Calderdale, Kirklees, Wakefield and Barnsley (CKWB)

Transforming Care Partnership Plan

NHS
Greater Huddersfield
Clinical Commissioning Group

NHS
Wakefield
Clinical Commissioning Group

NHS
North Kirklees
Clinical Commissioning Group

NHS
Barnsley
Clinical
Commissioning
Group

NHS
Calderdale Clinical Commissioning Group

BARNSLEY
Metropolitan Borough Council

Kirklees
COUNCIL

wakefield
City of Wakefield Metropolitan District Council

Calderdale
Council

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1. Executive Summary

The Calderdale, Kirklees, Wakefield and Barnsley (CKWB) Transforming Care Partnership has been formed to collaboratively develop a programme that will transform our community infrastructures and reshape services for people with a learning disability and/or autism. The plan will be framed around Building the Right Support and the National Service Model October 2015 and it will be developed to ensure the needs of the five cohorts below are included as well as the wider population when transforming services.

- A mental health problem, such as severe anxiety, depression or a psychotic illness which may result in them displaying behaviours that challenge
- Self-injurious or aggressive behaviour, not related to severe mental ill-health, some of whom will have a specific neurodevelopmental syndrome with often complex life-long health needs and where there may be an increase likelihood of behaviour that challenges
- 'Risky' behaviour which may put themselves or others at risk (this could include fire-setting, abusive, aggressive or sexually inappropriate behaviour) and which could lead to contact with the criminal justice system
- Lower level health or social care needs and disadvantaged backgrounds (e.g. social disadvantage, substance abuse, troubled family background), who display behaviour that challenges, including behaviours which may lead to contact with the criminal justice system
- A mental health condition or whose behaviour challenges who have been in in-patient care for a very long period of time, having not been discharged when NHS campuses or long-stay hospitals were closed

The CKWB region was rated as the 6th highest for CCG commissioned in-patient beds in July 2015 and, although work has been ongoing and the number has reduced, we are still well over the national planning assumptions for in-patient beds. For NHS England commissioned beds, the region was mid table, but following several discharges since July 2015 the numbers are now within the national planning assumptions.

Each area within the partnership had already developed programmes locally to transform services, but it has been acknowledged that the partnership will prove invaluable to harness the collective knowledge and experience to further build on progress already made and to use our resources more effectively and efficiently to gain more momentum in the delivery of new models of care and support for the most complex people.

The key aims for our plan will be:

- **Reduction of in-patient beds, delivering an almost 60% reduction across the partnership by 2019 taken from baseline data in December 2015**

- **Developing better/new/broader range of specialist community services that are flexible and responsive to manage crisis better and prevent admission**
- **Developing capable communities to enable people to live in their own homes**
- **Developing a better understanding of our local populations with complex needs and how best to support them in a crisis**
- **Ensure people with a learning disability and/or autism have the opportunity to live meaningful and fulfilled lives**

2. Mobilise communities

2.1 Governance and stakeholder arrangements

2.1.2 Governance arrangements for this transformation programme

There are strong partnerships in place across the CKWB region and these have enabled many of the key partners to be brought together and engage in the development of this plan. NHS and Local Authority commissioners and a wide range of other stakeholders are committed to developing and delivering the new models of care and support for people with learning disabilities with complex needs. This will be achieved working closely with all key partners and people with learning disabilities, their families, carers and advocates and will be provided through more detailed co-produced plans.

The CKWB Transforming Care Partnership Board has been established to oversee the development and delivery of the transformation programme across the region. This Board has endorsed the draft plan and during the next two months the final draft will be completed and formal endorsement will be sought from Health and Wellbeing Boards within the region. Partners represented at the CKWB Transforming Care Board include:

- Kirklees Council
- Calderdale Council
- Wakefield Council
- Barnsley Metropolitan Borough Council
- Calderdale Clinical Commissioning Group
- Greater Huddersfield Commissioning Group
- North Kirklees Clinical Commissioning Group
- Wakefield Clinical Commissioning Group
- Barnsley Clinical Commissioning Group
- Specialist Commissioning Services
- Learning Disability Partnership Boards

Representation is from senior leaders from each organisation who have the authority or lead role to deliver the transformation programme.

2.1.2 Internal Governance

Transforming Care Plan (TCP)

Each CCG will also feed the TCP plan into their respective quality and safety groups to ensure the clinical governance is met; these will also go to their Governing Bodies for information.

Local Plans

Each area has currently got its own governance structure for reporting their local plans; these joint groups (listed below) will also be used to feed the TCP plan progress.

Calderdale – Joint Transforming Care Steering Group
Barnsley – Adult Joint Commissioning Group
Wakefield – Connecting Care Executive
Kirklees – Integrated Commissioning Executive

The terms of reference for the Board and further details regarding programme governance are embedded below.

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Health and Wellbeing Boards – Dates of next meeting for sign off

Kirklees Health and Wellbeing Board – 28th April 2016 - Approved
Calderdale Health and Wellbeing Board – 23rd June 2016
Wakefield Health and Wellbeing Board – 16th June 2016 - Approved
Barnsley Health and Wellbeing Board – 5th April 2016 - Approved

2.1.3 Stakeholder engagement arrangements

There have been multiple engagement events across the partnership around learning disability services and although the key stakeholders that have been identified above are actively working on the development of the transformation plan, it is recognised that much wider and targeted engagement needs to happen to develop a fully co-produced transformation plan. One of the key work-streams will be to develop a detailed communications and engagement strategy ensuring input from other stakeholders including:

- People with learning disabilities, carers and their families, all ages including those with lived experience of secure services

- Patient Reference Groups – Kinfo
- NHS service providers including
  - Primary Care
  - Community Services
  - Acute Care
  - Specialist learning disability service providers
- Voluntary and Community Sector
- Public Health
- Criminal Justice System
- Private Providers
- Health Education England
- Inclusion North

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

There have been numerous engagement events across the four areas in the TCP over the last three years which have focused on building better services in the community, including enhanced community team pathways with 24/7 coverage, accommodation, provider frameworks for community provision and crisis services. South West Yorkshire Partnership Foundation Trust has also delivered several engagement events around their transformation for LD community and in-patient services that covered the TCP region.

2.2 Engagement with Children and Young People

There has been lots of engagement across the TCP following on from the Future in Mind Report with children, young people and their families and carers. The feedback from this engagement has helped develop a 5 year strategy to improve access to services, developing new and innovative ways to meet mental health and learning disability needs whilst building up resilience in children, young people and their families in their schools and wider communities to improve outcomes.

Significant consultation and engagement has also taken place with children, young people and their families, specifically in relation to services for ASD / ADHD and LD.

The purpose of the Future in Mind consultation was to develop a new pathway for accessing services and improve engagement, and develop a more integrated delivery model for these services. A transformation group has been working together for two years, including practitioners and parent reps, developing and consulting on the pathway and changes to the services. There have been numerous engagement events with children, young people and their families and carers which have further helped shape the proposals, and update on progress to date. This work is continuing currently.

Following engagement, recovery plans have been developed for the ASD / ADHD pathway which are being redesigned to reduce waits, and increase capacity for undertaking assessments. The referral process has also been reviewed in line with the local transformation plan. This includes referrals direct from universal and early help services to improve information and develop a more multi-disciplinary offer. The pathway development also includes a non-clinical offer with the Educational Psychology team within the Local Authorities SEND service undertaking assessments.

The SEND Service have worked with the Community Paediatric service to develop an early intervention offer and package of support for ASD / ADHD / LD which aligns with the new pathway being developed, and fits in the recommendations in the transformation plan.

The developments for LD and ASD align with the transformation to develop early response and support for children and young people, and will support a reduction in in-patient services and minimise the impact of pre-admission care and treatment review (CTR).

The consultation within CKWB undertaken for Future in Mind is listed below:

- Education and Schools partnership group
- Third Sector partner engagement
- Listen to Mental Health
- Young Healthwatch Mental Health Forum
- Risk-taking Behaviours
- School Counselling Support
- New Technologies / Social Media
- Support for LGBT young people (Lesbian, Gay, Bisexual and Transgender)
- Emotional support for younger people
- Transition in to adult services
- Access to services through the hubs
- CAMHs Friends and Family Questionnaires
- Perinatal Mental Health user survey

The common themes from engagement, whether that be from the learning disability transformation programmes, the care closer to home programmes or the future in mind transformation, are the same, people want to be empowered and to have more control. This plan is about enabling people to be more resilient, providing them with the skills and tools and developing a robust community infrastructure that will be flexible and able to deliver high quality services as and when people need them.

2.3 Feedback from Engagement Events

Communication and Information

- Easy access to services and information that is easy to understand
- Using people's communication plans and person centred plans helps us understand what they want. It helps us make sure the Mental Capacity Act is being used affectively
- We need to get the voice of families in the JSNA
- Confusion of where to go for services/help and understanding what is available - no single point of access
- When communications are poor, people with learning disabilities feel they are not listened to and not understood – their views are not taken into account and changes in care are being made 'to them'
- More communication is needed with the people who use services, their families and carers. This needs to be ongoing genuine consultation resulting in recommendations that are acted upon and resourced

Accommodation

- Care closer to home, but do not want homes turned into hospitals
- Bespoke housing- right housing/environment for the individual
- Hospital / bed based care does work for some people; it is often very much like a house or flat not like a ward – it is home for some people and should be recognised
- Still too many people in high cost placements out of district
- Landlord/housing issues – not responding to repairs quickly, chasing up responses from housing
- Too much investment in specialist services and high cost placements without understanding the quality of these placements
- Short breaks tend to be building based
- More facilities for good respite care
- There is a negative impression towards hospitals following the Winterbourne View abuse scandal, and other hospital scandals

Workforce Development and Positive Behavioural Support Training

- Families should be recognised as being part of the workforce, could support be provided in the family home whilst Mum and Dad take a break elsewhere?
- Training does not just have to happen in a 'room'. Sometimes it's about sharing information and good ways of doing things
- There needs to be raised awareness at all levels of learning disability and autism
- Too much focus on risk and not enough thought given to independence

- Lack of understanding of MHA / Consent, some people noted that Sections are being used or managed inappropriately
- Personalisation needs to include people with challenging behaviours
- Staff can be caring and compassionate, basing their care around the person's needs as much as they can in the restrictions that they work in
- We need more learning disability and autism champions – on the Clinical Commissioning Group Board, in general practice, at the council and other providers of health and care services

Early Intervention and Prevention

- We need to invest in prevention to prevent families breaking down
- Transitions are problematic (children's services to adults, hospitals to community, from one provider or funder to another)
- Local register needs to include all people with challenging behaviour
- Care plans are often not complete or up to date or well followed; reviews are often infrequent or not robust; health action plans in primary care not being used
- Not getting diagnosed early enough- underlying conditions or co-morbidities not being addressed in a holistic way

Activities and Social Inclusion

- Accessible leisure activities e.g. swimming, football, drama group and other groups are important to our wellbeing and support to be able to do these
- Keep our activity centre and have more groups.
- People also find support in other ways such as community groups, voluntary organisations, friends and social groups
- Social connections and a sense of belonging is important to wellbeing and coping
- We need to make sure that people are not isolated. People need those who love them in their lives and support should be given to visit family and friends
- More supported work placements/job opportunities - we do not want to just walk round shopping centres all day
- Having access to the internet

Accessing mainstream services/Reasonable adjustments

- LD champions who work in general hospitals to ensure the nursing staff understand our needs
- Reasonable adjustments should be included within all health and social care contracts
- Supporting people who use services is critical to maintaining their care / wellbeing

- Visits to doctors are helped if the doctor or nurse knows the individual and their history and has time to listen carefully, it is important that if referring to hospital the right information is passed on
- Access to Mental Health Services is sometimes difficult
- Barriers to accessing universal services within the community
- Not all GP practices offer health checks

Support Services

- Lack of hydrotherapy services – time limited/cost
- Withdrawal of service bus and general bus services reducing
- Independent support such as advocacy is highly valued by users and carers
- Speech and Language Therapy and support in school, needs resourcing
- We need to make sure people who are away from home get access to advocacy
- Not enough independent / advocacy support to help explain and challenge restrictions / out of area decisions that take the person far away from family
- Better support and help for carers

Clearer and Improved Pathways

- Professional workloads / processes are not well designed to meet needs for this group – e.g. GP appointments too short, LD community teams have too broad a remit, support workers are isolated/ low wage based, specialist providers are few
- There is a lack of networking across the system to wrap care around people – reports of arguments between agencies and refusals to accept cases e.g. autism
- Professionals noted the lack of integration in systems, partnerships and funding leading to delayed decisions, particularly in relation to judicial requirements: 'people are getting stuck in the system'

2.4 The Health and Care Economy covered by the plan

There are various providers, including NHS providers, private sector and the voluntary sector that are providing services across the region and most are under single commissioner contracts, either block, frameworks or spot purchased. There is a mix across the TCP where some joint commissioning between local authorities and CCGs and pooled budgets are in place but not with all. The partnership is committed to further exploring ways of joint commissioning, pooled budgets and alternative ways of commissioning to support the delivery of the transformation plan.

The current model of provision, albeit slightly different in each area, is generally the 'traditional' model that is dependent on care home provision and 24/7 supported living services. It is recognised there is a need to develop new bespoke models of

provision to be able to care and support people with learning disabilities and/or autism with behaviour that challenges.

The arrangements below are for **all ages** including children and young people.

2.5 Current Commissioning Arrangements

Clinical Commissioning Groups – A range of local commissioning arrangements exist across each area but are not all consistent across the partnership:

- Personal health budgets are offered to enable personal choice and flexibility, this allows people to purchase their own support Block contracts are in place for community services from SWYPFT
- Block contracts are in place for some A&T beds and some are purchased on a spot purchase basis. Of the 35 beds currently commissioned, only 8 are included on a block contract, with the remaining 27 being spot purchases
- Spot contracts are in place for all in-patient rehabilitation beds
- Block and spot contracts are in place for respite services and day care services
- A mixture of Frameworks, spot and block contracts are in place for residential / nursing placements

Local Authorities – A range of local commissioning arrangements exist within each authority, but are not all consistent across the partnership:

- All local authorities offer personal budgets, enabling individuals to choose a managed budget, a direct payment or a mixture of the two. A range of support services are offered to people who chose a direct payment to help them identify and secure the support they need and to help manage the direct payment. In most authorities such options are supported by approved provider lists or a system for accrediting providers. Many of these are now featuring joint care and health budget elements
- Regarding provision of supported living services, accommodation and day care, most authorities have a Framework Agreements or Approved Provider mechanisms in place covering provisions for different levels or types of need.
- Provision of highly specialised services or tailored individual packages may involve traditional tenders outside of those arrangements if they do not fall under the supported living framework agreement
- The community support and supported living framework agreement, offers 3 levels of funding for specialist social care funded services, that enables individual bespoke packages of social care provision to be commissioned
- For respite provisions, authorities use a mixture of block and spot purchase contracts within traditional building based services and also provide personalised respite provisions via direct payments that focus on individual outcomes

- Residential care is usually on a block or spot-contract basis, but mainly spot as personalisation has meant a shift in commissioning block residential care.

NHS England Specialised Commissioning – Services such as Child and Adolescent Mental Health services (CAMHs) and Adults are commissioned for patients from NHS ?England. These services meet the four factors for specialised services as described in the prescribed services manual. (NHSCB 2013). The services are commissioned and contracted for using the NHS standard contract. Services are contracted on a block basis with an all-inclusive price. Currency for payment is usually by occupied bed day for impatient services and by activity for community services. CQUIN schemes are in place for all services and monthly contract monitoring meetings are held to manage performance against the contract.

2.6 Provider geography, natural alignments and collaborative arrangements

The partnership is committed to further exploring ways of joint commissioning, pooled budgets and alternative ways of commissioning to support the delivery of the transformation plan and there is one key area where this is already happening.

South West Yorkshire Partnership Foundation Trust currently provides the specialist community service and some of the assessment and treatment beds across the TCP. The partnership have developed in collaboration a service specification for the community services including the new enhanced community service and discussions are taking place for most of the CCGs to commission the in-patient assessment and treatment beds.

It is recognised there are benefits from further joint working with providers and this will be incorporated within the overall plan for further scoping to identify key areas where changes can be made at provider level, especially where care providers are present across all four partner regions.

2.7 System and market engagement

There are several provider forums across the partnership, which bring a range of social care, health care, private and voluntary sector providers together to share best practice, work in partnership to address key issues and challenges, make clear local priorities / need and give clear strategic messages on market development. This needs to be further developed to bring this together across the partnership and mechanisms put in place to ensure a strong collaborative approach to deliver the system wide changes.

2.8 Geographical boundaries and organisational considerations

There is a natural grouping across our TCP as we all commission from the same partnership trust for specialist learning disability services.

However there are considerations to be taken into account when further developing the plan including:

- Local variation in the need for market transformation
- Geography and deprivation
- Extremes of in-patient numbers
- Determining ordinary residence:
  - Our TCP has 36 secure beds and this can be an issue when stepping people down due to ordinary residence rules
- People from out of area currently in our transformation area or people from our transformation area placed 'out of area':
  - Our TCP is a net importer for residential placements and London is one of the main areas who export into our area
  - Our TCP is an exporter for college placements are there are not enough locally
  - Prison population is high in Wakefield
- Commissioning of specialised services
- Different pathways
- Transition from children to adult services
- Data and information sharing across transformation region
- Contracts
- Vanguards and Integrated Care Pilots

One of the key actions on our route map is to undertake an in-depth review of our current baseline considering all the above factors.

3. Understanding the status quo

3.1 Baseline Estimates

Baseline estimates – LD (within CKWB)				
Age Band	**2015**	**2020**	**2025**	**2030**
18-24	2,788	2,586	2,541	2,781
25-34	3,839	3,994	3,977	3,772
35-44	3,757	3,709	3,960	4,122
45-54	4,157	4,042	3,638	3,608
55-64	3,289	3,634	3,901	3,774
65-74	2,637	2,823	2,829	3,152
75-84	1,374	1,575	1,942	1,571
85 and over	498	590	729	914
Total	**22,339**	**22,953**	**23,517**	**23,694**

Information has been gathered from various sources and analysed to provide a baseline assessment of needs and services. This has included the

Learning Disability Self-Assessment Framework, Joint Strategic Needs Assessment's, Joint Health & Wellbeing Strategies, Transforming Care Data, Projecting Adult Needs & Service Information System, Projecting Older People Population Information System, Future in Mind Strategy and internal databases.

3.1.1 Population and Demographics 2105

Area	Total population	Adult population	LD/Autism Population	LD/Autism known to services
North Kirklees / Greater Hudds	423,000	335,826	7,912	1,530
Calderdale	203,000	169,798	3,827	672
Wakefield	332,000	287,379	6,180	1,374
Barnsley	231,200	199,749	4,420	1,106
Total	**1,189,200**	**992,752**	**22,339**	**4,682**

3.1.2 Analysis of in-patient usage by people from Transforming Care Partnership

The national plan 'Building the Right Support' published on 30th October 2015 sets out a planning assumption that each TCP will reduce reliance on in-patient care, and where they are currently above this level, will plan to reach an in-patient rate within the range 20-25 in-patients per million population for NHS England commissioned services and 10-15 in-patients per million for CCG commissioned services by March 2019. The CKWB partnership has an adult population of approx. 1.0 million and is basing the plans on the following by 2019:

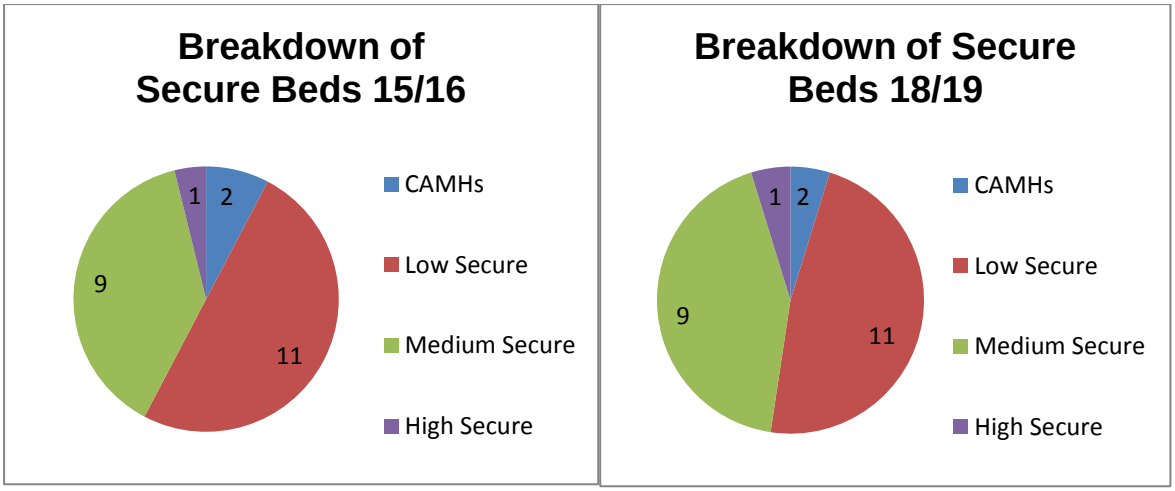
NHS England commissioned - 25 in-patient beds

CCG Commissioned - 15 in-patient beds

3.2 NHS England Commissioned Services

There are currently 23 people in secure services and the breakdown of type of bed is shown below. This number is already within the 20-25 planning assumption range, however work is ongoing to reduce these numbers, but following regional discussions it was agreed that we would remain at 23 to ensure we do not impact the regional requirement for numbers of beds due to other TCP's struggling to meet the national planning assumptions within the three years.

Secure Beds	Actual 15/16	Forecast 18/19
Adults	21	21
Children	2	2
Total	**23**	**23**



Attached is NHS Specialised Commissioning narrative to support this plan.

Spec Comm Narrative for YH TCPs

3.3 Clinical Commissioning Group Commissioned Services

There are currently 38 people in in-patient beds (as at December 2015 baseline exercise), this is more than double the national planning assumption level, however by the end of year 1 this will have reduced by 35% and by the end of quarter 1 in year 3 we will have achieved the national planning levels suggested of 15 in-patient beds across the partnership. It is worth noting that although the numbers are quite high for year 0, there has only been 4 people out of the 38 that have been in longer than five years. See below table for forecast in reduction of beds over the next three years.

3.3.1 Numbers and Projections for CCG Commissioned In-patient Beds

Year	Year 0 (2015/16)	Year 1 (2016/17)				Year 2 (2017/18)				Year 3 (2018/19)			
Period	**31/03/16**	**Q 1**	**Q 2**	**Q 3**	**Q 4**	**Q 1**	**Q 2**	**Q 3**	**Q 4**	**Q 1**	**Q2**	**Q3**	**Q4**
CCG In-patient Beds	38	35	34	33	28	23	21	21	20	18	17	17	15

3.3.2 Annual spend of in-patient beds commissioned by the CCGs and NHS England Specialist Services

	Annual cost (£) 2015/16	Annual cost (£) 2016/17	Annual cost (£) 2017/18	Annual cost (£) 2018/19
CCG commissioned patients	£6,365,346	£4,529,910	£2,844,699	£2,532,525
NHS England Specialised Commissioned patients	£5,980,476	£5,370,223	£5,004,406	£4,760,305
Total	**£12,345,822**	**£9,900,133**	**£7,849,105**	**£7,292,830**
Cumulative Reduction in spend		**£2,445,689**	**£4,496,717**	**£5,052,992**

The current spend is in excess of £12m and the planned reduction of spend in in-patient beds is over £5m with the largest reduction coming from CCG commissioned beds which will be used to reinvest into community provision.

3.4 Current Services and Provision

3.4.1 Learning Disability Community Teams

All 5 CCGs commission their local specialist learning disability service from South West Yorkshire Foundation Partnership Trust (SWYPFT) at an annual cost of approx. £7.7m. In some of the areas Social Workers and Community Nurses work together as part of the integrated Community Teams for Learning Disabilities (CTLDs) which is managed by the Local Authorities, but this is not consistent across the TCP as some have moved away from this approach.

3.4.2 Assessment and Treatment Units

SWYPFT provided assessment and treatment across two areas in the partnership. One unit being a 5 bedded unit in Kirklees of which 4 beds were commissioned on block contract and the other a purpose built 8 bedded unit in Wakefield. The 5 bedded unit was identified as not appropriate in the longer term to deliver assessment and treatment and it was therefore agreed to close the facility down and transfer over to Horizon as there were 4 voids within the service. Kirklees and Wakefield currently block contract 3 and 4 beds respectively and Wakefield intend to reduce their block purchase to 2 beds by the end of 16/17. Barnsley have now served notice on their block bed with another provider and are moving to a contracted bed within Horizon as of Q2 16/17. Calderdale currently purchase on a spot basis from private providers. There will be an agreement across the patch that all CCGs can utilise any voids within the Horizon Centre to prevent people being placed out of area.

3.4.3 In-patient Rehabilitation

All other in-patient rehabilitation beds are spot purchased by all CCGs from private providers who all offer a similar service.

These placements are mainly out of area of the TCP, see table below showing current position.

Provider	Total of Beds either commission or used	No of beds in TCP area	No of beds out of TCP area
Priory Group	5	5	0
Cambian Healthcare	15	2	13
Lighthouse Group	5	0	5
Other Provider	4	2	2
Turning Point	1	0	1
St George's Healthcare	2	0	2
Total	**32**	**9**	**23**

NB The above figures were based on the December 2015 Baseline data

3.4.4 Respite and Short Break Services

Across the TCP there are different respite services and short break services commissioned by both health and social care including joint commissioned services. Demand continues to grow for these services.

A recent trend since the introduction of personal budgets has seen a steady increase in the number of people taking a direct payment as an alternative to traditional, building-based short break services. A direct payment / PHB can be used to create an individually designed person-centred short break, possibly visiting a place of interest, friends or extended family, staying in ordinary accommodation with a personal assistant or paid carer. This more personalised, creative approach still gives carers a break from caring but also enables the cared for person to have a new life experience.

We expect to see continued demand for short breaks services grow, but expect more people to take up direct payments / PHB to purchase an individually designed short break. We also expect individuals to join together personal budgets to collectively purchase short break services with friends.

3.4.5 Residential / Care Home

Learning disability care home provision for individuals with challenging behaviour and complex health needs represents a significant cost pressure within the overall care home provision expenditure. The TCP all commission care home provision via

spot purchasing arrangements to promote user choice. The local authorities all work in partnership with its independent sector market and has developed 'fair rates for care' where the Council is statutorily required to implement 'usual rates' in an attempt to balance local market conditions, the strategic aim to promote and support independence, organisational pressures and to provide reasonable levels of stability and sustainability within the local care home market. The Council has an approach of working with providers to raise standards of care through its contract monitoring and annual review processes and provider forum mechanisms. Each area within the TCP has an accommodation strategy in place which clearly states the intentions to reduce the use of care home provision and develop supported living, this is a more cost effective provision and also support the move towards more independent living.

3.4.6 Supported living

There are various levels of supported living across the regions and this is one of the largest provisions currently commissioned by all areas.

Intensive care and support provided on a 24 hour - 7 days a week basis (where the Council typically commissions both the care and support service plus the accommodation).

Support and enablement services for people with lower levels of need who have their own living arrangements in place (e.g. living with parents etc.).

3.4.7 Support and Enablement / Care at Home

There are many packages of support offered in a person's home across the area, this is also significant spend for all areas.

3.4.8 Day Care

There are several day care facilities commissioned by both local authorities and CCGs across the TCP, these range from dealing with low to high complex people with a learning disability.

3.4.9 Other services commissioned include the following

- Shared Lives – We are currently in the process of working through a business case to apply for the funding that has been made available to further develop our shared lives model of delivery.
- Advocacy Services
- Transport Services
- Housing Related Support
- Information and Advice Support

Current spend on LD Services across CKWB:

Provision	Annual cost to CCG(s) in 15/16 (£)	Annual cost to local gov't in 15/16 (£)	Total
Community Teams	£7,646,832	£3,242,000	£10,888,832
Other Community Teams	£62,002	£0	£62,002
Day Care Facilities	£1,601,353	£9,704,025	£11,305,378
Domiciliary/Home Care	£3,486,537	£1,252,310	£4,738,847
Educational Establishment	£525,562	£0	£525,562
Care Home	£16,639,562	£26,606,000	£43,245,562
Respite Services	£954,182	£1,107,621	£2,061,803
Shared Lives	£137,952	£1,067,000	£1,204,952
Supported Living	£2,827,027	£31,303,183	£34,130,210
Short Breaks Service	£0	£570,000	£570,000
Housing Support	£0	£0	£0
College Transport	£0	£221,860	£221,860
Support / Advice Services	£28,500	£651,500	£680,000
Other Costs requires further breakdown	£9,801,216	£18,810,000	£28,611,216
Total	**£43,710,725**	**£94,535,499**	**£138,246,224**

3.5 How does the current system perform against current national outcomes?

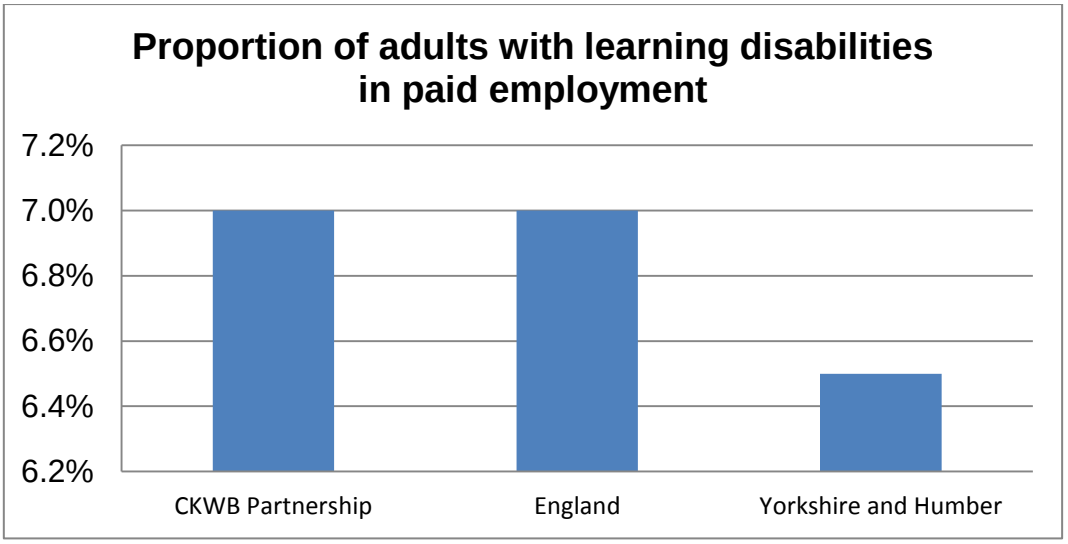
3.5.1 In-patient Bed Commissioned v National Planning Assumptions

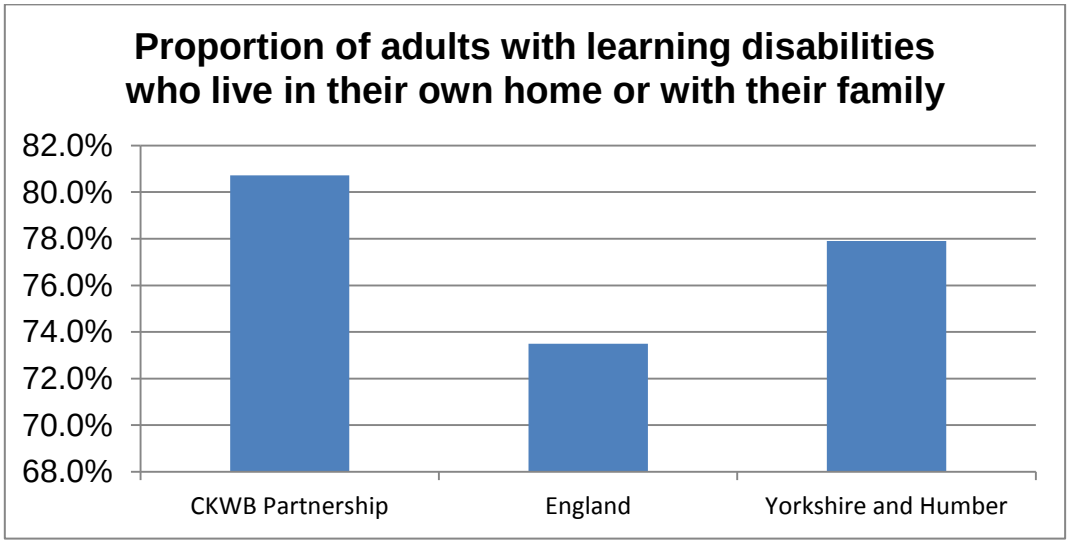
When 'Building the Right Support' was published, the CKWB partnership was ranked 6th in the country for the highest number of in-patient beds commissioned by the CCG, by population. Since this data was taken based on July 2015, we have already reduced our in-patient beds by 6, with a further 3 by the end of quarter 1 in 16/17. The current position of secure beds commissioned is already aligned to the upper planning assumption.

3.5.2 Adult Social Care Outcomes

The two key measurements which relate to people with a learning disability on the Adult Social Care Outcomes Framework (ASCOF) are shown below.

The performance for the CKWB Partnership for both outcomes, is equal to or greater than the England average, and both outcomes are greater than the average for Yorkshire and Humber region.





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

Each of the partner areas has a range of accommodation provision through, in house, independent and voluntary sector provision locally. Wakefield for example has over 60 supported living establishments for individuals and up to 12 people living together and Calderdale has a 12 bed short stay, emergency and respite provision. This estate is reviewed locally on an ongoing basis for its quality, usage and relevance to the overall need of the LD population.

There will be a full consolidated review of the estates for all areas included in the TCP and this is a key area that will sit under the market development work stream.

3.6 What is the case for change?

3.6.1 Challenges within the current care model

- Lack of specialist enhanced or crisis support teams over 7 days per week that support parents and care providers in the individual's home

- No step up ‘safe places’ for people to go when a crisis occurs, the default is an in-patient bed
- Lack of a preventative approach to people in crisis and clarity about action / support needed
- Lack of support / training for carers to manage family members with complex needs behaviours that challenge
- Lack of understanding of numbers ‘at Risk’ potential to need crisis support to prevent admission
- Not enough robust specialist respite provision
- Lack of highly skilled providers across the area to manage challenging people in a community setting
- Availability of specialist-designed suitable premises for people with behaviours that challenge / autism
- Lack of positive risk taking across the board
- Lack of partnership working in the wider community to assist in safe discharge of people with history of offending behaviours
- Lack of good information systems and sharing data, forward planning
- A lack of robust outcome measures (possibly a knock-on effect from poor information systems) means that progress had been hard to measure and is a key element that needs to change
- The length of time required to develop sustainable community-based alternatives to admission. Particularly housing, architectural based solutions
- A lack of systems / capability to identify people at risk of poor outcomes / potential admission
- Commissioning for specialised services is done on a system wide basis rather than sub regional basis
- We have no control over admissions directed by the courts
- The need to change the culture across the board / re-shape the current market provision, by giving clear messages
- The health and social care system faces unprecedented funding pressures and significant future challenges. More focus on individual outcomes and value for money
- Although direct payments are well established, there is still a lot of work to fully roll out and implement personal health budgets further

3.6.2 How can the current model of care be improved?

Due to the challenges within the current system, we must transform to increase the efficiency and quality of our local services which requires new thinking and radical changes across the system. Our services need to be organised and aligned to deliver high quality and evidenced based care. We need to ensure we have the right people delivering the right service in the right setting at the right time. We need to develop a clear understanding of the type and volume of specialist service required now and in the future.

- Person-centred planning ensuring choice and control is the key to all service provision and planning
- Promotion of personalised budgets to provide more control to people, better planning and co-production
- Together with our partners we need to make sure the needs of people with learning disabilities are fully met with timely and appropriate care that is planned, proactive and coordinated and evidenced-based
- Systematic early identification and intervention and detailed complex needs prevention planning
- Effective prevention from a young age, especially as young people prepare for adulthood, addressing or reducing the impact of challenging behaviours. Helping people to stay out of trouble and supporting people who enter the Criminal Justice System
- Development and retention of a consistently highly skilled, confident and value driven workforce
- Create and support capable communities ensuring families and carers are trained and supported utilising organisations such as Kinfo to deliver specific training around learning disabilities
- Clear and concise service specifications to ensure providers are clear of their roles and responsibilities and better contract monitoring, with a focus on developing outcome specifications
- Clear criteria around the threshold for admission into an in-patient bed
- Further development of the CTR process to improve the process from pre-admission to discharge along the pathway
- Standardised performance measures for all providers to allow regular reporting of performance and activity
- Agree a set of minimum outcome measures to allow benchmarking and tracking of performance, (NDTi Community Inclusion Web, Triangle - Outcome Star)

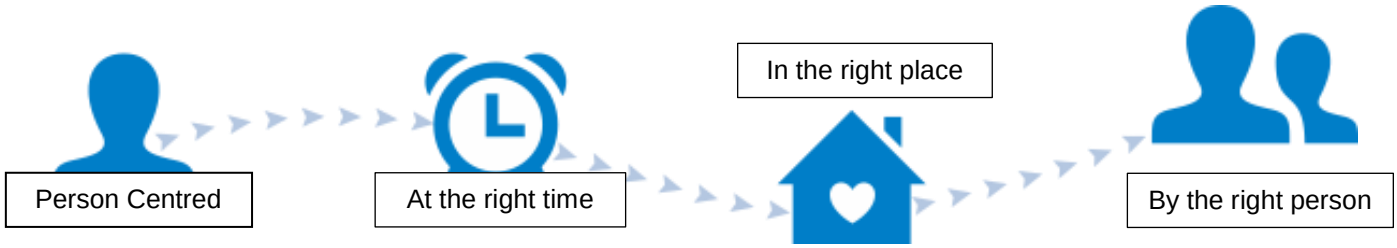
4. Vision for the future

4.1 Vision, strategy and outcomes

Our vision is to radically change the parts of the system that are not working well and become an area of best practice in which each locality is able to meet the needs of its complex needs population locally in all but the most complex cases. We will do this by building upon what we know works well and identifying gaps in service and areas for improvement. We will then invest in a model of care and support that meets the needs of the LD population now and in the future. It is worth noting that we are already doing well at managing people in their own homes and exceed the national average by 7% and we will build on this to ensure the five cohorts can also be managed in their own homes. We will work collaboratively and innovatively to look at the way we commission and deliver future care and services. We will ensure that

the change is system wide and encompasses the cultural shift that is required to succeed.

The core strategy will be to develop capable communities, a highly skilled workforce and more quality accommodation options across the pathway, with a clear focus on personalised care at the right time in the right place by the right person. It will be aligned to our care closer to home strategy which encompasses the wider determinants of health and social care, enabling people to be independent, living in their own homes and communities with access to all services when required.



4.1.1 Describe your aspirations for 2018/19

The partnership will work together to achieve positive outcomes for people with a learning disability and/or autism, ensuring they have the same choices and control to have a meaningful and fulfilling life. We will support individuals to use mainstream services and participate in their local communities whenever possible and when problems arise, people will be supported by specialist services and facilities to prevent crisis, and if a crisis situation does occur it will be managed well.

As a result of the changes covered in this plan we will ensure:

- Good quality learning disability services delivered by highly skilled, multi-disciplinary staff will have an approach based on strong community support services, planned around people in the environment that they are in, focussing on person-centred care, and looking at each individual's needs and where appropriate the family/carers needs. This approach should be applied to all, including people with very complex needs
- People with a learning disability and/or autism, including people with complex and challenging behaviour, will sometimes have physical or mental health problems and will be supported to access mainstream health services whenever possible that will make reasonable adjustments to the provision of their care
- More people with learning disability and/or autism will be supported to live in the community / in their own home and when people display challenging behaviours, the appropriate support will ensure that they will be kept safe within their communities wherever possible
- We will become centres for excellence in supporting people with learning disabilities and/or autism in the community. We will develop and apply best

practice and evidence based interventions to ensure we facilitate the most successful outcomes for people

- We will ensure that population data, including equality monitoring, is kept up to date and use this to better understand the needs of our population ensuring flexible and intelligent commissioning practices that make the right services available and at the right time.
- All generic health and social care services will be encouraged to extend the range and provision of Learning Disability / Autism champions to improve the care experience
- There should be provision for those people who have low level needs, who may not currently meet the criteria for services, through appropriately accessible local prevention and wellbeing services.
- We will build community capacity to encourage co-production based choice and control. Where people need more specialist support, including specialist support arising from complex and challenging behaviour, individuals will have access to skilled support staff and where necessary the support of specialist professionals to assist assessment and help plan more effective support
- The service will be committed to achieving the outcomes of 'rights, inclusion, independence and choice', and to ensuring that it 'sticks with' individuals in spite of the difficulties experienced in meeting their needs
- Services should ensure that those with learning disabilities and their carers are able to access the right level of information, advice and advocacy support.
- Carers should be provided with support in accordance with the national and local Carers Strategy and the Care Act, and services should ensure that appropriate attention is given to meeting the needs of older carers and people with learning disabilities and/or autism who are carers themselves
- A named single point of contact who will lead on co-ordinating all professionals involved in support the individual.

4.2 How will we know if we have succeeded?

There are a number of different tools and frameworks that are being used or developed to measure outcomes and the TCP will be including this as a key action within the plan to review what is available and align this to the overall outcomes that this plan is working towards.

When all the national measurements have been published from NHS England, we will identify any gaps that we feel need to be captured from an outcomes perspective to ensure we are not duplicating work by using many different methods. This is about streamlining the process to implement a framework that everyone can use across the system that is easy to use, whilst providing meaningful information.

4.2.1 Improved quality of care

- I get the right treatment and medication to keep me well

- I am cared for by people who are well supported
- I get the additional support I need in the most appropriate setting
- I get good quality general healthcare
- I have regular care reviews to assess if I should be moving on
- I am involved in decisions about my care

4.2.2 Improved quality of life

- I am safe
- I am supported to live safely and take an activity part within the local community
- I have a choice about living near to my family and friends
- I am protected from avoidable harm, but also have my own freedom to take risks
- I am treated with compassion, dignity and respect
- I am supported to make choices in my daily life
- I am helped to keep in touch with my family and friends

4.2.3 Reduced reliance on in-patient services

- Reduction in in-patient services
- Reduction in secure in-patient beds
- Reduced length of stay
- Delayed discharges will be minimised

4.3 How will improvement against each of these domains be measured?

Our objectives are as follows and denominators will be included in all contracts to ensure these can be measured through contract monitoring.

4.3.1 Improved quality of care

- Quality review of care plans via contract monitoring
- Use of quality initiatives such as ‘quality checkers’ using the experience of people who use services.
- Service user / Carer feedback
- Increased % of people with health checks and health action plans
- Increased uptake of screening and immunisation
- Improved management of long term conditions e.g. diabetes
- Improvement in health lifestyle indicators e.g. smoking, BMI, etc.
- Reduction in A&E attendances
- Reduction in avoidable emergency admissions
- Equality monitoring to ensure all our populations are benefiting from change

4.3.2 Improved quality of life

- Reduction in avoidable and premature deaths
- Reduction of unplanned respite

- Reduction of placement breakdowns
- Number and % of people in their own homes
- Number and % of people in settled and secure accommodation of their choice
- Number and % of adults in employment

4.3.3 Reduced reliance on in-patient services

- Reduction in in-patient services by 50%
- Reduction in secure in-patient beds by 10% bringing the number lower than then national expectation
- Reduction in length of stay
- Delayed discharges will be minimised
- Any hospital stays will be closer to the individual's home and support networks

5. Implementation planning

5.1 Proposed service changes

5.1.1 Overview of your new model of care

The proposed model will be based on the principles described in the national service model and will be developed across the life span taking into consideration the changing needs and requirements of people with learning disabilities.

5.2 Key themes for implementing the Transformation Programme:

- Choice and control at the heart of all service provision and planning
- Systematic Early Identification and Intervention
- Planned, proactive and coordinated care in the community
- Effective Prevention and Management of Crisis
- Helping people to stay out of trouble and supporting people who enter the Criminal Justice System
- A consistently highly skilled, confident and value driven workforce
- Equitable service provision and high quality evidence based care in the community

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

5.3.1 Community Service Model – Enhanced Pathway

Across the TCP we are working jointly with SWYPFT to develop a more robust community service including an enhanced pathway in line with the national service model. A new service specification has been designed and agreed and we are currently working with SWYPFT on an implementation plan. This service specification encompasses the principles within the national service model and the aims and objectives are below:

- Ensure people with a learning disability are included as equal citizens, with equal rights of access to equally effective treatment enabling a purposeful and fulfilling life
- Provide a robust care coordination framework (CPA) with an underpinning principle to provide a single integrated health and social care process to deliver continuity of care
- Implement person-centred practice and individual service design including the following principles:
  - Prevention and early intervention
  - A whole systems life course approach
  - Family carer and stakeholder partnerships
  - Behaviour that challenges is reduced by better meeting needs and increasing quality of life support for communication
  - Physical health support
  - Mental health support
  - Function based holistic assessment
  - Support for additional needs
  - Positive behavioural support
  - Safeguarding and advocacy
  - Specialist local services
  - Workforce development
  - Monitoring quality
- Ensure care and support is proactive, planned and coordinated and the individuals and families have more choice and control over what this looks like
- Ensure better and quicker identification and treatment of mental health problems within the learning disability or autism community
- Ensure that any hospital admission needed is as short as possible, part of the integrated pathway and in a local generic mental health or specialist in-patient service
- Ensure individuals are resettled in the community with a highly personalised health, care and housing package put in place through careful planning with the individual, their family and independent advocate
- Ensure personal health budgets are promoted and offered where appropriate and the required support to be provided to individuals and their families to manage this
- Development and implementation of a risk register to ensure early intervention and to prevent unnecessary admissions

5.4 What new services we will commission

5.4.1 Crisis response capacity

A key element of the new service spec is that community teams should be ensuring that patients identified as ‘at risk’ have the necessary care plans, relapse prevention and contingencies in place so that crisis occur as rarely as possible. We will also

build on current work to know who is at risk within the community and manage this group more successfully.

However, even best managed plans cannot avoid all crisis situations. The first point of contact for a developing crisis should be the CLDT who will work though the care and contingency plan to try and avoid escalation and to de-escalate the situation. However, if a full crisis occurs in an unforeseen way or when the CLDT is not available it is essential that services can respond to their needs with appropriate and effective advice and support 24 hours a day, 7 days a week. This service will be delivered by an intensive support team. As well as improving service accessibility and responsiveness this will positively impact on the number of out-of-hours admissions to in-patient units. It would be consistent with current commissioning guidance to develop this service through investment in the existing mental health crisis response service with the caveat that it is also suitable for people with learning disability and/or autism who experience behavioural crises. Linkage to services such as appropriate short break facilities and to the out of hours management system for local learning disability residential / supported living services could provide some flexible options to lessen immediate pressures and provide 'holding solutions' until the day-time services can resume responsibility. Where the person in crisis is in the 'core group' they should have in place a well thought out contingency plan, which should assist the effective management of the situation.

Community services across the partnership generally operate on a traditional working day pattern, Monday to Friday 9.00-5.00. Outside these hours Social Services Emergency Duty Teams provide the principle crisis response. Those caring for somebody with a learning disability and/or autism often describe the challenges posed are when individuals get up preparing to leave for a day centre or in the early evening once they have returned to the family home. Services need to be flexible enough to offer some support during these periods. Each person identified as 'at significant risk' in receipt of care should have a crisis plan, accessible to the individual and their carers outlining what actions they can take and who to contact.

The focus of all crisis responses should be:

- Providing specialist support in the most familiar setting, their own home, family home, care home via providing specialist advice and additional support to the people who know the person best
- Provide support in a specialist 'safe, calming therapeutic unit' that enables the contingency plan to be implemented in a safe environment, ensuring whenever possible the least restrictive intervention is used and the individual returns home on a night whenever possible
- As above but with the addition of short term overnight stay.

5.4.2 Respite Care and Short Breaks

It is recognised by health and care commissioners that respite care and short breaks are an important part of the current provision available to users and carers. This provision can help to avoid the need for admissions to bed based care or the escalation of difficulties that could lead to care breakdown.

Whilst it is accepted that it will be carried forward into the new model, there is also an opportunity to refresh the approach and leverage any new benefits that integrated working will bring. At the most basic level, respite can mean different things not only to different people using services but also to different commissioners. This plan recognises that respite may not be fully maximised at present because it will inevitably be bounded by where it is commissioned from and by whom.

In particular the focus on personalisation will enable personal budgets as well as direct payments to be used for care that is designed and controlled by the users and carers – which will mean that respite provision can be more responsive, more innovative and fit with the individual's interpretation of what respite means to them and works for them.

Opportunities for short breaks tailored to individual needs are available to every family supporting a person whose behaviour presents a challenge at home. Providing carers with a break when they are under pressure will prevent crises developing and help to prevent placements from breaking down.

5.4.3 An Effective Response to Challenging Behaviour

Learning disability services should give priority to people with complex needs and challenging behaviour. They are the people with the greatest need for services and marked improvements can be achieved by the provision of quality services. The adoption of a Challenging Behaviour Policy by all providers will underpin this and ensure that there is a consistent response across all services. It should commit staff to maintain input and contact with service users to resolve problems.

The group of people whose behaviour is complex and presents a serious challenge to services should be identified, and logged on the 'At Risk Register' and the services that are assessed as necessary to meet their needs developed through a person centred planning process. The plans should be clear about environmental risk factors, triggers, warning signs and contingency arrangements and ensure that back-up resources can be made available to sustain arrangements through difficult periods, and that services are put in place to support this.

The new service specification for SWYPFT includes the need for access to specialist staff that have the appropriate skills and knowledge about complex and challenging behaviour that can provide specific support to individuals, their carers and families,

providing specialist assessment, supporting development of proactive support plans giving advice and information and provide training.

Further modelling is required whilst the Programme is in implementation and cohorts are migrating to optimised care options, so that we can test and refine our assumptions on capacity and demand and match these with the quantity of staff and caseloads in the model.

The CLDT should have an adequate workforce with appropriately accredited training to equip them with the specialist knowledge and skills required to work with people with learning disabilities who have complex challenging behaviour. All staff working with people with learning disabilities should receive appropriate training in relation to challenging behaviour commensurate with their role.

Services should use a competency framework to oversee staff training and competency based on Skills for Care Guidance for Employers (2013). A positive behaviour service will need to be embedded within and alongside other services by establishing working protocols that are communicated and agreed with relevant stakeholders. Ensuring effective links with other key services are created by amenable working practices and appropriate formal arrangements.

5.4.4 Specialist Providers

This will be a key area the partnership will be working together on in the market development work-stream. There is a need for providers to support people with very complex needs and it is recognised that a regional framework will be beneficial for economies of scale. As mentioned, existing frameworks are in place for learning disability provision and these frameworks could be used as a basis to extend into a more specialist and bespoke service across the partnership.

5.4.5 Safe Place Accommodation

At times people with learning disabilities may need access to short term residential care to provide a safe environment. This service should include access to day facilities as well as overnight accommodation and should only be utilised in the short term with the expectation that it would be no longer than 4-6 weeks before moving back into their own community setting or returning home. This facility would be used to support individuals that live in the community and are either approaching a crisis or have reached crisis and require a safe environment where the enhanced community team can work with the person undertaking assessment and treatment to prevent admission to an in-patient facility.

5.4.6 Bespoke Homes in the Community

It is acknowledged that some people (the most complex and challenging) stepping down from in-patient settings will require more bespoke person-centred homes designed to the individual needs to live in that will keep them safe and they will be

supported by personalised packages of care that will be flexible according to their needs. Whenever possible these bespoke individual homes will provide long term assured tenancies whilst balancing the need to ensure active engagement with ongoing therapeutic care and support. It is expected that there may need to be a period of relatively intensive support, together with focused rehabilitation work to successfully manage their transition. These individual homes will be smaller developments in community settings and the key to their success will be co-produced planning with people with a learning disability and their families, providers and other stakeholders. It is also really important that when identifying people who would like to live in these homes, they are matched appropriately to the other people that will be living in the development.

Calderdale has already developed a number of houses able to support up to 4 people with similar needs in the community and this has facilitated the return to area of a number of people, learning will be shared from this across the partnership.

Within Kirklees we currently have a property that we are considering for the development of four to six individual homes which would cater more towards the five cohorts of people identified in 'Building the Right Support' and we are in discussions with providers regarding the delivery of care. This is something that as a partnership we have discussed and we will be reviewing our current cohort of people in an in-patient bed to ensure we have the right mix of people in these individual homes. We have also got some potential funding from the sale of two properties with the release of the legal charge and are currently developing a PID to submit to NHS England for approval to reinvest into this service.

5.4.7 Supported Living Services

There are many supported living services across the partnership and a review of these will be undertaken to identify if some of these can be redesigned to meet the needs of the five cohorts that this plan refers to. We will work with providers to identify what the gaps are in terms of training and building viability to see if any existing services can be adapted or whether we need to look at building new provision to meet the needs of people with more intensive needs and forensic backgrounds.

5.4.8 Positive Behavioural Support

Across health and social care, statutory and the independent sector, the workforce plan will specify the use of the Positive Behavioural Support Competency Framework This will underpin the development of a Positive Behavioural Support Hub. This will be a coordinated, planned network for the development and delivery of accredited training and bring together local expertise to develop full range of training, supervision and coaching for front line staff including personal assistants, their supervisors, managers and families. We will be discussing with local universities and Health Education England how this can be scoped and delivered.

5.4.9 Personalisation

In keeping with the national personalisation agenda, we will work to increase the numbers of people on self-directed forms of care and support. In support of the roll out of personalisation, commissioning and contracting, arrangements have already been evaluated and amended with the specific purpose of encouraging and enabling providers to offer choice and flexibility not only to those seeking control over support, but to all individuals in receipt of services, including self-funders. This has been supported by a dramatic reduction in block or cost and volume contracts, with a continued migration to framework and spot contracting arrangements.

The table below shows the numbers of people receiving a direct payment or personal health budget and whilst the numbers look quite high, it only reflects 16% of the overall LD population known to services. The expertise of local authorities on direct payments is being utilised for further roll out of personal health budgets across health and this will be another key action within the plan to further analyse the position and identify how we can work collaboratively to further roll out personalisation across the TCP.

People receiving personal health budgets/Direct payments	**Number**	**Value**
Personal Health Budgets	61	£ 2,642,734
Direct Payments	711	£ 11,598,285
Total	**772**	**£ 14,241,019**

Local offers are currently being developed in each area for expanding the implementation of PHBs and the partnership will take the opportunity to review the viability of extending these across the region and it will consider how and what can be done as part of the overall plan together. Our plan is to offer individuals and families ongoing support to identify a personalised solution via taking control of a direct payment and the responsibilities within that. Some of the areas that will be included will be:

- Individual service funds / pooled funds to enable people with a learning disability to work closely with providers and user led organisation to co-produce a personalised plan – it is felt that these could be a good option for the five cohorts identified
- We will also work with the voluntary sector such as Mencap to utilise their expertise and support for the further development and implementation of PHBs focussing on the five cohorts identified
- We will develop the local market place to ensure quality, creative and flexible services and support available including specialist support for people with more challenging behaviours. This should lead to increased local choices for individuals and increase take up of such budgets

- Commissioning and contracting arrangements will be evaluated and amended with the specific purpose of encouraging and enabling providers to offer choice and flexibility not only to those individuals seeking absolute control over the support provided but to all individuals in receipt of services. This anticipated outcome will be a reduction in block or cost and volume contracts and a continued migration to framework and spot contracting arrangements.

There is a real commitment to supporting the delivery of personal health budgets and the board have agreed that Barnsley will lead on this as they have become an Integrated Personal Commissioning demonstrator site which will link into the TCP.

Integrated Personal Commissioning (IPC) is a new approach to joining up health, social care and other services at the level of the individual. It enables people, carers and families to control the resources available to them and to 'commission' their own care. It also supports people to make the most of local community resources, and supports them to develop their knowledge, skills and confidence for self-management through targeted peer support, community capacity building and an expanded role for the VCSE sector in preventing, reducing or delaying the need for crisis intervention and acute care.

IPC is a highly ambitious programme requiring demonstrator sites to work at a fast pace to implement wide-ranging transformational change. The programme is committed to ensuring that local ambition is matched by national support to enable the change to happen. This support will lay the foundations for an increased pace and scale of delivery in 2016-17. A vital part of this support will be the IPC Voluntary Sector Partners Programme, consisting of 25 voluntary, community and social enterprise (VCSE) partners. Significant investment has been made across these organisations to bring their experience, expertise and perspectives to the delivery programme, to provide practical support to both sites and the central delivery team.

A bid has been completed to access the following resources identified as key areas to enable the partnership to effectively implement personal health budgets:

- Challenging Behaviour Foundation
- Skills for Care
- National Development Team (Inclusion).
- Think Local Act Personal

The emerging IPC framework is characterised by five key shifts in the model of care, underpinned by a number of specific service components. Together these drive improved outcomes for people, the system and the tax payer.

The five key shifts of the IPC model:

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

Young people with behaviour that is complex and challenges should be the subject of focused attention and support and recorded in EHC plans. The arrangements will specify that no young person be placed in a distant residential school or other distant placements (including respite and short breaks) when their needs can be met effectively nearer to home. Commissioners will ensure that the necessary work is undertaken to build the capacity and confidence of local communities to support young people with more complex needs.

Effective transition support is based on person-centred planning and partnership working and place young people's needs and aspirations at the centre of the transition process. This will help the processes of consolidating identity, achieving independence, establishing adult relationships and finding meaningful occupation. Transition planning should start at the age of 14 years and adult services should become increasingly involved from this age and remain involved during a planned and coordinated handover.

Transition planning will start at a very early age with raising people's hopes and aspirations, we have a statutory duty to start formal planning from 14 years of age (Year 9) for those with an Education Health and Care (EHC) plan in place or transitional assessment.

Preparing for adulthood must focus on:

- Higher education and/or employment – this includes exploring different employment options, such as support for becoming self-employed and help from supported employment agencies
- Independent living – this means young people having choice, control and freedom over their lives and the support they have, their accommodation and living arrangements, including supported living
- Participating in society, including having friends and supportive relationships, and participating in, and contributing to, the local community
- Being as healthy as possible in adult life (SEN Code of Practice 2014 – page 122)

Draft protocols have been developed to ensure all parties understand each other's roles and the statutory duties placed upon them. For the most complex young people this is and will always be a challenge. Having a clear preparing for adulthood multi-agency protocol and pathway in place will help make the transition a more positive experience.

Preparing for
Adulthood Multi-Agen

In Kirklees they are developing an All Age Disability approach which will bring together key disabled children services and adult learning disability services into one single lifelong planning approach, this is a key theme that will be reviewed across the TCP as part of the early intervention and prevention work stream.

5.6 How will you commission services differently?

There will be an increased focus on outcomes when commissioning services, notably around the quality of care and support, and the quality of life enjoyed by those with a learning disability and/or autism, and their family and carers. The outcomes measures will also encourage care settings to be in the community and away from in-patient services unless they are appropriate.

Local commissioners have a commitment to work with the independent and third sector to ensure there is a vibrant and high quality market to support the needs of people with complex needs. One way this is achieved is via the production of Market Position Statements, they are aimed at care providers giving them clear messages regarding need and strategic market priorities.

Attached is Kirklees as an example of how this is being approached, but each area has their own and we will work on developing a market position statement across the TCP.

KIRKLEES MPS LD
AUG 2013 final (2).pd

A significant amount of work has already taken place developing a framework for complex community care for learning disabilities in some of the areas within the TCP and this will be reviewed to look at extending across the partnership for health and social care to ensure economical consistency and sustainability of the provider market.

Greater understanding of the children's learning disability and autism population will mean commissioning arrangements may need to change. Market development activities will be required where providers do not currently provide the capability required. Market position statements will be key in signalling new and changed commissioning intentions to the market, and commissioners are likely to need to follow this up by working with the market closely to encourage and support these commissioning intentions being addressed.

The increase in complexity of needs and also the increased use of personal budgets and personal health budgets means that small niche providers are likely to be required to address some of the accommodation requirements. Therefore commissioning mechanisms, as well as market development activities, are likely to need to encourage a much smaller type of provider. There may also be a need to encourage social enterprises as a good way to deliver services. This will require additional market development effort to ensure suitable social enterprises are developed that can take on such services. Collaborative commissioning will be considered wherever appropriate and this will be one of the key discussions when further work has been done around new services that will be commissioned.

Resettlement of long term hospital people

There are currently 12 people who have been in hospital longer than five years, split into the following:

CCG Commissioned	4
NHS England Commissioned	8

It is recognised that these people may find it difficult to resettle back into a community setting and the TCP will use progression modelling to ensure this is done successfully.

A new community rehabilitation service has also been developed within the footprint that provides a step through pathway to work intensively with service users and their families/carers, enabling them to live independently and successfully in the community. The key aims of the service are:

- The service will actively enable each and every one of the people in our care to achieve their personal best in order to move towards their discharge.
- Our services are dedicated and structured to ensure that each person enjoys the same right to a happy and fulfilled life regardless of their level of support.
- Each individual in our care begins an inclusive and personalised pathway of support from the point of access designed to support them to develop the necessary skills and experience to achieve and maintain their optimal level of independence working towards community discharge.
- We aim to develop and nurture the best 'team around the person' to ensure each individual's success. This includes ensuring individuals friends and family are equal partners with the professionals we employ.

The Care and Treatment reviews will ensure a clear and co-produced pathway and personalised and flexible packages will be available to ensure the transition is appropriate to meet the individual's needs. Personal health budgets will be offered whenever appropriate as the default choice for procuring a package to support the individual.

The funding of these packages in 16/17 has been included in the transformation funding bid following confirmation that the dowries will not be transferred with the person. It is anticipated that future dowries will transfer down once NHS England specialist commissioning have decommissioned beds. However, this has been included on the TCP risk register.

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

- This plan is being developed based on local strategies and in line with national guidance. We will ensure that as the plan is further developed the following plans and guidance are all aligned to ensure we meet the requirements of these. Local Transformation Plans for Children and Young People's Health and Wellbeing
- Local action plans under the Mental Health Crisis Concordat
- The 'local offer' for personal health budgets, and Integrated Personal Commissioning (combining health and social care)
- Work to implement the Autism Act 2009 and recently refreshed statutory guidance
- The roll out of education, health and care plans as part of the SEND agenda

6. Delivery

6.1 What are the programmes of change/work streams needed to implement this plan?

The key work-streams including themes have been agreed by the board as follows. The identified leads are included in the terms of reference embedded in this document:

- **Early intervention and prevention**
  - Develop excellent Case Management / Care and Treatment Reviews processes
  - Standard Risk Registers
  - Children's Transformation Plan including Transition
  - All age approach
  - Develop better links with Youth offending and probation services, police, Safeguarding, etc.
- **Data Sharing and Intelligence**
  - Further information gathering on current baseline
  - Review of current systems / databases
  - Information Sharing Protocols
  - Benchmarking and peer reviews
  - Develop an agreed quality and standards framework
- **Finance and Contracting**
  - In-depth analysis at how current monies are spent
  - Mapping exercise – current external providers, contracts and framework agreements
  - Personal health budgets / Direct payment
  - Co Commissioning
  - Framework agreements
  - Co-funding opportunities, e.g. DCLG grants
- **Market Development including estates**
  - Looking at people's needs and what services we currently have. CKWB market position statement
  - Aim to develop new services, support choice and control and helping people into work or activities
  - Develop more housing and social care options
  - Reducing the reliance on care homes
  - Developing a better community LD / Autism team
  - Be aware and mindful of future legislative changes
- **Workforce Development and Training**
  - Supporting the development of a suitable workforce
  - Improving training for staff across different services
  - Training and supporting carers
  - Rolling out Positive Behavioural Support

- Work jointly with external providers

- **Communications and Engagement**
  - See plan attached in section 6.4

6.2 Workforce Development Plan:

Each area within the partnership currently has its own initiatives within workforce development around overall quality of support, specific training requirements such as MCA and Safeguarding, provider engagement to assess current and future workforce needs, as well as management and leadership support. Local authorities have a responsibility to ensure that an adequately trained workforce is available to meet the social care need and each area is meeting that requirement. Support for learning disabilities provision forms part of this overall workforce development.

As a TCP we will review the current work happening in workforce development and identify the gaps relating to this plan. It has been discussed that we may build on the existing workforce development strategies and ensure representation is appropriate from a Transforming Care perspective, rather than creating another work-stream to deliver this. However, the principles will be followed on the attached workforce development plan below.

CKWB Workforce Plan.xlsx

It is recognised that in order to deliver the outcomes required through transforming care, the learning disabilities workforce needs to have a range of the right skills, capability and capacity to deliver personalised and high quality support. Services along the spectrum from secure down to universal and community need appropriate skills to be able to support and intervene effectively, and importantly know how to access higher levels of support if required. So someone who works in a job centre, for example, who is trying to support an individual with autism may have a basic awareness of the condition but may need to ask a CTLD nurse or other professional for advice if the level of skill required exceeds their knowledge. Likewise a supported living provider for learning disabilities would have skills to deliver the designated care plans of the individuals within their service but may need to draw upon psychological support from a clinical professional if an aspect of behaviour was causing concern at the time.

By achieving this, the TCP will not only be able to deliver appropriate support but achieve effective use of resources. Positive Behavioural Support training is specifically mentioned in the Building the Right Support (Oct 2015) documentation as best practice for people with LD/Autism and who display behaviour that challenges and the partnership needs to respond to this in particular. However, a model of

up-skilling community services will enable more people to remain as independent as possible and in effect 'raise the bar' to which community services can safely operate.

Under pinning this is the principle that people with learning disabilities and/or autism can learn, develop and become more independent, hence a new requirement; that of progression planning, innovative service design and improved commissioning skills will also be required.

As a result, the priority is to develop a comprehensive workforce strategy including individual local and TCP wide requirements. Adequate resourcing will need to be identified to not only deliver the work-stream but also keep existing staff through professional development and recognition both financially and personally that the role they do is valued (the NMDS-SC states that there is a 22.8% turnover rate within Y&H region). This will also include the key roles of care management, integrated working and collaborative commissioning.

Internal financial constraints through austerity measures within the LA and external cost risks through examples such as the living wage need to be incorporated into the workforce plan as direct staffing costs are the largest percentage of spend across both health and social care.

6.3 Estates Plan

Where there are gaps identified then the TCP will develop provision collectively or where there is a commissioning case for change. What is acknowledged across the partnership is a need for a flexible accommodation options and work has and will continue to be carried out working with providers of support and accommodation to enhance the range of accommodation provision.

As a partnership we have agreed that estates will be a key theme that sits under the market development work-stream.

6.4 Engagement Plan

TCP LD Engagement
Equality and Commun

6.5 Key Enablers to success

Shared Vision – It is essential that all organisations within the partnership have the same vision to change the system and deliver better services for people with a learning disability and/or autism.

Commitment – There needs to be the appetite to deliver from each organisation and this needs to be supported from the top to ensure it is deemed a priority for the people involved.

Public Support – Engagement is a key factor to ensure the public fully support the principles of the transforming care plan across our partnership

Funding – To be able to deliver better services in the community, there will be a requirement to pump prime and there will be times where organisations are double funding whilst the transformation is ongoing. There are already huge constraints across health and social care with funding cuts, so it is essential that agreed funds are made available and match funded to succeed.

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

The key milestones have been captured in the below document with timeframes for achieving the milestones. This will be reviewed and updated on a monthly basis.

CKWB TCP Milestone Report 23.06.16.xlsx

What are the risks, assumptions, issues and dependencies?

6.6 Key Risks

The key risks identified to date are in the document below, however as the work streams further develop, it is likely that further risks may be identified.

CKWB Risk issue logs.xls

6.7 Key Dependencies

There are other partner agencies that need to be more involved in discussions and they will be included within the stakeholder engagement plan:

Criminal Justice System - we recognise that they will need to be involved in the transfer of people being placed in the community. Need to be aware that there will be some people living in the community that may need additional support and resource.

Primary Care as there will be individuals being supported in the community accessing mainstream services. Raise awareness of the individuals and their circumstances. They may need more intensive support and care management.

Police so that we raise awareness of the individuals living in the community and provide additional education to the workforce. Police could potential be involved in MDT discussions. In Kirklees we have worked with West Yorkshire police to roll out National Mencap 'Stand by Me Police Promise', one element has been to link PCSO

with local care service provision. This is an area that we will look at sharing across the TCP.

Council Services to raise awareness with them that include housing, employment services and leisure providers to ensure people are supported to access services.

6.8 External policies / External changes

The shift of responsibilities from NHS England to CCGs needs to be understood and factored into commissioning arrangements. NHS England and all CCGs are represented within the governance structures for the programme of work.

What risk mitigations do you have in place?

Please see the risk register in section 6.6

7. Finances

7.1 Activity finance tracker data

finance and activity plan v4.xlsx

7.1.1 LD Patient Projection Tab

The numbers of inpatient beds commissioned by the CCG from 31st March 2016 onwards are based on projections made as at the 22nd June 2016 and are best estimates based on current pathway timeframes taken from both the most up to date CTRs or the most up to date CPAs whichever was undertaken at the latest date.

The SCG commissioned beds are taken from the data submitted by SCG on the 28th January 2016 and have not been amended in this plan as the target reduction is in line with the national planning numbers.

7.1.2 Finance and Activity Tab

As a TCP a decision was made to only include people that had been in an inpatient bed and discharged after the 1st April 2009 and all Children's packages. However, it is acknowledged that not all areas submitted numbers for children and this will be picked up in the further analysis of baseline data.

The decision to not populate the 'at risk of admission' section was agreed across our TCP because every other person receiving a package of care would not necessarily be at risk and it would actually only be a small percentage of people that would be at risk. There was a concern by stating that all other packages were at risk, we would have to undertake CTRs on everyone in line with the CTR guidance and it would not be practical or beneficial to undertake these for several hundred people.

As part of this plan a new service specification has been developed for LD community services and there is a requirement within this specification to maintain the at risk register. This has been built into our CQUINS for 16/17 and it has been agreed that we will agree specific criteria for the risk register, to ensure there is a consistent approach across our TCP to manage people at risk more effectively.

To enable us to consolidate all spend across the TCP into meaningful information, it was agreed to look at what services we are currently spending our budgets on. The focus will be to review spend in each area and understand where we can decommission services to enable monies to be released to reinvest into better community services.

7.2 Transformation Bid for Funding

CKWB
Transformational Bids