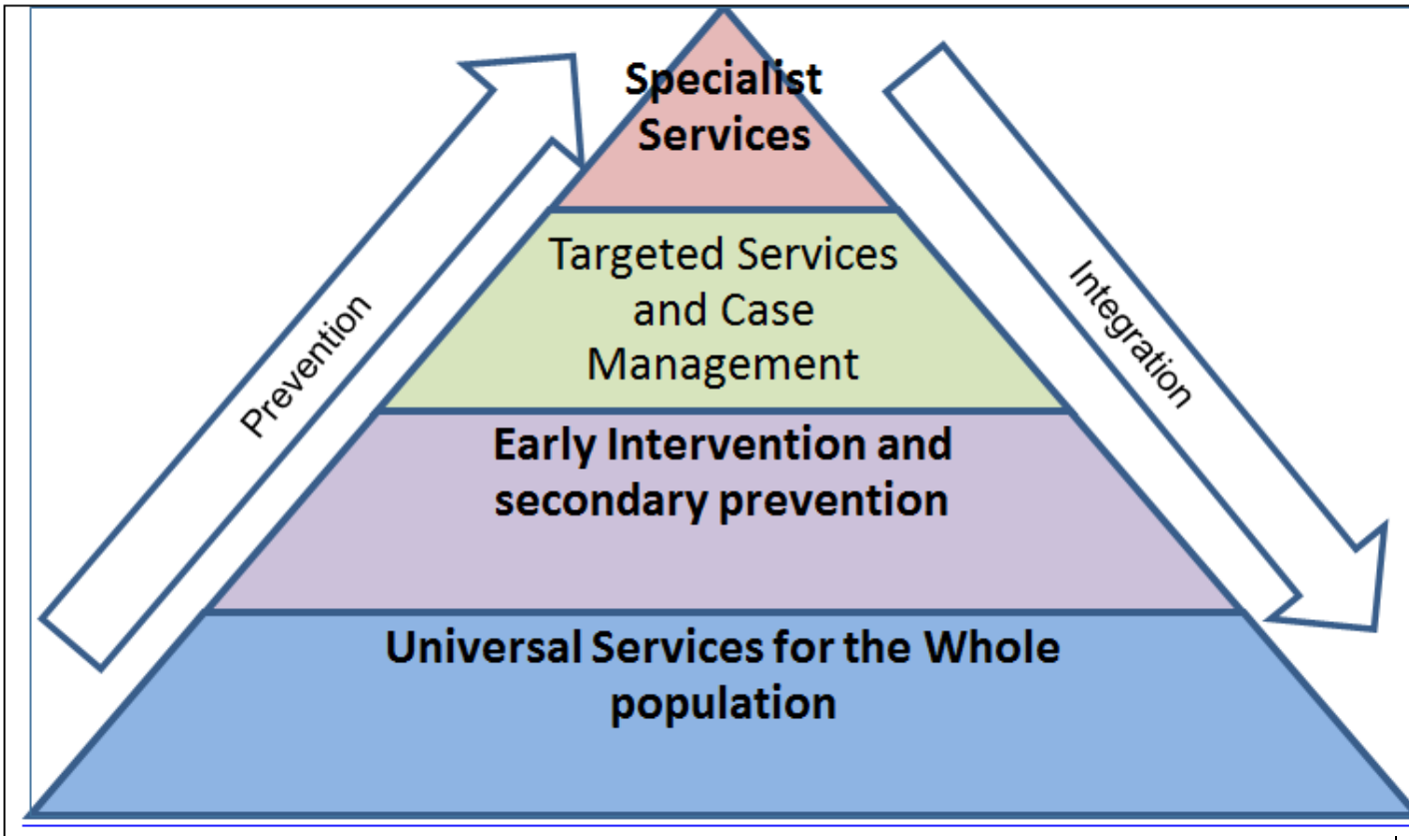
In addition, we will use the 14 core principles The recently published Core Commissioning Tool, Ensuring Quality Services as a basis for commissioning practice, emphasising the need for education, health and social care to work together to deliver a whole life approach to support:

1. Positive Behavioural Support
2. A whole systems life course approach
3. Prevention and early intervention
4. Family carer and stakeholder partnerships
5. Function based holistic assessment
6. Behaviour that challenges is reduced by better meeting needs and increasing quality of life
7. Support for communication
8. Physical health support
9. Mental health support
10. Support for additional needs
11. Specialist local services
12. Safeguarding and advocacy
13. Workforce
14. Monitoring quality

4.Implementation planning

Proposed service changes (incl. pathway redesign *and* resettlement plans for long stay patients)

Overview of your new model of care



Under our new model of care the extent of community provision relative to inpatient provision will be much more extensive than it is now. Community provision will be focused on three cohorts

Cohort	Description	Services
The wider learning disability and autism population	This is the cohort that is currently unknown to services, with the exception of primary care. Mainstream services and community networks will need to support people with a learning disability and/or autism living well in the community without the need for specialist services for those with learning disabilities and/or autism where possible.	• Annual health checks • Primary care liaison nurses • Targeted health promotion (using risk stratification tools) • Third sector Health promotion and facilitation • Improved access to mainstream services including education, employment and housing • Main Acute hospital liaison support services • Advice and Information • Local Offer
The current community	The community provision will need to keep people with a	• Care and Treatment Reviews if at risk of admission

cohort	learning disability and/or autism living well in communities, preventing deterioration in their wellbeing and crises so that their need for residential care and inpatient services is reduced to when they are the best option for the person concerned.	• Enhanced LD Outreach Team • Personalised services through PHB's. • Dedicated Autism support services • Personalised respite care options • CAMHS multi agency First Response service • Specialist community CAMHS service for children with moderate to severe learning disabilities & related MH needs • Peer support networks • Access to short breaks for those living with at home
The current in-patient cohort, including those in forensic settings	The community provision will need to effectively accommodate those previously served by inpatient settings, so that the people concerned can improve their quality of life, and the quality of care and support is improved so that they can stay living in the community and any inpatient admissions are minimised.	• Care and Treatment Reviews • Personalised services through PHB's • Dedicated Care co-ordinator (discharge planning NHSE and Independent Hospital placements) • Enhanced and expanded Outreach Team • Supported housing schemes including ' step through' • Independent advocacy • Access to short breaks for returning to the family home • Community Forensic support services for people with LD and related MH needs.

Our new model of care we be delivered through the following initiatives:

Providing more proactive, preventative care, with better identification of people at risk and early intervention

- Continuous development and promotion of a secure CCG web based at 'risk of admission' register to support early identification of those at risk of admission to hospital. This will include children and young people at risk of admission.

- Year on year increase in the take up of Learning Disabilities annual health checks and associated Health Action Plans in particular ensuring screening for long term conditions, cancer and dementia.

- Using population based risk stratification tools to identify patient on GP's learning disability register that have significant comorbidities which would benefit from increased primary care support.

- We will commission a LLR multi-agency "First Response" service which will assess the level of distress and risk facing a child, young person or family, and co-ordinate the right intervention and support.

- We will ensure all person centred care and support plans for adults and Education, Health and Care Plans (EHC) for children, will include crisis and contingency arrangements.

- Scoping the need to commission the voluntary and community sector to work alongside primary

care on health promotion- running a series of programmes aimed at encouraging and supporting people with learning disabilities and their family carers to live healthier lifestyles

Empowering people with a learning disability and/or autism, for instance through the expansion of personal budgets and personal health budgets and independent advocacy.

- Clear targets to increase the number of people with a learning disability on an integrated or Personal Health Budget over the next 3 years.
- To expand the use of personal Health Budgets for families of children with complex care needs
- Developing the provider market to support individuals with high support needs through personal budgets.
- To strengthen information, advice and support services to support our Personal Health Budgets offer for people with learning disabilities who have high support needs, building on learning from local and national best practice.
- To develop regional circles of support to support sharing of good practice and outcomes and allow users and carers to 'tell their story'
- Review need to enhance advocacy services to act as a key enabler for new models of care when individuals are undergoing a significant change, in particular for those in inpatient facilities, at risk of admission or going through transition.

Supporting families to care for their children at home (under 18 year olds), and the provision of high-quality social care with appropriate skills

- We will implement the LLR 'Transformational Plan and Implementation Plan for the Mental Health & Wellbeing of Children and Young People 2015-2020' which aims to improve early prevention help and specialist support services, including those with a learning disability and associated mental health needs
- Commission a specialist community CAMHS service for children with a moderate to severe learning disabilities and related mental health difficulties.
- We will develop training programmes in child mental health for social care practitioners and others working with children and families.
- Developing early intervention programmes for families and carers of people who challenge, including evidence based parent training programmes and associated skills training.
- Development of peer support networks to provide support to other families.

Providing greater choice and security in housing.

- Evaluation of the effectiveness of the recently established 4 unit local 'step through' facility.
- To work with housing and support providers to further develop 'step though' accommodation, particularly for those with significant challenging behaviour or behaviour that poses a risk to others.
- To further develop a choice of long term housing, including small scale supporting living to support step through and independent living. The development of additional step through provision will require market development and additional capital investment.

- To develop a 'needs assessment' the housing needs of people with learning disability, including those with autism and those being released from prison.

- Develop options to support people locally who are currently resident in out of area placements; including young people returning to Leicester from school placements.

Ensuring access to activities and services that enable people with a learning disability and/or autism to lead a fulfilling, purposeful life (such as education, leisure)

- To increase life opportunities through the use of personal budgets

- Develop and range of initiatives to support employment and volunteering opportunities

- Through local partnerships work with local colleges and support providers to increase education opportunities for young people with profound and multiple learning disabilities

- Improve communication standards and accessibility information for community services.

- Development of peer support networks to provide support to other individuals and their families.

Ensuring people with a learning disability and/or autism whose behaviour challenges are able to access mainstream health services (including mainstream mental health services in the community)

- Review current building based short breaks provision in order to develop person centred and flexible provision. Initially to pilot PHB for short breaks provision with young people coming though transition in 2017/18.

- Implement LLR Autism Strategy 2014-2019 including commissioning a post diagnostic support service for those people without an intellectual disability.

- Improve communication standards and accessibility information within GP Practices

- Reviewing the effectiveness and level of need for liaison support workers within the main acute hospital and enhance this if necessary

- Develop an alert (e.g. flagging systems) between GP practices and mainstream acute hospitals to ensure reasonable adjustments are made when required a person with a learning disability is admitted to hospital

Providing specialist multi-disciplinary support in the community, including intensively when necessary to avoid admission to hospital

- Refocused and enhanced LD Outreach team with the purpose of enhancing the intensity of care and support in the community and therefore reduce the likelihood of admission by
  - Increase the Outreach working hours to a 7 day service 8am to 9pm, when most crisis have been identified to occur
  - Employ dedicated therapy staff within team
  - Strengthen the admission pathway by expecting the involvement of the Outreach team in all patients considered as risk of hospital admission, and therefore improve the likelihood of intensive community based care.
  - Maintaining outreach team involvement during any inpatient admission to support early discharge.

- Through the Future in Mind transformational fund we will commission a LLR multi-agency intensive community and home treatment services. These services will operate extended hours seven days a week, and will provide home visits and intensive work with the young person, their carers and other agencies such as school or social care. The aim will be to reduce and avoid admission to either ED or mental health in-patient units and also support planned discharge from in-patient units

- Review recently established LLR blue light, pre-admission and inpatient Care and Treatment policy and practice to improve efficiency and effectives.

- Consider the need for further enhancements to the LD Outreach Team to increase service specialism in supporting people at risk of admission.

- Scope the need to develop a LLR Learning Disabilities crisis intervention service or facility which provides intense support for a short period in a time of crisis, preventing admission into a hospital setting

Ensuring that services aimed at keeping people out of trouble with the criminal justice system are able to address the needs of people with learning disabilities and/or autism, and that the right specialist services are in place in the community to support people with a learning disability and/or autism who pose a risk to others

- Working with local police teams to ensure they are aware of people with a learning disability and/or autism who pose a risk to themselves or others and who key contacts are.

- Building on existing strong local liaison and diversion services, including the street triage service.

- Develop basic awareness training programmes for criminal justice organisations on meeting the need of people with learning disabilities and/or autism.

- Review the role of the Agnes Unit in being able to support the 'resettlement' people from low secure forensic units back into the community

- To review need to enhance current community forensic support services to meet needs of individual stepping down from secure services.

Providing hospital services that are high-quality and assess, treat and discharge people with a learning disability as quickly as possible.

- Current plans to reduce the number of short stay assessment and treatment beds from 8 to 4 (Overall unit bed size from 16 to 12) by 2019.

- We will ensure there is a community (pre-admission) CTR or blue light meeting take place before any proposed inpatient admission.

- Ensure all assessment or treatment admissions will have a clear stated purpose and expected outcomes.

- All admissions to the local Agnes Unit be case managed by the LD Outreach team to support any early discharge

- In relation to children and young people the need to work as part of regional collaborative commissioning arrangements to strengthen the provision of in-patient facilities within our region and ensure that there are good protocols for partnership working between Tier 3 and Tier 4

commissioners and providers.

What new services will you commission?

Planned	For scoping/ dependent on funding
• LLR multi-agency "First Response" service which will assess the level of distress and risk facing a child, young person or family, and co-ordinate the right intervention and support. • CAMHS Crisis Resolution and Home Treatment Service • Increased number of integrated and Personal Health Budgets for people at risk of admission due to a learning disability or associated mental health needs or for respite care purposes. • Advice and support brokerage services to support the development of Personal Budgets. .	• Third sector primary healthcare facilitation services • Specific advocacy services for those undergoing significant change, in particular for those in inpatient facilities, at risk of admission or going through transition • Support for sector workforce and implementing Positive behaviour practice and admission avoidance approaches through care and Treatment reviews. • New 'step through' supported accommodation provision • LLR Crisis intervention service or facility to provide intensive support for a few weeks at times of crisis, preventing admission into a hospital setting. • Review need to enhance SALT provision with the LD Outreach Team

What services will you stop commissioning, or commission less of?

- Reduction on local A &T unit short stay beds (Two in 2017/18 and two in 2018/19). We plan to further review opportunities for further reduction in local Assessment and Treatment short stay beds following strengthened community services being in place
- OOA independent inpatient placements, only made in exceptional circumstances
- Building based short breaks linked to development of more flexible and person centred provision including Personal Budgets/ Integrated Budgets/ Personal Health Budgets.

What existing services will change or operate in a different way?

- Micro-commissioners and community support providers will work to local Care and Treatment Review policies to support admissions avoidance.
- Refocused and enhanced the LD Outreach team to support admissions avoidance and early discharge.
- Specialist Autism service expanded and enhanced in order to provide ongoing holistic support to people with and without intellectual disability.
- Review the role of the Agnes Unit in being able to support the 'resettlement' people who have been in hospital for many years.

Describe how areas will encourage the uptake of more personalised support packages

The CCG's are establishing **dedicated PHB team** hosted with East Leicestershire and Rutland CCG to develop our local offer. This team include a learning disabilities nurse whose remit is support an increase in

the number of people with a learning disability on an integrated or PHB.

Our plan for the expansion of integrated and PHBs to people with learning disabilities includes :

- Children and young people with learning disabilities and who have significant health needs who could be offered personal budgets (or personal health budgets) to enable them to remain living in the community and avoid out of area placements.

- People with learning disabilities and mental health needs. For example, people with learning disabilities who are on the Care Programme Approach would be a readily identifiable group who might benefit from a PHB to support them at home or in supported housing.

- People with learning disabilities who are inpatients and those at risk of admission.

- Identify other LD groups with significant health needs that might benefit from a personal health budget.

The targets for people with learning disabilities to be on an integrated or PHB is as follows:

	15/16	16/17	17/18	18/19	19/20	CCG total
ELR CCG	1	15	15	15	15	61
LC CCG	1	17	17	17	17	69
WL CCG	1	16	16	16	16	65
					Overall total	195

In relation to children and families the vision is to put young people and their families in control of the planning process across 4 outcomes by shifting control through the Local Offer. Post 14 reviews have a planning structure to focus on the following 4 outcomes using a person centred approach:

- Better outcomes for health
- Better outcomes for education, training and work,
- Better outcomes for developing independence and housing options
- Better outcomes for community access and inclusion

What will care pathways look like?

We plan to employ a care co-coordinator with specific responsibility to support discharge back to the local provision for patients in AHP's and specialised commissioning placements.

To support this we have initially scoped Discharge arrangements for LD patients from Specialised Commissioning local Assessment & Treatment Unit/ Alternative Hospital Placements:

Transforming care - Discharge arrangements for LD patients from Specialised Commissioning local Assessment & Treatment Unit/ Alternative Hospital Placements			
Resource	**Process**	**Funding responsibility**	**Notes**
Specialised commissioning unit to specialised commissioning unit			
Planned & agreed through CTR (MH Act applies)	Direct transfer, no section 17 leave	Specialised commissioning responsible, region may	
Specialised commissioning to local ATU			
Planned & agreed through CTR (MH Act applies)	Direct transfer, no section 17 leave	Specialised commissioning to CCG	
Specialised commissioning to Step Down			
Planned & agreed through CTR & CHC (MH Act applies)	Direct discharge, consider section 17 leave or CTO	CCG/GEM assessment / LA Section 117 applies	community support including Back-up & contingency plans
Agnes Unit (Local Assessment & treatment unit) to Step Down			
Planned & agreed through CTR (MH Act applies)	Direct discharge, consider section 17 leave or CTO	CCG/GEM assessment / LA Section 117 applies	community support including Back-up & contingency plans
Planned & agreed through CTR (Informal patient)	Direct discharge	CCG/GEM assessment / LA	community support including Back-up & contingency plans
Agnes Unit (Local Assessment & treatment unit) to Community (family,			
Planned & agreed through CTR (MH Act applies)	Direct discharge, consider section 17 leave or CTO	CCG/GEM assessment / LA Section 117 applies	community support including Back-up & contingency plans
Planned & agreed through CTR (Informal patient)	Direct discharge	CCG/GEM assessment / LA	community support including Back-up & contingency plans
Agnes Unit (Local Assessment & treatment unit) to Specialised			
Planned & agreed through CTR (MH Act applies)	Direct transfer, no section 17 leave	Specialised commissioning responsible region may change	
Alternative Hospital Placement (AHP - GEM) to **Agnes Unit**			
Planned & agreed through CTR (MH Act applies)	Direct transfer, no section 17 leave	GEM to CCG	
Alternative Hospital Placement (AHP - GEM) to **Step Down**			
Planned & agreed through CTR (MH Act applies)	Direct discharge, consider section 17 leave or CTO	CCG/GEM assessment / LA Section 117 applies	community support including Back-up & contingency plans
Alternative Hospital Placement (AHP - GEM) to **Step Down**			
Planned & agreed through CTR (Informal patient)	Direct discharge	CCG/GEM assessment / LA	community support including Back-up & contingency plans
Alternative Hospital Placement (AHP - GEM) to **Community** (family, res. care,			
Planned & agreed through CTR (MH Act applies)	Direct discharge, consider section 17 leave or CTO	CCG/GEM assessment / LA Section 117 applies	community support including Back-up & contingency plans
Planned & agreed through CTR (Informal patient)	Direct discharge	CCG/GEM assessment / LA	community support including Back-up & contingency plans
Alternative Hospital Placement (AHP - GEM) to Specialised			
Planned & agreed through CTR (MH Act applies)	Direct transfer, no section 17 leave	Specialised commissioning responsible region may change	

There are slightly differing care pathways for locally funded health and social placements in Leicester, Leicestershire and Rutland; however these will not make it any more difficult for people to access the right support in the right place and at the right time.

How will people be fully supported to make the transition from children's services to adult services?

The SEND Reforms of 2014 required the production of a coordinated Education, Health and Care Plan (EHCP) for children and young people aged 0-25 who require one due to the complexity and severity of their special educational needs and/or disability (SEND). This plan must include an assessment of all education, social care and health needs and a description of the provision that must be made to meet these identified needs.

The planning process is person centred and fully involves the young person and their family, with a clear focus on outcomes and life aspirations. Taking a holistic approach ensures that all aspects of the young person's life are integrated, with commissioners discussing and agreeing funding allocations to meet needs in a joined up way.

Providing control of funding though person budgets and direct payments offers up the opportunity for families to help reshape the local market of provision and encourages commissioners to listen and respond to these needs by unlocking resources tied up in block contracts. Diversifying the local market will provide a broader range of choices for young people to ensure their outcomes can be met in ways that best suit them, this in turn will ensure best value, reduce unnecessary spend and deliver an improved quality of life for the young person and their family.

- We will have a clearer understanding of the future accommodation needs of young people coming through transition with a learning disability and/or autism.
- We will develop options to support people locally who are currently resident in out of area placements; including young people returning from school placements
- Future 52 week placements will only be made out of area in exceptional circumstances where needs cannot be met locally. A confirm and challenge process will be put in place before OOA placements are made.

How will you commission services differently?

- Dependent on transformation funding, a dedicated care co-ordinator will be employed with specific responsibility for discharge planning for suitable CCG and specialised commissioning funded inpatients.
- To further integrate and strengthen health and social care funding pathways in order to reduce funding barriers to early discharge.
- To drive up and manage quality of independent provision by jointly commissioning care and support providers.
- Developing the independent and third sector market to meet needs of people with high support needs through Personal Health Budgets.
- Develop more innovative commissioning arrangements based on achieving outcomes rather than block or activity based contracts.
- To scope opportunities for moving away from block arrangement NHS Leicestershire Partnership Trust LPT to support development of person centred services, particularly for respite care provision.

How will your local estate/housing base need to change?

Local NHS Trust Assessment and Treatment Unit
Currently, 16 out of the 20 beds are commissioned towards the assessment and treatment of individuals with Learning disabilities presenting with Challenging behaviour and/or Mental health problems. 4 of these beds have never been used and as part of the BCT planning, clinical models have been developed with an objective of further reducing the reliance on inpatient units by intensive care and Crisis management in the Community. This will lead to a reduction in a reduction of 4 beds over 2017/18 bringing the total number of beds in use to 12 beds.

It is recognised that a high cost and inflexible PFI on local Assessment and Treatment is a significant challenge on our current ability to redesigning services. During 2016/17 the partnership will need to detailed consideration to the ability to further reduce the local assessment and treatment bed base over the next 3 year and whether it is viable to continue provision at the Agnes Unit?

Independent sector inpatient facilities:
There are no specific adult independent sector LD inpatient facilities in LLR geographical area so no specific estate changes have been identified.

Where treatment and rehabilitation needs cannot be met by NHS Leicestershire Partnership Trust, some placements are made in regional and national facilities run by providers such as Cambian Healthcare and St. Andrews. Therefore there will be a need to work with regional partnership to understand the impact of their plans for independent sector provision on our patients in these facilities.

Short Breaks provision
Short breaks bed based provision currently includes:

- 15 health beds in three unit run by NHS Leicestershire Partnership Trust
- 28 social care beds in the county across 4 sites based in: Melton (6 beds), Wigston (6 beds), Hinckley (10 beds), Coalville (6 beds)

Short breaks (respite services) are currently provided by health and social care, with no consistency of cost or outcome. There is therefore a need to review the provision that is currently available with a view to increasing the choice and availability of short breaks to support carers of people with a learning disability and/or autism. This is also further supported by the increased take up of Personal Budgets in social care and the development of Health Personal Budgets allowing people more choice and flexibility about how, where and when they receive their support.

Our intention is to review all short break provision across LLR, which includes Health Short Breaks currently provided by Leicestershire Partnership NHS Trust at Rubicon Close, Gillivers and 1 The Grange. We will consult with people who use/ may use short break services on future options, based on the information we gather from current and potential service users, carers, commissioners and providers of services.

We will continue to ensure that people's health and social care needs are appropriately met but with greater flexibility. Our desired outcome is to provide a wider range of short break options that enable carers to have a break and provide a stimulating and enjoyable experience for the person accessing the service. Individuals should not be restricted to accessing particular short breaks because of their needs or because of the way in which services respond to their needs.

As part of BCT planning, various models of community short break provision are being scoped, with a view to improving the offer of more locally based short break provision responsive to Service user/carer needs.

Housing in the community
There is a particular challenge to develop appropriate long term accommodation for people with significant

challenging behaviour or behaviour that poses a risk to others and develop or identify suitable long term housing.

We have already started work with housing colleagues within Leicester City council and with District Councils to raise awareness of future needs and in individual cases look at potential options. We have also started exploring housing opportunities with independent sector providers.

Our planned market position statement will also support this challenge.

Alongside service redesign (e.g. investing in prevention/early intervention/community services); transformation in some areas will involve 'resettling' people who have been in hospital for many years. What will this look like and how will it be managed?

- We plan to employ a care co-coordinator with specific responsibility to support discharge back to the local provision for patients in AHP's and specialised commissioning placements. This post holder will work closely with NHS England/ CEM CHC Team/ providers to develop pen pictures of individuals suitable for resettlement and associated future accommodation needs.

- To use recently developed 'Step through' supported living.

- To review the role of the Agnes Unit in 'resettling' people who have been in hospital for many years supporting Step down and potential use of Agnes Unit.

- To review need to enhance current community forensic support services to meet needs of this cohort

How does this transformation plan fit with other plans and models to form a collective system response?

This plan closely aligns with:

- LLR 'Transformational Plan and Implementation Plan for the Mental Health & Wellbeing of Children and Young People 2015-2020'
- The 'local offer' for personal health budgets, and Integrated Personal Commissioning (combining health and social care
- The Leicester City Learning Disabilities Joint Commissioning Strategy 2015-19
- The LLR Autism Strategy 2014-19
- Leicester, Leicestershire and Rutland action plan to enable delivery of shared goals of the Mental Health Crisis Care Concordat
- Leicestershire County Council Commissioning Strategy 2016– 2020
- Better Care Together Strategy 2014-19

Any additional information

5.Delivery

Plans need to include key milestone dates and a risk register

What are the programmes of change/work streams needed to implement this plan?
To ensure delivery of this 3 year programme we will employ through transformational funding:

- A senior project manager (NHS Band 8a) to co-ordinate delivery of the plan.

- A care co-coordinator (NHS Band 7) with specific responsibility to support discharge for patients in AHP's and NHSE specialised commissioning placements.

We have identified the need of the following work streams to support deliver:

No.	Work stream	Key Deliverables	Key enablers	Supporting resources
1	**Admission & Prevention**	• Secure web based Admission Avoidance Register • Mainstream CTRs • Provide training and briefings for partners organisations	Quality leads with each CCG: Fiona Pimm LCCCG Anne Scott ELRCCG Alison Cain WLCCG	LD support officer within ELRCCG
2	**Strategic Commissioning**	• Scoping of integrated assessment, care management, commissioning and budgets • Better understanding of children's and autism cohort • Ensure people with a learning disability and/or autism and family carers are engaged and able to influence the scope and shape of the programme	CCG's/ LA's: Cheryl Bosworth ELRCCG John Singh LCCCG Yasmin Surti Leic. City Council Amanda Price Leics. County Council Emma Jane Perkins Rutland Council	Transforming Care Partnership Project manager
3	**Operational Commissioning**	• Enhanced and outreach support team staffed and operational by April 2016 • Support GP practices to implement health checks from 14+ • Safeguarding to prevent unnecessary admissions • Develop Person centred assessment and support planning • Explore Discharge to Assess model for in-patient services	LA's/LPT: Avinash Hiremath, LPT Tracey Burton Leics County Council Ranjan Ravat Leic. City Council	Programme Discharge care coordinator
4	**Market Development & Workforce**	• Develop and publish a health and social care Market Position Statement • Development of new local community based services • Support mainstream services to make reasonable adjustments • Develop a quality assurance scheme supported by experts by experience • Providers and carers trained and provided with tools to avoid admission	Sally Goadby Leicestershire Social Care Development group Nicola McCormack HEEM Christine Collymore Skills for Care	Workforce development post hosted by LSCDG
5	**Personal Health Budgets**	• Produce information and advice in accessible formats • Scope the potential for	CCG's/ LA's/LPT: Joyce Bowler ELRCCG Mariyam Sidik	Hosted PHB team with ELRCCG progressing

		integrated personal budgets • Support to help individuals and families manage their personal health budget • Provide support to assist people with learning disabilities and/or autism to communicate their needs and aspirations • Develop consistent and tailored advocacy support	ELRCCG	programme. Team includes a LD Nurse
6	**Short Breaks & Crisis Response**	• Scope the potential for a crisis intervention service • Develop enhanced support for carers, including short break provision • Support the decommissioning of inpatient beds	CCG's/LPT/ LA's Cheryl Bosworth ELRCCG Jane Martin LPT	BCT intern assigned to project manage work stream
7	**Finance**	• To identify total CCG, local authorities and NHS England Specialised funding available to support transformation • Scoping the likely effects financially, including the shifts from specialist to each CCG and secondary to each LA • Provide a detailed risk assessment and advice on how we will consider either pool or co-manage budgets • Ensure plans are being delivered within the financial resources available to partners • To develop a local NHS dowries policy framework for people who have been inpatients for more than five year at April 2016 & ready for discharge	CCG's/ LA's/NHSE Richard George Leic. County Council Daniel MacSwiney ELRCCG NHSE- tbc	Finance lead for each organisation to be allocated
8	**Comms and Engagement**	• To engage on plans with local LD Partnership Boards and BCT users and carer reference group • To undertake wider public engagement on plans (e.g. Online) • To develop a communication strategy to support the programme • To provide comms and engagement support to specific programme initiatives (e.g. Short breaks plans)	Rebecca Oakley Leicester City Council	

A detailed communication and engagement plan will be developed on this plan is agreed.

The Estate strategy to support the plan will be developed by the strategic commissioning work stream during 2016/17.

Through the Better Care Together programme we have already undertaken a workforce impact statement (see Annex B). This will form the basis of our workforce development plan.

Who is leading the delivery of each of these programmes, and what is the supporting team.

The LLR Transformation Care Partnership Board provides assurance of delivery of the programme and oversees progress across all the agreed work streams.

Its membership includes:

- Senior Responsible Owner (SRO), Sandy McMillan, Leicestershire County Council
- Deputy SRO, Jim Bosworth, East Leicestershire and Rutland CCG
- Clinical Lead, Avinash Hiremath, Leicestershire NHS Partnership Trust
- Learning Disabilities Implementation Manager, Cheryl Bosworth, East Leicestershire and Rutland CCG
- Implementation Lead, Yasmin Surti, Leicester City Council
- Specialised Commissioning Lead, Marcus Callaghan
- NHS England Lead, Russell Woolgar
- Head of Strategic Commissioning, Sue Wilson, Leicestershire County Council
- Head of Strategic Commissioning, Kate Galoppi, Leicester City Council
- Operational Team Manager, Emma Jane Perkins, Rutland County Council
- Steph Chapman, Family Carer, Better Care Together Public and Patient Involvement LD Lead

What are the key milestones – including milestones for when particular services will open/close?

2016-17	• Enhanced and redesigned LD outreach team fully operational April 2016 • Develop a PHB pilot for short break provision (as an alternative to residential provision). • Commission CAMHS Crisis Resolution and Home Treatment Service • Issue a Market position statement
2017-18	• 2 short stay beds closed Agnes Unit • Enhanced Autism service providing able to provide ongoing support to those with and without intellectual disability operational • Implement new health respite commissioning models • Scope need and feasibility of developing LLR Crisis intervention service or facility
2018-19	• Further 2 short stay beds closed Agnes Unit
	•

What are the risks, assumptions, issues and dependencies?

Risk No.	Category of Risk *(e.g. financial, reputational)*	Risk *(Include any assumptions made)*	Impact (1-5)	Probability (1-5)	Risk Score (1-25)	Mitigation actions
1	Programme Funding	Failure to secure central transformation funds to support programme RISK; lack of resources to deliver programme	5	2	10	Seek early clarity from NHSE on allocation of transformation funding. Consider secondment roles within Partnership to help deliver programme
2	Project Focus	The project is multi-faceted – requiring collaboration across organisational and professional boundaries RISK: Failure to successfully collaborate	5	2	10	Dedicated senior project manager to be appointed from transformational funding. Focus on defined, affordable, deliverables in key areas and delivery through identified work streams.
3	Programme Board membership	Ability to establish appropriate level of stakeholders on the board RISK: Not having suitable stakeholders and thus not having intended level of views and opinions.	5	1	5	Ensure stakeholders are hand-picked and agreed in.
4	Commitment	Programme requires high level of commitment from stakeholders RISK: Failure to maintain commitment and attendance	4	2	8	Ensure meeting dates are agreed in advance and circulated with appropriate notice.
5	Enhancing LD Outreach Team	Recruitment of additional nursing and therapy staff to outreach team RISK: Failure to mobilised enhanced service for April 2016	5	2	10	Monthly meeting with service to support mobilisation of enhanced service
6	Review of Short Breaks provision	Failure to remodel current building based model given previous attempts RISK: Development of personalised models and impact on take up of PHB	4	3	12	Close project management of work stream and strong consultation plans to be developed. Develop a phased approach with initial PHB pilot focusing on young people going through transition.

7	Care & Treatment Reviews	Failure to implement Care and Treatment Reviews and Positive follow work plans appropriately. RISK: Admission avoidance options not fully considered in individual cases	**4**	**2**	**8**	Dedicated post within each CCG to managed CTR process Training for health and social care staff on CTR process.
8	ATU buildings cost	Managing cost of PFI funding on Agnes Unit whilst reducing bed numbers and exploring alternatives uses. RISK: Financial sustainability of programme & being able to develop community resources	**4**	**4**	**16**	Consider transitional funding to support service redesign. LPT to explore future options for Agnes Unit as part of their Estates Strategy.
9	Workforce Skills	Required workforce skills and capacity do not develop sufficiently	**3**	**3**	**9**	Development of sector wide workforce development plan in 2016.

What risk mitigations do you have in place?

See above table

Any additional information

6.Finances

Please complete the activity and finance template to set this out (attached as an annex).

End of planning template

Annex A – Developing a basket of quality of care indicators

Over the summer, a review led by the Department of Health was undertaken of existing indicators that areas could use to monitor quality of care and progress in implementing the national service model. These indicators are not mandatory, but have been recommended by a panel of experts drawn from across health and social care. Discussion is ongoing as to how these indicators and others might be used at a national level to monitor quality of care.

This Annex gives the technical description of the indicators recommended for local use to monitor quality of care. The indicators cover hospital and community services. The data is not specific to people in the transforming care cohort.[1]

The table below refers in several places to people with a learning disability or autism in the Mental Health Services Data Set (MHSDS). This should be taken as an abbreviation for people recorded as having activity in the dataset who meet one or more of the following criteria:

1. They are identified by the Protected Characteristics Protocol - Disability as having a response score for PCP-D Question 1 (Do you have any physical or mental health conditions lasting, or expected to last, 12 months or more?) of 1 (Yes – limited a lot) or 2 (Yes – limited a little), and a response score of 1 or 2 (same interpretation) to items PCP-D Question 5 (Do you have difficulty with your memory or ability to concentrate, learn or understand which started before you reached the age of 18?) or PCP-D Question 13 (Autism Spectrum Conditions)
2. They are assigned an ICD10 diagnosis in the groups F70-F99, F84-849, F819
3. They are admitted to hospital with a HES main specialty of psychiatry of learning disabilities
4. They are seen on more than one occasion in outpatients by a consultant in the specialty psychiatry of learning disabilities (do not include autism diagnostic assessments unless they give rise to a relevant diagnosis)
5. They are looked after by a clinical team categorised as Learning Disability Service (C01), Autistic Spectrum Disorder Service (C02)

[1] Please refer to the original source to understand the extent to which people with autism are categorised in the data collection

Indicator No.	Indicator	Source	Measurement[2]
1	Proportion of inpatient population with learning a disability or autism who have a person-centred care plan, updated in the last 12 months, and local care co-ordinator	Mental Health Services Data Set (MHSDS)	Average census calculation applied to: • Denominator: inpatient person-days for patients identified as having a learning disability or autism. • Numerator: person days in denominator where the following two characteristics are met: (1). Face to face contact event with a staff member flagged as the current Care Co-ordinator (MHD_CareCoordinator_Flag) in preceding 28 days; and 2. Care review (Event record with MHD_EventType 'Review') within the preceding 12 months.
2	Proportion of people receiving social care primarily because of a learning disability who receive direct payments (fully or in part) or a personal managed budget (Not possible to include people with autism but not learning disability in this indicator)	Short and Long Term Support statistics	This indicator can only be produced for upper tier local authority geography. Denominator: Sum of clients accessing long term support, community services only funded by full or part direct payments, managed personal budget or commissioned support only. Numerator: all those in the denominator excluding those on commissioned support only. Recommended threshold: This figure should be greater than 60%.
3	Proportion of people with a learning disability or autism readmitted within a specified period of discharge from hospital	Hospital Episodes Statistics (HES) and Assuring Transformation datasets. Readmission following discharge with HES main	HES are the long established and most reliable indicator of the fact of admission and readmission. • Denominator: discharges (not including transfers or deaths) from inpatient care where the person is identified as having a learning disability or autism • Numerator: admissions to psychiatric inpatient care within specified period

[2] Except where specified, all indicators are presumed to be for CCG areas, with patients allocated as for ordinary secondary care funding responsibility.

		specialty - Psychiatry of Learning Disabilities or diagnosis of a learning disability or autism.	The consultation took 90 days as the specified period for readmission. We would recommend that this period should be reviewed in light of emerging readmission patterns. Particular attention should be paid to whether a distinct group of rapid readmissions is apparent. NHS England is undertaking an exercise to reconcile HES and Assuring Transformation data sets, to understand any differences between the two. At present NHS England will use Assuring Transformation data as its main source of information, and will be monitoring 28-day and 12-month readmission.
4	Proportion of people with a learning disability receiving an annual health check. (People with autism but not learning disability are not included in this scheme)	Calculating Quality Reporting Service, the mechanism used for monitoring **GP** Enhanced Services including the learning disability annual health check.	Two figures should be presented here. • Denominator: In both cases the denominator is the number of people in the CCG area who are on their GP's learning disability register • Numerator 1. The first (which is the key variable) takes as numerator the number of those on their GPs learning disability register who have had an annual health check in the most recent year for which data are available • Numerator 2. The second indicator has as its numerator the number of people with a learning disability on their GPs learning disability health check register. This will identify the extent to which GPs in an area are participating in the scheme
5	Waiting times for new psychiatric referral for people with a learning disability or autism	MHSDS. New referrals are recorded in the Referrals table of the MHSDS.	• Denominator: Referrals to specialist mental health services of individuals identified in this or prior episodes of care as having a learning disability or autism • Numerator: Referrals where interval between referral request and first subsequent clinical contact is within 18 weeks
6	Proportion of looked after people with	MHSDS. (This is	Method – average census.

	learning disability or autism for whom there is a crisis plan	identifiable in MHMDS returns from the fields CRISISCREATE and CRISISUPDATE)	• Denominator: person-days for patients in current spell of care with a specialist mental health care provider who are identified as having a learning disability or autism or with a responsible clinician assignment of a person with specialty Psychiatry of Learning Disabilities • Numerator: person days in denominator where there is a current crisis plan

Annex B Workforce Impact Assessment

BCT Work Stream: Learning Disability

Identifying Gap	Approach to Filling Gap	Actions / Owners / Time Line – Delivery Dates	Challenges / Risk / Mitigation
What is the workforce change required to delivery "redesigned service/new models of care/new setting of care"? The move to left-shift Learning Disability services into the community means a move from larger specialist providers, such as LPT, to a much more diverse and fragmented range of providers in the private and voluntary sector, as well as Personal Assistants and Domiciliary Care Providers. This workforce is less well paid, sometimes with poor English, and consequently more transient, much harder to quantify, assess and train. In additional there is heavy reliance on e-learning with fewer opportunities for supervision and synthesising new learning into practice, all of which mitigate against promoting independence and trying new approaches. There are a high number of prisons within LLR and it's known that nationally people with Autism and learning disabilities are over-represented and under-diagnosed in prisons, and there is no reason to assume LLR is different. LPT provide healthcare services in several prisons, drawing from the same pool of potential staff. Both Leicestershire County and Leicester City	**Are new roles required or changes to existing roles?** Services to people with Learning Disabilities and Autism would improve if all health care staff, including non-clinical staff, had a better understanding of how to communicate with people with LD. This is particularly the case in Primary Care **What, if any, is the educational intervention required to deliver the required future workforce?** BCT 'Challenging Behaviour Strategy' will help identify training for anyone involved in health and social care services to support access to universal health care services. Joint training between health and social care specialist LD staff would help improve their understanding of each other's services and ways of working. LPT and Leicestershire County Council have both found that newly qualified nurses/social workers are poor at communicating with people with Learning Disabilities (anecdotally some social work recruits were reluctant to attend an interview which involved a user panel). LPT	**Retraining & Recruitment** Shortage of LD nurses and social workers, both newly qualified and more experienced. **Balance of skills** Need for skills in specialist LD services but also importance of knowledge of LD/Autism among the whole health and social care workforce to ensure access to ordinary services. For example, a disproportionate number of people with LD die in UHL due to late diagnosis of cancer. This could be due to lack of screening, fragmented support staff, difficulties in describing the symptoms to health care staff, dismissal of symptoms by GPs, lack of support in accessing treatment etc. Many people with Autism struggle access services, often not getting through GP receptionists or Local Authority call centres: the LLR Autism Strategy aims to address this through training for all staff re basic awareness of Autism and some re-configuration of Local Authority systems. Within Leicester City CCG Autism awareness has been included in protected learning time for GPs	**Supply** Shortage of LD nurses and social workers, both newly qualified and more experienced. **Recruitment & Retention** Difficulties in recruiting staff who as general shortage of qualified staff, so applicants are often juggling several job offers, or fail to turn up for interview. **Education** The range of different service providers across LD means that it is very difficult to know what training they supply to staff and its quality e.g. does it follow NICE Guidance. See example in balance of skills section. **Experience (community v acute)** Balance between specialist / general services and arranging specialist services to be able to make links with general services while maintaining critical mass of expertise. **Modelling** Not discussed, though noted that LPT LD services functionally mapped eight of their

Councils are re-organising their Care Manager teams into more specialist teams which will increase the level of knowledge re LD in these teams, and should create a more appropriate approach to managing contracts, where the provider has to take some responsibility for supporting the service-user when things become 'difficult' It's noted that the current arrangements for managing CHC – out-sourced to GEM – doesn't measure the right outcome to provide good services to people with LD. Five Year Forward View encourages the development of multi-speciality providers but in a neighbourhood /locality model there would not be enough expertise to provide a good service to people with Learning Disabilities. Instead LPT are re-designing their Community Services to work in three geographical areas: this should provide a more local service but retain a critical mass of LD expertise who can share information and forge stronger links with universal local providers. This will happen in this financial year, and will produce more detailed workforce information. Other developments which will impact of workforce ▪ Review of LPT Short Breaks service	Are working with DMU to address their concerns with the curriculum in LD nursing and SaLT and have also ensured that general nurses have some experience of LD services during their pre-registration training. There is a need for education and training across the whole LLR non LD workforce in ▪ Mental Capacity Act ▪ The 2014 Care Act ▪ Recognising and working with people with Autism. The LLR Autism Board (across health and social care) is currently auditing what training is available and how many health and social care staff have accessed it. **Managing Supply (International recruitment, redeployment, secondment, improved retention, return to practice, adaptation etc.)** It was noted that LD nursing commissions at DMU have increased in the last year, but some of this is to make up a shortfall from Nottingham University, and DMU will be seeking placements for these extra students north of LLR. LPT is struggling to recruit LD nurses at both newly qualified and experienced level, but finds it even more difficult to recruit RMNs.	The delivery of support to people with LD with additional physical health needs by a wider variety of providers will increase the demand for skills in specific health tasks such as peg-feeding. Unlike the tasks covered in the Health and Social care protocols these are often tasks required for life rather than a few weeks. LPT is the local organisation with the skills to supply this training but need to ensure that ▪ Providers are aware of the training and access it, across a changing staff team ▪ There are appropriate structures and protocols to ensure the training is effective in the place of care ▪ LPT is paid for this work Failure to address these issues will mean that these patients will become ill and become emergency admissions at UHL ED. **What further work is required?** Influencing GP training Finding ways to provide safe effective training re specific health care tasks to varied and changing support workforce employed in community and domestic settings. **Is further support required, and from whom?**	pathways in 2012-13. **7-Day Working** Not discussed

▪ Development of LPT enhanced outreach service for challenging behaviour which will support people in the community and reduce acute admissions. ▪ Development of Leicestershire County Council Step Up Step Down service supporting people to live in the community All of these initiatives will produce demand for a new/different workforce and these will be quantified over the next few months **What are the capacity gaps for this area/clinical pathway?** There is a need for really good communication skills including easy read documents, understanding non-verbal communications, positive behavioural support among both the specialist LD workforce but also in general health care workforce so that people with LD and Autism receive good access to ordinary health care through GP and other community services. This includes non-clinical staff such as receptionists. The BCT LD work-stream may develop a 'Challenging Behaviour Strategy' across LLR to support a consistent approach to clients/patients/service-users and prevent them being 'bounced' around the system.	Similarly both Local Authorities are finding it difficult to recruit Social Workers	Given the lack of knowledge re Learning Disability/Autism among GPs it would be useful to have some influence / input into GP training, but LPT has not yet found a way to achieve this.	

Mainstream Mental Health services use a 'Green Light' tool to assess if a person with mental health problems also has LD/Autism. With better networking and informal arrangements have improved services to people with LD/Autism in specialist mental health services and UHL but there is still room for improvement in both LPT Community Hospitals and General Practice. There is a particular problem in identifying people with LD who develop dementia, and this has been raised with the BCT dementia work stream. **Supply of workforce at what level? (e.g. Foundation, Generic, Enhanced, Specialist)**			