Joint transformation planning template

1) Introduction
2) Planning template
   a. Annex A – Developing quality of care indicators

Introduction

- **Purpose**

This document provides the template and key guidance notes for the completion of local plans aimed at transforming services for people of all ages with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition, in line with *Building the Right Support – a national plan to develop community services and close inpatient facilities* (NHS England, LGA, ADASS, 2015). These plans should cover 2016/17, 2017/18 and 2018/19.

- **Aims of the plan**

Plans should demonstrate how areas plan to fully implement the national service model by March 2019 and close inpatient beds, starting with the national planning assumptions set out in *Building the Right Support.* These planning assumptions are that no area should need more inpatient capacity than is necessary at any one time to cater to[1]:

- 10-15 inpatients in CCG-commissioned beds (such as those in assessment and treatment units) per million population
- 20-25 inpatients in NHS England-commissioned beds (such as those in low-, medium- or high-secure units) per million population

These planning assumptions are exactly what the term implies – assumptions for local commissioners to use as they enter into a detailed process of planning. Local planning needs to be creative and ambitious based on a strong understanding of the needs and aspirations of people with a learning disability and/or autism, their families and carers, and on expert advice from clinicians, providers and others. In some local areas, use of beds will be lower than these planning assumptions, but areas are still encouraged to see if they can go still further in supporting people out of hospital settings above and beyond the these initial planning assumptions.

- **National principles**

Transforming care partnerships should tailor their plans to the local system's health and care needs and as such individual plans may vary given provider landscape, demographics and the system-wide health and social care context.

[1]The rates per population will be based on GP registered population aged 18 and over as at 2014/15

However local plans should be consistent with the following principles and actively seek to evidence and reinforce these:

a. **Plans should be consistent** with **Building the right support** and the **national service model** developed by NHS England, the LGA and ADASS, published on Friday 30th October 2015.

b. **This is about a shift in power.** People with a learning disability and/or autism are citizens with rights, who should expect to lead active lives in the community and live in their own homes just as other citizens expect to. We need to build the right community based services to support them to lead those lives, thereby enabling us to close all but the essential inpatient provision.

   To do this people with a learning disability and/or autism and their families/carers should be supported to co-produce transformation plans, and plans should give people more choice as well as control over their own health and care services. An important part of this, is through the expansion of personal budgets, personal health budgets and integrated budgets

c. **Strong stakeholder engagement:** providers of all types (inpatient and community-based; public, private and voluntary sector) should be involved in the development of the plan, and there should be one coherent plan across both providers and commissioners. Stakeholders beyond health and social care should be engaged in the process (e.g. public protection unit, probation, education, and housing) including people with direct experience of using inpatient services.

Summary of the planning template

Planning template

1. Mobilise communities

Governance and stakeholder arrangements

Describe the health and care economy covered by the plan

Current providers are 5BP for inpatient services, commissioned collaboratively across the local footprint (Halton, Warrington, Knowsley and St Helens) via a block contract. Each area commissions Community LD Health Services (e.g. Nursing, Psychology) via in house mechanisms or via 5 Boroughs Partnership NHS Foundation Trust. Care management is provided by each respective Local Authority.
Voluntary sector contracts provide advice guidance and support to children, young people and adults with additional needs
Local social care provision is a mix of in-house and independent sector with strong links.

A number of Local Authorities and CCG's have pooled budget arrangements (LA/CCG) for service users in receipt of either Continuing Healthcare and/or Section 117 funding.

In the context of Warrington. Similar to a number of areas they commission the Independent sector for individuals who require bespoke packages of care, but require a locked rehabilitation environment. Opening in 2016 is an establishment that can meet the needs of a small but complex cohort (ASH House Rehabilitation and resettlement service in Warrington).Warrington are looking to explore with mid Mersey colleagues the potential to use this as a resource to support individuals with complex needs within their own or nearest place of origin. This is focused at optimising outcomes for the individual patients, their Carers and Commissioning organisations.

Describe governance arrangements for this transformation programme *Guidance notes; who are the key partners, what is their involvement*

The Cheshire and Merseyside (C&M) Transforming Care Board brings together the 3 C&M delivery hubs to oversee and support the transformation and delivery of learning disability service provision across the C&M footprint.

The Lead Officer for the 5BP/Mid Mersey delivery Hub is John Edwards (St Helens Integrated Commissioning), with Lisa Birtles Smith (Halton CCG) as the Deputy Lead Officer.

The core hub membership comprises of the following people:

David Pye (St Helens LA/CCG Commissioning Manager)
Jill O Neill (Knowsley LA Commissioning Manager)
Jan Warburton (Commissioning Manager, Knowsley CCG)
Keiron Gibbons (Clinical Co-ordinator Warrington CCG)
Margi Butler (Commissioning Manager, Warrington CCG)
Tom Fairclough (Commissioning Manager, Knowsley CCG)
Sheila McHale (Head of Children and Families Commissioning, Halton CCG)
Lorna Pink (Community LD Team Manager, 5BP)
Alastair Barrowcliff (Consultant Clinical Psychologist, 5BP)

The board is accountable to the NHS England North TC board. The governance structure is attached at Appendix 2.

Key Stakeholders

C&M has a strong history of working in partnership to improve care for people with learning disabilities across the C&M footprint which has enabled many of the key partnerships to be brought together and engage in the development of this plan. Key partners involved in the TC programme and represented at the C&M TC board include;

- Health and Social care commissioners;
- 12 CCGs
- 9 LAs
- NHS England Specialist Commissioning
- Service users, Experts by experience, family members, self-advocates
- NWADASS representing the 9 C&M LAs
- Providers organisations:
- CWP
- Merseycare
- 5BP
- Cheshire & Merseyside Learning Disability Network
- Public Health England
- NHS Health Education North
- Confirm and Challenge Group supported by Pathways/NWTDT

Representation is from senior leaders from each organisation who have the authority to deliver the transformation programme All partners are committed to delivering new models of care and support for people with a learning disability and/or autism. This will be achieved with people with learning disabilities, their families and advocates and will be provided through more detailed co-produced plans.

Describe stakeholder engagement arrangements

Stakeholder day

A local stakeholder event was held on 16 Dec 2016 at Daresbury Park Warrington to understand the local 'ask' of the National Transforming Care programme across the Cheshire & Merseyside footprint.

Over 85 delegates attended the event, with representation from health, local authority, social care, NHS providers, Healthwatch, advocacy, housing, and experts by experience and family members.

An annual self advocacy event coordinated by Pathway's Associates is being delivered in Blackpool on 26th February 2016. This is another opportunity for Self Advocates and Carers to comment on local plans.

Work is also on-going at a local level, examples include Knowsley's "Being Involved Advocacy Group – BIG" who are doing some work around the area.

Members of the National Transforming Care Programme (NHS England and LGA) outlined the national 'ask' and timescales for mobilisation and delivery. As Senior Responsible Officer

for this programme of work, Alison Lee, Accountable Officer, West Cheshire CCG endorsed the progress and work to date in this field across Cheshire & Merseyside, but also acknowledged the challenge ahead.

Moving into their relevant delivery commission hubs, the stakeholders started to work together to:

- Describe the vision for services for people with a Learning disability/autism or behaviours that challenge living in Cheshire & Merseyside?
- Established the strengths and weakness of current LD service provision in their locality
- Identify any key stakeholder that are missing and need to be involved
- Describe what does success look like
- Identify some local quick wins, and
- Begin to prioritise services developments for Years 1, 2 and 3
- Give thought to how the delivery hubs will progress locally

Details from the event have been collated and shared with stakeholders present (Appendix 2). NHSE England will now utilise the detail from the event together with the findings of the retrospective reviews to develop a strategic plan for Cheshire & Merseyside which will be shared with the 3 delivery hubs and relaxant governing bodies.

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

Use of co-production has been undertaken via group work. Each area is slightly different however such forums include, 5BP Autistic Spectrum Conditions Focus group, Autism Service Development Groups; Local discussions with peoples cabinets and at LD partnership boards. Self advocacy representation was facilitated at the NHS England Stakeholder day in December 2015 at Daresbury Park. Plans will also be discussed at the Annual Self Advocates conference (coordinated by Pathways Associates) in late February 2016.

It is recognised by the 5BP Mid Mersey Hub, that further work is required over the next 12 months to engage with Children's Services, to ensure the plans are fit for purpose and reflect the needs of individuals across the entire life cycle. In the first instance Commissioners from the 5BP Hub will engage with Children's Services commissioners in order to mobilise this area of work.

Please go to the 'LD Patient Projections' tab of the Transforming Care Activity and Finance Template (document 5 in the delivery pack) and select the CCG areas covered by your Transforming Care Partnership

Any additional information

Financial Information will be added in due course.

2.Understanding the status quo

Baseline assessment of needs and services

A comprehensive LD/Autism JSNA has been completed by Liverpool John Moore's university.

Learning Disabilities and Autism: A health needs assessment for children and adults in Cheshire and Merseyside

In order to support the plan, a review was also conducted by Colin Vose (Independent Consultant) entitled:

"Transforming Care for people with Learning Disabilities and/or Autism in Cheshire and Merseyside Baseline assessment: A review of learning disabilities service performance across Cheshire and Merseyside 2010-2015 and Model of Care 2016-2018.

Provide detail of the population / demographics

The Four Borough Commissioning Alliance was established in 2010 to co-ordinate commissioning between the then 4 PCTs of Knowsley, Halton, St Helens and Warrington for Mental Health and Learning Disability Provision. The alliance was inclusive of PCTs and Local Authorities.

The Alliance aimed to redesign Learning Disability services by introducing a new Model of Care. This is based on a number of principles, including:

- flexibility and accessibility,
- inclusion,
- quality,
- independence,
- specialist health intervention innovative solutions to behaviour management within the community to support those within their homes/community placements for as long as possible
- admission as an in-patient as a last resort whilst ensuring in- patient admissions are not seen as an alternative to social care provision, for example respite care
- Repatriation of those in out of area placements.

The Alliance, in developing its Model of Care, consulted extensively with Local Learning Disability Partnership Boards, placing service users at the heart of this process. Its Model of Care was published in summer 2011. The principle service provider is 5 Borough Partnership NHS Foundation Trust.

As part of the re-design, a new range of interventions would be available through an enhanced Specialist Intensive Community Support Team. This also included an analysis by the Alliance the admissions data, which found that many of the admissions occurred as a result of tenancy or family breakdowns, often due to difficulties in supporting an individual with challenging behaviours. Since the redesign, each area has commissioned and in some cases decommissioned services relevant to each area. This process will require each member of the TC Hub to identify gaps in provision, to support/promote preventative community level interventions.

The increase in resource and support from the SICST would be provided by closure of one ward, Willis House and transferring that resource to the SICST. The core aim is was to reduce these admissions by working with all those involved and keeping individuals in their own setting and environment for as long as possible. Enclosed is the latest CQC report regarding the 5BP Community Services for people with LD and Autism.

http://www.cqc.org.uk/sites/default/files/new_reports/AAAE1366.pdf

Prior to this redesign the 4 Mid Mersey PCTs utilised 16 beds across two separate units, one in Warrington and one in Whiston, Willis House.

Through the impact of this enhanced community service, the number of Assessment & Treatment beds reduced from 16 to 8, with the delivery of the remaining 8 beds from the most suitable, best and appropriate venue.

It was collectively agreed by the Alliance to utilise the 8 beds from the Byron Unit in Warrington and close the beds at Willis House in Whiston. The site at Whiston was refurbished and used to deliver community learning disability services including colocation with Learning Disability Social Workers from Knowsley.

Prior to the service change the Byron Unit underwent a major refurbishment and was regarded as a high quality, spacious environment. Enclosed is the latest CQC report from the Byron Ward.

https://www.cqc.org.uk/sites/default/files/new_reports/AAAE2027.pdf

Other particulars of the Mid Mersey service re-design included:

- Extension of the hours of work by the SICST from the Traditional 9-5 model to 8am and 6pm, Monday to Friday.
- The adoption of the LD Direct Enhanced Service (LDDES) for delivery of health checks across all primary care practices within the Alliance Geography,
- Adoption of reasonable adjustments across acute hospital sites, Warrington General, Halton General and St Helens & Knowsley hospitals,
- Full compliance with of the Green Light Toolkit by mental health services (national standard for inclusive delivery Mental Health service for those with a Learning Disability).
- Creation of clear service pathways, related service specifications and adoption of Health of the Nation Outcome Scale (Ho-NOS LD) measures across services.
- Adoption of key performance measures which included monthly monitoring of all LD admissions, discharges lengths of stay and delayed discharges.
- Effective transition arrangements between Children and Adult services
- Development of a number clinical pathways relating Learning Disability, Early onset dementia with a Learning Disability, Dysphasia and Challenging Behaviour. The pathways identify what multi-disciplinary assessments the patient will be offered and treatment programmes available.

As a result of the service design (as described above), a retrospective review of occupied bed days over the 5 year period 2011/12 to 2015/16 has demonstrated a reduction in occupied bed days in A&T beds across Mid Mersey in tables 1&2 below.

Further work is required across the areas encompassed in the Mid Mersey Hub to better

understand the demographics of Children's Services, particularly the numbers of Residential Placements and Children placed under the mandate of the Mental Health Act. Commissioners from across the mid Mersey hub will communicate with Children's Services colleagues on a six monthly basis to establish the numbers of people placed in residential school settings and patients detained under the Mental Health Act.

Analysis of inpatient usage by people from Transforming Care Partnership

Table 1: LD in patient activity 2010/11-2015/16, Knowsley, St Helens, Halton

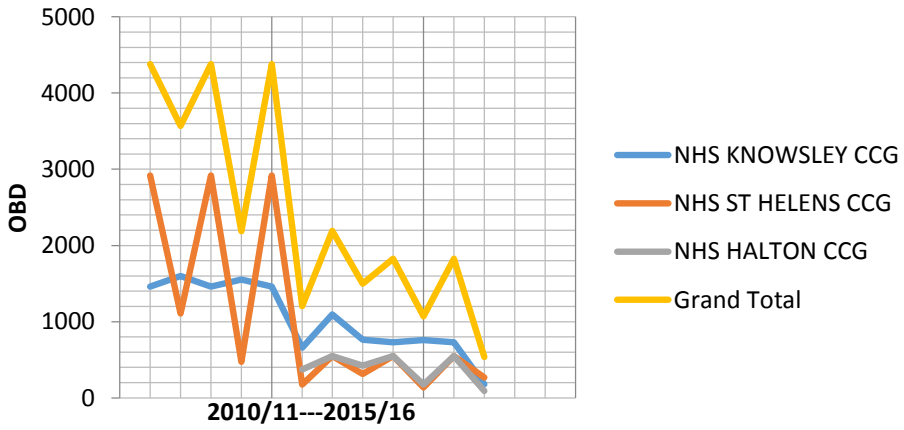
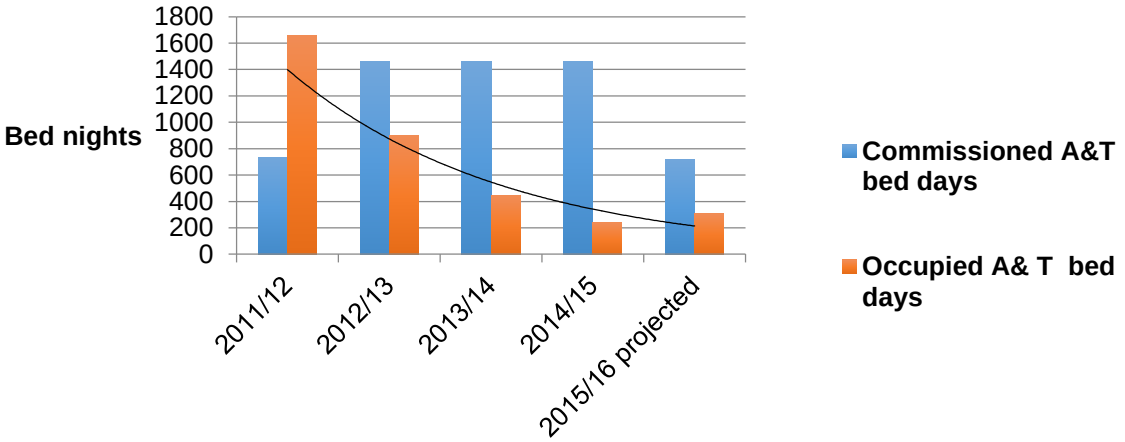


Table 2: Warrington A&T LD Occupied bed activity 2011-2015



Describe the current system

The Four Borough Commissioning Alliance was established in 2010 to co-ordinate commissioning between the then 4 PCTs of Knowsley, Halton, St Helens and Warrington for Mental Health and Learning Disability Provision. The alliance was inclusive of PCTs and Local Authorities.

The Alliance aimed to redesign Learning Disability services by introducing a new Model of Care. This is based on a number of principles, including:

- flexibility and accessibility,
- inclusion,
- quality,
- independence,
- specialist health intervention innovative solutions to behaviour management within the community to support those within their homes/community placements for as long as possible

admission as an in-patient as a last resort whilst ensuring in- patient admissions are not seen as an alternative to social care provision, for example respite care . Adults requiring additional inpatient support are assessed via the Green Light tool kit to sign post to the most appropriate service.

- Repatriation of those in out of area placements.

The Alliance, in developing its Model of Care, consulted extensively with Local Learning Disability Partnership Boards, placing service users at the heart of this process. Its Model of Care was published in summer 2011. The principle service provider is 5 Borough Partnership NHS Foundation Trust.

Across the footprint other current Health and Social Care provision is commissioned through Local Authorities, PBSS Services, Social Care Providers, Social Landlords, Independent Hospital Providers and the Voluntary/Third Sector.

The current model of care in recognises all of the 5 cohorts outlined in the national model, however it is recognised by Halton, Knowsley, Warrington and St Helens that further work is required in terms of redesign, commissioning and transformation to sustain positive performance, reduce where appropriate and to optimise outcomes for people with Learning Disabilities where appropriate.

A key challenge for all areas encompassed within this plan is to effectively capture and support individuals who are vulnerable and have lower level support needs, usually managed within the community with minimal or no Health or Social Care input.

The promotion and development of education, health and social care plans, is in line with the SEND reforms.

Commissioners from the 5BP delivery hub will also work with local in patient providers over the next 12 months to better understand the landscape in terms of in-patients who do not originate from the TCP area. Basic numbers will be ascertained. More robust protocols will also be developed around information sharing when an individual is placed outside of the area of ordinary residence.

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

Across the mid Mersey footprint Housing is provided by registered landlords and individuals have their own tenancies. Further adapted accommodation is being built in some boroughs to support repatriation and provide accessible accommodation to meet specific needs of those with LD and ASC.
Some boroughs have also developed core and cluster/core and flexi style accommodation, which focuses on independence, individualised tenancies in one complex with 24hr oversight from a support provider.
Small residential homes are also commissioned for people with LD.

Each area has existing framework agreements with their Social Providers. Some areas are also reviewing their existing frameworks.

The current understanding of estates and the facilities available is clear. The TCP area uses the Byron Ward at Hollins Park as the Primary Assessment and Treatment facility. The focus over the next twelve months is to sustain the current position, however beyond this further work is required to review the amount of beds required, and to support further repatriation of individuals. Plans need to be developed in conjunction with Housing Strategy colleagues to ensure that there are appropriate housing options within local communities to meet the needs of the complex co-hort of people that need to be repatriated particularly individuals who are transferring from secure settings.

What is the case for change? How can the current model of care be improved?

Developing more individualised budgets and Personal Health Budgets and the local offer to include all the 5 cohorts encompassed in the national model.

Develop a core and cluster model that gives autonomy but also supports independence minimising risk.

There needs to be a proactive approach to build on current successes and to progress further. This includes the enhancement of existing community services to afford more capacity and flexibility in the system. The philosophy of prevention is integral to the plan.

New Services will also need to be commissioned across the footprint to ensure that there is continued progression and to avoid more people being admitted into in-patient facilities.

There is a clear need and focus regarding joint working across the mid Mersey footprint to repatriate individuals from secure settings such as Calderstones, as such patients will be the most difficult cases to repatriate as some cases pose risks and exhibit presentations linked to historical index offences.

The 5BP area of planning recognise that further work is required to support the uptake of personal budgets, as each respective area does not have a relatively huge uptake. To do this, work will be undertaken to understand a baseline of how many service users are in receipt of a personal budget; with realistic targets of how many will be issued between 2016 – 2019. Further work will also need to be undertaken with Health and Social Care Assessors in each respective area to ensure that the message around personal budgets is engrained within organisational structures and everyday practice.

Please complete the 2015/16 (current state) section of the 'Finance and Activity' tab of the Transforming Care Activity and Finance Template (document 5 in the delivery pack)

Any additional information

Financial Information is currently being collated and due to the high volume of specific information required, this will only be completed by 31st March 2016.

3.Develop your vision for the future

Vision, strategy and outcomes

Describe your aspirations for 2018/19.

The outcomes that will change as a result of the transformation programme can be grouped into 4 broad categories;

- Improved quality of care
- Improved quality of life
- Reduced reliance on inpatient services
- Improved service user /family experience

What outcomes will change?	What will change be?	How improvement against each of these domains will be measured
Reduced reliance on inpatient services - Reduced admissions to in patient LD beds where appropriate - Reduced LD inpatient beds in line with national assumptions - Reduced Length of stay - Increased use of IPC - Increased use of personal budgets	50 % reduction in admissions to in patient LD beds *(Jackie we thought the 50% reduction was only across fast track sites???)* Further development, redesign in community teams, and commissioning of some new services in order to enhance resilience and prevent MH admissions.	To monitor reduced reliance on inpatient services, we will use ; - the Assuring Transformation data set - uptake of IPC -
Improved quality of care - Compliance with national CTR policy - Continued year on year improvement in health checks and health action plans - Commissioned LD eye pathway across C&M - Increased uptake in screening programmes including Imm and vacs - Increased use of IPC - Increased use of personal budgets		To monitor quality of care, we are supporting the development of a basket of indicators (see Annex A); exploring how to measure progress in uptake of personal budgets (including direct payments), personal health budgets and, where appropriate, integrated budgets; and strongly support the use by local commissioners of quality checker schemes and Always Events
Improved quality of life - reduction in avoidable and premature deaths - Increased placement stability Development/enhancement of	South Cheshire LD mortality review	Make use of the Health Equality Framework In addition to the HEF the World Health Organisation QOL Assessment

Health facilitation and standardised health checks with GPs re DES to include known health risks for people with specific health conditions e.g. in Cerebral Palsy, Downs Syndrome.		Framework. CIPOLD recommendations, requirements and outcomes.
Improved service user /family experience - SAF feedback - Feedback from service user/family forums - Increase in reasonable adjustments, Co-production service design as a wider view with reasonable adjustments as an example of this. Identification of disability groups within all health and social care coding i.e. LD, ASC, MH. -		SAF monitoring

Describe any principles you are adopting in how you offer care and support to people with a learning disability and/or autism who display behaviour that challenges.

Across the footprint, organisations and Providers are following person centred approaches and promoting positive behavioural support. Even areas that do not have specific PBS Services, the model of PBS is intrinsic to and underpins practice.

Follow principles of the Mental Capacity Act.

Please complete the Year 1, Year 2 and Year 3 sections of the 'Finance and Activity' tab and the 'LD Patient Projections' tab of the Transforming Care Activity and Finance Template (document 5 in the delivery pack)

Any additional information
Is the plan both
Financial Information is currently being collated and due to the high volume of specific information required, this will only be completed by 31st March 2016.

4.Implementation planning

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

Overview of your new model of care/ What new services will you commission?

St Helens, Knowsley, Halton and Warrington are working closely and have developed a core set of strategic objectives which are pertinent to each area, some of which can be developed and implemented using a collaborative approach.

The objectives include:

1. **Accommodation & Support** for people from across the mid Mersey footprint (St Helens, Halton, Knowsley, Warrington) with complex presentations and/or linked index offences who currently are placed in secure settings. Warrington has a facility which is due to be opened, which could potentially meet the needs of St Helens, Knowsley, Warrington and Halton patients.

2. **Post Diagnostic Support for ASD /ADHD-** a model for ASD has been proposed by 5 Boroughs Partnership NHS Foundation Trust, which focuses on augmented services and support for people once they have received a diagnosis. This is currently a service gap across St Helens, Halton, Knowsley and Warrington. The development of such services is cited in the "Think Autism" national strategy. The focus of this type of service model is community orientated prevention/integration and to avoid the deterioration of people's Mental Health.

3. **Supporting People's challenging behaviour** –further support for people in their home and for families requiring psycho therapeutic intervention support (to compliment PBS) across the footprint. In the specific context of PBS Halton and Knowsley currently have PBS Services in place commissioned via Halton Borough Council. St Helens does not currently have a dedicated or specialist Positive Behaviour Support (PBS) Practitioner employed within or supporting the local Learning Disability Service offer. Whilst practitioners within existing Community Learning Disability teams may have skills pertinent to the assessment for and delivery of behavioural interventions, this is part of the generic skills mix and no dedicated support is provisioned. It is recognised that a dedicated practitioner role within existing services with a remit to coordinate local resources and professional groups could enhance current delivery of and deployment of a PBS model of working within St Helens. Warrington currently has systems in place via the LD Nursing Team, which is currently adequate and fit for purpose.

4. **Primary Care** health checks / Acute Liaison LD Nurse and/or health facilitators in those boroughs that do not currently have this provision. This is to ensure that the Physical health needs of people with Learning Disabilities are addressed (including the cohort of people with LD/Autism 14-18 in transition requiring Health checks), and to ensure that patient mortality is given the level of priority it deserves. The focus of enhancing such services is to address any health inequalities that people with Learning Disabilities and/or Autism face, to reduce health deteriorations which could potentially contribute to admissions and to improve quality of life to reduce the potential for premature deaths as far as possible.

5. **Peer Advocacy** which includes enhancing capacity into the system. It is important to strengthen and enhance the existing offer, in order for people with Learning Disabilities and Autism to continue to contribute to the respective LD/ASD agenda's across Health and Social Care. Co-production is of paramount importance.

6. **24/7** – crisis response for people for LD/ASD (e.g. Operation Emblem). Street triage services can potentially be developed or redesigned for the LD /ASD population to avoid admissions where appropriate, and to avoid people with LD/ASD entering the Criminal Justice system.

Commissioners will ensure that the objectives are aligned to the national model and also the national SEND reforms.

Some areas have enhanced operations around Clinical Coordination and CTR's to oversee repatriation and ensure timely discharge from inpatient units is achieved moving forward. The role will include coordinating "blue light reviews" as appropriate and post admission CTR's. Each area needs to consider operations around this going forward to enhance efficiency.

Local Authorities and CCG's are working closely around funding arrangements for people who are detained/admitted under the Mental Health Act or at risk of an admission.

The investment of NHSE Transforming Care funding would be integral to the development and support of these initiatives, in order for St Helens, Knowsley, Halton and Warringon to not only current sustainability but continued progression.

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

1. Less Residential Schooling Placements.

2. Less out of area Hospital and Acute Placements including rehab facilities.

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

Local services will be required to adopt a more proactive approach utilising the Multi-Disciplinary Team /Care and Treatment Review model and optimise support to individuals who are deemed at risk of an inpatient admissions. Significant work is required with local Health and Social Care Providers at Strategic and Operational Levels with a focus of enhancing resilience and effectiveness ultimately to negate admissions where appropriate and safe to do so.

There needs to be a greater emphasis on delivering more personalised services via Personal Budgets/Personal Health Budgets.

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

- Consideration of those children with EHC plans having personalised integrated budgets.
- Consolidate the use of integrated complex care budgets.
- Enhance the infrastructure in place for integrated budgets.
- *Baseline work to be undertaken to understand the current uptake of Personal Budgets.*
- *Realistic targets for improvement to be developed.*
- *Monitoring of Personal Budget uptake/allocation.*

What will care pathways look like?

MDT/CTR approach to provide clarity of where roles and responsibilities sit.

5BP pathways need to be reviewed to ensure that the pathways are still relevant and efficient. Improvements need to be made where appropriate.

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

Transition strategy and protocols are under review in some areas. Including a more whole of life approach.
Enhancement of MDT/CTR approaches. Some areas have Transitional Operational Groups to discuss individual cases.

Some areas have integrated Departments to there is strategic and operational oversight of transitional processes. For example St Helens have recently integrated Children and Young People's Services and Adult Social Care and Health Departments into a single People's Services Department. This will provide greater consistency moving forward. Other areas also have similar arrangements in place.

How will you commission services differently?

- More pooled budget arrangements.
- Mid Mersey commissioning hub approach.
- Outcomes based Commissioning.
- Ensuring Social Value is intrinsic in the relevant services.
- Greater consistency in terms of costs and charges to Providers.

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

- Developing accommodation options for people who need to be repatriated from secure settings.
- More efficient Core and Cluster/Core and Flexi support needs to be considered.
- More local community residential support for people with LD/ASD who exhibit more complex challenging behaviours.

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

- Use of Dowries where appropriate.
- Repatriation of OOB individuals using barriers tool and MDTs

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

- The plan aligns to all Local Authority's approach and commitment to the Care Act particularly around prevention.
- National Autism Strategy, particularly the development of post diagnostic services.
- Mansell Report around supporting people with LD who exhibit complex challenging behaviours.
- Valuing People Strategy and Death by indifference reports, particularly around the area of Health Facilitation.

Any additional information

5.Delivery

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

Guidance notes; As a minimum, set out a workforce development plan, an estates plan and a communications and engagement plan

1. Workforce development plan
2. Estates plan
3. Communications and engagement plan
4. Transition group to look at transition protocol and strategy
5. Revised LD/ASD Strategies
6. Revision of any joint commissioning strategies.

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

Guidance notes; Who are the key enablers to success, what resources have been identified

1. Organisational Development Leads for responsibility for LD.
2. To be determined.
3. Asset management working group – estates.
4. Communication and Engagement Managers/Leads.
5. LD/Autism Operational and Strategic Commissioning Officers/Leads.
6. Commissioning Leads LA's/CCG's

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

Implementation of Joint approach around complex placements for people who are detained in secure settings – Autumn 2016.

What are the risks, assumptions, issues and dependencies?

Guidance notes; Are there any dependencies on organisations not signatory to this plan, or external policies/changes?

A risk register will be developed in due course, with a full risk analysis and mitigation plan.

Key risks include:

1. *The level of financial commitment involved with implementing and delivering the Transforming Care programme. The financial envelope across the TCP is yet to be decided in order to deliver the key initiatives outlined. There is a risk that due to significant financial challenges across the local health and social care economy (due to national pressures) there may not be sufficient resources available to commission adequate levels of service in order to deliver the programme successfully.*

2. *Market risk. There is a risk that the social care market for complex care and support may continue to stay the same; this could result in not enough capacity to repatriate*

the number of individuals encompassed within the plan.

3. *There is a risk that if the local A&T bed base is further reduced, Commissioners may be in a position whereby placements may have to be commissioned on a more reactive spot purchase basis, which predominantly denotes higher costs and also undermines the principles of Transforming Care, which is focused on delivering care closer to home.*

What risk mitigations do you have in place?

Guidance notes; Consider reputational, legal, safety, financial and delivery, contingency plans

A risk register will be developed in due course, with a full risk analysis and mitigation plan.

1. *Financial work to be undertaken to determine what is needed in terms of resources across the collective 5BP hub of planning in order to deliver the programme successfully. Any resource commitments will need to have full endorsement and approval from each respective CCG and LA within the TCP.*

2. *Commissioners will communicate with the market to ensure that the market is clear around expectations of services, in order to meet the needs of the local population.*

3. *Close monitoring and risk analysis of the bed usage of Byron Ward will continue as a collective across the hub of planning.*

Any additional information

6.Finances

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

End of planning template

Annex A – Developing a basket of quality of care indicators

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

This Annex gives the technical description of the indicators recommended for local use to monitor quality of care. The indicators cover hospital and community services. The data is not specific to people in the transforming care cohort.[2]

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

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

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

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

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

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

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