NHS
Greater Huddersfield
Clinical Commissioning Group

Calderdale, Wakefield, Kirklees and Barnsley (CKWB)

Transforming Care Partnership Plan

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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 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 inpatient 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 inpatient 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 inpatient 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 inpatient beds, delivering a 60% reduction across the partnership by 2019**

- **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 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 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

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.

CKWB Board TOR Draft v5.doc

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

Kirklees Health and Wellbeing Board – 31st March 2016
Calderdale Health and Wellbeing Board – 17th March 2016
Wakefield Health and Wellbeing Board – 24th March 2016
Barnsley Health and Wellbeing Board – 5th April 2016

2.1.3 Describe 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 and 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

2.1.4 Describe how 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 inpatient 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 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 has 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 an 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 CTR (care and treatment review).

The consultation undertaken for Future in Mind is listed below.

- Education and Schools partnership group
- Third Sector partner engagement
- Listen to ME(ntal 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

- Easy access to services and information that is easy to understand
- Care closer to home, but do not want homes turned into hospitals
- Bespoke housing- right housing/environment for the individual
- Personalisation needs to include people with challenging behaviours
- 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
- 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
- We need to make sure people who are away from home get access to advocacy
- 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
- We need to invest in prevention to prevent families breaking down
- Having access to the internet
- 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
- LD champions who work in general hospitals to ensure the nursing staff understand our needs
- Keep our Activity centre, and have more groups.
- Reasonable adjustments should be included within all health and social care contracts
- Very important to have efficient caring help. Priorities for carers; plenty of help and more facilities for good respite care
- Supporting people who use services is critical to maintaining their care / wellbeing
- Independent support such as advocacy is highly valued by users and carers
- 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
- 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
- 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
- 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
- Local register needs to include all people with challenging behaviour
- Still too many people in high cost placements out of district
- Access to Mental Health Services is sometimes difficult
- Barriers to accessing universal services within the community
- Short breaks tend to be building based

- Too much investment in specialist services and high cost placements without understanding the quality of these placements
- Not all GP practices offer health checks
- Lack of hydrotherapy services – time limited/cost
- Landlord / housing issues – not responding to repairs quickly, chasing up responses from housing
- Withdrawal of service bus and general bus services reducing
- The negative impression of hospitals that have been given since winterbourne, and other hospital scandals
- More supported work placements/job opportunities - We do not want to just walk round shopping centres all day
- Speech and Language Therapy and support in school, needs resourcing
- There needs to be raised awareness at all levels of learning disability and autism
- 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
- 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
- Not getting diagnosed early enough - underlying conditions or co-morbidities not being addressed in a holistic way
- Confusion of where to go for services/help and understanding what is available - no single point of access
- Transitions are problematic (children's services to adults, hospitals to community, from one provider or funder to another)
- 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
- Not enough independent / advocacy support to help explain and challenge restrictions / out of area decisions that take the person far away from family
- 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
- 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
- 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

- 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'
- 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 Describe 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
- Spot contracts are in place for all inpatient 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 individual 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 mechanism 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 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 is already working on a joint 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 inpatient 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 inpatient 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 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 - LD				
Age Band	**2015**	**2020**	**2025**	**2030**
18-24	2788	2586	2541	2781
25-34	3839	3994	3977	3772
35-44	3757	3709	3960	4122
45-54	4157	4042	3638	3608
55-64	3289	3634	3901	3774
65-74	2637	2823	2829	3152
75-84	1374	1575	1942	1571
85 and over	498	590	729	914
Total	**22339**	**22953**	**23517**	**23694**

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

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 inpatient 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 inpatient care, and where they are currently above this level, will plan to reach an inpatient rate within the range 20-25 inpatients per million population for NHS England commissioned services and 10-15 inpatients per million for CCG commissioned services by March 2019. The CKWB partnership has a population of approx. £1.2 million and is basing the plans on the following

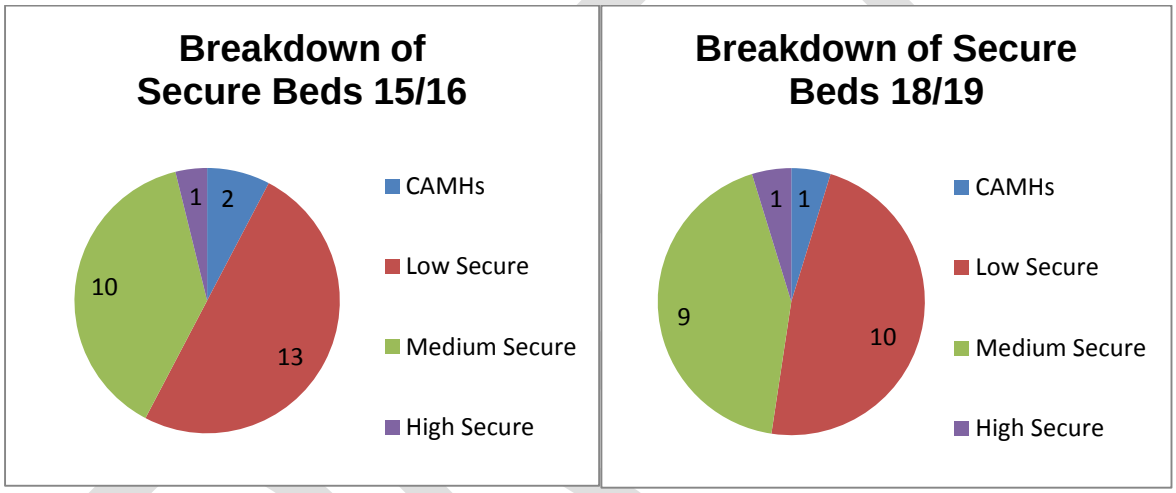
NHS England commissioned - 30 inpatient beds

CCG Commissioned - 18 inpatient beds

3.2 NHS England Commissioned Services

There are currently 26 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 and it is forecast that this will be 21 in 18/19 which will be lower than the planning assumptions.

Secure Beds	Actual 15/16	Forecast 18/19
Adults	24	20
Children	2	1
Total	26	21



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 inpatient beds, this is more than double the national planning assumption level, however by the end of year 1 this will have reduced by 45% and by the end of year 2 we will have achieved better than the levels suggested of 18 inpatient beds across the partnership. It is worth noting that although the numbers are quite high for year 0, there as 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 Inpatient Beds

Year	Year 0 (2015/16)	Year 1 (2016/17)				Year 2 (2017/18)				Year 3 (2018/19)			
Period	**31/03/16**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
CCG Inpatient Beds	38	31	28	26	21	16	16	16	15	14	14	14	14

3.3.2 Annual spend of inpatient beds commissioned by the CCG's 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 inpatient beds is over £5m with the largest reduction coming from CCG commissioned beds which will be used to reinvest into community provision.

3.4 Describe the current system 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 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 provide assessment and treatment beds across two units. Fox View has 4 beds and is in Kirklees and Horizon is an 8 bedded unit and is in Wakefield. Assessment and Treatment beds are currently block commissioned by three of the CCGs and these services include a number of therapies including psychology. Of the other two CCGs, one commissions a block bed from another trust and the other CCG commissions from the private sector on a spot purchase.

3.4.3 Inpatient Rehabilitation

All inpatient 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 Georges Healthcare	2	0	2
Total	**32**	**9**	**23**

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 represent 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.

3.4.6 Supported living

There are various levels of supported living across the regions and this is one of the largest provision 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
- Advocacy Services
- Transport Services
- Housing Related Support
- Information and Advice Support

Current spend on LD Services

Provision	Annual cost to CCG(s) in 15/16 (£)	Annual cost to local govt 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**

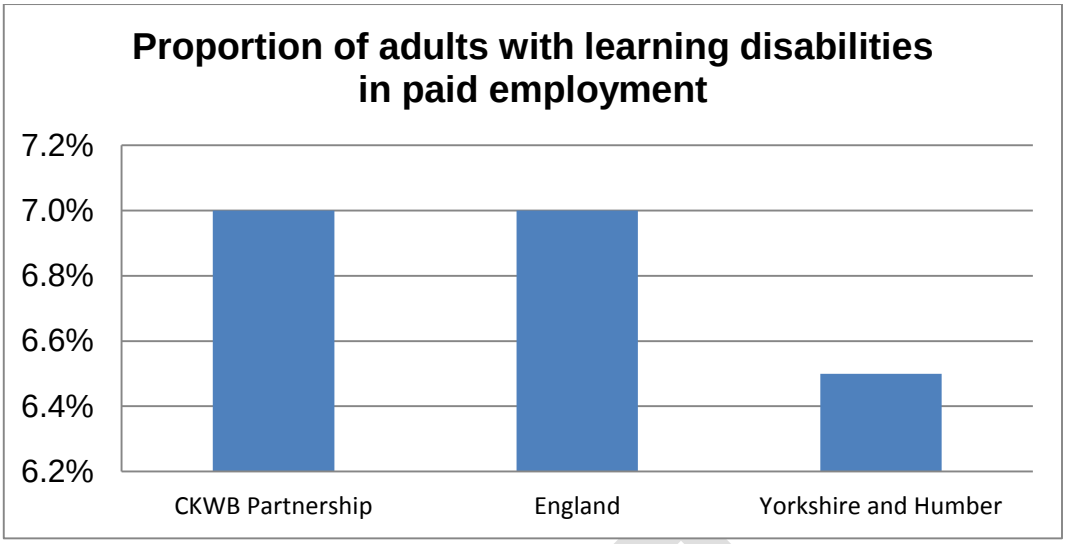
3.5 How does the current system perform against current national outcomes?

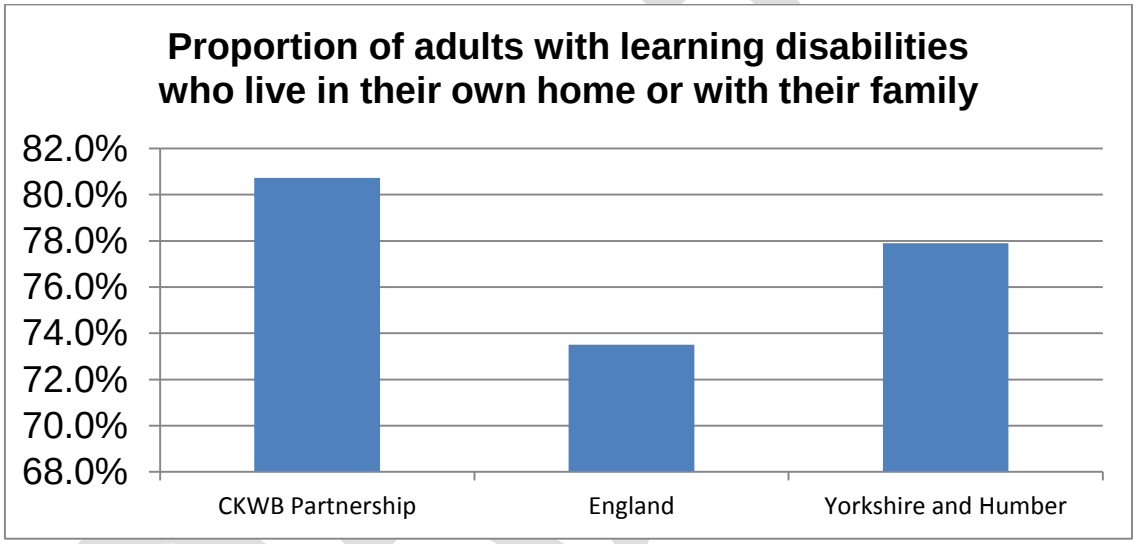
3.5.1 Inpatient Bed Commissioned v National Planning Assumptions

When Building the Right Support was published, the CKWB partnership was ranked 6th in the country for the highest number of inpatient beds commissioned by the CCG by population. Since this data was taken based on July 2015, we have already reduced our inpatient beds by 6, with a further 7 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, are 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 a full update will be provided in the next plan.

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 inpatient 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 understand 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

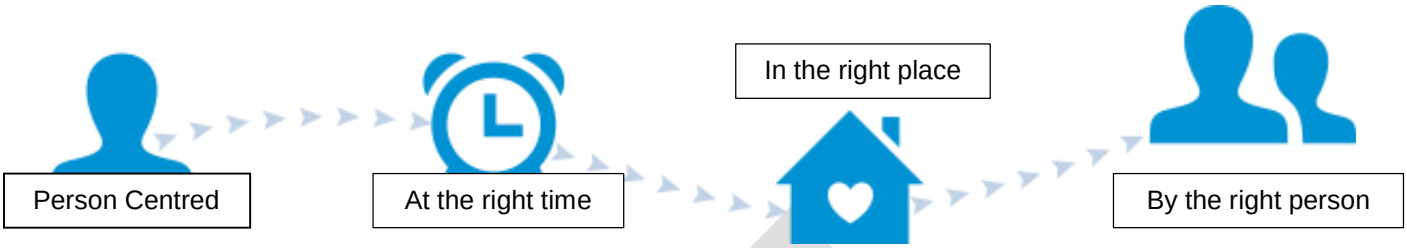
- Promotion of personalised budgets to provide more control to people, better planning and co-production
- Together with our partners we need to make sure the needs of people with learning disabilities are fully met with timely and appropriate care that is planned, proactive and coordinated and evidenced 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 of 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 inpatient 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. Develop your 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, 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 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 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 at 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 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 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 they need more specialist support, including specialist support arising from complex and challenging behaviour they 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 carer's are able to access the right level of information, advice and advocacy support.
- Carers should be provided with support in accordance with the national 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 needs 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 inpatient services

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

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

Our SMART objectives are:

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.
- Reduced A&E attendances
- Reduced avoidable emergency admissions

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 inpatient services

- Reduction in inpatient services by 50%
- Reduction in secure inpatient beds by 10% bringing the number lower than then national expectation
- Reduced 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

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 is currently under review with all organisations for sign off. 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 inpatient 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, there are current discussions about including the

maintenance of the risk register as a CQUIN in the 16/17 contract with SWYPFT to ensure a consistent approach across the region.

However, even best managed plans cannot avoid all crisis situations. The first point of contact for 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 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 inpatient facility.

5.4.6 Bespoke Homes in the Community

It is acknowledged that some people (the most complex and challenging) stepping down from inpatient 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 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.

Please note the above is not a group home, they are individual homes with their own front doors and gardens, where people will have personalised packages to support them to live independently. I think there has been a misinterpretation of this on the assurance framework as it refers to group homes.

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 will be reviewing our current cohort of people in an inpatient bed to ensure we have the right mix of people in these 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 That 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 on 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 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 areas for 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 PHB's 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.

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 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 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 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.

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 inpatient 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 approach, but each area has their own and we will work on developing a market position statement across the TCP.

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 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.

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 have been included in the transformation funding 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 has 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 including in the terms of reference embedded in the document. These are subject to change following the engagement event with stakeholders:

- **Early intervention and prevention**
  - Develop excellent Case Management/Care and Treatment Reviews processes
  - Risk Register
  - Children's Transformation Plan including Transition
  - All age approach
  - Develop better links with Youth offending and probation services
- **Data Sharing and Intelligence**
  - Further information gathering on current baseline
  - Review of current systems/databases
  - Develop an agreed quality and standards framework
- **Finance and Contracting**
  - In-depth analysis at how current monies are spent
  - Mapping exercise
  - Personal health budgets/Direct payment
  - Co Commissioning
  - Framework agreements
- **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

- **Workforce Development and Training**
  - Develop a suitable workforce
  - Improving training staff across lots of different services
  - Training and supporting carers
  - Rolling out Positive Behavioural Support
- **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 and 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 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

A draft plan is embedded below.

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 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.

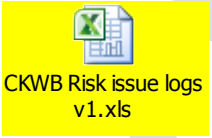
Public Support – Engagement is a key factor to ensure the public fully support the principles of the transforming care plan across our partnership

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?

What are the risks, assumptions, issues and dependencies?

6.6 Key Risks



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

Please refer to appendix 1 for the finance and activity tracker


TCP Activity Master v2.xlsx

Estimated costs to deliver the programme

Cost	Costing assumptions	Funding	TCP Funding	Matched Funding
Programme Manager	This plan requires a full time experienced programme manager to enable the plan go be delivered in a timely manner	£210,000	£105,000	£105,000
Project Support	The programme manager will require full time project support to deliver the plan	£75,000	£37,500	£37,500
Case Managers x 2	To facilitate the discharge of people currently in CCG commissioned inpatient beds, two dedicated case manager will be	£266,658	£133,329	£133,329

	required			
Communications and Engagement	A budget has been calculated in the comms and engagement plan, albeit this is not yet fully scoped	£122,000	£61,000	£61,000
PBS Training	The extent of this training is so significant the TCP will require dedicated funding to enable this to be successful Estimate	£100,000	£50,000	£50,000
Double funding of packages	This is an estimate as full mapping has not yet been undertaken, it is assumed no dowries will be passed down in 16/17	£750,000	£375,000	£375,000
Total		**£1,523,658**	**£761,829**	**£761,829**

With regards to capital monies, this requires a full audit of current estates across the region to identify if we can reinvest in these assets or whether we need to build new provision across the partnership. This work will be one of the key deliverables and will also require input from funding organisations, providers and architects and although discussions are already taking place in individual areas.