The Right Track

Transforming Care in Lancashire

For individuals with Learning Disability and Autism

2015

1. Introduction

Lancashire has a strong history of working in partnership to improve care for people with learning disabilities – it is one of the few areas in the country to have a Strategic Clinical Network for Learning Disability Commissioners and there are robust collaborative arrangements for the annual Self-Assessment Framework.

There is a recognition that improvement is required and a Case for Change and a new model of care was in progress, with an agreed programme signed off by the Lancashire Collaborative Commissioning Board, which the Fast track has accelerated and enhanced.

This plan outlines the Pan Lancashire change programme that has been developed as a result of this accelerated focus and leadership. The Plan aims to deliver safe, sustainable services to the local population with Learning Disabilities and/or Autism, in accordance with National Directives and Local Drivers. The plan starts with those individuals who we know as the 'Winterbourne' or 'Transforming Care' group – people who are in hospital based provision or at risk of needing admission – before moving on to include all people with learning disability and/or autism in our communities.

The Lancashire Collaborative Programme is framed around a new model of care that is aligned to the recommendations in the recent 'Bubb report' (Winterbourne View – Time for Change, November 2014) and its predecessor mandates for change, drawing on the learning, principles and models still relevant from 'Valuing People', 'Six Lives' and the 'Mansell report'. The recent Winterbourne focus reinforces and expedites previous policy drivers. It shines a spotlight on those areas where progress has been slower and failed to meet national and local expectations.

The Transforming Care Programme nationally is more directive about the requirement for system change and sustained progress, embedded in new models of care and written into new specifications, with a strong emphasis on greater health and care integration. The Bubb report framed this as having 'one shared plan' 'one lead commissioner' and 'one pooled budget'. The NHS 5 Year Forward View and associated Planning Guidance released in December 2014 also referenced the requirements.

Being selected as one of the five Fast Track areas chosen by NHS England in 2015 has given a renewed pace and vigour to local efforts. The existing Strategic Clinical Network of commissioners has been bolstered by the creation of a Leadership Group to steer the Fast track, creating a link between the practical knowledge and experience of those working on the model and those responsible for system governance and resources.

This is an unprecedented opportunity for Lancashire to harness the knowledge and build on progress already made, producing an agreed plan across health and care; commissioners and providers; users and carers – that will reshape resources, contracts and the delivery of care from 2016. The Plan includes the necessary steps to ensure safe delivery of a new model, mitigation of potential risks and management of the necessary pathway and market changes that will be needed as the system re-design is implemented.

It will finally and definitively move services away from a bed based model of care to a community based model a system that not only enables but insists upon person centred care, for people with learning disabilities and/or Autism – including those whose behaviour is often described as challenging – but where often it is the service infrastructure that has, up to now, created a challenge to the users themselves.

Pan-Lancashire

CCGs:
Blackburn with Darwen
Chorley, South Ribble
Greater Preston
East Lancashire
Fylde and Wyre
Blackpool
West Lancashire
Lancashire North

Councils:

Blackburn with Darwen Unitary Authority
Blackpool Unitary Authority
Lancashire County Council

2. Background

Winterbourne / Transforming Care

Incidents that occurred at Winterbourne View, a residential care setting for people with learning disabilities, were publicised by a Panorama documentary in 2011 and subject to a review and inquiry by the Department of Health and CQC. A subsequent Serious Case Review was published after criminal proceedings had reached their outcome with 11 individuals prosecuted and sentenced http://hosted.southglos.gov.uk/wv/report.pdf.

In December 2012 the Department of Health published 'Transforming Care, A National Response to Winterbourne View Hospital: Final Review Report'. (An interim report also published in June 2012).

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213215/final-report.pdf

The above report set out "a programme of action to transform services so that people no longer live inappropriately in hospitals, but are cared for in line with best practice based on their individual needs, and that their wishes and those of their families are listened to and are at the heart of planning and delivering their care". The programme covered quality and appropriacy of care, governance and accountability, corporate responsibility, regulation, inspection and monitoring.
Follow up and progress reports have been published since 'Transforming Care One Year On', 'Transforming Care Two Years On'.

In 2014 NHS England asked Sir Stephen Bubb, ACEVO, to Chair a Steering Group and produce recommendations to accelerate the changes required, given the initial deadline of June 2014 had

passed without the corresponding transfers out of hospital care being achieved. A publication known as the 'Bubb report' was produced: 'Winterbourne View - A time for change'. www.england.nhs.uk/wp-content/uploads/2014/11/transforming-commissioning-services.pdf

This was followed in July 2015 by an Independent Progress Review published by ACEVO 'Winterbourne View – Time is running out' with a further call to address the inpatient reduction requirement. Other criticisms in this report included the lack of dialogue with social care providers. Some progress was noted in Care and Treatment Reviews and the NHS England programme of work. https://www.acevo.org.uk/sites/default/files/Time%20Is%20Running%20Out%20FINAL%20WEB_0.pdf

Transforming Care is now overseen by a **Transforming Care Delivery Board,** which brings together the six national partners: NHS England, the Association of Adult Social Services (ADASS), the Care Quality Commission (CQC), Local Government Association (LGA), Health Education England (HEE) and the Department of Health (DH). The focus remains on the five key areas of: empowering individuals; right care, right place; workforce; regulation; and data. The most recent Progress Report can be found on NHS England webpages for Transforming Care.

Bringing the chronology up to the current point – where Five Transforming Care Fast Track areas have been identified as; Greater Manchester and Lancashire; Cumbria; North East, Arden, Herefordshire and Worcestershire, Nottinghamshire and Hertfordshire. This aims to bring together, health and care to accelerate service re-design and transformation, with access to a £10 million Transformation Fund. Plans must outline a bid identifying

3. Governance

The requirement to produce a fast track plan was discussed at the Collaborative Commissioning Board on 09/06/15, where Jan Ledward, Chief Officer for NHS Chorley and South Ribble CCG & NHS Greater Preston CCG, was appointed as the Senior Responsible officer and it was agreed that a dedicated Steering Group would be responsible for the Lancashire plan development.

The plan is to be taken back to the Collaborative Commissioning Board on the 08/09/15. Sign off from Health & Wellbeing boards and CCG Governing Bodies will be required thereafter.

Governing Body Meetings

West Lancashire CCG	24 November 2015
Blackburn with Darwen CCG	04 November 2015
Blackpool CCG	03 November 2015
Lancashire North CCG	20 October 2015
East Lancashire CCG	23 November 2015
Fylde & Wyre CCG	17 November 2015
Chorley and South Ribble CCG	23 September 2015
Greater Preston CCG	24 September 2015

Health & Wellbeing Boards

Blackpool Borough Council	22 October

Blackburn with Darwen Borough Council 22 September
Lancashire County Council 29 October

The scope of this fast track work programme has aimed for a whole system inclusive approach, organisations included in this plan:

Local Authorities:
Blackburn with Darwen Council
Blackpool Council
Lancashire County Council

Commissioning Groups:
Blackburn with Darwin CCG
Blackpool CCG
Chorley & South Ribble CCG
Greater Preston CCG
East Lancashire CCG
Fylde & Wyre CCG
Lancashire North CCG
West Lancashire CCG
NW Specialised Commissioning

The two main providers in Lancashire are:
Lancashire Care NHS Foundation Trust
Calderstones Partnership NHS Foundation Trust
Service users, families and stakeholders:

Service users, families and stakeholders have been engaged in the development of this plan via a stakeholders visioning event held on the 18th August 2015.

The event consisted of a morning workshop session that was attended by patients with Learning Disabilities (LD), carers, families (including a number of parents) as well as Third Sector representatives. CCG managers from the area also attended to support and facilitate discussions.

In particular the Stakeholder Day looked at:

- Values and Principles
- What is currently working well
- What is currently not working well
- What would good care look like

The outcomes and intelligence from this day, along with other consultations and engagement findings such as that from the LD Self-Assessment Framework carried out in 2014, are incorporated throughout this Plan and will continue to be used as a check and balance as the Plan is implemented.

"We want the right track, at the right pace" Healthwatch Representative

We must acknowledge however that there has been less engagement with people who have autism but do not have a learning disability. We will ensure that this is addressed and plans are in place to utilise the locality Autism Partnership Boards to involve people and their families in this work.

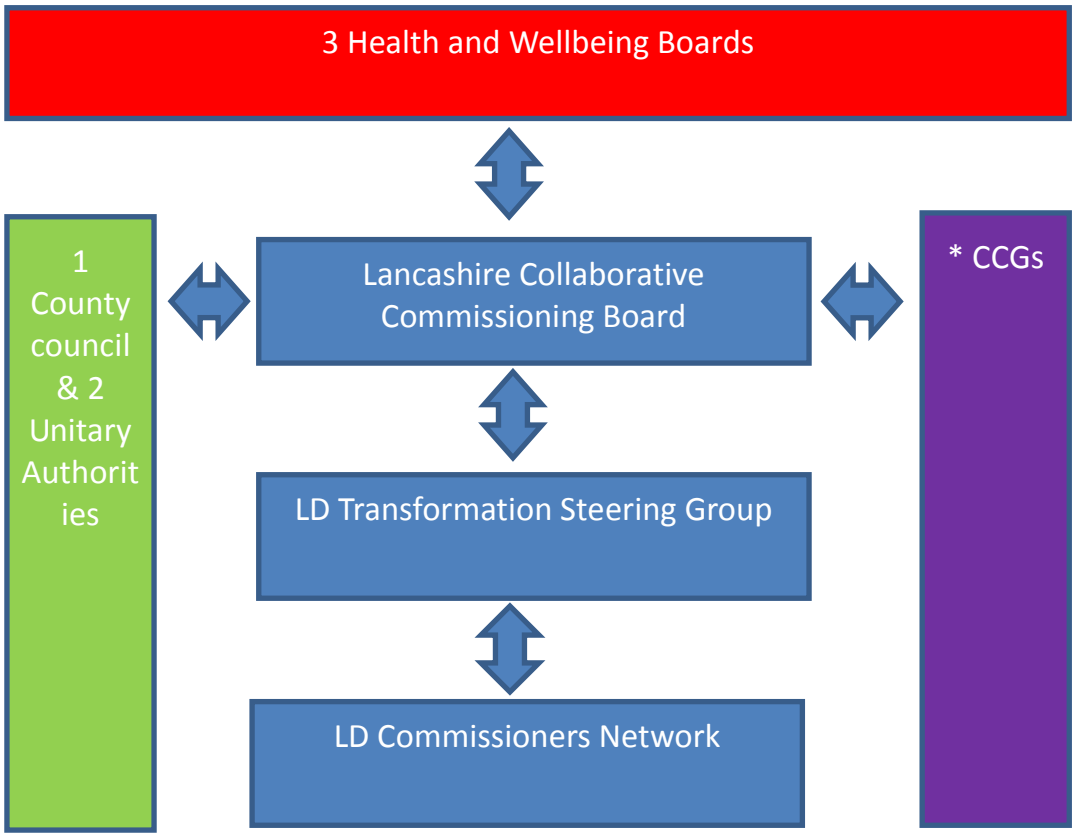
Clinical Engagement

Clinicians from across Lancashire attended the stakeholder's event on the afternoon of the 18th August to provide a broad spectrum of clinical input from what is currently in place and what is required for future service development and improvement.

Clinical engagement has also been sought from the Greater Manchester, Lancashire and South Cumbria, Strategic Clinical Networks and Senate LD Advisory Group and from Calderstones and LCFT provider leads via the steering group.

Steering Group:

Development of this plan has been led by a steering group with attendance from CCGs, Local Authority, Specialised Commissioner, NHS E, Health Education England and Providers. The vision and new model of care have been operationally developed by the LD Commissioners Network informed by the stakeholder's events and via a series of workshops. The governance structure as per the diagram has been agreed along with Terms of Reference for the steering group.



Values and Principles

"Be the best I can be"

These are the themes that emerged from the Stakeholder Day and these will inform the implementation of the Plan:

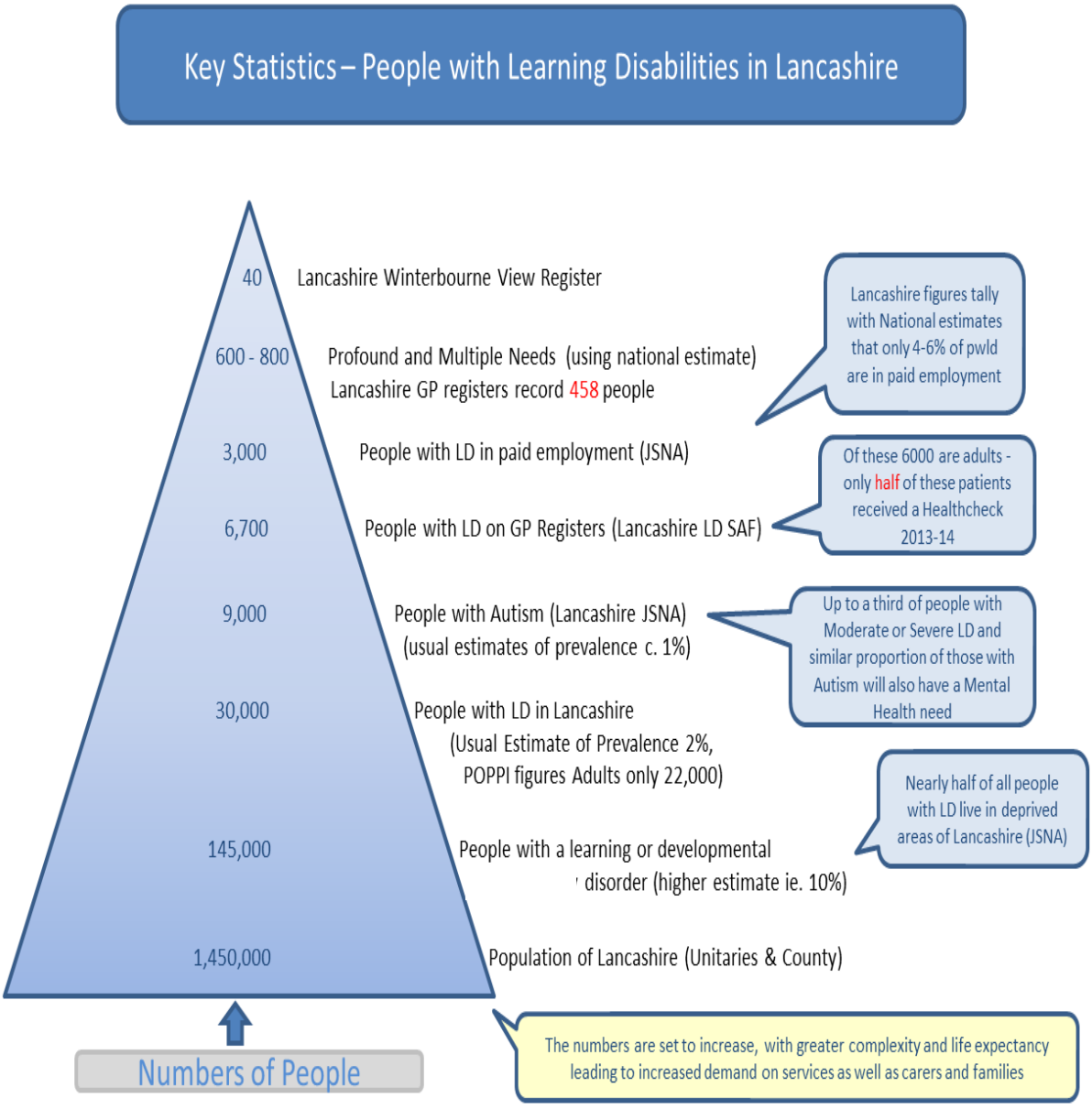
- Putting a high value on prevention and early intervention
- Person centred care as a default and a non-negotiable
- Recognition of personal value to improve health and wellbeing
- Fair and equal access to all services; education/ awareness and responsiveness
- High standards of care and improved experience for users, carers and support workers
- Working better together at all levels across the system to manage transitions and conflicts
- Taking the right risks, empowering people to do the right thing not forced to be expedient
- Really focusing on outcomes; the right kind of metrics, the best use of evidence bases
- Setting the bar high across the professional network and holding each other to account
- Creating an environment for candour and compassion
- Putting the system's money where its mouth is…

4. Baseline Assessment

The Population

There are a number of data sources that can be used for population and cohort counts for people with learning disabilities / autism. The numbers that follow provide figures taken from different sources such as GP registers, prevalence estimates, needs assessments. These figures will therefore not 'tally up' with each other exactly as they are recording particular groups or aspects or making projections – but together they paint an important picture of this population in Lancashire.

The figure below is a useful starting point and provides 'ball park' figures. These are not meant to be exact but were rounded for this use, from a snapshot taken at the time (January 2015). It helpfully makes visual the relationship between complexity and size of cohorts:



The Population Data

There are 1,519,892 registered people Pan Lancashire with 6056 registered as having a Learning Disability Quality and Outcome Framework (QOF) 2013/14

CCG	Blackpool	Blackburn and Darwen	East Lancashire	Fylde and Wyre	North Lancashire	West Lancashire	Chorley and South Ribble	Greater Preston
Registered Population 1,519,892	172,202	170,828	373,000	150,650	160,000	111,946	176,023	207,390
Adult LD Population 6056	763	717	1489	477	721	452	755	682
Children's 5-19yrs LD Population 5110	475	615	1315	460	555	395	575	720

Predicted Population Changes

Whilst the total numbers with Learning Disabilities are predicted to increase the split is not evenly distributed across all age ranges. Predicted changes will vary across the pan-Lancs footprint due to the uneven distribution of local services and deprivation indices. Deployment of resources in each area will be tailored appropriately.

Lancashire-14 - LD - Baseline estimates				
Age Group	**2015**	**2020**	**2025**	**2030**
People aged 18-24 predicted to have a learning disability	3,605	3,276	3,214	3,469
People aged 25-34 predicted to have a learning disability	4,440	4,512	4,358	4,084
People aged 35-44 predicted to have a learning disability	4,320	4,200	4,445	4,550
People aged 45-54 predicted to have a learning disability	4,948	4,667	4,146	4,057
People aged 55-64 predicted to have a learning disability	4,013	4,415	4,654	4,384
People aged 65-74 predicted to have a learning disability	3,414	3,564	3,478	3,851
People aged 75-84 predicted to have a learning disability	1,841	2,083	2,520	2,630
People aged 85 and over predicted to have a learning disability	701	825	1006	1,243
Lancashire-14 Total	**27,282**	**27,542**	**27,821**	**28,268**
Source POPPI & PANSI data extracts September 2015				

CeDR Centre for Disability Research Report 2008:6 Lancaster University

These predictions are based on prevalence rates detailed in a report by Eric Emerson and Chris Hatton of the Institute for Health Research, Lancaster University, entitled Estimating Future Need/Demand for Supports for Adults with Learning Disabilities in England, June 2004.

A study by CeDR focuses on future adult social care needs for people with LD and it suggests that there are three things that will drive an increase in LD prevalence

- Decreasing mortality among people with learning disabilities, especially in older age ranges and among children with severe and complex needs; - This fits in with the LD life expectancy levels increases
- The impact of changes in fertility over the past two decades in the general population; - This is a reference to the decreasing birth rates in England
- The ageing of the 'baby boomers', among whom, there appears to be an increased incidence

of learning disabilities.

Estimated total number of children with a learning disability-

People with learning disabilities are more likely to experience mental health problems (Emerson, E. et al, 2008). Emerson et al (2004) calculated prevalence in children and young people with learning disabilities for different age groups as follows: 5 to 9 years: 0.97%; 10 to 14 years: 2.26%; and 15 to 19 years: 2.67%. Estimation of the population prevalence of learning disability is problematic and should be treated with caution.

The following table applies these prevalence rates to Lancashire and the 8 CCGs.

CCG	Children aged 5-9 yrs with a learning disability (2014)	Children aged 10-14 yrs with a learning disability (2014)	Children aged 15-19 yrs with a learning disability (2014)
NHS Blackburn with Darwen	110	230	275
NHS Blackpool	80	170	225
NHS East Lancashire	230	490	595
NHS Fylde and Wyre	75	170	215
NHS Greater Preston	125	255	340
NHS Lancashire North	80	175	300
NHS West Lancashire	65	140	190
Pan Lancashire	**865**	**1855**	**2430**

Source: Office for National Statistics mid year population estimates for 2014. CCG population estimates aggregated from GP registered populations (Oct 2014). Emerson E. at al (2004).

These rates for different age groups reflect the fact that as children get older, more are identified as having a mild learning disability. The Foundation for People with Learning Disabilities (2002) estimates an upper estimate of 40% prevalence for mental health problems associated with learning disability, with higher rates for those with severe learning disabilities. The following table shows how many children with learning disabilities who also experience mental health problems might be expected in Lancashire and the 8 CCGs.

Children with a learning disability with mental health problems (2014)

CCG	5-9 yrs	10-14 yrs	15-19 yrs
NHS Blackburn with Darwen	45	95	110
NHS Blackpool	35	70	90
NHS Chorley & South Ribble	40	85	105
NHS East Lancashire	95	200	240
NHS Fylde and Wyre	30	70	90
NHS Greater Preston	50	105	140
NHS Lancashire North	35	70	120
NHS West Lancashire	25	55	80
Pan Lancashire	**350**	**750**	**975**

Source: Office for National Statistics mid year population estimates for 2014. CCG population estimates aggregated from GP

registered populations (Oct 2014). The Foundation for People with Learning Disabilities (2002).

School Population

Schools are very aware of children who have particular difficulties in learning. Every term they report to the Department for Education about all children who have special educational needs. They say what sort of needs the children have. There are four levels of learning difficulties: specific difficulties (like dyslexia), moderate learning difficulties, severe learning difficulties and profound and multiple learning difficulties. The indicator shows the number of children in every thousand who have moderate learning difficulty. These children have difficulty in all areas of learning. They may have speech and language delay. The school census covers all pupils enrolled in state-funded primary, secondary or special schools. A formal medical diagnosis is not required; as such these numbers may not reflect those seen in data from medical sources.

Terminology differences regarding Learning Difficulties and Learning Disability are acknowledged. Cohorts do not match exactly although the majority of children and young people considered to have a severe learning difficulty are likely, as an adult, to be considered to have a learning disability.

Indicator	Lancashire	
	2012/13	2013/14
Children with Moderate Learning Difficulties known to schools	**3422**	**2927**
Children with Severe Learning Difficulties known to schools per 1,000 pupils	**723**	**669**
Children with Profound & Multiple Learning Difficulty known to schools per 1,000 pupils	**270**	**47**
Children with Autism known to schools per 1,000 pupils	**1687**	**1766**
Children with learning disabilities known to schools per 1,000 pupils	**3821**	**478**

Source: PHE Learning Disability Profiles

Health of the LD Population

Proportion of eligible adults having a GP Health Check

Authority	Lancashire	Blackburn and Darwen	Blackpool
Count	1985	292	313
Value	43.4	40.7	41
North West	50	50	50
England	44.2	44.2	44.2

Source: Public Health Outcomes Framework 2013/14 data

Secondary Care Admissions

Between April 1st 2009 and March 31th 2015, there were 248 admissions between secondary care

and patients with a learning disability.

These 248 admissions were generated by 184 patients.
There are 74 planned admissions and 174 emergency admissions.

Source: SUS

Planned / Unplanned	POD	Count	Total
Elective and Day Case admissions	DC	29	74
	EL	45	
Emergency Admissions	NEL	165	174
	NELNE	4	
	NELST	5	
Grand Total		**248**	

The average length of stay across the 45 elective admissions was 198 days, with six patients recording length of stays in excess of 1,000 days. In total the 45 elective admissions resulted in 14,682 bed days.

The majority of these admissions came from patients aged 15-24 (31%)

Age band	Total	%
05-14	7	9%
15-24	23	31%
25-34	17	23%
35-44	12	16%
45-54	11	15%
55-64	1	1%
65-74	2	3%
75-84	1	1%
Grand Total	**74**	**-**

59% (44) of these patients were male, with 41% (30) female

The most commonly used primary diagnoses for planned admissions was F70.1: Mild Mental Retardation, accounting for 14% (10) of all planned admissions.

Meeting the needs of the Learning Disability Population

The extract below is taken for the Lancashire Learning Disability JSNA
http://www3.lancashire.gov.uk/corporate/web/?siteid=6167&pageid=35899&e=e

The analysis of learning disabilities in adults in Lancashire has highlighted a number of key issues:

- Nearly half of people experiencing a learning disability live in the most deprived areas of Lancashire.
- People with learning disabilities are much less likely to be in paid employment.
- People with learning disabilities are over-represented in prison populations.
- The changes to benefit allocation will also affect people with learning disabilities disproportionately.
- Housing needs of people with learning disabilities are considerable and will increase.
- People with learning disabilities experience much poorer health outcomes across a range of

conditions.

- Prevalence and need is increasing whilst available budgets have been decreasing and are likely to continue to decrease.
- This has major implications for how services are delivered and will require a different approach to commissioning and developing co-produced services.

Experiential Evidence

We know from engaging with users, carers, support workers and stakeholders that there are things in the system that work well and things that don't work well currently.

At the stakeholder event on 18th August 2015 the key themes were:

Working Well	Not Working Well
• 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 • Fulfilling activities are important as part of regular routines and opportunities for development – one person told us about the importance of his morning visit to the gym in Preston for example • The role of the support worker is vital – when there is a good 'match' between the user and their support worker it helps promote independence and wellbeing • 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 • Hospital Passport highly praised, where it	• Not getting diagnosed early enough- underlying conditions or co-morbidities not being addressed in a holistic way • 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 • Staffing is inconsistent – leading to breakdowns in key care relationships and difficult transitions / poor experiences • 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

is in use and embedded in practice • Person centred planning also described as 'fantastic' where it works well: *'everything has to fit around my son, not the other way round, that's the beauty of it'*	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" • Market issues and lack of responsiveness and resilience also raised by partners

Personal budgets - 1,022 people with learning disabilities in the county of Lancashire received a personal budget in 2009/10, and this increased to 1,825 in 2010/11 (Central, East and North Lancashire Learning Disability Partnership Board annual reports, 2011). 67 people with autism in the county of Lancashire receive a personal budget or direct pay. A focus of the plan needs to be increasing access to Personal Health Budgets as application is currently not consistent.

Poverty and deprivation - People with learning disabilities and autism are more likely to be living in poverty than the general population, partially because they are less likely to be in paid employment. Poverty is defined as having less than 60% of the median national income (currently the median income is £406.40 per week so those living in poverty are earning less than £243.84 a week).

When people's resources are significantly below average, they are in effect excluded from normal living patterns, customs and activities. They are precluded from having a standard of living considered acceptable in the society in which they live. Because of their poverty they may experience multiple disadvantages through unemployment, low income and limited employment, poor housing, low educational attainment and health care issues. They can become marginalised and excluded from participating in activities (economic, social and cultural) that are the norm for other people.

Many people with moderate to severe learning disabilities receive benefits to support or supplement their income, such as disability living allowance and housing benefits and, for young people, employment support allowance in youth.

Many of these benefits are changing or being replaced altogether following the reforms to the benefits system. In particular, disability living allowance and many other benefits are being replaced with universal credit. It is anticipated that the additional payments for disability under universal credit will be lower than under the previous system, affecting individuals with disabilities, including learning disabilities. Additionally, housing benefits changes may adversely affect many people with learning disabilities who rely on this income. It is expected that £360million will be saved benefits and tax credits spending in Lancashire.

Some technological as well as process changes, for example the move to more electronic benefit systems could also inadvertently create difficulties in accessing essential finance for people with a learning disability.

Employment - Fewer than 15% of people with a learning disability across Lancashire are in employment. All areas have an employment strategy for people with learning disabilities in line with Valuing People Now: Real Jobs for People with Learning Disabilities.

Data about the number of adults with autism in employment is not currently recorded. A subgroup of the Lancashire Autism Partnership Board is working to develop measures for the number of adults with autism in employment.

Crime, prison population and secure mental health services - Lancashire Probation Trust regularly assesses the education, training and employability status of offenders subject to supervision through completion of the offender assessment system (OASys). Data from a 'snapshot' of these assessments provides evidence that 4% of offenders in Lancashire have severe learning difficulties, with particular issues in the districts of West Lancashire and Lancaster (7%) and Burnley (5%). In such cases, offenders will have attended a special school for either behavioural or learning difficulties, or may have received a statement of educational needs. 10% of offenders assessed may have had problems at school or present evidence of difficulties coping in everyday situations. 23% of offenders under the supervision of Lancashire Probation Trust have no educational qualifications, with particular issues in Blackpool (29%), Lancaster (26%) and Preston and Burnley (24%) (Figures quoted above will also include people who do not have LD and/or autism).

People with learning disability and autism in secure services (both LD & MH Secure Services) and prison may not have been known previously to services, and those that are known may have demonstrated signs of pre-offending behaviour when they were younger.

Resources are needed to ensure that information about potential pre-offending behaviour is recorded and passed onto Adult Services through transitions, which would then enable earlier intervention. Also, factors that affect whether a person subsequently is admitted to secure provision or not need to be scoped, so that people at risk can be targeted and preventative strategies identified and developed.

Housing - Across the Lancashire county area over 1,800 people with a learning disability are estimated to have a housing need. It should be noted however that the methodology used to determine these estimates has been controversial, so are intended as indicative only.

Lancashire County Council currently support approximately 2,000 people committing £79 million within a range of 24 hour domically support services, with each person having a tenancy agreement with a housing provider and support commissioned through the pooled budget . The schemes are referred to as 'supported living'.

Blackpool Council currently support approximately 115 people committing around £9 million within a range of 24 hour domiciliary support services, with each person having a tenancy agreement with *Learning disabilities in adults in Lancashire – a* housing provider and support commissioned through the social care budget . The schemes are referred to as 'supported living'.

Blackburn with Darwen Council also have supported living, domiciliary care and adult placement services across the borough. These services are provided to over 200 people and commit circa £10 million per year from the adult social care budget.

As at August 2011 there were 81 people with learning disabilities across the county of Lancashire who were in residential placements out of area as there is no suitable housing available in the area: 20 of these were in North Lancashire, 41 in Central Lancashire and 20 in East Lancashire. This

information only relates to Lancashire County Council - Scoping is underway to develop more up to date intelligence around out of area placements and treatments across the whole life course for people with LD and/or autism.

Health outcomes - People with learning disabilities are at increased risk of early death and generally have a shorter life expectancy than the general population. Estimates at quantifying this additional risk suggest the all-cause mortality rate for people with learning disabilities is three times higher. However, life expectancy among people with learning disabilities is gradually increasing, which will likely lead to increased demand for social care and health services, as people with learning disabilities will begin to outlive their parents, who currently provide the bulk of informal care.

Since 2009 Primary Care Trusts, followed by NHS England who took over the primary care commissioning in 2013, have been required to fund GP practices to carry out annual health checks for adults with learning disabilities through direct enhanced service (DES). The health check includes an assessment of physical and mental health; health promotion; review of chronic illness; a physical examination; review of epilepsy; review of behaviour and mental health; a syndrome specific check; review of prescribed medications; a review of co-ordination arrangements with secondary care; and a review of transition arrangements where appropriate.

Around 60% of people in Lancashire with a learning disability received a health check in 2010-11; this varied from 45% in East Lancashire and Blackburn with Darwen to 79% in North Lancashire. Data suggests that the cumulative percentage take–up of AHC's across pan-Lancashire has decreased since 2011. This is partly due to the changes made to the LD ES in 2014 (eligibility criteria expanded to include people 14yrs upwards) which enlarged the patient cohort however addressing this decrease is a strategic priority for all partners to this plan – AHC's are seen to be a key tool in reducing health inequalities for people with learning disabilities.

People with learning disabilities are at increased risk of many health conditions compared to the general population. Common problems include:

- **Respiratory disease** - the leading cause of death for people with learning disabilities (46%-52%) and is much higher than for the general population (15-17%).
- **Gastrointestinal cancer** - people with learning disabilities have proportionally higher rates compared to the general population (48%-58.5% vs 25% of cancer deaths)
- **Long term conditions** - up to a third of people with a learning disability also have a physical disability, most often cerebral palsy which puts them at greater risk of associated health problems. The increased prevalence of **epilepsy** ranges from 10 - 20% in people with a mild learning disability up to 50% in those with profound learning disabilities. This is compared to 1% in the general population. Epilepsy is of a more complex nature with higher levels of poly pharmacy, complex seizure types and sudden unexplained death as a result of seizures12.
- **Anxiety and depression** - particularly common among people with Downs' syndrome.
- **Schizophrenia** - limited evidence suggests prevalence is three times higher among people with learning disabilities than the general population (3% versus 1%)
- **Challenging behaviours** - such as aggression, destruction and self-injury are present in 10-15% of people with learning disabilities. This can result from pain associated with untreated medical disorders.
- **Dementia** - prevalence is higher amongst older people with learning disabilities (22%) compared to other older adults (6%). People with Downs' syndrome have a much higher risk of developing dementia than the general population, with onset often 30 to 40 years earlier.

Sensory impairment

People with a mild learning disability (aged under 50 years) have 21% prevalence of hearing impairment compared to 0.2-1.9% in the general population. The prevalence is higher in people with profound and multiple disability. People with a mild learning disability (aged under 50 years) experience 4% prevalence of visual Impairment 4 compared to 2-7% in the general population.

The results of an audit of people with learning disabilities in Preston showed that a third could not verbally communicate that they are in pain. Almost half use behaviour to communicate health needs and less than a fifth had access to Speech and Language Therapy.

Improving the baseline

The baseline can be improved by providing a consistent Lancashire wide approach to addressing the needs of the Learning Disability and Autistic population across the whole life course. Adopting early identification, integrated case management, individualised care planning, early interventions, positive behaviour therapy, community based support services, providing short term intensive community based support and respite care facilities.

Where inpatient treatment is required, small scale assessment, treatment and discharge services can be developed and in-patient low and medium secure treatments should be as short as possible with lifelong enhanced support services to meet individual needs, in the community available for those who need it.

The Provider Base

Each CCG currently commissions different services for patients with Learning Disability and Autism. The level of service input also varies. The providers market across Lancashire includes:

- Lancashire Care FT is the largest Provider of Acute and Community Mental Health and LD services. The Trust specialises in inpatient and community mental health services but also provides the Community LD Teams and where commissioned, Children's LD provision. Lancashire Care NHS Foundation Trust covers the whole of the county.

- Some inpatient services used for specialist LD are provided from Calderstones Partnership. Their core business is a forensic service although there are some legacy placements for people with complex non-forensic behaviours still in operation. They are commissioned to provide medium secure, low secure, secure step down unit and specialist NHS services to adult men and women with learning disabilities or other developmental disorders who present with extremes of serious offending behaviour. They also provide Enhanced Support Services (ESS) and Individual Packages of Care (IPC), for people who have stepped down from secure provision but who are not yet considered ready to be discharged into the community. The expectation is that a significant number of the clients from the ESS and IPC beds would be resettled as part of this work.

- Assessment and Treatment services are commissioned via Midlands and Lancashire CSU – these services ae mainly spot purchased from NHS and private providers.

- CCGs to varying levels commission services from the voluntary community and faith sector including but not limited to:
    - Supported Employment
    - Advocacy
    - Self-Advocacy
    - Peer support – Empowerment

- Independent health sector providers - There are multiple placements commissioned from Private Providers, in the main these are for individual packages of care. These placements are commissioned from providers which include but are not limited to
    - Lighthouse
    - The Priory
    - Partnerships in Care

Local Authorities commission supported living services and social care services from a range of domiciliary and residential based providers both inside and outside their own boundary areas and make use of direct payments and personal budgets. The Local Authorities will now be managing provider allocation and payment in accordance with Care Act requirements.

Placements can be funded jointly in even/uneven splits. The provider market across pan-lancs is diverse and has approximately 80 service providers commissioned to support people with learning disabilities and/or autism and their families. Commissioned organisations include those from the voluntary, charitable and private sectors.

Commissioning Arrangements

Learning Disability services are jointly funded through CCGs and Councils however pooled budget arrangements are not consistently used across Lancashire.

Overall services are commissioned by open tender with individual packages of care commissioned through a mini-selection process which is open to existing or new providers. LD Care at Home frameworks are in place in some localities. Work is ongoing to upskill the local market so that it is able to provide more specialist care and support but this is not consistent across Lancashire.

Block contracts are in place with Calderstones and Lancashire Care FT.

Patient Flows

Due to the size of Lancashire and number of boarders there are multiple cross boundary issues which complicate patient flows, notably:

- West Lancashire has significant patient flows into Merseyside (not in the Fast track area)
- Lancashire North has a shared health care economy with Cumbria (in another Fast track area)
- There are patients who are registered out of area but live in Lancashire and vice versa.

Due to the specialist Learning Disability Providers in Lancashire, we have historically been an importer of patients and had a higher number of local patients in inpatient beds than other areas.

There is not an integrated Health and Social Care Team managing the flow of patients across Lancashire and managing out of area placement. The health and social care teams are currently fragmented with both size and team make up varying between CCG / LA area.

Key Partners

This list isn't comprehensive but starts to demonstrate the complex interdependencies within the system and the key bodies that have a stake in the development of the Fast track Plan:

- CCGs (Fast track Commissioners but also boundary CCG Commissioners)
- Local Authorities (as above – within the Fast track primarily but also links to boundaries)
- NHSE Specialist Commissioning (and transitioning Primary Care leads)
- NHSE Transforming Care Teams and other Area / National leads on key area
- LD Providers – NHS; Independent Sector; Residential, Domiciliary, Third Sector
- Mental Health Providers in NHS and Independent / Third Sector
- Community Providers – NHS sector primarily as CLDT providers
- NHS Acute Trusts/ System Resilience & Crisis Concordat leads
- North West Ambulance Service / other patient transport providers
- Community Voluntary Sector; Faith Groups
- Police, Probation and other justice system leads
- Fire Service and other home support providers / telecare providers
- Advocacy and Peer Support organisations
- Oversight and Scrutiny Bodies; Healthwatch, Patient representative bodies
- Carer representatives

5. The Fast Track In-Patient Cohort

There is National drive and expectation to achieve at least a 10% reduction of the total in-patient cohort between 31/03/15 and 31/03/ 16.

The baseline figures for the North West in-patients - provided by NHS England Area Team :

Team / CCG	Baseline @31/3/15	Projected 10% @31/3/16
North of England	**909**	**818**
Greater Manchester	72	60
Lancashire	47	39
Specialised Commissioning	**495**	**470**
North West hub	205	195

Projected in year admissions from NHS England, based on the previous year admissions, for the 5 fast track areas are as below (these are straight-line calculations not including growth/ risks):

	Total inpatients	*Setting*		*10% Reduction*		*Setting*	*10% Reduction*	*Projection admissions#*	Discharges required	Transfer required	Transfer required
	Total	Non	Low	diff	all inpatients	Medium	transfer only	*15/16*	Non & Low	Low	Medium
North	**909**	**448**	**301**	**91**	**818**	**160**	**16**	**330**	**421**	**30**	**16**
Cheshire & Merseyside	**49**	**46**	**2**	**5**	**44**			**33**	**38**	**0**	
CWW	33	31	2	3	30			17	20	0	
Mersey	16	15	0	2	14			17	18	0	
Cumbria & North East	**131**	**130**	**1**	**13**	**118**			**57**	**70**	**0**	
CNTW	69	68	1	7	62			34	40	0	
DDT	62	62	0	6	56			23	29	0	
Lancs & GM	**119**	**112**	**7**	**12**	**107**			**23**	**34**	**1**	
GM	72	65	7	7	65			11	18	1	
Lancs	47	47	0	5	42			12	16	0	
Yorkshire & Humber	**115**	**112**	**3**	**12**	**104**			**52**	**64**	**0**	
NYH	40	40	0	4	36			27	31	0	
SYB	25	22	3	3	23			11	14	0	
WY	50	50	0	5	45			14	19	0	
Specialised Commissio	**495**	**48**	**288**	**50**	**446**	**159**	**16**	**166**	**215**	**29**	**16**
CWW SC	205	26	128	21	185	51	5	58	78	13	5
CNTW SC	140	12	93	14	126	35	4	56	70	9	4
SYB SC	150	10	67	15	135	73	7	53	68	7	7

NB .It must be noted that the projected admissions are new patients entering the system, and what must be understood is that many of the Specialised Commissioned patients transfer as part of their treatment pathway into the CCG figures. Therefore the CCG figures can increase above the projected figures due to movement within the existing cohort of patient journey.

Implications of the Fast Track Plan

The 5 fast track areas have been requested to create plans to exceed the 10% reductions supported by a £10 million transformation fund, to be distributed on the merit of the local plans developed and the confidence in reducing total numbers of in-patient beds.

The Current In-patient figures Provided by NHS England Area Team - August 15

CCG	Baseline 31/3/15	April	May	June	July
Lancashire	**47**	**43**	**42**	**38**	**39**
Blackburn with Darwen	7	6	6	5	6
Blackpool	2	2	2	3	2
Chorley & South Ribble	3	3	3	3	3
East Lancashire	11	10	9	9	8
Fylde & Wyre	3	3	2	2	2
Greater Preston	8	5	6	5	6
Lancashire North	9	10	10	7	7
West Lancashire	4	4	4	4	5

Provided by Specialised Commissioner for Lancashire

	Baseline Position at 31/03/2015				Position at 30/07/2015			
CCG	**Medium Security**	**Low Security**	**Rehab**	**Total**	**Medium Security**	**Low Security**	**Rehab**	**Total**
Blackpool	5	2	0	**7**	2	3	0	**5**
BWD	2	7	1	**10**	2	6	0	**8**
CH & SR	0	3	2	**5**	0	2	2	**4**
Grt Preston	1	3	3	**7**	1	1	4	**6**
East Lancs	7	4	4	**15**	4	10	1	**15**
West Lancs	1	2	1	**4**	1	1	1	**3**
Lancashire North	2	2	0	**4**	1	2	0	**3**
Fylde & Wyre	0	1	0	**1**	0	2	0	**2**
Totals	**18**	**24**	**11**	**53**	**11**	**27**	**8**	**46**

These figures will fluctuate as new patients are admitted to in-patient services and patients are discharged.

6. The Lancashire Vision

The Lancashire vision is consistent with the national service model and is that:

People with a Learning Disability and/or Autism, including people with complex and challenging behaviour, can lead fulfilling lives in the community supported by 'ordinary' services with appropriate support from staff with skills to support them and their needs in their local community, whenever possible.

The Principles of the transforming care programme in Lancashire are:

- 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 that will make reasonable adjustments to the provision of their care.
- Lancashire< Blackburn with Darwen and Blackpool 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.
- Good quality learning disability services 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. The service will be committed to achieving the outcomes of 'rights, inclusion, independence and choice', and to ensuring that it 'sticks with' individuals in spite of the difficulties experienced in meeting their needs.
- Services should ensure that those with learning disabilities and their carers are able to access the right level of information, advice and advocacy support. Carers should be provided with support in accordance with the national 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.
- Over and above all of this framework is the vision to make person centred care the reality, whether it's in the delivery of the ordinary or the specialist care – system leaders have been brought together in an unprecedented way to do the Fast Track Plan and will continue to use

their leverage to create an environment in which person centred care is the norm and personalisation mechanisms become part and parcel of delivery.

7. The Model

The model is based on the premise that people with a learning disability or Autism, including people with complex and challenging behaviour, should lead fulfilling lives in the community supported by 'ordinary' services with appropriate support from staff with skills to support people with learning disabilities. They will sometimes have physical or mental health problems and should be supported to access mainstream health services. All generic health and social care services should be encouraged to extend the current number and range of Learning Disability/Autism champions to improve the care experience.

There should be provision for those people who have low level needs, who may not currently meet the criteria for services, through appropriately accessible local prevention and wellbeing services.

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.

Lancashire will make person centred care the default, non-negotiable offer. The use of personalised budgets and the adoption of an all age approach will allow us to build on progress to date. Where plans exist already, the Fast track model will be used to expedite and accelerate these.

<u>Feedback from the Stakeholder Day on the emerging vision for Lancashire:</u>

"What do you think good care would look like?"

Service users, carers, support workers and patient representatives including Healthwatch emphasised the following points:

- Person Centred Care from the beginning that recognises that every person is different:
    - Individual care design, flexibility and choice
    - Caring staff who listen and understand
    - A "Plan B" in case of a break down in provision
- Early intervention including access to appropriate diagnostics with appropriate adjustments
- Starting in children's services and following the individual through their life
- Not waiting for a crisis to occur, pro-active risk management and access to the best in behavioural support as well as physical and cognitive support, with the least restrictions
- Emphasis on care that allows individuals to be safe, in a familiar environment, with consistent care and people they can trust and who know them
- When people to need to make changes to their care it is supported, with proper preparation, transition planning and discharge processes. To include reviewing social expectations, orientation and maintaining links to previous placement and peers to reduce risk of isolation
- Effective community services in place to identify triggers and able to act upon these, with strong support and professionals available the individual in the community
- Appropriate staff in place with bespoke training, mentoring, buddying and networking of professionals, enabling choice of key worker and appropriate skill / personality matching
- Eliminating blame culture and improving working conditions including pay
- Good access to universal services available when it's needed 24/7 and with reasonable adjustments that take into account people's differences e.g. those with autism
- Regular updates, explanations and meetings with the patient, family and/or carer and any other key individual, with independent support, underpinned by good processes and tools (e.g. hospital passport, LD Champions) to help people make informed decisions and take

control

- Movement away from solely medical models to social models which can be demonstrated by a person centred audit trail – going from good examples, to good practice for all

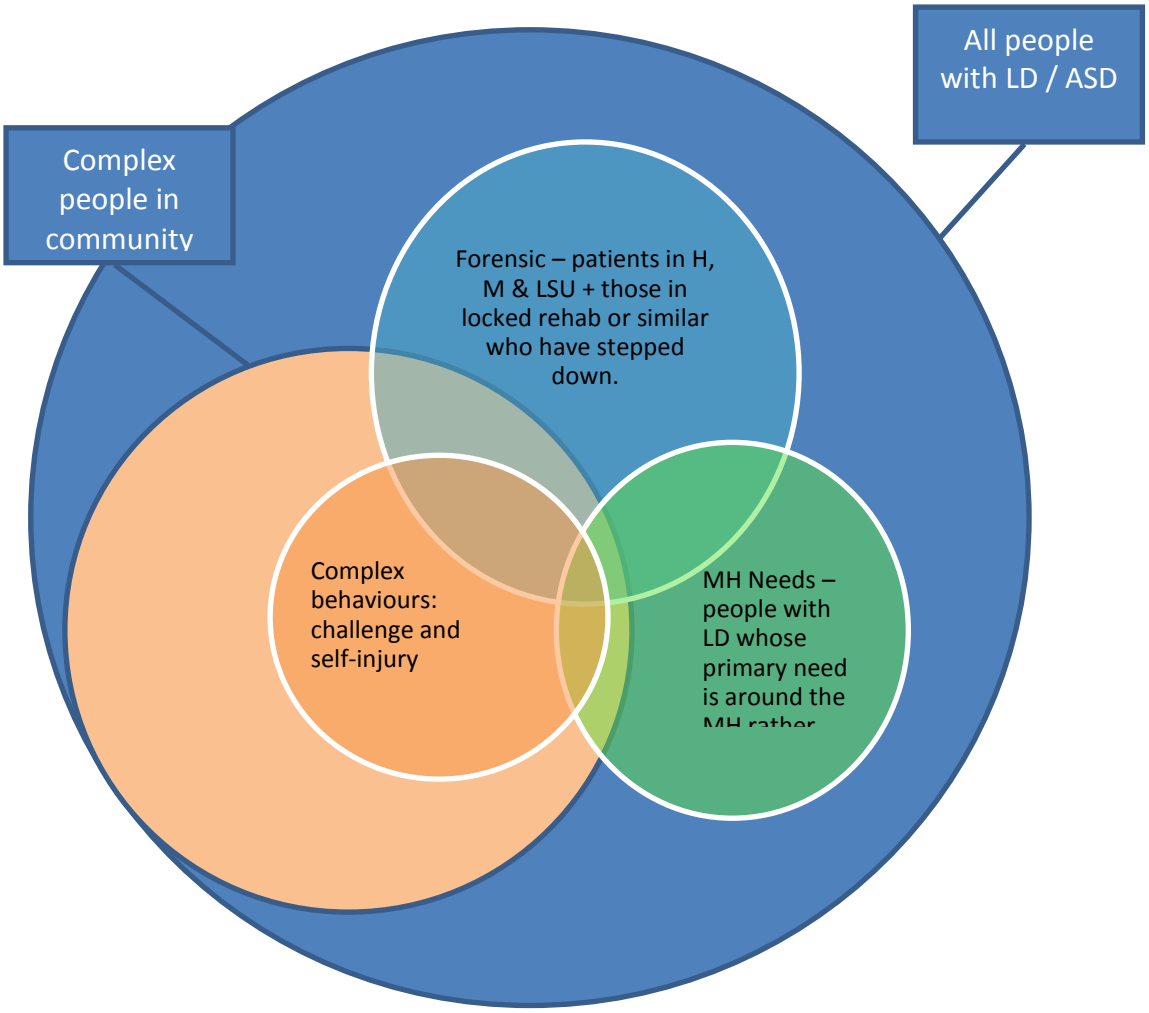
Professionals echoed the above points and had innovative ideas about delivering it! They suggested merging care packages to benefit from the skills and specialisms of more than one provider, networking support across different providers, sharing staff for infrequent but high skill responses such as crisis, clustering residential/ care home providers that are either geographically close or share specialisms such as care for those with autism, to increase resilience in the system. A shared approach to therapeutic approaches, risk assessment and management and legal requirements was suggested

Professionals also placed a high importance on values, candour, transparency and good working conditions to ensure people with appropriate skills and experience can be attracted and retained. As turnover is high it was suggested that innovative working models were adopted such as rotating staff between settings and providers, recognising the level of difficulty in some care types and the need to have breaks and time out, to recharge.

The need for two particular kinds of professional support was raised - confidential, supportive and empowering supervision, probably with a psychological / counselling emphasis. But also on a practical level – real mentors who know what it's like and can role model approaches and skills.

"This can be the most difficult, as well as the most rewarding care to work in – staff can burnout easily and need good support networks".

The Cohorts



Children's services

The Lancashire Collaborative Commissioning Board have agreed a Pan Lancashire programme of work to review and redesign the approach to children and young people's emotional health and wellbeing. A System Board has been set up and a Director position, resourced jointly between all CCGs and Local Authorities, is being recruited to lead this ambitious and important work.

The current priorities, to be developed into workstreams include whole system finance; shared records and IT; contracting models and operating principles.

This work will have an impact on service design at all Tiers of CAMHS provision, including the CAMHS LD Service. It is a transformational programme across 5 Years which encompasses the themes and principles in the 'Future in Mind' Taskforce document released in 2015 for children's mental health.

Transitions are a priority and the plan includes the intention to move to a 0-25 years approach with some elements of the service being all age where this is clinically appropriate.

As both the CAMHS programme and the Fast track programme mobilise their Plans, the interdependency will be tested and refined and any service models will include interdependent checks / impact analysis to ensure responsibilities are clear and new silos are not created.

Transition

"If we get the service right, we won't need to transition people anymore" – CCG Commissioner

The ultimate aim is to have an integrated pathway with networked providers managing service level changes in responsibility, service provision and case management so that they are not evident to the user or carer, other than when they have chosen to make changes.

A young person will not need to transition for age reasons in the all-age model – however there will still be times when they will have some care transitions in relation to services to meet emerging needs.

Also, it is recognised that until an improved system is fully up and running, there is a need for robust and sufficiently resourced transition arrangements. These will be consistent with the objectives of the current national policy and guidance and have the support of all of the relevant services for children and adults.

Young people with behaviour that is complex and challenges should be the subject of focused attention and support. 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 measured handover to adult services post 18th birthday.

Comprehensive Community Support

Effective community services should have at their core an integrated Community Learning Disabilities Team that is sufficiently and appropriately resourced to fulfil its role in meeting local needs including the capability to respond effectively to the needs of people with complex needs and challenging behaviour. It should have, or ensure access to; the necessary skills to manage all age provision from adolescents to old age and the diseases of old age in combination with LD such as dementia.

Effective CLDTs will lead to a greater level of admission avoidance and accelerated discharge from in patient's services. Evidence of the success of integration can be seen in other areas of the northwest including Salford. Funding will be based on the principles of supporting individuals to live independent, fulfilling lives; resources currently committed to in-patient services will migrate to community services as activity migrates.

The workloads of the CLDTs will be carefully monitored, so that the impact of any change in in-patient capacity and of any refocusing of the use of in-patient services (such as focusing solely on meeting acute mental health needs) can be identified at an early stage and effectively managed.

The Integrated CLDT will work to support Primary Care and Hospital services in delivering high

quality health services to promote and maintain good health and well-being for people with learning disabilities. Teams will support the needs of the people with whom they work holistically, ensuring that all health and social care needs are assessed and understood.

This includes access to mainstream health screening services and encouraging individuals to attend GP Health checks when offered.

Appropriately resourced Community Learning Disability Teams (CLDTs)

Comprehensive community support requires:

- Appropriately resourced Community Learning Disability Teams
- Accessible specialist professional support
- Education, work and day opportunities
- The capacity to respond to crises 24 x 7
- Accessible resources to facilitate effective support for people with complex and challenging behaviour
- Policies and protocols for the prevention of placement breakdown
- Respite / short breaks for carers of people with challenging behaviour
- Effective integration of the components of the service

Accessible specialist professional support

Where the CLDT is unable to meet all of the needs of an individual and requires additional specialist input this should be readily accessible.

The specialist service professionals such as psychiatrists, psychologists, Occupational Threapists and speech and language therapists need to have the capability to respond effectively to the needs of people with complex needs and challenging behaviour and to respond in a timely fashion in situations of crisis including potential placement breakdown. In most cases this will mean utilising the skills of the teams which already exist in mainstream services such as Mental Health to blend the skills of the CLDT and the specialist service.

The Specialist/Intensive Team professionals will work closely with other community colleagues in a programme to repatriate people from out of area placements, prevent admissions and support people and families in the community

The CLDT will work to support Primary Care and Hospital services in delivering high quality health services to promote and maintain good health and well-being for people with learning disabilities. This includes access to mainstream health screening services and encouraging individuals to attend GP Health checks when offered.

The various elements of community services for people with learning disabilities will operate more efficiently and effectively where there is good joint working, with a high level of co-operation and co-ordination, and where services share the same priorities. Integration means combining the strengths of both health care and social care through fully integrated teams.

<u>Model Aims, objectives and values of a Community Learning Disability service</u>

This service is a critical component in the delivery of the Lancashire Vision – to support people in both ordinary and specialist services; and to make person centred care our default position. Specifically, this service will:

- Support people with learning disabilities in all settings, providing specific and additional input as required responding to their health care needs.
- Provide health facilitation to support people with learning disabilities to improve their health, well-being and social inclusion, both directly via interventions and in-directly through their support and relationships with mainstream NHS and Service Providers.

The Service has an essential facilitation, clinical and therapeutic role, which will include support to people with learning disability, their families and carers, and service providers beyond the traditional 9.00-5.00 day:

- Facilitating access to mainstream health and social care services for those patients with learning disabilities whose needs could be more appropriately met by those services
- The provision of longer term support for patients who may have complex and continuing health needs
- Proactive care planning to de-escalate situations as they arise and planning for the emergency / crisis contingencies to manage without admission wherever possible
- Managing the transition from child and young person's services to adult services where necessary for education and other mainstream health services
- The teaching role; to enable a wide range of staff, to become more familiar with how to support people with learning disabilities to have their health needs met
- Developing behaviour strategies and interventions with the support of a Positive Behaviour Support Service where appropriate
- Health promotion role; working closely with local health promotion services
- Work with individuals and families to promote the use of Integrated Personal Budgets

Crisis response capacity

Part of the work of the community team should be about ensuring that patients 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 successfully. 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. 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 in Lancashire 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 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.

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. In many cases it is avoiding 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.

Local Authority Commissioners have a lead role in the procurement and management of respite care currently and will be supported within the new system approach across health and care to make improvements and tailor this component of the care model in accordance with the emerging intelligence that will be produced, as the system moves from one state to a new model.

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.

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 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.

Our model includes access to specialist staff that have the appropriate skills and knowledge about complex and challenging behaviour that can provide specific support to individuals and their carers and families, providing specialist assessment, supporting development of proactive support plans giving advice and information and provide training.

This requirement will be part of the CLDT Specification but we are also pursuing options for additional specialist behavioural inputs. We have visited the team delivering Positive Behaviour Support in Knowsley and will progress with further modelling using the evidence base available from this work which provides an invest to save basis for this aspect of the model.

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.

Intensive Support Service

At times people with Learning disabilities may need access to short term residential care to provide a safe environment. This service should be utilised for the shortest time possible (from overnight up to 6 weeks). This facility would be used to support individuals that may require short term accommodation for times such as undertaking repairs to damaged property or during times of carer's illness, where lack of supported living may result in an otherwise avoidable crisis admission.

Again we will conduct further modelling during implementation to test and refine bed base and caseloads/ staffing quantities as the system shifts to new ways of working. Initial assumptions have been built in to this Plan and its associated resources which will need to be reviewed.

Learning Disability In-Patient Services

This is the part of our model that has the greatest national driver for change. There is a requirement for not only a significant reduction in bed numbers in inpatient settings but also, supporting this and inextricably linked with it, a sea-change in the delivery and clinical model within these settings.

Partners have agreed that some inpatient provision will continue to be needed, for intensive support, assessment and treatment that cannot be safely managed in another setting and where there is a clear, clinical need for a bed based period of care in an NHS staffed setting.

Discussions on this element of the model have been productive and lengthy and this plan is written at a snapshot point in time - whilst we have worked hard to agree a model that we believe is safe now and based on robust assumptions at this point in time, we know we need to review and modify in the light of changes as they are being made.

There are existing service providers in this market whose provision also needs to be taken into account so that any transition opportunities are fairly and openly made within the market.

This Plan will therefore use the wording 'inpatient services' as a general reference point for this component, acknowledging that this doesn't fit exactly with CQC licensing descriptors, with provider terminology or with all partners preferred frames of references.

Within this overall heading the term "Crisis Response" is favoured as it describes care that can be delivered in multiple settings – and it links with the ambition for fewer, shorter, more focused periods of assessment and/or treatment, leading to shorter lengths of stay and greater flow.

We will commission inpatient care based on the principles that:

1. People with learning disabilities have the same right of access to mainstream mental health services as the rest of the population
2. Mental health services that are commissioned need to have the appropriate skills and services to address the specific needs of people with learning disabilities who have or are suspected to have a mental illness
3. Psychiatric hospital care should be based on short-term, highly focused assessment and treatment of mental illness through a very specifically defined, time-limited service

The aim of an In Patient Service is to provide intensive inpatient assessment and treatment for adults with a learning disability, who require more intensive services than local services can provide, in order to enable them to return to live in their communities. The Service will work in partnership with community learning disability services and community mental health services to provide effective integrated care arrangements along an agreed pathway of care.

General Overview

The Inpatient Service fulfils an important role within the range of services locally available to meet the needs of adults with learning disabilities. Most people with learning disabilities will have their needs met in the community however a small number, in particular circumstances will present with needs that cannot be managed by local community based Intensive Support Services.

The Service will offer comprehensive, multidisciplinary, person-centred, inpatient assessment and treatment for people with complex needs who display challenging behaviour is not being managed by community services.

The Service will provide a 24-hour service and the full range of appropriate professional input. It will assist with the development of appropriate individual care packages and provide outreach provision to assist with rehabilitation back to the local community.

The Inpatient Service will adopt a whole system approach to the provision of service, and will actively support local partnership working. It will contribute to local service planning and development and support the improvement of local services by contributing to the provision of training and having both in-reach and outreach capability ensuring a consistency of approach between community and inpatient services.

Scope
The service will be funded for the registered population for the CCGs, which it serves providing evidence based inpatient assessment and treatment for adults aged 18 plus with learning disabilities and additional mental health issues.

The Service will meet the needs of people with learning disabilities including:

- People with learning disabilities who have severe challenging needs and present major risks to themselves and/or others
- People with learning disabilities and severe mental health problems who cannot be addressed by general psychiatric services
- People with learning disability and autistic spectrum disorder with severe challenging behaviour
- People with learning disability and autistic spectrum who have forensic needs.

Any such centre is predicated on short-term length of stays to enable assessment, treatment and discharge planning. It therefore requires effective management of admissions and discharges

- With effective monitoring and management of use of the available capacity
- Commissioners should ensure that only appropriate admissions take place and that they follow an agreed admission / discharge pathway with clear admission criteria
- The CLDT should ensure that people are moved on from the centre as soon as possible once they are considered appropriate for discharge
- Length of stay of patients should be formally monitored and if there appear to be impediments to a timely discharge resources should be identified as a priority to enable discharge to proceed
- Having access to appropriate accommodation is essential and a unit that includes a live in may be particularly helpful in this regard.
- Discharge planning should commence on the day of admission

Supported Accommodation

Decisions about where a person is to live need to be made on the basis of what is best for each individual. Where people need to be supported other than with their families, they should be supported in a home, (their own home or small residential home) near their family and friends. Each authority needs to ensure that it has a range of appropriate accommodation options available to meet local needs and to make best use of the opportunities provided by personalisation to build flexible individualised models of support

There may be particular complexities associated with the provision of appropriate local accommodation in relation to:

- People returning from out of area

- Transition support for young people approaching adulthood who are in - or being considered for – an out of area placement
- Move on from hospital
- Placement breakdown / crisis support
- Supported living from forensic settings

Wherever possible the accommodation needs of people in any of these circumstances should be met within the above framework. However, there may be some people who need a period of relatively intensive support, together with focused rehabilitative work to enable them to successfully manage in the family home or in local supported accommodation.

8. In-patient Commissioning Plans & Discharges

Specialised Commissioning Support for Lancashire CCG LD Fast Track Plans

Specialised services in the North West commission Low and Medium Secure care for people with a primary diagnosis of learning Disability with a forensic history or who are at risk of offending. In addition it commissions a small cohort of 'step down' beds, as part of a pathway into community based care.

The current commissioned in-patient bed provision is as follows:

	Medium secure	**Low secure**	**Step down**
Calderstones (GM & Lancs) and Cumbria	52 beds (inc 6 f)	86 beds (inc 24 f)	20 beds (inc 5 f)
5BP (primarily Cheshire/ Mersey service but can take GM & Lancs pts)		10 female beds	
CWP (primarily Cheshire/ Mersey service but can take GM & Lancs pts)		15 male beds	

The vision of NHS England Specialised Commissioning in the North West is to create a sustainable forensic service for people with learning disabilities/ASC, ensuring the availability of highly specialised services for the most vulnerable people. We will work with credible and competent providers to ensure that there is integration between forensic inpatient and community based services. This vision will apply equally across the geography of the North West.

NHS England is committed to the principles of least restrictive practice and the strengthening of both locally commissioned services and in patient and forensic out-reach services who will work to ensure only those admissions that are absolutely necessary and in the persons best interests will occur and that these will be for the shortest possible period.

Forensic outreach services will work with our partners in offender health, local learning disability / ASC services and education to ensure that the necessary support and treatment is available to the person preferably within their home environment. This works to ensure that pathways will be optimised to ensure that individuals are cared for in the least restrictive environment and for the appropriate length of time in that setting and according to their needs. Those pathways will be driven by care and treatment reviews embedded in both commissioner and provider arrangements. In-patient care will no longer be a replacement for home and this will be reflected in a significant reduction in the number of beds commissioned by NHS England.

The realisation of that vision and breaking the cycle of over reliance on inpatient services is

dependent on the success of the transforming care plans of the Lancashire and Greater Manchester CCGs to develop, grow and fund the transformation of community based services to better meet the needs of those patients no longer requiring the physical, relational and procedural levels of security offered by in-patient secure forensic services. Specialised commissioning is committed to working collaboratively to achieve these goals.

Special consideration needs to be given to the learning disability/ASC provision for CAMHs tier 4 in patient services. This will be considered further within the national procurement for CAMHs tier 4. Additional beds where facilitated across the country in 2014/15 for PICU and generic services to meet demand and whilst this has eased pressure it has identified the difficulties that this group experience in mainstream services. The availability of specialised services across the country is limited and often demand outweighs provision. It is expected that this will be addressed as part of the procurement work and the aim is to keep children as close to home, in the right service and for the least time as possible. Please note the figures provided relate to adults only.

The implementation of NHS England's plans to provide services in the community for people who do not need to be cared for in a hospital setting will, over time, remove or reduce the need for, or configuration of, some in-patient services that are currently provided in the North West. The services required to do this with be both specialised and local and will work together to strengthen care and treatment pathways for people.

Most recently there has been an agreement on the reduction of in-patient beds commissioned across the country by NHS England Specialised Services over the next five years and is detailed below.

	Current	**Future**	**Assumptions**
High secure	80	80	No change
Medium secure	460	360	25% reduction
Low secure	853	525	50% reduction plus 100 short term assessment beds

With regard to the Lancashire fast track area, below are the patient numbers;

Current Lancashire Population at Calderstones with expected discharges by April 2016

CCG	Medium Security	Low Security	Stepdown	Total	Should all expected discharges occur	Projected cohort by April 2016
Blackpool	2	3	0	5	1	4
BWD	2	6	0	8	3 – LSU, 1 - MSU	4
CH & SR	0	2	2	4	1	3
Gtr Preston	1	1	4	6	3	3
East Lancs	4	10	1	15	3 plus 1 other provider	12
W Lancs	1	1	1	3	2	1
Lancashire North	1	2	0	3	0	3
Fylde & Wyre	0	2	0	2	0	2
Totals	**11**	**27**	**8**	**46**	**14 (+1)**	**32**

Lancashire – other providers

Across the north west there are 13 people identified on the CTR Tracker who are placed in other secure services, 9 Low secure and 4 medium secure. (1 out of area – MSU).

In addition to this, work is underway nationally within specialised commissioning to address both the long term national vision for forensic secure services the financial implications of the transforming care agenda. There is a commitment to transferring the necessary funding from bed based specialised services to more appropriately commissioned local services for the population. However this work is not yet complete and there is no definite timetable for this work to be completed. We are unable at this time to be more definite about the resources and how these will be reused. What we can say with confidence is that there is a commitment to ensure the resources released from bed closures are redistributed between commissioners to ensure the new models of care delivery are

appropriately funded.
This will most significantly affect services provided by Calderstones FT Hospital. As a single specialty provider with a relatively small provision compared to other multi-specialty FT providers, it has already been vulnerable to the financial challenges placed on it by the NHS over recent years. The Transforming Care agenda will reduce the annual income of Calderstones and add to those financial challenges. In light of these developments it is inevitable that the Trust will not be viable as a standalone single speciality trust in the short to medium term.
With this uncertainty, staff morale has suffered and attrition and sickness rates have risen over recent times, bringing new challenges for managers in ensuring a capable, safe and sustainable workforce.
Specialised Commissioners have worked with Calderstones Hospital to identify potential solutions and have been involved in the identification of a neighbouring, multi-specialty Trust willing to acquire Calderstones and create a more resilient and effective centre of excellence for secure care for both learning disability and mental illness patients. Merseycare Trust is working with Calderstones to develop an outline business case for this acquisition. It is envisaged that this will take place in April 2016.
In the short term NHS England Specialised Services in the North West have worked with Calderstones to rationalise existing pathways and service configurations in the context of reducing patient numbers to use their staff more efficiently. They have also subsidised the Trust by £3m to ensure short term financial stability by agreeing not to withdraw committed income from beds where patients have been discharged already through the Transforming Care process.
NHS England Specialised Commissioners are supportive of the plans being put in place by both Greater Manchester and Lancashire CCGs in support of the Transforming Care agenda. We have been involved at both Board and Delivery group level and are engaged with them in their planning for alternative provision based closer to home and outside of a hospital setting. The plans fit well with the NHS England vision for future Specialised Services commissioned for secure forensic LD provision.
In addition to our commitment to continue to work with CCGs across the North West on delivering their transition plans, we have non-recurrently employed an additional 1.5 WTE case managers and 0.5 WTE administrative support to continue the CTR process across the North West and to act as key links for CCG Case Managers and Commissioners around individual patient pathways from in-patient into community based services. Commissioners are working with providers to embed these processes in normal business for both parties.
The risks associated with this process and mostly centre on the capacity of the specialised commissioning team to undertake the associated workload. Most specifically capacity issues lay with the current lack of commitment around the non-recurrent funding for CTR implementation after 31st March 2016 this will mean that the case management resource employed for the chairing of and following up of CTRs and actions will cease. The remaining team cannot pick up the work due to the effects on the rest of the system and this will result in the slowing down of pathways for people transferring out of secure care.
Another risk to be considered is that of the lack of capacity from supplier management on working with providers on contractual and reconfiguration of services. The team will require the commitment of an additional supplier manager to undertake this process. This will allow for the proper management of the contractual issues and changes that will be required.
Service reconfiguration across the North West will include the rationalisation of low secure services in non-fast track areas and will involve significant commissioning of new service models and units that will allow for the more appropriate delivery of care for the population going forward. Outreach services will require significant development to support people as described above.
Our aim is to achieve a service provision across the North West that is responsive, least restrictive and only accessible to those who meet the criteria after rigorous assessment and development of clear and time limited treatment plans.

Clinical Commissioning Group Support for Lancashire Fast Track Plans

Calderstones

Achieving a high level of discharges on a fast track programme has the potential to significantly destabilise this organisation. In order to manage the reductions in bed numbers is essential for transformation to be undertaken in a carefully planned and managed process. Lancashire & Greater Manchester CCGs have agreed to collaborate and work with the provider to design an approach to ensure stability. Staffing issues have been highlighted by the provider and all organisations are committed to ensuring that every opportunity to retain the scarce skilled LD workforce should be maximised. Therefore where possible redeployment and TUPE arrangements for staff will be explored. Ensuring staff are supported and informed during the transition will be a priority and a robust staff communication process will be crucial to minimise the disruption caused by uncertainty in the future for the Trust and its employees.

A two phased plan is identified:

Phase 1 - Transition

A co-produced investment and action programme has been produced, to ensure adequate and sufficient clinical leadership and management capacity, to deliver the required re-configuration of in-patient services at Calderstones, and thereby enable:

- A workforce development plan as the mechanism to equip workers with the education, skills, values, knowledge and behaviours they need to effectively deliver and improve services, both now and in the future – ensuring the service is supported in providing a range of professionals and workers with the right attitudes and skills
- Rationalise and merge ESS/Low Secure resources to enable speeding up of discharge care pathways over the next year to support transition placements
- Re-design of specialist and criminal justice systems/forensic support diversion care pathways - including expanding the Forensic Outreach Support Service
- Build on the Calderstones LDD NOMS national best practice work with Probation Trusts and Police Forces, including work to:
    - identify and improve outcomes for offenders who have a Learning Disability
    - better identify the prevalence of learning disability within offending cohorts reducing the discrepancy between the reported number of cases in GMPT and Lancashire Constabulary with a learning disability compared to the expected prevalence as identified in the research.
    - extend cross criminal justice service working parties including Probation Services, Police, HMP, the National Autistic Society, and partnership agencies such as the National Careers Service and Work Solutions – and targeting work, centred around identifying an offender's pathway through the criminal justice service and solving the 'roadblocks', gaps in provision and best practice, in the areas of screening, identification, information sharing, safeguarding and sentence planning.
    - continue use of the Communication Reflection Tool developed by Calderstones to gauge levels of communication skills within probation and prison cohorts
    - support offender managers to avoid misinterpreting the behaviour of offenders with a communication need as non-compliance, rather than that of an individual with a communication need and so improve the early identification of offenders who have

a learning disability.

- improve offender engagement through more effective use of existing workforce skills and competencies.
- enhance interventions through the development a range of practice tools.
- improve assessment and planning by a clear focus on presenting need and improved professional judgement.
- ensure that the new ways of working are embedded in business as usual models.
- promote more effective multi-agency responses to risk and vulnerability.

Phase 2 – Long term sustainability

Following the authorisation of Mersey Care as a foundation trust there is a proposal for Mersey Care to acquire Calderstones from April 2016.

Mersey Care has been working with Calderstones since April 2014. Both trusts care for service users with similar offending profiles. In September 2014 the two trusts agreed a joint strategy for clinical working which has led to several developments, including joint clinical appointment(s). Throughout this period, clinicians from both trusts have developed a good working relationship and have a shared clinical model for the future which will offer specialist, intense progressive care based on interventions that demonstrate the best outcome for people with learning disabilities and or mental health conditions. The current business case focuses on the opportunity to fully integrate forensic services with Calderstones, builds on the expertise of both trusts and is a natural progression of the work that has been developing between the two trusts during the past year.

In order to achieve reductions in the number of hospital in-patients the Lancashire Health and Care System's commissioning strategy is to commission community based packages of care where it is safe and effective to do so for patients who require Enhanced Support Services. We have already stopped admissions into the beds at Calderstones from the community and therefore reduced admissions. In addition, the direct pathway from LSU down to ESS beds has also been closed.

We will examine the referral gateway to inpatient beds so that all referrals for admission using the civil sections of the Mental Health Act will be via the lead health workers of the Integrated Learning Disability Teams.

Discharge Plans

CCG in-patients with projected discharge dates are identified by quarter in the tables below with the confidence levels of achieving the date set taken from the tracker on the 26th August 2015, these dates will fluctuate as individual circumstances change and are dependent on multiple organisation input such as social care, community health services, housing and the impact of medical conditions.

The colours in the table below are RAG ratings, indicating the confidence level of achieving the date, according to guidance provided by NHS England, during Care and Treatment Reviews. The initial date setting was done on clinical presentation at a point in time and without reference to contextual and external factors. Each responsible commissioner has mitigations in place for each case and a rationale for their confidence rating.

Confidence in discharge:	High	Medium	Low	Unsure	Not given

CCG Projected Discharges

2015/2016							
Q2		Q3			Q4		
Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
31/08/2015	01/09/2015	1/10/15*		15/12/2015	31/01/2016	28/02/2016	
	30/09/2015	06/10/2015		31/12/15*	31/01/2016	29/2/16*	
		09/10/2015		31/12/2015	31/01/2016		
		31/10/15*			31/01/2016		
		31/10/2015					
3		**8**			**6**		

17 CCG Patient Discharges expected by the end of March 2016
*Identify patients not in Calderstones

2016/2017					
Q1		Q2		Q3	Q4
Apr	Jun	Jul	Sep	Dec	Mar
30/04/2016	30/06/2016	30/07/2016	01/09/2016	15/12/2016	31/03/2017
	30/06/2016	30/07/2016			
3		**3**		**2**	

8 CCG Patient Discharge dates identified so for in 2016/17

2017
01/09/2017
01/09/2017
01/09/2017
3

3 Patient Discharge dates identified so far for 2017/18

Specialised Commissioning Projected Discharges

The dates may need to be altered as care reviews are undertaken as those indicated in the tables are from the initial reviews where dates were not to exceed a specified date by NHS England. The first section in the tables show the dates from the cohort expected to be discharged by end of March 2016, second section are those admitted after 31st March 2014.

Some of these patients have restrictions in place such as Ministry of Justice, which will have an impact on the options for discharge destinations and the length of stay of the patient.

Many of the discharges do not have a specified place of discharge, 16 not yet known, 4 have a community setting identified, 11 in-patient medium or low secure, 1 in-patient non-secure.

2015/16 Discharges

Q2	Q3			Q4		
Sep/2015	Oct/2015	Nov/2015	Dec/2015	Jan/2016	Feb/2016	Mar/2016
01/09/2015	09/10/2015	30/11/2015	30/12/2015	31/01/2016	01/02/2016	01/03/2016
	31/10/2015	30/11/2015	30/12/2015		28/02/2016	01/03/2016
	31/10/2015	30/11/2015	30/12/2015			30/03/2016
		30/11/2015	30/12/2015			30/03/2016
			31/12/2015			30/03/2016
						31/03/2016
						31/03/2016
						31/03/2016
						31/03/2016
						31/03/2016
Admitted since March 2014						
30/09/2015	11/10/2015	05/11/2015	01/12/2015		19/02/2016	
30/09/2015			01/12/2015			
			31/12/2015			
3	**17**			**14**		

2016/17 Discharges

Q1			Q2		Q3	Q4
Apr/2016	May/2016	Jun/2016	Aug/2016	Sep/2016	Nov/2016	Dec/2016
30/04/2016	30/05/2016	30/06/2016	31/08/2016	30/09/2016		30/12/2016
		30/06/2016	31/08/2016	30/09/2016		
		30/06/2016	31/08/2016			

			31/08/2016			
Admitted since March 2014						
30/04/2016					24/11/2016	
6			**6**		**1**	**2**

9. Delivering the New Model of Care

Achieving safe discharges

Achieving discharges for those individuals currently in LD in-patient services is a complex process, encountering a variety of issues and difficulties. The Lancashire commissioner's network held a workshop to consider the best approach to managing discharges of the current LD in-patient cohorts and identify solutions to overcome the challenges that present.

Cohorts of patients identified fall into the following categories:

- Restrictions by Ministry of Justice
- Court of Protection and Deprivation of Liberty Safeguards (DoLS)
- Enhanced Support Services – Community type care packages delivered in accommodation where the person would choose to live
- Enhanced Support Services - Community type packages delivered where the person would NOT choose to live
- Unknown – as yet no person centred care plans are in place

All Patients need discharge co-ordinators to ensure the discharge process is progressed effectively and to agreed timelines. This role should be responsible for ensuring that all organisations are aware of the plan and that a holistic approach can be taken for all aspects of health and social care. These roles will be linked to the Dedicated Community Nurse and Dedicated Social Worker for each individual. 5 new posts will be recruited to enable these discharges and case manage all patients in in-patient beds.

The co-ordinators should work across all inpatient groups and have a complete understanding of the issues, restrictions and requirements of the identified cohorts in order to ensure robust case management to meet the needs of the individuals and achieve a safe and smooth transition of care delivery.

There must be a uniform process for case management to ensure that there is system wide support to meet the needs of each individual case and that all drivers and progress made is in the best interests of the patient.

Governance arrangements - any issues arising during the discharge process should be entered onto a log, with clear actions taken, and an escalation process should be developed, to ensure they are addressed quickly to minimise any disruption to the discharge timeline:

- Via the contract & performance meetings for Calderstones contract
- Via the LD steering group for other issues

Estates

Currently the care providers are responsible for arranging accommodation, which is undertaken case by case. A more planned and proactive system of management could help prevent some of the issues encountered.

There are currently no links to Housing Associations to enable proactive planning, to ensure demand can meet supply, through a deliberated process.

Issues encountered are:

- Market availability
- Suitability – requirement for alterations & timely completion
- Timescales for funding – Landlords let to other tenants, while approval is being sought.

Mapping of individuals to areas and earlier notification of requirements for accommodation would assist to prevent delays occurring.

Where individuals are currently living in accommodation that is community based, suitable for their needs and where they wish to reside long term, the accommodation should where possible be reclassified for their permanent use.

There should be exploration to consider alternative accommodation options and development of suitable housing solutions. Opportunity for Capital investments and optimising use of current property investments will need to be undertaken and continue to develop to meet demand.

Procurement

Partners have access to CSU and Local Authority support and expertise in legal requirements relating to market exercises. Whilst legal obligations are important to consider there are increasingly innovative procurement devices that can be used to promote more dynamic purchasing. All partners will be progressing with greater joint approaches to the market management and purchasing frameworks.

The Collaborative Commissioning Board have recently agreed the development of a Health and Care Strategy which is setting an overarching shared vision to care delivered in individual packages. This programme of work whilst separate to the Fast track will be linked in as a key interdependency and enabler.

The Community Offer

The aim in Lancashire is to create a truly integrated community service offer for the all age LD population. We need to ensure that there is an integrated approach to specialist support provision, determining packages of support that can be tailored to individual needs.

Community-based support will be delivered via a network of 8 LD centres covering each CCG area (this is the footprint of the existing locality teams and is considered as a starting point option however as the model evolves this will be reviewed so that opportunities for networking of specialisms can be maximised). The hubs will operate as drop-in centres, enabling self- and support-worker referrals. Typically they will be accessible between 12-7pm daily for core services (capacity / demand for extended access e.g. 8am-7pm will be explored during implementation planning).

The centres will all provide the same core service, incorporating duty workers, LD nurses and day services as a standard offer to ensure a consistent approach across Lancashire for the LD population. The service will operate across Lancashire providing a uniform process of case management incorporating, Person Centred Care Planning, Care & Treatment Reviews (CTRs), Blue Light CTRs and an ongoing programme of case reviews to ensure a culture of learning organisations is developed to maximise the impact of transformation. Understanding where system pressures and failures are encountered will allow services to adapt meet local needs.

Other specialist services, operating part-time, on the basis of local demand, will facilitate a flexible approach and enable services to be tailored to individual needs. Duty workers will function as the first point of contact within centres, undertaking initial assessments and directing individuals to appropriate support functions. Support workers must operate as part of the locality team provision, unblocking referral routes to centres (currently a disconnect in some areas)

Social activities must be considered on an individual basis as part of care plans. Capacity building / training required to progress this element, not only for carers but for parents and families too. A web portal either developed or purchased can enable brokerage of social activities there will need to be research into existing models being delivered elsewhere to identify the right solution for Lancashire.

In the long term a holistic view of support is needed but the initial focus will be LD individuals with behavioural issues and prevention of reoffending for those with forensic histories. The new model of care is to be community-based with provision to offer services currently provided as an in-patient such as Enhanced Support Services and Step Down services at Calderstones.

Stratification of individuals by their specific needs / issues must be assessed and regularly reviewed to reduce risk of harm to themselves or others.

In addition to the service offer provided by the hubs community services on a wider footprint will also be provided. These services will link into each of the hubs to provide individualised packages of care such as speech and language therapy, psychology, psychiatry and where mainstream services are not appropriate specialist occupational therapy and physiotherapy.

Personalisation and Personal Budgets

This is at the heart of the Lancashire vision and model – all services will be expected to deliver truly person centred care; supported and empowered to do so, by the league of leaders that will continue to oversee and review the Plan as it is implemented across the system.

Plans that already exist to use Personal Budgets are showing benefits and this Fast track opportunity will provide further impetus to enable progress to be accelerated.

Personal budgets will be embraced not just as a requirement and another device but as a fundamentally accepted part of the control and choice that allows people to get the care they really need – expediting discharges, preventing admissions and readmissions.

The Lancashire Plan includes the deployment of Discharge Facilitators to work with the initial priority cohort in inpatient settings – these facilitators will be encouraged to see personalisation and personal budgets in particular as tools in their toolkits, to work with families and users and their support professionals to design bespoke and tailored care.

Positive Behaviour Support (PBS)

As part of the Fast track planning process a Lancashire representative visited the PBS Service in Knowsley to understand the model employed by them specifically for behavioural support. There is strong evidence of benefits being realised, which offset investment in the service, notably in reductions in behavioural incidents and related admissions / lengths of stay etc.

The Lancashire LD Commissioners Network are keen to develop this feedback further and include this element in the model, further exploration is required particularly with clinicians and social care practitioners to understand how the model could be adapted to a large footprint in Lancashire and how it would be maximised alongside the existing and planned service model elements.

There are proposals in place to implement and pilot this in two CCGs initially, with a view to develop a full business cases for future roll out Lancashire wide.

PBS is recommended as best practice within professional practice documents (Royal College of Psychiatrists, British Psychological Society & Royal College of Speech & Language Therapists, 2007) and in national policy statements. In England, for example, this includes Meeting Needs and Reducing Stress (NHS Protect, 2013) Positive and Proactive Care (Department of Health, 2014), Ensuring Quality Services (Local Government Association and NHS England, 2014) and A Positive and Proactive Workforce (Department of Health, Skills for Health & Skills for Care, 2014), all of which champion the role of PBS in providing effective support to people who challenge.

Crisis Support

Wherever possible individuals should be supported by community crisis response services that work together with individuals and their carers to overcome issues within the home setting to minimise disruption to all involved. A community support in-reach service will be part of the wider support offer across all of the hubs. It should be the first line of offer for those in crisis to prevent disruption to home life as much as possible.

Local Intensive Support Units

The team supporting these units should be the same leadership that provide the wider support to the hub based community services, to ensure a consistent holistic approach to care. The principles and culture of this service should be for home based care whenever possible.

- Crisis Community Care Beds

  At times individuals need a safe place to stay during times of crisis but do not require hospital treatment. This may be at time such as; to cover unexpected illness of carers; for repairs to be carried out to damaged property or when seeking alternative accommodation. These beds do not need to be hospital registered, however will need to be staffed by appropriately skilled staff to support people with challenging behaviour. The length of stay should be as short as possible (a few hours or overnight to 6 weeks).

- Assessment, Treatment & Discharge Beds:

  Development of intensive support to be undertaken to provide assessment, treatment and discharge registered hospital beds. These facilities will be an alternative time limited (maximum 6 months) treatment offer, to current large scale hospital treatment services.

Optimally in order to ensure services are as local as possible, sustainable and financially viable, two 6 bedded units would be proposed for Lancashire with 3 beds for each types of need.

Forensic Outreach Teams

A highly specialised community forensic service (Tier 3) is a pivotal integrator to the future model of care. Forensic Outreach Teams will interface with health and social care services and criminal justice agencies to share specialist forensic skills and knowledge in order to provide appropriate support to individuals who are at risk of, or engage in offending. The main focus of the teams will be to help people to remain in the community, either by preventing admission to inpatient secure services or following their discharge from them.

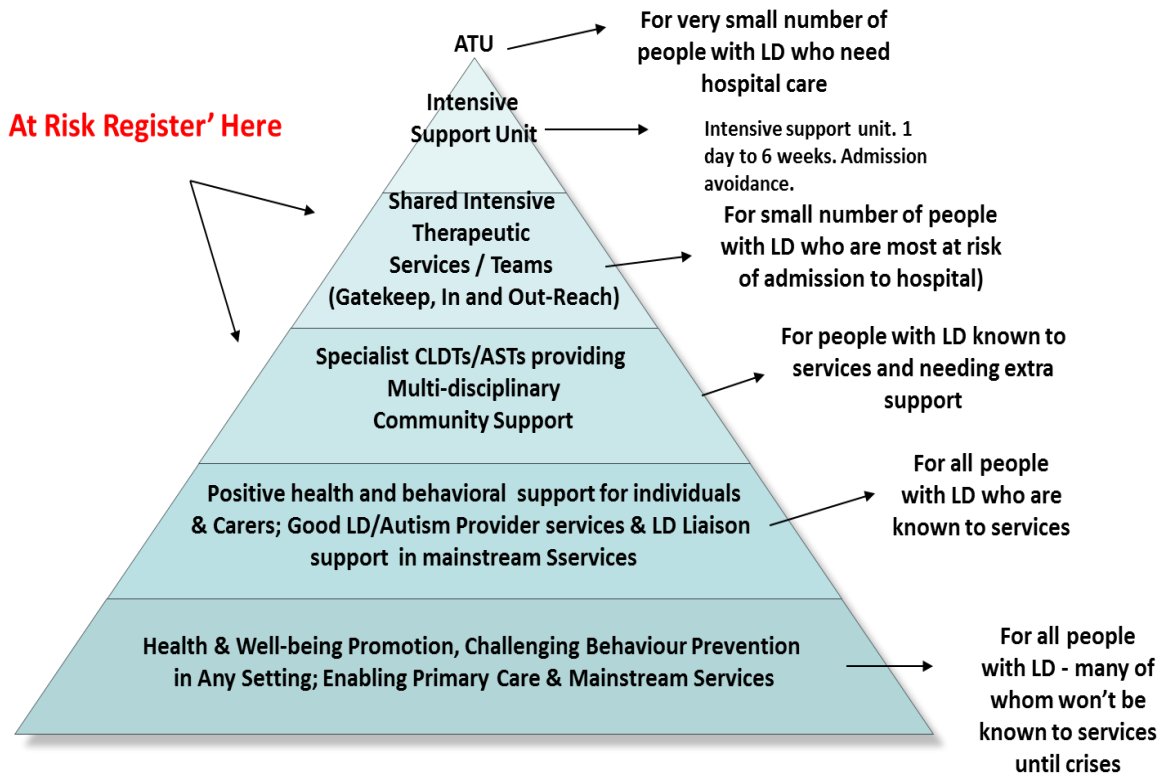
The decision to accept a patient for forensic outreach services will be based on a comprehensive risk assessment, including how the potential risk identified can be managed safely in the community. People accessing the service will be provided with a package of care which is developed with the individual and which:

- is sensitive to their personal needs;
- clearly defines responsibilities for services and individuals who use services;
- Is outcome focussed

The team would be a highly specialist resource working on a regional basis and their offer to local Community Learning Disability Teams and the Criminal Justice System would be clear. The Forensic Outreach Service will form an essential component of the pathway providing clear and continuous lines of sight of people with problems who present significant risk to themselves or others, enabling them to safely avoid admission to, or leave secure inpatient services and move back to the community or an alternative setting, when the time is right.

Enhanced Respite Care

As more of the learning Disability and Autistic population are cared for in community settings enhancement of respite services will need to be mapped to the growing community cohorts to ensure that family and carer support packages do not break down due to burn out.



Specialist Services

Inpatient admissions are required if the risk posed by the behaviour of an individual is of such a degree that it cannot safely be managed in the community. Individuals will require hospital treatment placements in low and medium secure settings and may have restrictions imposed such as from the ministry of justice or court of protection. The length of treatment however should be time limited based on an assessment of the person's needs and risks including the nature of their index offence and forensic history

Supported Living

Some individuals may require further support and may even have lifelong needs. This should be delivered within safe and secure high level supported living accommodation. Individuals should be supported by skilled staff to live in a community location that ensures safety of both the individual and the local community.

10. Workforce

Workforce development

The learning disability workforce needs to have the right skills, capability and capacity to deliver personalised, high quality care and outcomes for people with learning disabilities and their families. This includes the delivery of the ambitious transformation of services as set out in the Fast Track Transformational Plan. A key priority is the development of a comprehensive Workforce Strategy,

identifying needs from both, an at scale cross Lancashire and locality based workforce.

The development of competency based care requires a move beyond education or training targeted only at individual workers, to include a wider whole system remit which develops the capacity for a skills and culturally competent workforce. This training and development approach must then be supported with comprehensive continuous professional development, case management and skills based supervision.

Lancashire recognises the additional challenges of delivering an integrated model of care. Significant barriers can exist, and have proved challenging to overcome. Jacobs (2007) suggests that whilst individual partners such as commissioners, service providers, and educational institutions may have different ultimate goals, the ability to reconcile them is a defining feature of integrated systems based workforce development.

The learning disability sector across the region is in agreement about the need to develop capacity and competence in local services, that workforce development is a priority to support this, and also that expert support is needed to develop excellence at a local level. Workforce development within the Transformation Programme will ensure we have the right people with the right skills and knowledge and behaviours to deliver and commission, high quality personalised care and outcomes.

The two main NHS learning disability providers (Calderstones FT and Lancashire Care FT) have been contacted to understand their current workforce planning assumptions.

Calderstones plans are attached, and provide information on the forecasting of future staffing needs up to 2020. They do not see significant reductions in actual staffing numbers, which may reflect the learning disability skills shortages, in particular qualified nurses, and the challenges of managing recruitment difficulties and current vacancy rates of 20%. This may have a significant impact on the implementation of the integrated new community model, and will see the need to develop new learning disability roles and skills. This will need support at a national and regional level with the transformation of the LD workforce. They also offer their views of the development of specialist community services with particular focus on people with significantly complex needs including forensic support.

Lancashire Care FT, do not have a current LD workforce development strategy.

Both providers are fully engaged and supportive of the requirement to develop the LD Workforce plans for the period 2015 - 2020 in alignment with the proposed new service model for Greater Lancashire.

The transformation journey to the proposed new model will almost certainly involve significant provider restructuring and reconfiguration. The demand for training of staff will be significant and is likely to include national and regional training programmes that need to cover the following areas

- Evidence based health and social care interventions/skills (including PBS)
- Transformational change of focus to be person centred and relinquish control to service users and their families
- Leadership of the LD integrated system including performance management (operational and commissioning)
- Planning, commissioning and monitoring
- Use of new technologies in terms of data bases and use of service datasets to manage and

monitor quality improvement for services and outcomes

The national shortage of skilled LD nurses means that the future workforce will include skills and roles that do not currently exist. There is significant concern the closure of beds in Calderstones will not lead to the transfer of qualified and skilled staff to the community, and this will need to be addressed in the workforce strategy.

Workforce commissioning

Health and social care workforce commissioning will influence and shape the labour market including co-producing commissioning plans that are clear about financial investment and disinvestment, and the skills and competencies of the workforce such as PBS. Developing innovative joint commissioning practice will be required to encourage providers to pool resources, work collaboratively and find creative solutions to learning and competency development. Commissioners are key in articulating the workforce requirements within service specifications, and including metrics and specific funding for workforce development within contracts. These contracts will require robust management to ensure providers deliver a workforce with the right people, with the right skills, knowledge and behaviours to deliver personalised, preventative and safe care. The strategy needs to incorporate both the health and social care workforce implications of the integrated model.

There will need to be the appropriate commissioning capacity and capability in place to deliver the LD transformation plans, opportunities need to be explored to ensure there is sufficient commissioning expert LD capacity and capability to deliver improved outcomes for people with learning disabilities and their families.

Developing the Workforce

The NICE Guidelines Development Group published its recommendations for people with learning disabilities who present challenges in May 2015; Many of the recommendations can be summarised as key elements of the new vision and model of care, these principles will need to be a continuous thread through the workforce strategy

- The continuation of development of evidence and best practice
- Development and maintenance of standards CROMs, PROMs, PREMs (including physical health outcomes)
- Engage in the creation of a comprehensive training curriculum that utilises innovative learning methods including work place coaching and mentoring, effective case management and skills supervision
- A rolling programme of appropriately accredited training and development for stakeholders across the health and social care learning disability field.

The parallel development of leadership programmes will be essential to the success of a skills based training strategy to ensure the system change required to delivery true transformational change.

Learning Disability Staff Development

In order to deliver the new integrated model staff will require additional training in the following areas:

- Upskill to reflect the needs of the new model including clinical, therapeutic and management skills

- New technologies: databases, case management systems
- Developing new understandings of care provided through a person centred culture, handing over choice and control back to the service user and their families
- Positive learning and transparency when things go wrong
- Providing education, advice and awareness raising to a range of community stakeholders including health, social care and communities

Learning Disability Leadership Development

Lancashire will develop leaders who have the skills and capability to lead across the integrated health and social care system with a focus on transforming services to generate better outcomes for people with a learning disability and / or autism.

6. Next Steps

Lancashire recognises there has not been sufficient time to develop a comprehensive Workforce Strategy through the Fast Track Planning process. There is a need to ensure the full involvement and engagement with a range of key stakeholders including people who use services, their carers and families, and providers of care. This will enable us to finalise plans on who should provide care, how care should be provided and what are the skills and competencies of the workforce to deliver a positive experience of care, and improved health wellbeing and quality of life, to people with learning disabilities. Lancashire are committed to delivering an outline workforce strategy by December 2015, and a cross organisational workforce development agreement by April 2016

Timeliness of notification of discharge package requirements does not always enable the required workforce to be put into place for individuals when they need them. The requirements need to be mapped out with the expected discharge dates and an outline of the staffing levels and skill requirements that will meet the needs of the individuals.

All stakeholders need to be fully aware of the issues providers face in order to minimise delays due to staffing.

Training programmes, which should include court of protection, are required to enable the development of staff at the rate the care packages are planned.

11. Implementation

Implementation will require transformation programme management and an implementation group. A project team will need to be established for 12 months in the first instance consisting of:

Role	Band	WTE
Project Manager	8a	1
Project Support	6	1
Administrator	3	1
GP		0.1
Clinical Leadership		0.1 x 2

Finance	7	0.5
Business Intelligence	7	0.2
Communication & Engagement	6	0.1

The work programme will be co-ordinated via the Transforming Care Programme Board who will oversee an implementation group, consisting of stakeholders who will each lead on identified areas of the implementation plan. The SRO will report into the Lancashire Collaborative Commissioning Board.
The programme will include the following deliverables:

Programme Area	Key Deliverables	Oct - Dec 15	Jan - Mar 16	Apr - Jun 16	Jul - Sep 16	Oct - Dec 16
PMO	Mobilise the PMO to oversee the programme including: Project Implementation Risk Management and Mitigation Stakeholder, clinical and patient engagement Development of service specification Recruitment of Discharge Coordinator					
Engagement	Establish a Co design Group to further inform the model					
Engagement	Consultation on the new model of care					
Engagement	Patient Group to lead on Advocacy Development Lancashire wide.					
Service Specific	Market Stimulation and work with providers on innovative potential models of care					
Service Specific	Agree system wide definitions and a service specification for integrated community team including Uniform processes / pathways Service footprints defined Responsibilities H&SC Roles Outcomes Lancs wide standard interventions Hub delivery optimisation Uniform approach to pathways Early identification process Early Intervention service Individual Care Planning Forensic Support Community and Residential					

	Individual Persona Centred Culture Carers Support Footprint						
Service Specific	Implement New Service Specification						
Service Specific	Commission Positive Behavioural Therapy Service as part of Integrated Team (pilot in two CCGs)						
Service Specific	Commission Crisis Bed						
Service Specific	Review residential bed model for the system including respite care						
Discharge Coordinators	Implement discharge coordinators and dedicated social workers to ensure standard approach to CTR						
Workforce	Complete workforce strategy and plan						
Quality Impact Assessment	Complete Quality Impact Assessment on the model						
Outcomes	CQUIN for HEF to be contracted						
Outcomes	Providers to implement HEF						
Outcomes	Work with NHSE on children's HEF						
Training	Training plan- Mainstream training programme around the rights of people with LD including specialist Pharmacy support for: • Primary Care • Acute Targeted training to support mainstream services to make reasonable adjustment.						
Training	Explore targeted training to support people with LD to create their own opportunities to support meaningful and employment.						
Training	Develop mentorship / clinical supervision model for new service						
Finance	Develop Contracting Framework for integrated model, including move to more outcomes based model						
Finance	Agree commitment of available funds						
Finance	Model Financial requirements of new community service offer						

Finance	Explore Pooled Budgets - Implications & Risks					
Finance	Understand the Impact of dowries					
Finance	Baseline Contracts Activity & Values					
Finance	Programme to maximise the use of Personal Budgets in individual planning					
Procurement	Procurement advice on new model and procurement options					
Procurement	Explore cross lancs protocol for placement procurement.					
Procurement	Redeployment opportunities					

12. Health outcomes

Measuring the Impact of our plan

1. The Health Equalities Framework

From 2015/16 the Lancashire Health and Care System will use The Health Equalities Framework (HEF) to assess improvement in care for people with a Learning Disability over a five year period. The HEF is an Outcomes Framework based on the determinants of health inequalities for people with learning disabilities. It is designed to measure the impact of interventions on reducing exposure to the known determinants of health inequalities. It is not an eligibility tool or a needs assessment. It was developed by the consultant nurse group, but can be used by all specialist services for people with learning disabilities.

The HEF uses five-point (Likert) impact scales, alongside Indicators for each determinant in order to profile the impact of each determinant on any given person with learning disabilities. High scores indicate a significant detrimental impact of exposure to the determinants, whilst low scores indicate minimal impact. The central role of learning disability services is seen as tackling the impact of exposure to the determinants of health inequalities, which can be demonstrated through individual and population HEF profiles.

The HEF rates the *consequence* of exposure to determinants of health inequalities for individuals, rather than merely profiling the complexity of a person's needs, specific conditions or presentations. People with learning disabilities are much more likely to have medical conditions, require more hospital care and are more likely to suffer premature death than the general population. Rather than focusing on individual diagnoses, the intention is to ensure that long-term conditions and needs are identified and that individuals are receiving appropriate support. For example, someone with complex epilepsy or severe challenging behaviour receiving a good level of care and support in appropriate accommodation may score lower than someone else with a less complex presentation whose needs are being less well met. It is also feasible for an individual's health to deteriorate but for outcome scores to improve (as a result of being in receipt of good quality palliative care, for example). The approach aims to quantify the success of interventions in reducing the impact of these known determinants and therefore demonstrate reduced probability of exposure to health

inequalities.

An electronic template (eHEF) has been designed to enable a team to record this information easily, and enable data to be aggregated to monitor health equality impact and for commissioning purposes. Lancashire will use the HEF to demonstrate improvement across a 5 year period.

The HEF is currently adults only and the Lancashire Health and Care System will work with NHS England to review suitable tools which will allow us to assess improvement in care for people with a Learning Disability over a five year period

For 2016/17 we intend to offer a CQUIN to all NHS providers to implement and embed the HEF. We will also explore opportunities to apply to non NHS contracts including the Private Sector and Residential Care.

Further information is available at
http://www.ndti.org.uk/uploads/files/The_Health_Equality_Framework.pdf

2. Activity Outcomes

The Lancashire Health and Care System will also deliver improvement in the number of in-patient bed days – the 5 year trajectory is a 70% reduction.

3. Annual Health Checks

From 2009 PCTs were required to fund GP practices to carry out annual health checks for adults with learning disabilities through a direct enhanced service (DES). The health check includes an assessment of physical and mental health; health promotion; review of chronic illness; a physical examination; review of epilepsy; review of behavior and mental health; a syndrome specific check; review of prescribed medications; a review of co-ordination arrangements with secondary care; and a review of transition arrangements where appropriate. Currently the Lancashire CCGs are not achieving the planned target and therefore this has been identified as a priority area within this plan.

Outcome	Metric	Timescale	Baseline performance	
Achieve 80% of people with a learning disability of GP DES Register having an annual health check	80% of people with a learning disability will have an annual health check	Mar-17	13/14 Lancashire Practice participation	13/14 Lancashire Health Check coverage
			66.80%	43.60%

4. Clinical Outcomes

Numbers of LD individuals with access to a full range of community services will be identified from personalised care plans. Year on year improvement in the number of care plans identifying community service access is in place.

13. Finance

Total Current Spend

CCG & 2 Unitary

Services	Notes	Totals	
		2014-15	2015-16
Inpatient Services			
ESS Contract - Calderstones	Indicative only for 15-16 - based on information as at 26-08-15	**3,328,354**	**3,721,579**
DaisyBank - Calderstones	Lancs North CCG contract	**1,527,539**	**1,503,158**
Mental Health Contracts			
LCFT	LD Psychology	**638,010**	**749,696**
LCFT	Learning Disabilities		
Community Contracts			
LCFT Community Contract	LDS Admin		**9,473**
LCFT Community Contract	Children's Learning Disability	**545,424**	**1,465,131**
LCFT Community Contract	Learning Disabilities	**2,523,111**	**8,214,098**
LCC		**202,464**	**213,528**
ELHT Community Contract		**21,367**	**21,367**
Blackpool Borough Council		**1,544,261**	**1,519,553**
IPA Team - Personal Health Budgets etc.			
CPOC <65 LD		**1,606,101**	**1,684,479**
LD <65		**1,008,076**	**1,268,507**
LD >65	This information is taken from the IPA teams month end finance report.	**218,274**	**235,607**
CPOC <65 LD		**126,283**	**126,629**
LD Pool			
CCG Contribution	MOA - Budget Setting	**8,511,177**	**8,582,949**

LCC Contribution	MOA - Budget Setting	**87,336,843**	**87,336,843**
LDDF Contribution	MOA - Budget Setting	**58,497**	**58,497**
Other LD Spend		**124,841,270**	**125,376,908**
Total		**234,037,050**	**242,088,003**

Lancashire County Council	**2014-15**	**2015-16**
-Residential	15,250,000	12,280,000
-Nursing	490,000	500,000
-Shared Lives	218,000	174,000
-Dom Care	21,490,000	22,880,000
-Day care	2,420,000	3,790,000
-DP/SDS	41,800,000	43,202,000
-Service User Income	-5,880,000	-6,300,000
-In House Dom care	14,480,000	14,480,000
-In House Respite	3,009,000	3,009,000
-In house Day	8,340,000	8,340,000
-Psychology/Psychotherapy	630,000	630,000
-Historic Supported Living Housing based support top-up commitments	8,500,000	8,500,000
-Advocacy	163,000	163,000
-Gtr Preston CCG Health Comm Service	481,000	481,000
-W Lancs CCG Health Community	277,000	277,000
-C & SR CCG Health Community	699,000	699,000
-LDDF	101,000	0
-Balshaw Block	226,000	226,000
-Care UK/C Support blocks	463,000	463,000
-Transport	2,390,000	2,390,000

-Assessment & Care Management and other Staff costs	5,770,000	5,770,000
LCFT Community Contract		
-Gtr Preston LCFT Social Care	2,278,605	2,278,605
-W Lancs LCFT Social care	1,144,303	1,144,303
	124,739,908	**125,376,908**

Care Package Costs

The cost of care packages for LD individuals managed in the community setting varies greatly and there is a combination of arrangements for the packages currently delivered.

Average costs are:

100% Social Care funded	Joint Funded	100% Health Funded
£70k	£110k	£155k

An average cost for planning assumption purposes has been set at £125k per patient irrespective of the funding source of the care package. Many of the patients currently in hospital settings are complex, long term patients therefore this average has been weighted slightly to a higher value.

Fast Track Bid and Match Funding

The table below demonstrates the required Fast Track funding and the matched funding arrangements agreed by pan Lancashire organisations.

Plan	Fast Track Funding 15/16 £000's	Match Funding 15/16 £000's	Match Funding 16/17 £000's
New Care Packages	680	0	875
Discharge Co-ordinators	150	0	150
Social Worker Support	60	0	120
Notional Capital Costs	200	0	0
PMO	111	0	111
Training & Engagement	180	0	0

PBS pilot in 2 areas	150	0	300
	1531	0	1556

Estimated Cost of New Community Care Packages

The profile of 15/16 discharges delivers a total of 68 months of new community placement costs whilst maintaining an inpatient block contract up to the end of March 2016. At the £125k per annum cost this equates to £680k of new care package costs. The 16/17 costs for these packages up to September 16, when the inpatient block arrangement ceases will be £875k incurred locally (with a further £875k incurred for the following 6 months but without an inpatient block contract).

Discharge Co-ordinators

In order to ensure the discharge process is as effective as possible maximised discharge co-ordinators to be appointed for 12 months. This will facilitate a uniform discharge planning process that commences on admission.

Role	Band	WTE	Cost £
Discharge Co-ordinators	8a	5	293,670

Average caseload 20 individuals to manage.

Social Worker Support / Capital Costs

Additional Specialist support in respect of discharge from Social Care has been agreed for an 18 month period to ensure that all aspects of discharge are facilitated without delay. With this in mind there is a notional request for a £200k provision for potential capital resource to be made available in the event that one or more community placements require reasonable building adjustments.

Implementation Project Management Office (PMO)

The proposal is for 12 months in the first instance and will be responsible for developing the work programmes required to progress the implementation of the plan. Whilst discharging the individuals who have been in-patients for a considerable length of time is an initial phase of the plan, without a whole system culture change and service offer transformation the effects will not be maintained.

The proposed PMO support is:

Role	Band	WTE	Cost £

Project Manager	8b	1	70,917
Project Support	6	1	43,489
Administrator	3	1	25,122
GP		0.1	15,000
Acute Specialist LD/MH Clinician x2		0.1	30,000
Finance	7	0.5	25,143
Business Intelligence	7	0.2	10,057
Communication & Engagement	6	0.1	4,349
			224,017

Training opportunities

A mainstream training programme to be implemented over the next 6 months around the rights of people with LD and the new model of care to be delivered across:

- Primary Care
- Acute Care
- Social Care
- Pharmacy Provision

There will be targeted training to support mainstream services to embedding 'reasonable adjustment' into working practice.

Communication & Engagement

A programme of communication and engagement is to be devised to ensure appropriate stakeholder involvement and consultation is achieved, alongside a wider approach to supporting a better community and social awareness of LD.

Positive Behaviour Support

The cost of developing a PBS service has been completed for the pilot project and extrapolated for a pan Lancashire service is expected to be in the region of £1.2 million, however for the purposes of Fast-Track a pilot approach across two CCG areas is agreed, with Matched funding supported by the respective CCG Governance arrangements. The 12 month cost for the pilot is constructed as follows

Role	Band	WTE	Cost £
Integration and Partnership Co-ordinators	6	3	130,467

Behaviour Support Nurses	5	3	105,420
Positive Behaviour Support Staff	3	6	150,732
Administrative Support	3	2	50,244
Non-Pay			13,000
			449,863

It is expected that the pilot will commence in December and run for a 12 month period. On-going evaluation will ensure appropriate recruitment can be facilitated for a wider roll-out of the pilots

Cost of New Service Model

Full costs have not yet been calculated as a main contributory factor will be workforce. Since there is a plan to work with providers to establish how current services can be aligned and reshaped to fit the new model, it is not possible to understand the full costs of transition from the current service to the new.

Development of the hubs and Lancashire wide support services will require full work up to determine the optimum number and geographical locations, based on population and access. Full business cases will need to be developed and approved by relevant governing bodies.

Intensive Support Service

The development of Crisis support services will need an options appraisal to determine the optimum method of delivery. This may be a process best procured in collaboration with neighbouring areas. 6 Crisis beds are projected to cost in the region of £200k per CCG at an annual cost of £1.6m. It is not expected that these beds can be facilitated within the timeframe of the existing bid proposal.

Activity Reductions

Specialised Commissioning Cohorts

A planned reduction of 25% in Medium Secure and 50% Low Secure with some added provision of short term assessment beds**.** Current expectation and trajectories indicate that Specialised Commissioned patients should be managed within the bed capacity identified and not project into CCG in-patient episodes in the future.

CCG In-patient figures

The new model of care will change the current long-term placements of in-patient care with community care packages. The expectation is for future in-patient care to be short term assessment, treatment and discharge, which has the ability to react to individual requirements via earlier intervention programmes.

Current in-patient services are in the main commissioned on block contract and not per bed. Activity assumptions however reflect that each individual is currently occupying a bed, so the trajectory to 14 beds (representing 1 bed per 100,000 population) is set out below in terms of bed requirements, allowing for the inclusion of a reducing but significant number of new individual admissions (not readmissions) to the system during the period.

The table below identifies the planned changes to achieve the 70% overall reduction from the current in-patient number.

CCG In-Patients	March 15 Baseline	August In-Patient No.	Planned Discharges	Full Year Admission Projections	Year End Projection	% In year Reduction
2015/16	47	39	17	12	34	28
	Discharges					
	March 16 Baseline	Projected Admission	Planned	Escalated	Year End Projection	% In year Reduction
2016/17	34	10	4	12	28	18
	March 17 Baseline	Projected Admissions		Discharges	Year End Projection	% In year Reduction
2017/18	28	8		12	24	14
	March 18 Baseline	Projected Admissions		Discharges	Year End Projection	% In year Reduction
2018/19	24	6		12	18	25
	March 19 Baseline	Projected Admissions		Discharges	Year End Projection	% In year Reduction
2019/20	18	6		10	14	22

The projected admissions number is the annual bed impact rather than number of individual admissions.

14. Risks

Programme Management

A programme management risk log has been maintained and is attached at Appendix XX. The main risks of the model however are captured below, with the current mitigations and residual risk score attributed to them. These form the basis of major discussions at Steering Group Meetings

Risk	Impact (1-5)	Likelihood (1-5)	Overall Risk	Mitigations	Mitigated Risk Score	Comments
There is a risk that we will be unable to recruit appropriately to offer Positive Behavioural Support Interventions, and this may inhibit step down into or maintenance of community placements	4	4	16	Develop a programme to 'grow our own' staff, working locally with HEE. Pilot PBT across CCGs to evidence workforce and outcome delivery	12	Pilots agreed in 2 CCG areas
The system may not support new entrants to any market development, and staff	4	4	16	Develop a framework with providers to support new entrants	9	

transferability may impact on new placements and discharge				Develop training opportunities for providers and staffing cohorts		
CCGs may not be able to afford new packages of care in the current financial climate, leading to delays in discharge where risk shares are supporting differential funding	4	4	16	Collate evidence base of costings and opportunities for savings, facilitate invest to save programmes pan Lancashire Provide evaluation criteria for prioritisation decisions which reflect Winterbourne and Bubb Report	12	

The above risks represent those whose initial ratings are highest. Mitigations and mitigated risk levels are to be monitored via the Steering Group.