Joint transformation planning template

Introduction

- **Purpose**

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

- **Aims of the plan**

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

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

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

- **National principles**

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

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

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

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

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

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

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

Summary of the planning template

The Bedfordshire, Luton & Milton Keynes Transforming Care Partnership:

Plan for transforming the care of children and adults with a learning disability and/or autism who display challenging behaviour

Executive Summary

> Quote from service user following repatriation after a 2-year period in hospital out of area
>
> "I have a lot more freedom here, as now I have left hospital I'm doing a lot of things myself, and I don't need a lot of help from anybody really"
>
> "In the past I needed a lot of support, I'm pretty independent now"

The vision of this partnership is that we will work with service users, their families and carers and other stakeholders to deliver a plan that

- reduces the numbers of in-patient admissions required for people with a learning disability and/or autism
- manages effective discharge and transition for people in hospital
- builds resilient community services to support people to live as independently as possible in the most appropriate community setting.

1. Introduction

The 2012 investigation into criminal abuse at Winterbourne View Hospital initiated a national response known as "Transforming Care" to transform services for people with learning disabilities and/or autism who have mental health conditions or behaviours that are challenging. This national model of care aims to

- change services for people with a learning disability and autism away from institutional models of care
- close some inpatient provision
- strengthen the support available to individuals in their local areas.

To achieve this systemic change, 49 transforming care partnerships (commissioning collaborations of CCGs, NHS England's specialised commissioners and local authorities) are mobilising now. They will work with people who have lived experience of these services, their families and carers, as well as key stakeholders to agree robust implementation plans by April 2016 and then deliver on them over three years.

Throughout this summary and the attached plan, the term 'people' will refer to children and adults with learning disability and/or autism and challenging behaviours, including those with a mental health condition.

2. Context

2.1 National

Following the publication of the Department of Health's report 'Transforming Care: A national response to Winterbourne View Hospital' in December 2012, a significant amount of work has been undertaken to make improvements in the care and services available for children and adults with learning disabilities and/or autism spectrum disorders.

However, subsequent reports including 'Transforming Care for People with Learning Disabilities – Next Steps' in January 2015 recognised more needs to be done. Simon Stevens, Chief Executive of NHS England, identified in June 2015: "We need a closure programme for long stay institutions, with more power in the hands of families."

Further national policy documents, 'Supporting People with a Learning Disability and/or autism who display behaviour that challenges, including those with a mental health condition' Oct 2015 and the national plan 'Building the Right Support' Oct 2015, set out expectations to transform care.

Transforming Care relates to the transformation of services for people with a learning disability and/or autism and challenging behaviours, including those with a mental health condition. The programme of work is designed to strengthen community services, reduce reliance on in-patient beds (non-secure, low and medium secure) and close some in-patient facilities.

NHS England (NHSE) has asked Local Authorities, Clinical Commissioning Groups (CCGs) and NHSE specialised commissioners to come together to form Transforming Care Partnerships (TCPs) to build up community services and close unnecessary inpatient provisions over the next 3 years and by March 2019. TCPs should allow for areas to commission at sufficient scale to manage risk, develop commissioning expertise and commission strategically for the relatively small number of individuals whose packages of care can be very expensive.

2.2 Local

The Bedfordshire, Luton and Milton Keynes (BLMK) Transforming Care Partnership (TCP) is a newly formed arrangement set up to transform care for people with a learning disability and/or autism across Bedfordshire, Luton and Milton Keynes. It covers four local authorities and three Clinical Commissioning Groups (CCG) in central eastern England.

Two of the local authorities in the partnership area have coterminous CCGs' (Luton and Milton Keynes). Bedford Borough and Central Bedfordshire are served by Bedfordshire CCG.

In line with NHSE requirements BLMK TCP has been required to produce a joint transformation plan for the next three years (this document.) On the 22nd March NHSE awarded this plan the status of "met" and the BLMK TCP has worked on final enhancements in preparation for the final submission on the 11th April prior to formal approval and sign off through partners' governance arrangements. Work is now beginning on mobilisation of the plan.

Across the partnership all three CCG areas have patients placed in secure inpatient settings that are either funded by the CCGs or via specialist commissioning, funded via NHS

England. In addition, there are a range of independent, voluntary and statutory sector providers that provide community support, supported living, residential care and education to people with a learning disability and /or autism. Much of this care and support is spot purchased or provided through small block contacts by the individual CCG's and councils across the partnership area and more widely across the country when need cannot be met locally.

The numbers of in-patients across this partnership are relatively low compared to other areas in eastern and central England. At the end of January 2016 there were 32 people in an in-patient environment (this includes those funded by the CCGs and by specialised commissioning)

Across the area there is a strong commitment to improve health and wellbeing outcomes for people with a learning disability and/or autism. This Transforming Care Partnership is aligned to the developing Sustainability and Transformation Planning footprint for Bedfordshire, Luton and Milton Keynes; reflecting the strategic goals of all partner organisations. The aims and approach of this plan through the Transforming Care Partnership will also be incorporated into the Sustainability and Transformation Plan as it emerges in June 2016.

3. The Solution

The guidance documents from NHSE set out the expectations of the Transforming Care programme. These expectations include the implementation of a national service model.

The proposed BLMK solution has been articulated in the attached submission, the key elements of which are based on the national service model principles of

- reducing the numbers of in-patient admissions required for people with a learning disability and/or autism
- managing effective discharge and transition for people in hospital
- building resilient community services to support people to live as independently as possible in the most appropriate community setting.

In reducing the inpatient capacity there will need to be an increase in community provision that provides person centred support and services to people and their carers that achieve

- improved quality of life
- services that support people to take positive risks whilst ensuring that they are protected from potential harm
- choice and control - working with people in their decisions about their health and care services decision must be made in their best interests involving them as much as possible and those who know them well
- support and interventions provided in the least restrictive manner
- equitable outcomes, comparable with the general population, by addressing the determinants of health inequalities outlined in the Health Equalities Framework.

The cohort of people affected by the implementation of the service model will include

- those currently living in the community, supporting them to lead independent lives including crisis prevention and management
- those currently in in-patient and residential placements out of area who are able to be successfully transitioned back to the community.

The plans include the development and/or strengthening of service provision in the areas of

- Healthcare
- Social Care
- Preventative Services
- Advocacy
- Carer support
- Universal welfare
- Education and training

4. Conclusion and recommendations

The partnership has developed an ambitious three-year transformation plan which aims to further progress the personalisation agenda providing local people with a learning disability and / or autism with high quality individualised support in the community and enable to them to live ordinary lives and meet their full potential. The Partnership will develop the care market, build on existing good practice, continue to advance preventative support and build sustainable person centred solutions. It will also ensure that individuals have access to effective clinical support at time of crisis and acute mental ill health.

The partnership expects to move towards a seamless “all age” pathway that provides local solutions for people that not only reduce the reliance on inpatient care but enable people to live and receive support closer to home. The Transforming Care Board will carefully monitor and review the progress of the plan to ensure that the partnership is making progress and delivering successful health and wellbeing outcomes for the individuals covered in the plan

Bedfordshire, Luton and Milton Keynes Planning template

1. Mobilise communities

Governance and stakeholder arrangements

Describe the health and care economy covered by the plan

Background

In 2012, following an investigation into criminal abuse at Winterbourne View Hospital, the Department of Health initiated a national response known as “Transforming Care” to transform services for people with learning disabilities and/or autism who have mental health conditions or behaviours that are challenging. Transforming care aims to change services for people with a learning disability and autism away from institutional models of care, closing some inpatient provision and strengthening the support available to individuals in their local areas.

The Bedfordshire, Luton and Milton Keynes (BLMK) Transforming Care Partnership

The BLMK Transforming Care Partnership (TCP) is a newly formed arrangement set up to transform care for people with a learning disability and/or autism across Bedfordshire, Luton and Milton Keynes. It covers four unitary local authorities and three Clinical Commissioning Groups (CCG) in central eastern England.

Chart 1.01 Map showing Bedfordshire, Luton and Milton Keynes CCG Boundaries – area covered by the Bedfordshire, Luton and Milton Keynes (BLMK) Transforming Care Partnership. Source: https://www.england.nhs.uk/resources/ccg-maps/

Two of the local authorities in the partnership area have coterminous CCGs' (Luton and Milton Keynes). Bedford Borough and Central Bedfordshire are served by Bedfordshire CCG.

Bedfordshire and Luton CCGs contract with East London Foundation Trust (ELFT) for learning disability and mental health services. Specialist Learning Disability Community Services (SPLD) are shared across Bedfordshire and Luton (including learning disability inpatient beds). Milton Keynes CCG commissions Central North West London Foundation Trust (CNWL) to provide Mental Health and Learning Disability Services. There is no collaborative commissioning between Milton Keynes CCG, Bedfordshire and Luton CCGs at the present time. The TCP is a newly formed partnership between the four Local Authority areas, predicated on this new arrangement, relationships between the different organisations and directorates will need to be formed and built upon particularly at this initial planning phase. The importance of getting this right from the start has been identified and described throughout the plan.

Table 1.01 Local Authority, CCG and Key Mental Health and Learning Disability Providers across the BLMK TCP Area.

CCG	Local Authority	Mental Health and Learning Disability Provider
Bedfordshire	Bedford Borough	East London Foundation Trust (ELFT)
	Central Bedfordshire	
Luton	Luton Borough	
Milton Keynes	Milton Keynes	Central North West London Foundation Trust (CNWL)

All three CCG areas have patients placed in secure inpatient settings commissioned though specialist commissioning and funded via NHS England. In addition, there are a range of independent, voluntary and statutory sector providers that provide community support, supported living, residential care and education to people with a learning disability and /or autism. There are also a small number of placements in independent hospitals. Much of this care and support is spot purchased or provided through small block contacts by the individual CCG's across the partnership area and more widely across the country when need cannot be met locally.

Partners work with many independent and voluntary sector providers often on a spot purchase basis and some of these are: Turning Point, Care Services (MK) CIC, MacIntyre, Dimensions, Philori Care, Consensus Support and Social Care Solutions (provide residential care and community support); POWHER and Talkback provides advocacy and engagement support.

Healthwatch is the independent consumer champion for local health and social care services – public engagement – including children and young people. Members from Healthwatch sit on local partnership boards, health and wellbeing boards and programme boards.

Across the area there is a strong commitment to improve health and wellbeing outcomes for people with a learning disability and/or autism. This Transforming Care Partnership is aligned to the developing Sustainability and Transformation Planning footprint for Bedfordshire, Luton and Milton Keynes; reflecting the strategic goals of all partner organisations. The aims and approach of this plan through the Transforming Care Partnership will also be incorporated into the Sustainability and Transformation Plan as it emerges in June 2016.

Describe governance arrangements for this transformation programme

The work of the BLMK Transforming Care Partnership is overseen and governed by a Programme Board. A robust governance structure is being implemented; this is overseeing the development of the plan and will oversee its delivery.

As mentioned earlier the partnership encompasses three CCGs and four unitary local authorities all of which are represented on the programme board in addition to other partners and stakeholders.

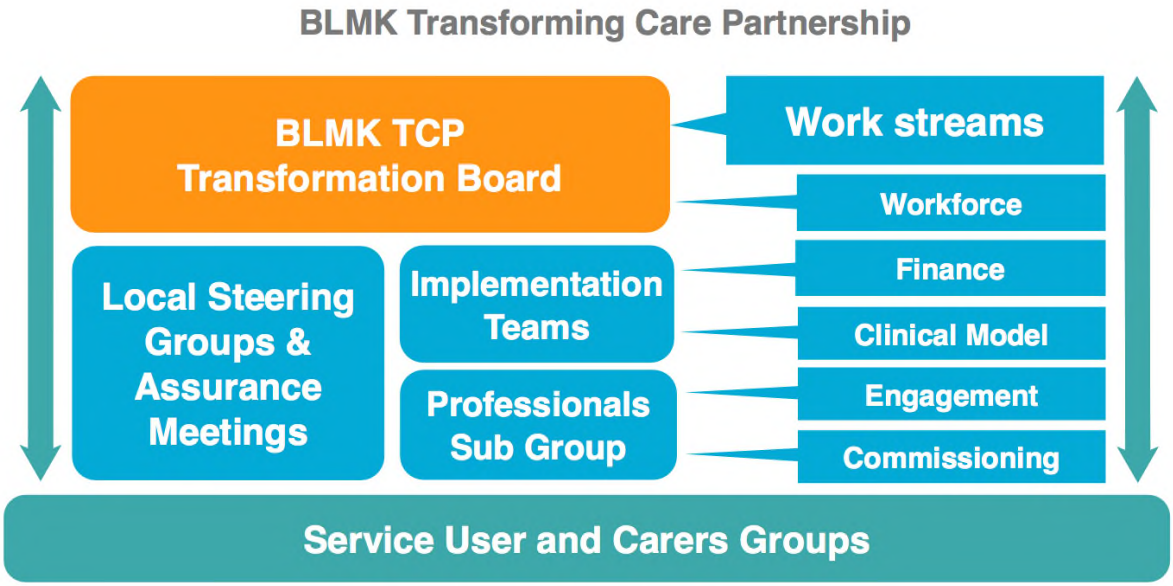
The current membership of the programme board is set out below and the terms of reference are included in the appendices to this plan. Further information about the names of the members of the Professionals subgroup and the service users and carers' groups can be made available.

Table 1.02 Transforming Care Partnership Board Membership

Organisation/Role	**Person and Job Title**
Luton CCG and **Senior Responsible Officer (SRO)**	David Foord (Director of Quality and Clinical Governance), Liz Cox (Deputy Chief Financial Officer)
Bedfordshire CCG	Anne Murray (Director of Nursing and Quality) Kaysie Conroy (Head of Mental Health and Learning Disability)
Milton Keynes CCG	Jill Wilkinson (Director of Nursing and Quality) David Pennington (Safeguarding Adults; Mental Health and Learning Disability Lead) Andrew Law (Senior Finance Manager)
Luton Borough Council	Pam Garraway (Director of Adult Social Care) Maud O'Leary (Service Director Adult Social Care) Bridget Moffat (Joint Commissioner Manager leading on Learning Disabilities) Vacant post (Learning Disabilities and Autism Service Manager) Lisa Levy (Communications Manager)
Milton Keynes Council	Michael Bracey (Corporate Director People) Mary Clifton (Director of Adult Social Care) Robin Goold (Joint Commissioner Milton Keynes CCG & Council) Amanda Griffiths (Head of Joint Learning Disability Services)
Bedford Borough Council and **Deputy SRO**	Kevin Crompton (Director of Children and Adult Services) Kate Walker (Assistant Director Adult Social Care)
Central Bedfordshire Council	Julie Ogley (Director of Adult Social Care) Stuart Mitchelmore (Assistant Director of Social Care) Nikki Kynoch (Head of Integrated Services Adult Social Care)
NHS England	Charmaine Cleaver (Specialised Commissioning East of England Transforming Care Lead) Transforming Care Lead Midland and East partnership NHS England Nerea Uriarte (Transforming Care Case Manager Regional Specialised Commissioning NHS England – Midlands and East (East of England)) Jenny Butler (Transforming Care Lead)

A graphical representation of the programme structure is shown in chart 1.02 below.

Chart 1.02 Bedfordshire, Luton and Milton Keynes Transforming Care Partnership Programme Structure



This programme will report into the BLMK TCP Transformation Board which in turn reports into the Joint Commissioning Boards, Change Programme Boards, Patient Safety and Quality Committee's and the Health and Wellbeing Boards for each area. Additionally, there will be highlight reporting to the Transforming Care programme team for NHS England. This will initially be on a monthly basis. The programme sits within the overall governance structure as illustrated in chart 1.03 below.

The sign off time frames for the plan are as detailed in table 1.03 below.

Table 1.03 Sign off time table for the Bedfordshire, Luton and Milton Keynes Transforming Care Partnership plan

Governing Body/Group	When	Comment	RAG for 30/06/2016
Bedford Health & Wellbeing Board	15/06/2016	On agenda.	ON TARGET
Central Bedfordshire Health & Wellbeing Board	By 30/06/2016	Virtual sign off by board in advance of next meeting 27/07/2016.	ON TARGET
Luton Health & Wellbeing Board	07/06/2016	On agenda. Date of board is provisional, but expected to go ahead.	ON TARGET
Milton Keynes Health & Wellbeing Board	09/03/2016	Sign off delegated to the chair of the H&WB Board. Signed off by Cllr Peter Marler, Leader Milton Keynes Council. COMPLETED.	COMPLETE

Note: RAG = Red/Amber/Green rating. Green on target or complete. Amber at risk of being

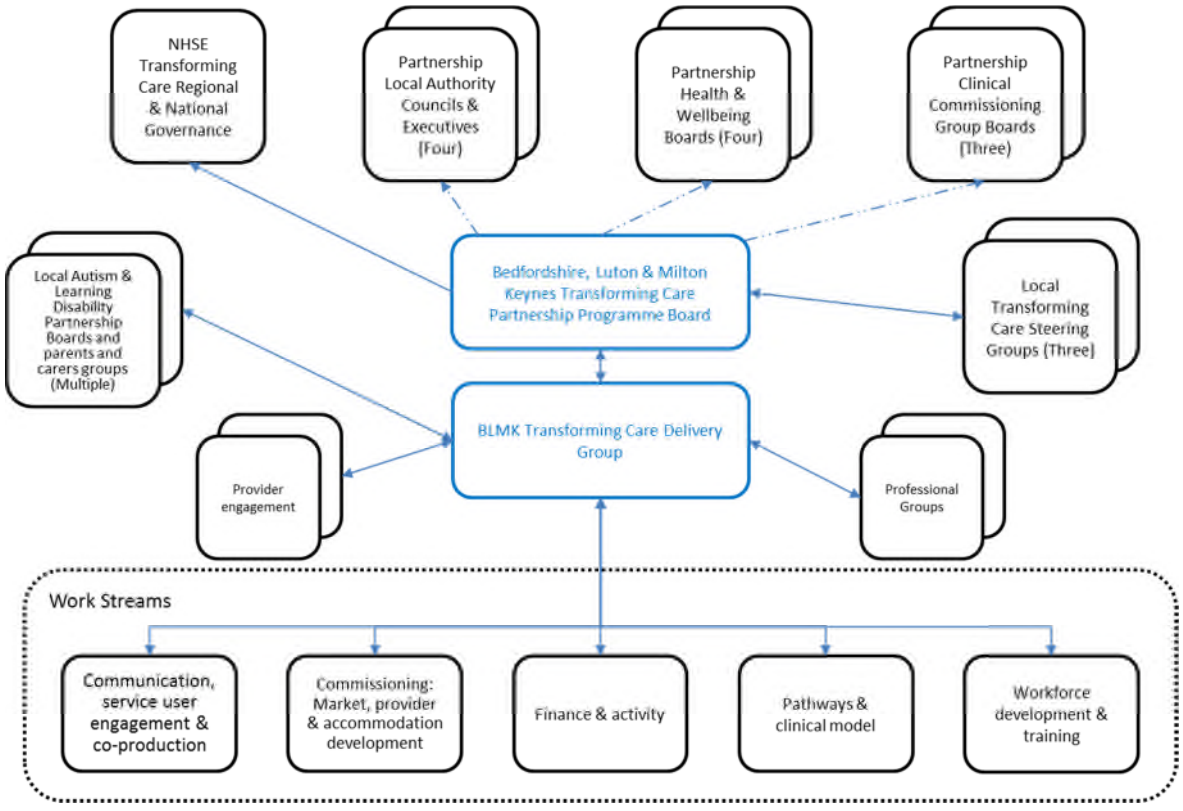
missed. Red will be missed.

Luton CCG is the lead authority for the Transforming Care Partnership. Our Senior Responsible Officer (SRO) is David Foord (Director of Quality and Clinical Governance, Luton CCG. Our deputy SRO is Kevin Crompton (director of Children and Adult Services Bedford Borough).

Additional assignments include:

- Programme Manager (reporting into the board) – Andrée Mitchell (Interim).
- Finance Lead – Liz Cox (Deputy Head of Finance, Luton CCG)
- Communications Lead – Lisa Levy (Communications Manager, Luton Borough Council)

Chart 1.03 Bedfordshire, Luton and Milton Keynes Transforming Care Partnership Board Governance Structure



Describe stakeholder engagement arrangements

The TCP programme board held its first meeting on 20th January 2016 and is now meeting monthly having published meeting dates for the following six months.

The implementation team, which comprises local commissioners, has been instrumental in putting together the BLMK Transforming Care draft plan. It has based the key principles and proposed model of service on relevant consultation with stakeholders, review and analysis of national and local strategy and an evaluation of current provision, unmet need, and the

current market.

Note: When any data or description is referred to as "current" throughout this draft plan this relates to the situation as of 11th April 2016.

The partnership has been, and continues to consult fully on this plan involving all relevant stakeholders that include:

- Service users of all ages, families and carers
- Providers
- Health care professionals
- Police
- NHS England Team for Learning Disabilities (including Court Liaison and Diversion)

There is agreement in principle for a provider to support coproduction and consultation and this element is further described in the bid within this plan. In addition to this the partnership is utilising provider representation provided through the NHS-England Transforming Care programme. The NHS Service users and carers will be supported to work with the TCP in relation to the development of the transformation plans going forward.

The local Learning Disability and Autism Partnership Boards within each of the Local Authority areas will contribute to the local Transforming Care plans and the draft plans have already been discussed at a number of board meetings.

The TCP has identified patients with a lived experience of transforming care and has started working with them on how best to engage them in this process in a meaningful patient centred way. We have been using our community services and voluntary sector self-advocacy experts to assist us with this.

- Talkback is a user-led engagement and self-advocacy group which works with the partnership and has been asked to work with us to support people with learning disabilities and/or autism and their carers to be involved in the Transforming care Partnership; to ensure that the authentic voices of people with those conditions and their carers are heard at every stage of planning and implementation.

- Service users are engaged within their own locality partnership boards where the plans are being discussed on an ongoing basis, for example transforming care has been raised in the Autism MK Partnership board in January and is agenda for the 18th April, and has been discussed at the last three monthly learning disability partnership boards.

- Joe has a lived experience of being in hospital and being supported to return to the community. Joe attends the steering group in Milton Keynes as an expert by experience. The BLMK wide plan has been shared with Joe and he has been able to contribute to discussions through his lived experiences. He will continue to attend the meetings in the immediate future as well as being supported with one to one discussions with commissioners across the partnership where appropriate. Joe has raised a number of issues and two particular issues, which are of importance to him:
    - How do we effectively share the information about the plans across the partnership area?
        - *We will develop a communications strategy and plan for the programme which will detail the ways in which we will:*
            - *Share information with our service users through a number of engagement events. These will be ongoing across the three years of*

the programme
    - *Consult with the people who use services and work together with them from the start to the end of the programme*
- How do we ensure providers involve service users in the recruitment of staff?
    - *Commissioners will specify this as a requirement in the revised specifications for our community providers*

- In June 2015 a provider awareness and engagement event was held across by the partnership. This was to give an overview of the transforming care needs in the area. This event was well attended by care and housing providers and has generated a lot of interest across the care market.

- Commissioners within the partnership area are actively engaged in informal discussions with current and potential providers. This includes providers with a particular interest in the area of transition from children to adulthood; including the provision of intensive supported living services.

One of the identified work-streams in the diagram in the section above is engagement and managing and delivering the right stakeholder engagement will be a critical success factor in achieving the agreed ambitions of the partnership. This engagement will deliver both the right voice and influence for service users and their families / carers; and will also deliver the right processes and channels for professionals and providers within the broadest system to provide their own views as well as receive feedback and guidance about what is being changed, what it means for them and how changed processes and system behaviours will be supported and reported.

The following provides a snapshot overview of the progress to date:

- All three of the CCGs have been briefed and approved the draft project plans through their Clinical Executives

- Plans are in place to fully brief the Health and Wellbeing Boards on the final plan following submission on 11th April 2016. And this process is ongoing with Milton Keynes Health and Wellbeing Board giving its full support to the plan 9th March 2016.

- Briefings have been completed with the lead members in all four local authorities.

The TCP partnership engaged with the 'National Development Team for inclusion' (NDTi) to provide support on a number of key areas including how we can improve our engagement across the partnership. This workshop took place on 23rd March 2016 and its outcomes will be incorporated into the communications and engagement work stream moving forward.

POhWER (the local advocacy provider for the partnership providing both statutory and non-statutory issue based advocacy) have been involved in care and treatment reviews and are well sighted on the Transforming Care agenda. They have taken on issue based advocacy case management where service users and family members have required support and will continue to both support people with a learning disability and their carers in this way and also to engage meaningfully with the partnership.

The above areas demonstrate the commitment that the TCP has made to working in partnership and the progress to date; at the same time, the partnership recognises

that the challenges go far beyond this initial engagement. A detailed communications plan is currently being prepared and will be finalised and shared with NHS England when it has been approved by the TCP programme board. As a part of the communications and stakeholder engagement strategy for the programme the partnership will look to stage launch events and also raise the profile of the programme especially at during World Autism Awareness week in April (a press release has recently gone out) and Learning Disability week in June.

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

The Board recognises that to successfully deliver the transformation plan there will be significant changes in the way services are provided and increased partnership working across the BLMK area.

A scope of the current engagement work currently taking place across the TCP footprint will be taken forward in the first year that will include the CAMHS transformation plans.

- Parental engagement activities are continuing. On behalf of the Partnership Milton Keynes are involved in regular engagement meetings with the Parents and Children's Alliance (PACA) to share emerging thinking and plans regarding Transforming Care. We are consulting with PACA on the best way to engage with them regarding these plans and PACA is currently working to identify a service user to specifically work with us on the Transforming Care Programme. In addition, Luton and Bedfordshire are consulting with local charities and groups that are in touch with children, young people and family carers (e.g. the FLAG group and specific services run by Autism Bedfordshire). This will ensure we are engaging with parents and carers who are more difficult to reach.

- Talkback is a user-led engagement and self-advocacy group which works with the partnership (see the previous section.)

- Service user Joe is attending his local steering group in Milton Keynes. The whole plan was discussed with Joe and he was able to contribute to the discussions through his lived experiences (See the previous section.)

Our next steps are to:

- Further engage with the two Autism Partnership Boards, three Learning Disability Partnership Boards, and four Carers Partnership Boards to ensure that we are all working together on this agenda, and that we have appropriate representation at both reference group and Transforming Care Board levels.

- Review the way we are involving people from all five cohorts in the design and development of the local service model to ensure we have ways of including all of them in ways that are meaningful to them.

- Establish with Children's and Transitions Services how they wish to lead on this aspect of work, and how we will work together towards the all age approach that is required

POhWER (the local advocacy provider for the partnership providing both statutory and non-statutory issue based advocacy) have been involved in care and treatment reviews and are

well sighted on the Transforming Care agenda (see previous section.)

The partnership has an ambition to involve more local people with lived experience of hospital as paid "experts by experience" in Care and Treatment Reviews, and to meaningfully involve Service Users and Carers in any partnership procurement exercises undertaken. We also plan to include Service Users in monitoring, as well as in the implementation of this plan. We will coproduce an "easy read" version of the plan. Part of our funding bid which accompanies this plan focuses on coproduction to help enable this work to happen.

It is also the TCP's ambition to develop further and work in partnership with people with autism and/ or a learning disability, their carers, families, and other stakeholders in the implementation of this plan. At the partnership's workshop with NDTi on 23rd March a major focus was the area of stakeholder engagement and coproduction and the outcomes of this will be incorporated into the communications and engagement work stream moving forward. During the early stages of the project a communications and stakeholder management strategies and plans will be developed and agreed. In addition to established channels, the work streams will consider evidence based approaches to co-production and stakeholder engagement, and the programme will look at current examples of best practice. Engagement will extend to universal services with a view to how they might best engage with this cohort.

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

We have attached an activity and finance template for the three CCG areas; this includes the current inpatient projections as of 11th April 2016.

2.Understanding the status quo

Baseline assessment of needs and services

Provide detail of the population / demographics

Transforming Care Partnership (TCP) Geographic Footprint – Bedfordshire, Luton and Milton Keynes (BLMK)

The TCP for Bedford Borough, Central Bedfordshire, Milton Keynes and Luton is a newly formed arrangement. As mentioned earlier, it covers four local authority areas and three Clinical Commissioning Group areas within Central Eastern England.

The area covers a mix of rural and densely populated urban districts, it has good transport links and a rapidly growing population, with population increase estimates in some parts of the partnership area being 20% over 20 years. In 2015 the total population for the partnership area was estimated by the Office for National Statistics (ONS) at 912,759.

Table 2.01 Office for National Statistics (ONS) Total Population Estimates published 2014

Local Authority	Population Estimate (all ages)			Predicted population increase (all ages) from 2015 estimate	
	2015	2019	2030	2019	2030
Bedford	164,397	171,360	188,990	4.24%	14.96%
Central Bedfordshire	269,600	283,084	316,059	5.00%	17.23%
Luton	213,696	223,936	246,885	4.79%	15.53%
Milton Keynes	263,051	277,293	309,133	5.41%	17.52%
Total	**912,759**	**957,692**	**1,063,097**	**4.92%**	**16.47%**

Remit of the Plan

The population that is in scope of this plan are children or adults with a learning disability and/or autism who have/display:

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

campuses or long-stay hospitals were closed

This comprises an extremely diverse group of people and often the care and support required will often be highly individualised. This plan applies to all those who are the responsibility of Health and/or local authorities within the Transforming Care footprint.

Where somebody lives in one social care area (e.g. Northampton) but are registered with a GP within the BLMK partnership area they will receive health care services from our local LD team, whilst social care will be provided by their own local authority. Further guidance on this can be found in 'Who Pays'.

Out of scope for this plan

- People with a learning disability and/or autism who are placed in hospital for the treatment of physical conditions
- People at risk of admission as a result of their physical health needs

Definitions of "learning disability" and "autism"

The White Paper, Valuing People, defines a learning disability as: a significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence); along with a reduced ability to cope independently (impaired social functioning). Certain conditions such as dyslexia are not considered to be learning disabilities, as while they make tasks such as reading or writing difficult they do not affect intellect; instead they are considered to be learning difficulties. Similarly, while learning disabilities are linked to mental health issues, poor mental health is not considered to be a learning disability in itself, as it can affect anyone, at any time and can usually be overcome with treatment and support (Department of Health, 2001).

Learning disabilities can be grouped into four main levels of severity:

- Likely to result in some learning difficulties at school. At this level, many adults will be able to work, maintain good relationships and contribute to society.
- Likely to result in marked developmental delays in childhood but most can learn to develop some degree of independence in self-care and acquire adequate communication and academic skills. Adults are likely to require varying degrees of support in order to live and work in the community.
- Likely to result in severe developmental delays and a continuous need for support throughout the life course.
- Likely to result in severe limitations in self-care, continence, communication and mobility. Requires a high level of constant care and support (Department of Health, 2001)

The National Autistic Society defines Autism in the following way:

> "Autism is a lifelong developmental disability that affects how a person communicates with, and relates to, other people. It also affects how they make sense of the world around them. It is a spectrum condition, which means that, while all people with autism share certain difficulties, their condition will affect them in different ways. Some people with autism are able to live relatively independent lives but others may have accompanying learning disabilities and need a lifetime of specialist support. People with autism may also experience over- or under-sensitivity to sounds, touch, tastes, smells, light or colours. Asperger syndrome is a form of autism. People with Asperger syndrome are often of average or above average intelligence. They have fewer problems with speech but may still have difficulties with understanding and processing language."

(From: What is autism? National Autistic Society)

Prevalence – Adults

At a national level there is no definitive record of the number of people with learning disabilities and/ or Autism in England. Projecting Older People Population Information (POPPI) and Projecting Adult Needs and Services Information (PANSI), web-based tools for use by commissioners, supported by the Institute of Public Health, projected that the number of adults living in England with a learning disability totalled 1,013,065 in 2015 and that the number of adults with an autistic spectrum condition totalled 422,164 in the same year.

It is estimated that there were a total of 16,427 adults with a learning disability within the partnership area in 2015. The breakdown of estimated and projected prevalence of learning disability, autistic spectrum conditions for adults is provided below (table 2.02), along with projected figures for 2030 (table 2.03).

There will be increases in the number of people with a moderate or severe learning disability, behaviours that challenge and autistic spectrum conditions over the next 15 years (table 2.04).

Table 2.02 Prevalence Estimates for 2015 (Source: POPPI and PANSI)

Area	Learning Disability Baseline (18 years and above)	Autistic Spectrum Conditions (ASCs) (18 years and above)	Challenging Behaviour (18- 64 yrs. only)
Bedford	3,003	1,246	45
Central Bedfordshire	4,956	2,078	74
Milton Keynes	4,664	1,935	73
Luton	3,804	1,597	60
Total	**16,427**	**6,856**	**252**

Table 2.03 Projected population in 2030 (Source POPPI and PANSI)

Area	Learning Disability Baseline (18 years and above)	Autistic Spectrum Conditions ASCs) (18 years and above)	Challenging Behaviour (18- 64 yrs. only
Bedford	3,456	1,451	48
Central Bedfordshire	5,796	2,446	80
Milton Keynes	5,541	2,312	80
Luton	4,410	1,892	67
Total	**19,203**	**8,101**	**275**

Table 2.04 Predicted percentage increase in estimated cohort between 2015 and 2030. (Source – based on POPPI and PANSI data)

Area	Learning Disability Baseline (18 years and above)	Autistic Spectrum Conditions ASCs) (18 years and above)	Challenging Behaviour (18- 64 yrs. only
Bedford	15.08%	16.45%	6.67%
Central Bedfordshire	16.95%	17.71%	8.11%
Milton Keynes	18.80%	19.48%	9.59%
Luton	15.93%	18.47%	11.67%
Total	**16.90%**	**18.16%**	**9.13%**

Services report higher levels of prevalence of challenging behaviour e.g. Milton Keynes' register for people with behaviour that challenges include 136 people.

What can we predict about adults with learning disabilities who display behaviours that challenge services?

Challenging behaviour usually begins in childhood or young adulthood and without effective intervention is highly persistent; around 30 per cent of young children (aged zero to three years) and 10-15% of adults with learning disabilities display behaviour difficulties (Emerson and Milton Keynes, 2011) or 0.045% of the population aged five or over based on the study "Challenging behaviours: Prevalence and Topographies, (Lowe et al (2007) Journal of Intellectual Disability Research, Volume 51)". Not all of these people will have a moderate, severe or profound disability and hence not all of them will be in receipt of learning disability services. Many of these people will be at risk of offending and will have come into contact with the criminal justice system, substance misuse services or mental health services. Interestingly though a study in 2007 indicated that of those in receipt of services, it tended to be the abler people with learning disability and challenging behaviour who experienced placement breakdown and eventually more secure settings (Broadhurst and Mansell, 2007).

The number of people with a learning disability registered as having a Learning Disability diagnosis by GPs provided by the Quality and Outcomes Framework (QOF). The estimated population with a learning disability that are currently accessing services is not necessarily the same as those registered on the QOF.

Table 2.05 QOF LD Register 2014/2015 - showing numbers of people on Learning Disability register and prevalence by CCG.

BLMK CCGs	Size of List	Number of people on LD register	Prevalence
Bedfordshire CCG	457,600	1,895	0.41%
Luton CCG	223,266	880	0.39%
Milton Keynes CCG	279,399	940	0.34%
Total	**960,265**	**3,715**	**0.39%**

As the QOF Register prevalence levels are lower than expected this might indicate further work is required with primary care across the partnership. Also the QOF list size for 2014/15 at 960,265 for the area is nearly 50,000 people higher than the estimated population for the area based upon ONS estimates for 2015. We recognise that there will be differences in the many different data sources for general and LD/autism population numbers and we will use a data-driven approach to ensure that we fully understand these differences. This also requires us to ensure that within individual localities and across the partnership area we have effective systems and processes in place to ensure that these differences in data do not lead to individuals failing to be identified and to be supported effectively.

Table 2.06 Number of adults with a learning disability known to services (Jan 2016)

Area	Number of adults with learning disability and/or autism known to Local Authority
Bedford	573
Central Bedfordshire	655
Milton Keynes	681
Luton	550
Total	**2,459**

Prevalence – Children

There are approximately 3,800 young people with some form of learning difficulty in the partnership area. One of the best sources of information around children and young people with Special Educational Needs and disability (SEND) is data from the School Census. This provides pupil level information for all pupils in the partnership area detailing their level of need and their primary type of SEN. As of January 2015 the number of pupils with their primary need being a learning difficulty was 3,802 for the total partnership area, with Milton Keynes and Luton having the highest number of pupils in this category.

Table 2.07 Special Needs and Disability Data from the School Census January 2015

Area	Specific Learning Difficulty	Moderate Learning Difficulty	Severe Learning Difficulty	Profound and Multiple Learning Difficulty	Total
Bedford	178	343	13	0	534
Central Bedfordshire	173	541	14	8	728
Milton Keynes	196	1,087	11	8	1,302
Luton	235	958	37	0	1,238
Total	782	2,929	75	16	3,802

Table 2.08 Out of area residential/ educational placements – all ages (as at 31st January 2016)

Area	**Under 18**	**18-25**	**Over 25**	**Total**
Bedford	5	11	2	18
Central Bedfordshire	5	6	4	15
Milton Keynes	10	2	51	63
Luton	15	10	28	53
Total	35	29	85	149

Note: *The data set described in the table above for Bedfordshire has been taken from the Phase 2 register 'out of area residential and / or educational placements for people with a learning disability and / or autism who have been placed out of area due to behaviour described as challenging' the data sets will be subject to validation across Bedfordshire CCG (including CHC), Central Bedfordshire and Bedford Borough Council.*

Local Population Issues

Milton Keynes is a growing population both in size and diversity. Milton Keynes CCG largely works to the same boundaries as Milton Keynes Council. In 2013 the population of Milton Keynes was 255,700. Between 2003 and 2013 Milton Keynes increased by 38,100 people (+17.5%).

The Population Bulletin 2013/14 outlines that the high population growth is expected to continue into the future. The population is forecast to grow to 302,100 people by 2026. This is an increase of 49,700 people or 19.7% between 2012 and 2026.The Milton Keynes (MK) population is getting older, the median age rose from 34 in 2001 to 35 in 2011 and by 2026 this is expected to be 40. However, the MK population remains young: 21% of the MK population were aged under 15 years compared with 17.7% in England.

The ethnic diversity of the total Milton Keynes population has increased more than that for England as a whole. In 2001, 13.2% of the total population in England were from an ethnic group other than 'white British'. In Milton Keynes the comparable figure was 13.2%. By

2011, 20% of the population of England was estimated to have an ethnic group other than white British while the comparable group in Milton Keynes has risen to 26%.

Milton Keynes' local authority is ranked 211th out of 326 unitary and district authorities in England, where first is the most deprived.

Milton Keynes has four dedicated special needs secondary school for 11-19 year olds with a further one planned.

The current population of Central Bedfordshire is 269,100 (2014). Central Bedfordshire is the 15th largest unitary council in England by population size.

The area of Central Bedfordshire is 716 square kilometres. Central Bedfordshire is the 11th largest unitary council in England by area. It is classified as 'largely rural', with 58% of residents living in rural areas. This includes 'hub towns', which are towns with populations of 10,000 to 30,000 that play an important role in providing services, employment and businesses to the rural areas around them. It is forecasted that Central Bedfordshire population will increase to 287,300 in 2021.

Central Bedfordshire is less diverse than England as a whole, and has a greater proportion of people who are White British. The biggest ethnic groups within Central Bedfordshire were 'White Other' (7,040 people, 2.8% of the population), 'White Irish' (3,150 people, 1.2%), and 'Indian' (2,530 people, 1.0%).

The population profile of Central Bedfordshire will change by 2021, with people aged 65 and over representing 19% of all people, compared to 16% in 2011. This is the result of a higher rate of growth in the number of older people compared to other age groups – 35% between 2011 and 2021.

Overall levels of deprivation in Central Bedfordshire are relatively low, with many areas being among the least deprived in England.

Bedford Borough covers an area of 476 sq. km and is home to an estimated 163,900 people (2014). Almost two-thirds of the population (64%) lives in the urban area of Bedford and Kempston, and 36% in the surrounding rural area which comprises 45 parishes. The Borough's population rose from 148,100 in mid-2001 to 163,900 in mid-2014, an average annual increase of approximately 0.7%.

Bedford Borough has a similar age profile to England, with the same median age of 39.7 (2014), but has a much younger profile than the East of England which has a median age of 41.3. The proportion of older people in the Borough is also lower, with 17.0% of the population aged 65+ in 2014 compared to 17.6% in England and 19.0% in the region. Further information will be included in the April 2016 plan submission.

Prior to 2014/15, the national data indicated that Bedford Borough supported a very "typical" number of people in relation to its population size - and reduced the numbers in a typical way over time.

In 2014/15 Bedford Borough experienced an unusual surge in demand – resulting in sudden growth in the number of people receiving home care – although not in the number admitted to residential/nursing homes. This is confirmed by the fact that the rate of new people admitted to Bedford Borough's Adult Social Care system in 2014/15 was relatively high – although only around 5% higher than the comparator average, and 2% higher than the national average. By the end of that year, 38% of people receiving support in Bedford

Borough were “new to its system” (compared with a national average of 31%).

As a result, Bedford Borough’s position in relation to other councils changed very dramatically. The new figures suggest that Bedford Borough now provides long-term support to rather high numbers of people (both in the <65 and 65+ age ranges). In the current year, this situation has largely been contained. The number of client packages increased by 2.8% (between April and September). This is consistent with demographic growth - and especially with the fact that the number of people aged 85+ is rising by 4% per annum.

Luton is the most densely populated local authority area in the eastern region of England. The borough’s population is projected to grow significantly with the latest forecast estimating a 20% overall increase over the next 20 years, with the school age population rising by 23% in this timeframe. The population is ethnically diverse with approximately 55% being from Black and Minority Origin (BME). The ethnic composition of Luton fits a model known as “super diversity” in which there are an increasing number of BME communities within the population each with its own needs and cultures. Luton is landlocked and has a significant problem with homelessness and there are currently over 160 families who are homeless or living in temporary accommodation, several wards within the borough fall within the top 10% of the most deprived areas within the country.

In 2014 there were 457 children and young people on Luton’s disability register and the children with disability team provided support to 407 children. According to the most recent Joint Strategic Needs Assessment (JSNA) for 2013/14 Luton has a significantly high number of children known to schools with a severe learning difficulty (7.09 per 1000 pupils compared to 3.73 – average for England). Woodlands, the borough’s main special needs secondary school for 11-19 year olds will be the largest secondary school of its kind in the country by 2017.

Analysis of inpatient usage by people from Transforming Care Partnership

Overall Picture:

The BLMK partnership area has relatively low usage of inpatient beds, compared to many other areas in Eastern and Central England. As of 31st January 2016 the partnership was reporting on 17 adults in inpatient settings (see table 2.09). It has been projected that by April 2016 eight of these patients will have been discharged or have a confirmed discharge date. The partnership is therefore confident that it will be able to meet the planning assumptions set out in “Building the Right Support” within a reasonable timescale through ongoing work and timely discharge planning and should be in a strong position to reduce inpatient levels further through effective collaborative working.

Reporting on inpatients across the Partnership (as of 31 January 2016)

Table 2.09 CCG Commissioned Inpatient Care

CCG area	Original “Winterbourne” Cohort admitted before March 2014	Patients admitted since March2014	Total
Bedfordshire	2	2	4
Milton Keynes	3	6	9
Luton	2	2	4
Total	**7**	**10**	**17**

Table 2.10 NHS England Specialised Commissioning (as of 31 March 2016)

CCG area	NHS specialised commissioning
Bedfordshire	9
Milton Keynes	3
Luton	2
Total	**14**

Note: These figures for specialised commissioning are to be validated, and may be subject to an increase as medium and high secure patients are identified during the Specialised Commissioning Care and Treatment Review process

Planning assumptions are that no area should need more inpatient capacity than is necessary at any one time to cater to:

- 10-15 inpatients in CCG commissioned beds per million of the population
- 20-25 inpatients in NHS England commissioned beds per million of the population

Picture at local level

Milton Keynes CCG currently reports on nine patients who are in inpatient settings supported by CCG funding. Three of these patients are from the original transforming care cohort. Two of these Two of these people will be shortly returned to Milton Keynes.

There have been six admissions since June 2014, three from the community and three transferred to Milton Keynes CCG from specialised commissioning. Over the same period, we have discharged four patients back into the community.

Of the three people currently reported on by Specialised Commissioning, one is likely to be transferred to Milton Keynes imminently. Our understanding from our community team is that two people are not going to be transferred back to Milton Keynes in the near future. The remaining three people are “disputed” and subject to confirmation that they originate from Milton Keynes.

Bedfordshire Clinical Commissioning Group is currently reporting four inpatients. Two of the four reported patients were inherited from Specialist Commissioning Group following their transfer from secure to specialised learning disability acute beds out of the Bedfordshire area and in independent hospitals. These patients form the original 2014 Winterbourne cohort.

The other two patients being reported were admitted into The Coppice (Bedfordshire and Luton inpatient provision) and plans are currently being developed to plan for discharge. These two admissions took place in December 2015 and January 2016 and therefore do not form part of the original Winterbourne cohort.

Luton CCG currently reports on four individuals who are in patient settings. This includes the two people who were in the original “Winterbourne” cohort and four people who have been admitted since March 2014 (one of the individuals was placed in hospital by children’s services and has turned 18 since being in hospital). In addition, NHS Specialised commissioning report on two people in secure settings. Of this total of six patients it is anticipated that four individuals will either have left hospital or have confirmed discharge dates by April 2016. Locally there is a transforming care action plan and steering group which oversees the progression of patients of through care pathways and their transition back into the community. The average length of stay at the local Crisis intervention inpatient service is 49 days; however, there have been three delayed transfers of care at the unit in

the last year due to breakdown in care arrangements and the need to source alternative accommodation in borough.

It is important to note at this stage that this data and information relates to people the CCGs know about. We understand there is small complex cohort of patients currently funded by specialised commissioning that are not yet allocated to a CCG. There is therefore a risk associated with any assumptions regarding funding requirements going forward.

Describe the current system

How we currently serve people covered by this plan

Within the partnership boundaries the four local authorities, three CCGs and NHS England are responsible for commissioning care for people who live in the area, care is provided by a range of providers including the NHS East London Foundation Trust (ELFT) for Bedfordshire and also for Luton. Milton Keynes is a joint health and social care service via a pooled budget arrangement between Milton Keynes CCG and Milton Keynes Council. Health professionals are employed by Central North West London NHS Foundation Trust (CNWL).

There is already a strong focus on delivering community based services and personalised support across the partnership and commissioning bodies across the area have taken significant steps to reduce reliance on inpatient care with the closure of the local NHS Assessment and Treatment Unit for adults with a learning disability in Bedfordshire and Luton. Other inpatient based services and campuses have also closed over the last 10 years, with only a residual crisis inpatient service in place currently accessed by Bedfordshire and Luton patients.

Milton Keynes also closed its inpatient facility in 2013 (the Oakwood unit) and in its place developed the Community Support Intervention Team focused on preventing hospital admission.

At present the three CCGs commission inpatient and specialist services separately although Bedfordshire CCG currently hosts the contract for Specialist Learning Disability Services on behalf of Luton CCG and these services are shared across Bedfordshire and Luton. There are currently seven NHS block contracted beds for adults with a learning disability across the whole partnership utilised by Bedfordshire and Luton patients. Milton Keynes has no NHS contracted beds for adults with a learning disability.

In Milton Keynes there is a local protocol with Adult Mental Health Services for access to an inpatient bed within the local mental health inpatient service. However this is often not considered to be clinically appropriate and inpatient beds are commissioned from a variety of NHS Trust and independent provision. Where a need for inpatient services is identified, the Community Learning Disability Team is involved in planning the admission, monitoring progress and planning and supporting the person's discharge from the in-patient service.

How We Serve adults

Current state: Adults

Details of the current inpatient population as of 4th April 2016 are detailed in the tables below for both within the TCP footprint (table 2.11) and out of area (table 2.12). Locations have been anonymised in order to maintain confidentiality.

Table 2.11 TCP inpatient population in beds in footprint

Unit (NHS)	Unit (Non NHS)	CCG or NHSE?	Type of bed	No of beds	No of beds commissioned / contracted by TCP	No of beds currently in use by TCP
NHS Unit 1		CCG	Crisis	7	7	6 (4/4/16)
	Non NHS Unit 1	CCG	Locked Rehab	53	0	4*
NHS Unit 2		NHS E	Low secure	UK**	Unknown	4

*Note that for Non NHS Unit 1, all beds are spot purchased.
** Unknown

Table 2.12 TCP inpatient population in beds outside footprint (out of area)

Unit (NHS)	Unit (non NHS)	CCG or NHSE?	Type of bed	No of beds currently in use by TCP
	Non NHS Unit 2	CCG	Locked rehab	3
	Non NHS Unit 3	NHSE	Secure	2
	Non NHS Unit 4	NHSE	Secure	2
	Non NHS Unit 5	CCG	Locked rehab	1
	Non NHS Unit 6	NHSE	Secure	2
	Non NHS Unit 7	CCG	Locked rehab	1
	Non NHS Unit 8	CCG	Locked rehab	1
	Non NHS Unit 9	CCG	Locked rehab	2
	Non NHS Unit 10	CCG	Locked rehab	1
	Non NHS Unit 11	NHSE	Secure	1
	Non NHS Unit 12	NHSE	Secure	1
	Non NHS Unit 13	CCG	Locked rehab	1

Specialist Learning Disability Services – SPLD (Bedfordshire and Luton)

The community SPLD is hosted by Bedfordshire CCG on behalf of Luton CCG. The community SPLD services include the following service areas:

- Occupational Therapy
- Specialist Medical
- Psychology
- Primary Health Facilitation
- Acute Health Facilitation
- Speech and Language Therapy
- Sensory Nurses
- Arts and Drama Psychotherapy
- Intensive Support Team
- The Coppice (seven bed short term acute crisis intervention**)**

NHS Acute Crisis Service – the Coppice (Bedfordshire and Luton)

The Coppice is a seven bedded acute crisis unit covering Bedfordshire and Luton. It is AIMS-LD accredited (Accreditation of Inpatient Mental Health Services – Learning

Disability). The focus of this service is different to that of a traditional "assessment and treatment" unit as it fully integrates with the areas' Intensive Support Team (IST), sharing a staff support and a Multi-Disciplinary Team (MDT). It provides seamless care to patients who need short term inpatient care because it is not safe or appropriate to provide interventions in a community setting, or there is a risk to safety or wellbeing. Discharge planning usually starts soon after admission. The average inpatient length of stay per admission is seven weeks.

The Intensive Support Team – IST (Bedfordshire and Luton)

The Intensive Support Team (IST) has a pivotal role and works across Bedfordshire and Luton with people with a learning disability who are experiencing a crisis in relation to a behaviour which is challenging or experiencing a mental health need whilst living in the community. It provides assessment, treatment and support to individuals in a safe and least restrictive environment. Interventions are person centred, intended to be time and goal specific, focus on the safety, empowerment and wellbeing of the patient and any carers involved, as well as minimising the need for admission to inpatient care.

The average caseload of the IST team is 60-80 patients at any one time across Bedfordshire and Luton. In the event of an admission to the Coppice, or any other hospital or inpatient unit IST will aim to facilitate a timely discharge and support the individual back into the community as soon as the individual is fit for discharge. IST are also able to work closely with adults with a learning disability who have been admitted to mainstream acute mental health inpatient unit or independent hospitals to facilitate timely discharge and smooth transition back into the community.

Patients with a learning disability across Bedfordshire and Luton and supported by IST to access local acute mainstream mental health inpatient units when appropriate and IST have supported six such admissions over the last year 2015/16.

Case study: How the Intensive Support Team and Crisis Intervention Service work in an integrated way to meet individual need, ensure inpatient stays are appropriate and for the minimum required time

Please note all personal information including the name of the patient has been changed in order to maintain confidentiality.

Dave was referred to the Intensive Support Team (IST) by his Care Co-ordinator for support with low mood, and psycho-education around treatment. Dave had a history of depression and substance misuse. He lived on his own with a few hours of support a week from paid carers to help him with everyday tasks.

IST completed an assessment the day after his referral. On assessment he was found to be very low in mood, experiencing sleep disturbances and a loss of appetite. He was not experiencing suicidal ideation but he had experienced this in the past. IST completed a depression rating scale which further demonstrated his low mood. Dave put his presentation down to recent bereavements and that he struggled to remember to take his anti-depressant medication.

He was allocated a named nurse who arranged a medical appointment with the IST consultant the next day. A plan was put in place to visit Dave every day to remind him to take his medication, monitor his mental health and work through his issues. Physical observations were also completed during visits to ensure that there were no underlying physical reasons for his presentation and that he was side-effect free. In addition to this IST rang Dave every evening to remind him to take his tablets. A referral was submitted for

psychological input for bereavement and his named nurse liaised closely with his care manager throughout.

Whilst this seemed to have an initial positive impact after around three weeks Dave's mood dipped. During one visit he stated that he was experiencing active suicidal thoughts and did not feel safe to be left alone. The nurse was concerned and decided to make enquiries about additional support, liaising with the IST senior nurse and IST Consultant. The local commissioner was also consulted and various options considered. It was agreed that a short admission to the crisis intervention service "The Coppice" would be the best course of action, to keep Dave safe and enable stabilisation of his mental state. David was fully informed of the discussions and felt that he would benefit from a short voluntary admission as he may act on his suicidal ideation.

The nurse supported Dave with his admission there and then. His named nurse remained the same throughout his admission and the staff team that visited him at home were familiar to him in The Coppice as the team are the same. Dave remained in The Coppice for three weeks. During this time his anti-depressant medication was increased and coping strategies/ a relapse prevention plan was developed with him. Dave also felt that much of his low mood had been due to boredom. He was assessed by an Occupational Therapist and an activity plan put in place. This then informed his care Co-ordinator who put in place extra support and activities for Dave on discharge.

Following discharge from The Coppice, IST visited Dave every day for the first seven days, again his named nurse remained the same. He was much more stable on discharge with an increase in medication and increased social support; he was also referred to advocacy services. IST remained involved with Dave but gradually reduced visits until he was well enough to manage. This was reviewed weekly by IST Multi-Disciplinary Team including the Consultant Psychiatrist.

Dave was discharged after a further four weeks to the locality Consultant Psychiatrist for his area and he remained on the waiting list for psychological input. Dave has the IST number as part of his relapse prevention plan. He is able to call this number on any day at any time for support and advice. He can also access crisis support including a home visit 24 hours a day seven days a week

Care management (Bedfordshire and Luton)

The care management function is delegated to Local Authorities (Bedford Borough, Central Bedfordshire and Luton) where the teams are made up of Social Workers, Community Nurses, Community Care Workers, Support Workers and Administrators.

Community Support Intervention Team (CSiT) (Milton Keynes)

Following the closure of Oakwood inpatient service in 2013 Milton Keynes CCG released additional funding into the pooled budget for a small specialist team focussed on preventing admissions to hospital. The Community Support Intervention Team of two nurses and three support workers work across during the day/evening seven days per week. This team works closely with the Behaviour Support Team, and the wider multi-disciplinary team based with Milton Keynes' Community Team for Adults with a Learning Disability.

Case study: How the Community Support Intervention Team (CSiT) work with individuals and providers to reduce or delay inpatient admissions.

Please note all personal information including the name of the patient has been changed in

order to maintain confidentiality.

John was living in his own flat in Milton Keynes supported by a local provider. His package was fully funded by Milton Keynes CCG. John has experienced several inpatient admissions during his adult life but he had settled well into his flat with the support of a staff team who knew him well.

Following the death of his father, John's mental and physical heath started to deteriorate with non-concordance with medication, verbal aggression, threats of physical aggression along with sleep disturbance. A 'Blue Light' Care and Treatment Review (CTR) was arranged as staff were indicating that a hospital admission might be required.

As an outcome of the 'blue light CTR' the Community Support Intervention Team (CSiT) were allocated to carry out an assessment and provide support to John and his support staff. This support was initially focussed on medication concordance but developed into providing support staff with coaching and support with their interventions. The CSiT has Outreach Community Nurses and support workers and intensive support was arranged for an initial period of seven days. In addition, the Community Team for Adults with a Learning Disability (CTALD) has a 24/7 on call system and the provider staff were encouraged to make use of this if they had any concerns about John.

The CSiT team worked closely with the CTALD to monitor John's presentation and several multi-disciplinary meetings were held to review John's plan and support. The inpatient admission was avoided at this time although John continued to present as 'unsettled'. The CSiT liaised with the CTALD consultant psychiatrist and John's medication was reviewed. Two further 'blue light' meetings were held and increased support was provided by the CSiT with community outreach nurses and support workers allocated to provide additional support to John and his staff team.

Community Team for Adults with a Learning Disability (CTALD) (Milton Keynes)

The 44-strong joint team is made up of a range of Health and Social Care professionals. This includes psychiatry, psychology and therapists, who assess needs, diagnose and deliver treatments. The team is funded via a pooled budget between Milton Keynes CCG and Milton Keynes Council.

As well as undertaking Care Assessments for new service users, and having responsibility for Care Act or Care Programme Approach reviews the team undertakes Safeguarding Vulnerable Adults investigations, assessments under the Deprivation of Liberty Safeguards and Continuing Healthcare reviews for service users who are in receipt of health funding. The Health Action Team aims to improve health outcomes for people with a learning disability by working out into mainstream health services to improve their effectiveness with people with a learning disability.

The team has a dedicated Behaviour Support Team aligned with both the Psychologists (two FTE) and the Mental Health and LD team of nurses and social workers.

Following assessment or review, the Brokerage Team works with individuals in a person centred way to plan services to meet their needs within their indicative budget.

In summary the CTALD includes the following functions:

- Occupational Therapy

- Psychiatry
- Psychology
- Health Action Team (health facilitation for primary and secondary care)
- Dietetics
- Speech and Language Therapy
- Community Nursing
- Social Workers
- Brokerage
- Behaviour support
- Intensive Support Team

Independent Hospitals (Bedfordshire, Luton and Milton Keynes)

Inpatient beds in independent hospitals are commissioned by both Bedfordshire and Luton CCGs on a spot purchase basis in exceptional circumstances only as a service of last resort They are commissioned for the shortest time possible when either the needs of the patient concerned are too complex to be supported by local (inpatient) services or when local inpatient services have no bed capacity. There are currently four patients from Bedfordshire and Luton accessing independent hospitals/inpatient services (figure excludes specialised commissioning patients.). These placements are in Central or Eastern England.

Similarly, Milton Keynes only commission beds in independent hospitals when intensive community support is insufficient to meet the individual needs of a patients, and an inpatient episode is required for assessment and/or treatment There are currently nine patients from Milton Keynes accessing independent hospitals (excluding specialised commissioning patients) These placements are also in Central or Eastern England, although placements are also occasionally made in London depending on individual clinical need.

Within the geographical footprint there are four independent inpatient services of significance. These are accessed by patients from all areas of the country and the partnership uses only a very small proportion of their bed capacity. The units concerned are:

- **Woodlea Clinic,** a forensic low secure inpatient service in Bedfordshire currently operated by South Essex Partnership University NHS Foundation
- **Milton Park Therapeutic Campus,** a 53-bed secure hospital for individuals with autism, a learning disability and/ or mental health needs. This is on the Bedfordshire/ Cambridgeshire border and is run by Brookdale Care.
- **Marlborough House,** a male only medium secure 28-bed unit situated on the Milton Keynes General Hospital site in Milton Keynes. Within this unit, Watling Ward is an acute admissions ward that has 20 beds, with an Intensive Care Unit including a de-escalation lounge. Chaffron Ward accommodates up to eight men who are progressing well in their recovery but still require medium secure services. Referrals are accepted from adult or forensic services, prison or high secure hospitals. Marlborough house is run by Oxford Health NHS Foundation Trust.
- **Chadwick Lodge**, a 52-bed medium and low secure unit within Milton Keynes, providing specialist treatment programmes for male and female patients who have been detained under the Mental Health Act (1983) and have a history of offending behaviour. The unit comprises 44 beds for men in four single gender wards (30 medium secure and 14 low secure) and eight beds for women in one single gender ward (medium secure). Chadwick Lodge offers care to those patients who present with a dual diagnosis of mental illness/personality disorder and mild learning disability and is run by the Priory Group.

The wider care pathway for adults with a learning disability (Bedfordshire and Luton)

Adults with a learning disability are able to access a range of specialist services as part of a pathway of health care including speech and language therapy, occupational therapy, psychology, outpatient medical care, art and drama therapy in accordance with their assessed clinical need as outlined earlier. The provision and function of community nursing is delegated to the Local Authorities through a S75 arrangement and care and support is provided through the care coordinator role. All these services work in close partnership with the Coppice and Intensive Support Team to provide an integrated model of health care. There is also a dedicated health facilitation team which focuses on supporting the wider population of people with a learning disability who access mainstream health services, health promotion and the completion of person centred health action plans and health checks.

The wider care pathway for adults with a learning disability (Milton Keynes)

Adults with a learning disability are able to access a range of 'specialist' health services as part of the wider health and social care CTALD team including speech and language therapy, bereavement counselling, physiotherapy, psychology and art therapy. There is no LD and/or autism specific inpatient provision within Milton Keynes, this was decommissioned in 2013 and in its place the Community Support Intervention Team (CSiT) was developed which supports people with LD and LD with autism with a focus on preventing hospital admission. The Health Action Team within the CTALD focuses on supporting the wider population of people with a learning disability to access mainstream health services, health promotion and the completion of health action plans and health passports. Milton Keynes also has a range of day opportunities and short breaks which are currently subject to review.

Forensic Support (Bedfordshire, Luton and Milton Keynes)

There is currently limited forensic/dedicated support for people with a learning disability and/or autism in the BLMK area with no embedded, dedicated learning disability forensic service or specialism.

Local diagnostic service for autism (Bedfordshire and Luton)

Since July 2013 adults aged 18 and over registered with a Bedfordshire and Luton GP have had access to an "in county" diagnostic service for autistic spectrum conditions This is available to people of any level of functioning including with a Learning Disability. The service is multi-disciplinary, person centred and flexible, offering a range of assessment tools/processes to take into account the individual's cognitive ability, individual circumstances and requirements. Short-term therapeutic intervention is offered to people for whom an autism diagnosis is confirmed. The service also considers referrals/enquiries on behalf of people with an established diagnosis with a view to offering signposting advice.

The diagnostic service builds networks with other local services and can offer specialist advice to other services regarding ongoing support/treatment requirements and reasonable adjustments, to promote equitable access for people with autism. This may form part of post-diagnostic intervention with an individual service user or more generic advice. To date the service has received 600 referrals undertaken 290 diagnostic assessments and given 130 people a confirmed diagnosis.

Living in the Community (Bedfordshire, Luton and Milton Keynes)

In Bedfordshire and Luton, a significant number of individuals with behaviour that challenges and/or complex needs are already successfully supported to live in ordinary housing within the local community, or in small scale residential care homes, with outreach support from specialist services as required. Hospital admissions and inpatient episodes are

generally kept to a minimum for this cohort, however may sometimes occur in the event of an acute mental health episode or escalation of challenging behaviour. There may also occasionally be a complete breakdown in placement and resultant hospital admission. We closely monitor inpatient admissions from these settings to see how the quality of care can be improved and care and support plans adapted to minimise the risk of admission.

In Milton Keynes 91% of people with learning disabilities are living within the boundaries of Milton Keynes with 33% of people known to services living with family.

Since 2001 there has been a strategic commitment to Supported Living as the first option for consideration when service users require accommodation away from the family home. Service users are tenants in their own homes and receive support through an external provider or the internal Community Support Team (CST). There were 239 people living in accommodation with a tenancy in 2015. This represents 43.4% of people with learning disabilities known to services aged 18-64 living in Milton Keynes.

The number of people living in residential or nursing care funded by Milton Keynes is significantly lower than its comparator authorities with 97 people (17%) accommodated in this type of provision. Almost half of them (40) are living out of area.

Case study: Personalised support for an individual with complex needs living in their own tenancy in the community.

Please note all personal information including the name of the patient has been changed in order to maintain confidentiality.

Phil is a person who we support He has a learning disability, autism and Pica. At times this affects him in such a way that he is at considerable risk, both at home and in the community. The Pica behaviours for Phil involved a focus on used cigarette ends, pieces of glass and small objects. If Phil saw any of these items he would have an uncontrollable urge to ingest these; the resulting effect being that Phil needed high levels of support and ongoing issues in relation to risk to his health, which often led to pain and discomfort and consequently behaviours which challenged those supporting him.

A referral was completed to the learning disability nurse and the in-house behavioural analyst. This led to a functional behavioural assessment and a behavioural support plan being developed. The team were supported to understand the behavioural support plan by working alongside the behavioural analyst throughout its implementation. This included training in behavioural support strategies to ensure staff possessed the necessary tools to actively redirect Phil at the necessary times in a safe and controlled way.

Alongside this, health investigations were carried out to eliminate any specific health issues that contributed to the behaviours. Medication was prescribed to counteract the health issues. Phil's living environment was assessed and changed to ensure Phil was able to live on his own with more focused support design.

Assistive technology was explored to identify solutions to managing the risks of Phil's Pica when in the community. A handheld 'vacuum' device was identified as an effective way of eliminating small objects from Phil's sight. Phil now leads a full and active life in his own property and accesses his community safely

This has resulted in Phil being able to be less intensively supported and a greater focus upon him living more independently. Phil is now supported by a well-matched, consistent

staff team who know him really well. He is continuing to thrive and his level of challenging behaviour has reduced considerably since we have been supporting him. Phil now lives a very happy and fulfilled life in the community and has avoided hospital admission.

Out of area (residential) placements (Bedfordshire, Luton and Milton Keynes)

There are presently 149 people with a learning disability and/or autism who may present behaviour that challenges who are placed out of area (please see table 2.08). Many have been placed out of area due to a lack of local options either as young people or in early adulthood. It is generally more difficult to monitor the quality of out of area placements and the input from local specialist NHS services can by highly variable. Occasionally there may be a complete placement breakdown for individuals in out of area placements, who may either be admitted to a hospital in the local area, or in some cases return to the Coppice (Bedfordshire and Luton) A significant objective of this plan is to address this particular issue and enable more people to either stay in area or return if they wish to do so, through commissioning appropriate services.

How we serve children and young people

Current state: Children

Details of the current inpatient population as of 4th April 2016 are detailed in the tables below for both within the TCP footprint (table 2.13) and out of area (table 2.14). Locations have been anonymised in order to maintain confidentiality.

Table 2.13 TCP inpatient population in beds in footprint

Unit (NHS)	Unit (Non NHS)	CCG or NHSE?	Type of bed	No of beds	No of beds commissioned / contracted by TCP	No of beds currently in use by TCP

Note: There are no children currently in this cohort within the TCP, therefore this table is empty.

Table 2.14 TCP inpatient population in beds outside footprint (out of area)

Unit (NHS)	Unit (non NHS)	CCG or NHSE?	Type of bed	No of beds currently in use by TCP
	Non NHS Unit A	NHSE	Low secure	1
	Non NHS Unit B	NHSE	Medium secure	1

Child and Adolescent Mental Health (CAMH) services Bedfordshire and Luton

The Bedfordshire and Luton CAMH service comprises:

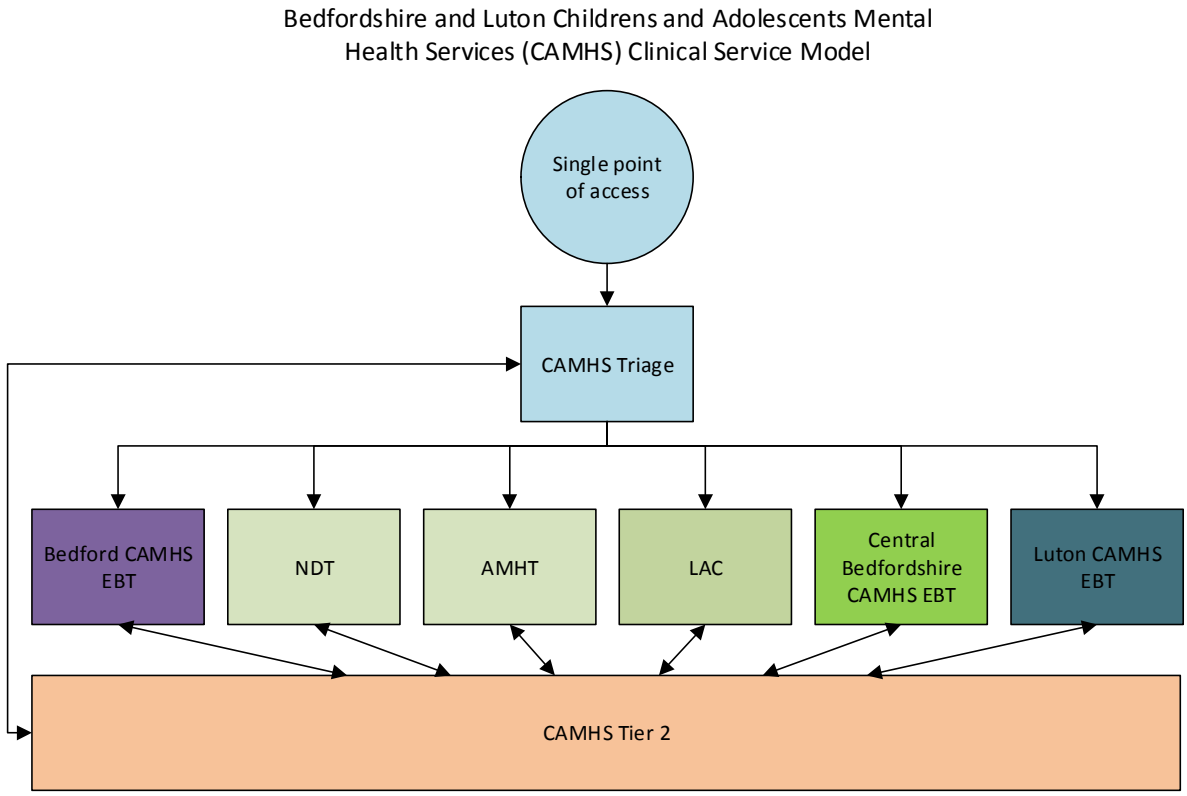
- CAMH Learning Disability
- CAMH TIER 4 provision is commissioned by NHS England.
- CAMH TIER 3 SEPT Paediatric, Occupational Therapy, Physiotherapy, Paediatric Nurses, Speech and Language Therapy and ELFT CAMHS service.
- CAMH TIER 2 Early Intervention

- CAMH TIER 1 is provided by universal providers, e.g. schools, GPs.
- CAMH Home treatment,
- CAMH Looked After Children and Young Offenders

Core elements required from the Bedfordshire and Luton CAMH service Model are highlighted below:

- an integrated service
- a single point of access
- a focus on early intervention
- improving input from children and young people
- Community-based delivery
- Moving from a medical to a social model.
- Key outcome measures
- A single assessment process
- Reduced waiting times and no internal
- Quick response to Mental Health crisis
- Focus on Early intervention.
- Vulnerable groups such and Looked after Children, those with a learning disability and Young offenders require dedicated resource to ensure that their specific needs are prioritised.

Chart 2.01 The Bedfordshire and Luton CAMHS Clinical Service Model



EBT = Emotional and Behavioural Team
NDT = Neurodevelopmental Team
AMHT = Adolescent Mental Health Team
LAC = Looked After Children

CAHMS Services (Milton Keynes)

CAHMS Services are structured in the following way in Milton Keynes:

- **Tier 1** is provided by universal providers, e.g. schools, GPs.
- **Tier 2** provision is commissioned from CNWL by Milton Keynes Council (MKC) as a key component of 'Early Help' commissioned services.
- **Tier 3** provision is delivered by CNWL and commissioned by Milton Keynes Clinical Commissioning Group (MKCCG).
- **Tier 3+** (Liaison and Intensive Support Team [LIST]) is a pilot provision is delivered by CNWL and commissioned by Milton Keynes Clinical Commissioning Group (MKCCG). The pilot runs to March 2016.
- **Tier 4** provision is commissioned by NHS England. On occasions of high demand and uncertainty of need, young people are admitted into the wards of Milton Keynes University Hospital Foundation Trust (MKUHFT) or the local adult Mental Health Unit – the Campbell Centre. The nearest unit for young people is The Sett in Northampton.

The geographical location of Milton Keynes presents specific challenges in relation to patient flows and the interface with NHS England Specialised Commissioning teams and the Tier 4 in-patient unit placements commissioned by them. This is primarily due to the academic and clinical networks of Milton Keynes predominantly facing into Thames Valley/Wessex area.

Mental Health and Wellbeing Local Transformation Plans (LTP's) – Bedfordshire and Luton

New provider guidance was issued in May 2015 to implement the requirements for 'Future in Mind'.

NHS England (NHSE) have identified five years of recurrent funding from 2015/16 up until 2020 for each CCG to implement changes to children's mental health services in recognition of the need to increase early interventions which will reduce the need for crisis services in the future and achieve parity of esteem for Children and Young People. From 2020 this funding will be base-lined into CCG budgets.

In order to release funding from NHSE to each CCG a robust assurance process has been undertaken through development of local transformation plans which includes key outcomes and KPIs against which we will be monitored to ensure the funding is spent according to the priorities identified in Future in Mind. Our local transformation plan has been completed jointly between LCCG and BCCG to ensure efficiencies in costs across specialist services such as eating disorders and perinatal pathways are achieved.

The LTP identifies the outcomes and key performance indicators' (KPI's) signed off through BCCG Executive team and both Health and Wellbeing Boards against the four priority areas:

- Eating disorders community service
- Perinatal mental health
- Early Intervention / crisis prevention
- Addressing the needs of vulnerable groups and embedding CYP- IAPT (improved access to psychological therapy) principles.

The plans provide NHSE the assurance process to enable them to release funding to the CCG. A monthly steering group titled 'Bedfordshire and Luton Future in Minds Steering group' has been set up with key stakeholders invited. This steering group will monitor the

progress of the LTP and report back through the appropriate governance structures identified into each of the organisations: Bedford Borough, Central Bedfordshire and Bedfordshire Clinical Commissioning Group.

In addition, BCCG have been successful at bidding for a further non recurrent fund of £50,000 to become part of a Schools/ CAMHS training pilot which commenced in November 2015 to support this programme. Part of the requirement for receiving this additional funding was to match fund an additional £50,000 from the NHSE allocated transformation funds. This will support KPI's identified to improve early identification and early intervention to improve outcomes for Children's mental health and wellbeing.

Community Support (Bedfordshire, Luton and Milton Keynes)

The majority of children with a learning disability and/or autism are supported to live at home in family settings. There are a number of well-regarded special day schools and children and young people are able to access a range of support options including direct payments, homecare and respite. CAMHS teams have a strong focus on behavioural support and multi-disciplinary behavioural support plans are used effectively to support the majority of children and young people to live at home, however a small cohort of individuals cannot currently be supported in this way because of their intensity of need.

There is currently a shortage of local resource to support this cohort who are at risk of moving into residential schools/ 52-week placements out of area. The BLMK area currently has a total of 35 young people under the area in such placements. There are very few admissions to CAMHS inpatient units and this is now a service of last resort. Milton Keynes currently have no children and young people in inpatient units, and there are no children or young people covered in the remit of this plan from Bedfordshire or Luton in CAMHS inpatient units.

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

There is not a significant estate in the BLMK area. The only relevant NHS estate for Bedfordshire and Luton is the Coppice, in Bromham, Bedfordshire. This is a seven-bedded unit accessed by people with a learning disability across Bedfordshire and Luton during episodes of crisis.

Locally the NHS does not directly provide accommodation or housing to individuals covered in this plan. The situation across the various local authority areas is detailed below:

Within Bedford borough partnership working is critical to meeting the housing needs of people with learning disability. There is a key role for Adult Services and the following links are also an important element to consider:

- Children's Services work with young people with a learning disability. An effective system must be in place for transition plans and year nine reviews to inform future accommodation planning and commissioning

- Bedford Borough Council does not hold a housing stock. Working with partners – particularly Housing Associations – is central to meeting housing needs.

- The Supporting People programme delivers housing related support to enable people with learning disability to live as independently as possible.

- The private rented sector is growing in size and importance within the overall

housing market. The Council's learning disability team members and Supporting People can work together on assured tenancies as a model for housing and support.

- This should include working with a range of bespoke solutions, e.g. solution housing supported by Turning Point; to make facilitate access to house ownership where that is a possibility.

Central Bedfordshire Council is committed to providing appropriate accommodation to people with a learning disability as part of its overall housing strategy.

Luton Borough Council works in partnership with a number of registered housing providers that provide either individual tenancies or small scale supported living schemes to some of the individuals covered in this plan. The council is currently reviewing its housing strategy for vulnerable adults; and is also looking to expand its own housing stock for people with a learning disability and/ or autism, particularly as there is a shortage of appropriate housing. A bid for TCP capital funding to support this is in the process of being submitted as a part of this programme.

Luton Borough Council is also building a new purpose built day centre and respite centre for adults with a learning disability. The services will be used by people with complex needs and challenging behaviour.

Milton Keynes Clinical Commissioning Group is coterminous with Milton Keynes Council, a unitary authority.

Housing in Milton Keynes is in high demand:

- There is limited housing stock directly owned by the Council.
- The majority of tenancies are a mix of the private and social housing sectors.
- Land in Milton Keynes, that is not privately owned, is controlled by the Milton Keynes Development Partnership and not the local authority

It is recognised that a cross-needs housing strategy needs to be developed in Milton Keynes for vulnerable adults considering Adult Social Care and Health and a housing steering group is to be established to manage this particular work stream. This will make best use of the available resources and provide a steer for housing partners, potential investors and developers. A combined approach is required to meet the needs of these groups in Milton Keynes and raise the profile of this work corporately within organisations at a time of extreme housing pressures across the population.

Milton Keynes has two NHS managed buildings where respite services are currently provided by the Joint Service. There is a 38-bed Mental Health inpatient unit which is rarely utilised for people with a Learning Disability and/or Autism. There is also a six bedded community unit that was decommissioned in 2013 as an LD inpatient facility, and re-provisioned for Mental Health services.

In addition to the above, the Council also delivers services for people covered by this plan from buildings it owns:

- Four day centres for adults
- A building for short breaks for adults
- A building for residential short breaks for children and young people
- A residential home for Looked after Children

The use of Residential Care has reduced locally, and is provided in housing association and privately owned buildings. The trend locally has been to de-register Residential Settings for a number of years. People have been supported to secure tenancies with social, or private, landlords and supported in their home by supported living providers. This trend is reflected in the Council's performance for Adult Social Care Outcome Framework (ASCOF) 1G indicator the proportion of adults with learning disabilities who live in their own home or with their family ("settled accommodation") with the 2015/16 Q3 performance of 80.1% compared to the England average (2014/15) of 73.3%. This will be the preferred option to support people covered by this plan wherever possible.

A combined approach, and housing strategy, across social care is required to meet the needs of the people of Milton Keynes going forward.

Moving forward the provision of additional accommodation and housing will be an essential element of the transformation plan across the partnership area.

Further detail is provided in section 4 of this plan under the heading "How will your local estate/housing base need to change". Work is in progress to develop the estates part of this plan and the overall programme which will address the demand/supply for accommodation; funding considerations and possibilities; and affordability issues/solutions. This includes the establishment of a housing steering group to scope accommodation and housing provision across the partnership and the development of an approved housing strategy for the partnership.

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

What is working well in the BLMK area?

The three CCGs and four local authorities have already taken significant steps to reduce inpatient admissions and promote individualised support to people with a learning disability and/or autism. There is already a clear focus on supporting people in the community rather than in hospital. However, there is still room for improvement and the model of care can be developed further, to reduce delayed transfers of care, provide enhanced behavioural support, develop forensic support and ensure that the individuals who are currently living in hospital or out of area have the option to live in the community / closer to home, with a personalised package of care.

In Milton Keynes and in Luton there are well-established joint commissioning arrangements and budget pooling, which lead to joined up approach to commission of care/services is this area.

Where are the gaps in provision?

The most significant gaps in provision that would enable more people to live as independently as possible in the local area have been identified as follows and how they will be addressed is detailed later in the plan:

- Lack of readily available suitable accommodation. This is one of the main barriers that prevents individuals from returning back to area or from leaving hospital in a timely manner and has been a significant factor in recent delayed transfers of care.

- Sufficient high quality community support providers to meet the range of needs covered by this plan. There are a number of providers in the area that work well to support individuals that display behaviours that can (severely) challenge in either small scale residential care or supported living units, however we need more of this

type of care provision to meet a wide range of needs.

- Limited forensic services and support. There is currently limited forensic support for people with a learning disability / and or autism in the BLMK area, for individuals who have either offended or who are at risk of offending, with no embedded/ dedicated Learning Disability Forensic Service or specialism. Following the changes made to the Criminal Justice Teams the role of Social Supervisor for those patients with a learning disability being managed in the community under the Care Programme Approach were not considered within the integrated Community Learning Disability Teams (CLDT). This has left a significant gap in current care management function that is delegated to the Local Authorities within the CLDT's.

- Limited provision and lack of clarity around care pathways for individuals who have autism but not a learning disability. There have been improvements for this cohort however we are still developing care pathways for individuals who have an autistic spectrum condition but not a learning disability to ensure that they receive the best ongoing clinical and community support

- Some areas of the partnership have significantly higher than average numbers of children and young people with severe/ profound learning disabilities, however there is no local specialist residential school to cater for their needs. There are a several highly regarded specialist day schools and good access to respite within the partnership area however these are often not sufficient to support young people with the most complex needs. Consequently, these individuals are often leaving the area, often as teenagers to access specialist residential schools. Once out of area it is more difficult to support these individuals to return to area when they reach adulthood. We would like to work with children commissioners to look at innovative solutions to support more young people stay in area and a strong focus on transition services.

It is the intention of the TCP to plug these gaps through commissioning appropriate services (See Section 4 Implementation Planning)

- The CAMHS Transformation Plan has identified a need to develop a multi-agency-approach to planning and monitoring progress for children/young people in Tier 4 placements including supporting their return to community services. Practice should be that local providers continue to case manage to ensure continuity of care and to facilitate and expedite care being provided closer to home

- There is a lack of clarity around the care pathway for children and young people with complex and challenging behaviour, including children with Learning Disabilities.

What are the biggest challenges for the current service model in BLMK partnership area over the next three years?

- The Transforming Care programme reflects the growing agenda initiated by Winterbourne View, which involved small numbers of patients with high and complex needs. Transforming Care has expanded to be about how we provide services for a much broader population with learning disability/autism, mental health and challenging behaviours. This will require much more discussion and the issue of financial resource presents a significant challenge given the unprecedented growth the councils and CCGs are experiencing.

- The TCP will need to carefully consider commissioning challenges to provide

appropriate services that provide excellent value for money.

- The need to further enhance local community services and behavioural support, develop forensic services and fund additional community packages thus enabling more people to live safely within the community with limited financial resources available

- The partnership area has only a small NHS estate and therefore limited opportunities to remodel existing (building based) services and free up capital to develop new services and/ or increase capacity.

- Population increases, particularly in numbers of children and young people with complex needs will put pressure on community capacity, schools, inpatient units and other resources.

- The ageing population of those with a learning disability and/or autism requires will also require more proactive support, integrated around co-morbidities which are more common in later life. This care needs to focus on keeping people healthy and well in the community, and maintain their independence

- Given the challenges of an increasing population, with complex needs. we will need to work hard to ensure that we do not increase the number of spot purchased beds in independent hospitals

- We will need to identify appropriate land and resource to develop new purpose building accommodation and/ or access the existing housing stock more effectively and flexibly to support more people to live locally.

- We need to enhance whole system awareness and working and enhance integration between children and adults' services

- We need to build up a skilled and flexible workforce to work with individuals whose behaviour may challenge, across the partnership area

- Local Authorities are facing further austerity measures and will have to make further substantial savings in the next three years

To address these challenges, we will build on our strengths and implement the following:

- A system wide approach across specialised and CCG commissioning, education health, and social care and other services e.g. housing, criminal justice services for those in Bedfordshire, Milton Keynes and Luton with a learning disability and/or autism and behaviours that may challenge.

- A collaborative approach to commissioning relevant services across the partnership area

- Enhanced care and support services designed to minimise inpatient care and out of area placements when it is the best place for the person concerned e.g. intensive support, behavioural support, crisis intervention and respite.

- Significant market development and provider liaison is required to achieve the

changes required by building the skills and capacity in the market, and to avoid destabilisation

What would improved provision look like?

Improvement priorities for the BLMK partnership include the following key areas:

- Further developing comprehensive behavioural and intensive support services across the partnership area, which integrate fully with crisis intervention services

- Provision of specialist forensic intervention and support for those who have either offended or who are at risk of offending to ensure that behaviours and risks are effectively managed in the community. This is likely to be a community based forensic service which provides support, assessment and intervention at all stages of the individual's contact with criminal Justice Services for a variety of offending behaviours. During years 2 & 3 of the programme we will scope the requirements for this service and develop an options appraisal and business case.

- Developing a range of accommodation and support options available to support the varying needs of people with a learning disability and/or autism who may display challenging behaviour (including young people in transition) This would include faster access, options for shared ownership and a dedicated provision for people who are at risk of being admitted to hospital or placed out of area, or those who have already been placed out of area and wish to return.

- Ensuring full and effective utilisation of all local resources for people with a learning disability and/or autism who may display challenging behaviour across the partnership area, that aim to reduce the need for inpatient care. This includes the existing services such as the intensive support team, the Coppice Crisis Intervention Service and respite/ short stay provision.

- Ensuring that the ongoing transformation of local day services and day opportunities provide a clear emphasis on supporting the needs of individuals with a learning disability and/or autism who may display challenging so that more individuals with complex needs can access this provision locally.

- Establishing a range of "preferred providers" across the partnership area creating a pool of community based providers that have a proven track record of delivering high quality, cost effective "specialist" care to individuals with a learning / disability or autism with complex needs and behaviour that may challenge services. This would help provide economies of scale across the TCP and avoid duplication of effort.

- Developing a well-defined care pathway and a range of support options for individuals who have autism but do not have a learning disability.

- Developing a wider understanding of the factors that can lead to behaviours that challenge, and models of care that promote active support and positive behavioural support across the health and social care workforce to help prevent the incidences of challenging behaviour and to enhance independence and community involvement across learning disability services in the partnership area.

- Aligned to this is working alongside children's services and CAMHS to gain a better understanding and awareness of the factors that lead to children and young people

with complex and /or intense needs moving into 52-week placements out of area before they reach adulthood. From this we will need to learn, explore best practice and develop more innovative solutions for supporting children and young people with this level of need to live within area.

- An integrated care pathway for children and young people with complex and challenging behaviour, including children with Learning Disabilities which includes a diagnostic service for Autistic Spectrum Condition (ASC), Attention Deficit Hyperactivity Disorder (ADHD) and conduct disorders which meet the needs of 0 to18 year old Children &Young People (C&YP).

- In consultation with children, young people and their families, the pathway for a young person with a learning disability will be developed and strengthened including existing services that promote mental health and wellbeing for C&YP with specific needs including long term physical conditions, and children with Learning Disabilities so that children with specialist needs have access to psychological support.

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

A finance template has been completed by the three CCG areas and is now shown as a combined template for the whole TCP area. This can be found as a separate attachment and includes notes and caveats as appropriate and where possible.

3.Develop your vision for the future

Vision, strategy and outcomes

Describe your aspirations for 2018/19.

Projected end state: Adults

Table 3.1 TCP inpatient population in beds in footprint

Unit (NHS)	Unit (Non NHS)	CCG or NHSE?	Type of bed	No of beds	No of beds to be commissioned / contracted by TCP	No of beds required by TCP**
NHS Unit		CCG	Crisis	10	10	10
NHS Unit		NHSE	Secure	UK*	0	4

*UK = Unknown

**The aspiration for the partnership is for all partners to move to the model where inpatient beds are used for crisis only enabling people to remain within the community as far as possible. However care will be planned around the person and the best course of action may be to make a longer term of arrangement. Due to the low numbers involved it is anticipated that this would be out of area

Table 3.2 TCP inpatient population in beds outside footprint (out of area)

Unit (NHS)	Unit (non NHS)	CCG or NHSE?	Type of bed	No of beds required by TCP
	Non-NHS units	CCG	Locked Rehab	1
	Non-NHS units	NHSE	Secure	7

Note that the level of need both within and outside the footprint is dependent upon the right package of support for the individual and this may not be available within footprint.

Projected end state: Children

Table 3.3 TCP inpatient population in beds in footprint

Unit (NHS)	Unit (Non NHS)	CCG or NHSE?	Type of bed	No of beds	No of beds to be commissioned / contracted by TCP	No of beds required by TCP

Note – at this stage it is anticipated that there will be no in area provision.

Table 3.4 TCP inpatient population in beds outside footprint (out of area)

Unit (NHS)	Unit (non NHS)	CCG or NHSE?	Type of bed	No of beds required by TCP
	Non NHS Unit/NHS*	NHSE	Secure	4

Note that the level of need both within and outside the footprint is dependent upon the right package of support for the individual and this may not be available within footprint.

What are our aspirations for LD services and outcomes?

Quote from service user following repatriation after a 2-year period in hospital out of area

"I have a lot more freedom here, as now I have left hospital I'm doing a lot of things myself, and I don't need a lot of help from anybody really"

"In the past I needed a lot of support, I'm pretty independent now"

The vision of this partnership is that we will work with service users, their families and carers and other stakeholders to deliver a plan that

- reduces the numbers of in-patient admissions required for people with a learning disability and/or autism
- manages effective discharge and transition for people in hospital
- builds resilient community services to support people to live as independently as possible in the most appropriate community setting.

At this stage the BLMK transforming care partnership "vision statement" matches that of the national service model:

"*Children, young people and adults with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition have the right to the same opportunities as anyone else to live satisfying and valued lives and, to be treated with the same dignity and respect. They should have a home within their community, be able to develop and maintain relationships and get the support they need to live a healthy, safe and fulfilling life"*

Source: Supporting People with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition: Service Model for Commissioners of health and social care services, October 2015.

The localised vision for the partnership was discussed further at a workshop supported by NDTi on 23rd March and discussed further in the TCP Programme board taking place in the afternoon of the same day. The localised vision will be developed further during the early stages of the programme (Q1 2016/17) with a focus on the individuals, their families and carers and their normal life and aspirations. This will take into consideration evidence based best practice and look at opportunities for innovation in prevention, workforce and market development.

Purpose and aims of the BLMK transforming care partnership

The purpose of the BLMK transforming care partnership plan is to bring about greater collaboration and strategic planning across adults and children's services and commissioning agencies to deliver an improved model of care for people with learning disabilities and/or autism with challenging behaviour across the partnership area. This will promote prevention and early intervention and further reduce admissions to hospital and inpatient units and delayed transfers of care. A significant part of our plan will also be about enabling more people to have a long term home in the local area, rather living in out of area placements.

The partnership expects that care and support will:

- Be closer to home (within partnership area)
- Informed by best practice
- Be personalised and responsive to individual needs over time
- Be based on individuals' needs and wishes (and those of their families)
- Be of high quality
- Provide value for money

The expected outcomes for people with a learning disability and or autism as a result of the transformation are:

- More people with learning disability and/or autism will be supported to live locally in the community/in their own homes, this includes people who are currently living out of area in residential placements and young people who are transitioning into adulthood.

- The frequency of people displaying behaviours that challenge will be reduced, as will the severity of behavioural episodes

- People with a learning disability and/or autism who display challenging behaviours will be supported and enabled to live safely in their homes wherever possible

- In the long term fewer people from the partnership area will be admitted to non-secure and secure hospitals, with fewer beds in independent hospital spot purchased for the Bedfordshire, Luton and Milton Keynes population

- Delayed discharges will be minimised

- Any necessary inpatient stays will be as close as possible to the individual's home and support networks, and for the shortest period necessary

- People with a learning disability and/or autism who display challenging behaviours will enjoy an improved quality of care and an improved quality of life

- More people with a learning disability and or autism will have a personal health budget or integrated personal budgets and more joined up planning over the course of their lifetime

How will improvement against each of these domains be measured?

The following national indicators are likely be used to measure improvements:
Table 3.01 National Indicators and source of data/evaluation tool

Indicator	Source of data/ evaluation tool
Reduced reliance on inpatient beds	Assuring Transformation Data Set
Quality of Life	Health Equality Framework
Quality of Care	To be confirmed, NHS England is supporting the development of a basket of indicators around personal budgets, direct payments, personal health budgets and other evaluation methods. This will be considered as a part of the programme. See Appendix A.

Alongside the quantifiable measures outlined in Appendix A, we will also measure our success against the expected outcomes identified above and against individuals' perceptions and outcomes in relation to the care and support they receive. The Building the Right Support service model "Supporting people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition" October 2015 defines 9 principles seen from the point of view of a person with a learning disability and/or autism:

- I have a good and meaningful everyday life
- My care and support is person-centred, planned, proactive and coordinated
- I have choice and control over how my health and care needs are met.
- My family and paid support and care staff get the help they need to support me to live in the community
- I have a choice about where I live and who I live with
- I get good care and support from mainstream health services
- I can access specialist health and social care support in the community
- If I need it, I can get support to stay out of trouble
- If I am admitted for assessment and treatment in a hospital setting because my health needs can't be met in the community, it is high-quality and I don't stay there longer than I need to

We will aim to build a local set of statements working with people to develop them. As an example, these could include working with people to develop "I statements" such as:

- I am safe
- I am supported to keep in touch with my family and friends
- I have regular care reviews to assess if I should be moving on
- I am involved in decisions about my care
- I am supported to make choices in my daily life
- I am supported to live safely and take an active part within the local community
- I get good quality general healthcare
- I get the additional support I need in the most appropriate setting
- I get the right treatment and medication to keep me well
- I am protected from avoidable harm, but also have my appropriate freedom to take risks
- I am treated with compassion, dignity and respect
- I have a choice about living near to my family and friends
- I am cared for by people who are well trained and supported

(These have been adapted from "Transforming Care for people with learning disabilities in Arden, Herefordshire and Worcestershire" and will be reviewed and updated by local Service Users and Carers to meet local requirements)

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

Policy, Legislation and locally agreed underpinning principles

The BLMK partnership will follow the main principles of the key Department of Health policy documents for people with a learning disability and autistic spectrum conditions. These include the long established strategy "Valuing People: A New Strategy for Learning Disability for the 21st Century" which fully promotes the rights, independence, choice and inclusion of people who have a learning disability, "Think Autism" and "Fulfilling and

Rewarding Lives: The Strategy for Adults with Autism in England." These national strategies promote the principle that adults with autism have the same rights as everyone else, and that they should be able to access services and participate in society on an equal basis

The partnership will also work to the key principles set out in primary legislation including The Mental Capacity Act (2005), the Care Act (2015) and Children and Family Act (2015), collectively these will support us to meet out aspirations, objectives and expected outcomes by embedding the following underpinning principles:

- Service users and their families will be at the heart of decisions about their care, they will be provided with more choice and control over their care, this includes promoting a culture of positive risk taking and coproduction.

- We will assume a person has the mental capacity to make decisions about their care, unless it is established that they lack capacity for that specific decision – and all practicable steps will be taken to support the individual make their own decisions

- We will establish the extent of a person's mental capacity as soon as there is any doubt as to whether the person has the mental capacity to make decisions

- Services will be commissioned which promote local solutions, prevention, early intervention and wellbeing to support people of all ages, including children, who are at risk of developing challenging behaviours and minimise inappropriate admissions to hospital, and the Criminal Justice System

- We will encourage the use of mainstream services as the starting point for care and support, available and accessible for those with a learning disability and/or autism

- Where mainstream services are insufficient to meet a person's needs we will provide access to specialist multi-disciplinary community based housing and support expertise

- We will work in partnership with care and housing providers, as well as others stakeholders to deliver the transformation agenda and ensure people's homes are in the community

- Commissioners and providers of care and support across the partnership area will collaborate and share knowledge, experience and best practice to achieve the best outcomes for service users, this includes collaborating regionally across the wider Eastern Region and with NHS England specialised commissioners where appropriate

- People involved in implementing the plan will use a problem solving 'can do' approach

- We will develop cost effective services which promote individuals' independence

- We will provide support in the least restrictive setting possible that is therapeutic and safe for all. Where restrictive interventions are required they should be for the shortest time possible

- We will proactively use intelligence from a range of sources to identify and respond to commissioning gaps and to facilitate and shape the local health, social care and housing market

- We will protect those with a learning disability and/or autism from abuse and neglect wherever possible, and address safeguarding concerns as soon as they arise

- We will ensure that people with a learning disability and/ or autism and their carers have access to advocacy support to voice their views at all stages of their journey.

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

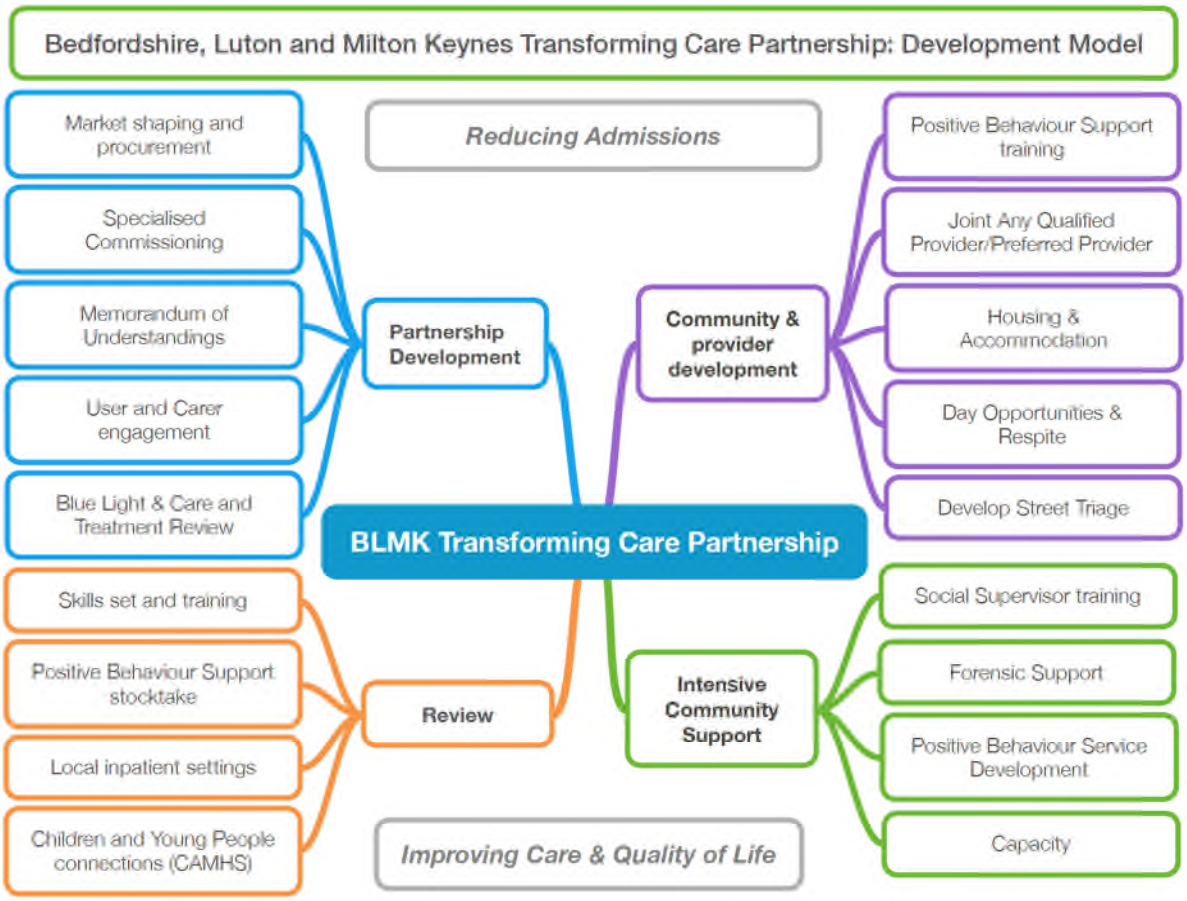
A draft finance template has been completed by the three CCG areas; the combined template can be found as a separate attachment.

4.Implementation planning

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

Overview of your new model of care

Chart 4.01 Bedfordshire, Luton and Milton Keynes Transforming Care Partnership: Development Model



Our current plan has three key phases to deliver this model and can be summarised as follows:

Phase 1 – 2016/17

- Establish the foundations of a tri-CCG approach to transforming care; this will include establishing a formal agreement across the three health commissioners. The purpose of the agreement is to formalise a memorandum of understanding on how the areas will work together in a way that enhances our services and improves the offer available.

- Development of a stakeholder engagement and communications strategy and plan also to incorporate:
  - Further engagement with the two Autism Partnership Boards and three Learning Disability Partnership Boards and four Carers Partnership Boards to ensure that

we are all working together on this agenda, and that we have appropriate representation at both reference group and Transforming Care Board levels

- A review of the way we are involving people from all five cohorts in the design and development of the local service model to ensure we have ways of including all of them in ways that are meaningful to them.

- Working with Children's and Transitions Services to establish how they wish to lead on this aspect of work, and how we will work together towards the all age approach that is required

- A joint approach will include sharing systems for working and commissioning providers, such as a joint Preferred Providers List (PPL) / Any Qualified Provider (AQP). We will jointly scope our market position and the viability of an enhanced supported living scheme across the footprint for those aged 16-25 years. This scoping will include Continuing Health Care (CHC), out of area placements and challenging behaviour.

- Further work on identifying the number of current and future patients likely to require forensic support. The formulation of a TCP footprint approach to this group also provides wider opportunities to understand and enhance day opportunities and respite for at risk groups.

- Development of a cross-needs housing strategy for vulnerable adults considering Adult Social Care and Health and including those with a learning disability and/or autism and challenging behaviours

- During this phase we will implement a process to share information, intelligence and quality data on the various providers of support and hospital admission.

- Robustly work on our data to ensure its validity and aid accurate and effective planning for Phase 2 and 3 to inform any regional commissioning outside of this partnership.

- We will look to extend the scope of the PPL/AQP to include social care across the TCP footprint.

The activities from Phase 1 will inform both Phases 2 and 3 which are likely to expand. The plan needs to be have sufficient flexibility to respond to newly identified and changing needs

Phase 2 – 2017/18

- We will understand, plan and cost a community based forensic solution focused on reducing the offending and reoffending rate of people with a learning disability/autism.

- We will scope out the unmet needs of individuals who have autism but not a significant learning disability to map out gaps in service provision and how the care pathway can be improved for this cohort.

- We will scope out the factors leading to 52-week out of area placements for children and young people under 18, and start to map out how the care pathway and models of support can be improved for this cohort.

- We will model the TCP footprint inpatient requirement assuming a reduction in out of area placements of 75%.
    - building up our community services- more providers providing better quality support accommodation
    - up skilling of our community workforce – preventing admission/reducing potential for people to escalate to a crisis situation
    - more robust service specification and monitoring of providers
    - increased provision of respite services
    - Improved transition plans for people returning to area

Phase 3 – 2018/19

- We will aim to build the capacity and capability of the market for community services, potentially commissioning a TCP forensic service working together across the footprint if appropriate.

- We will jointly provide an inpatient learning disability /autism solution across the TCP footprint, with a reduction in the average length of stay. Delivering a service model across the footprint that draws on a shared understanding of positive behavioural support, an emphasis on support being provided where the patient is, and available 24 hours a day seven days a week.

- We will start to explore an "all age integrated" approach for care, support and financial planning for the cohorts covered in this plan

Delivering this transformation requires significant planning and implementation effort, and a programme to achieve this will be in place for at least the next three years.

What new services will you commission?

The BLMK partnership will commission:

- Additional (individualised) care packages for those who are either currently in hospital, out of area residential placements (school) or living at home with families. This may involve collaborative procurement for priority commissioning areas (see above)

- Social Supervisory training for care managers within the Adult Learning Disability Teams in the Local Authorities to enable and skill the work force to manage those individuals who are under CPA and require a Social Supervisor.

- Training around Positive Behavioural Support (including cascade training) to up skill and develop a framework for the learning disability providers and family carers. This will be intelligence led and developed in partnership with in both the health and social care arena to enable providers to offer a higher quality and safe support to people living in the community.

- A review of transition services for young adults to include modelling a small intensive support unit shared across the partnership, with a view to procurement

- Specialist forensic intervention and support for those who have either offended or who are at risk of offending to ensure that behaviours and risks are effectively

managed in the community.

- Engage and scope innovative approaches to support more young people to stay at home or in area rather than move to residential school out of area and away from their friends and family network. This will be done in partnership with key stakeholders to enable the exercise to be system wide.

What services will change or commission less of?

The key expectations of the BLMK TCP Partnership are to:

- Reduce the usage of spot purchased beds in independent hospitals in the long term. This will be achieved by making more effective use of NHS learning disability crisis intervention services and mainstream mental health beds in area.

- Commission high quality and sustainable community based care and support packages; rolling out a programme for positive behavioural support; and where necessary intensive support, for those at risk of admission; as key measures to prevent the escalation of challenging behaviour.

- Commission fewer residential care placements out of area (including 52-week placements for children and young people). The partnership plans to develop appropriate (supported living) services in area. These will focus on young people in transition and individuals moving back into area from out of area placements, as well as providing long term support for those currently living with family members or carers as required. This will include:

    - the identification of additional providers of respite services to support children and families and reduce the risk of a crisis situation developing
    - scoping the potential for providing additional, specific therapeutic support for children outside what is currently provided by NHS or social care provision

- The provision of high quality and personalised support in area will positively promote continuity of care, independence and increased stability for the individuals concerned, with reduced the likelihood of placement breakdown.

- Individually and collectively, partner organisations will work with stakeholders, including people with Learning Disability and/or Autism, to identify additional services that do not add significant value to their lives to consider using resources more effectively in other areas.

- Over time commissioning will be towards those services that work and hence those that have no evidence base for better outcomes can be de-commissioned

More detailed proposals as to how the partnership can work towards significantly reducing the number of 52-week out of area placements for children and young people will emerge after initial scoping in Phase 2 of the partnership plan once we have a clearer picture of the key factors and challenges influencing current practice.

It should be reinforced that CCG's within the partnership area have already taken significant steps to reduce reliance on inpatient care and it is therefore not considered appropriate to further reduce residual NHS acute crisis inpatient beds.

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

The phase plan detailed above in the section "Overview of your new model of care" details how service transformation will be achieved.

Below we have identified some of the key changes that existing services will need to make within the lifetime of this plan. Individually and collectively, partner organisations will need to work with stakeholders, including people with a learning disability and/or autism, to identify what other changes existing services might to make to add the most value and make better use of available resource. All services will be encouraged to self-audit as a part of the clinical model work-stream.

Specialist Learning Disability Services

Commissioners will need to work with specialist services to ensure that all services delivered meet requirements of this plan, in particular this will require a review of capacity for forensic support and intervention for those whose have either offended or who are risk of offending. Commissioners will also need to work with specialist services to ensure that there will be adequate specialist medical and psychological support for individuals returning to area from long stay hospital placements.

NHS Acute Crisis Service and Intensive Support Teams

The partnership will explore the possibility of the Coppice acute crisis intervention unit taking limited referrals from Milton Keynes, as well as Bedfordshire and Luton This will involve a full options appraisal/ feasibility study. This action will support the objective to reduce usage of spot purchased beds in independent hospitals as Milton Keynes has no acute crisis inpatient service at present and currently uses independent hospitals for this type of provision.

A gap analysis will be taken forward by ELFT to review the Coppice and IST. We will build on the AIMS LD accreditation review for these services that is due to take place in Quarter 1 2016/17 to identify any gaps in service provision and any further changes required to make improvements. The ambition is to have a responsive modern crisis intervention service that can be utilised across the partnership.

The partnership would also ideally like to increase the capacity of the intensive support teams, this would enable a greater presence in and closer joint working with community teams in each of the local authority areas, and increased focus on crisis avoidance and potential further reduction in inpatient usage. We have submitted a bid to fund additional nurse support for the intensive support teams

Care Management

Care coordinators across the partnership will continue to operate a person centred approach ensuring where possible that the MDT provides a timely and responsive approach that avoids crisis and prevents hospital admissions. Care coordinators are well placed to promote the use of personal health budgets and direct payments to maximise choice and control for customers and their family carers and to ensure advocacy support is accessible when needed. The partnership will ensure that care coordinators have the right skills to respond appropriately to customer needs as they step down from secure and acute inpatient settings.

Independent hospitals

Within the transformation agenda it is essential that independent hospitals consider future

demand and the likelihood of a reduction in overall bed base. We will work with independent hospitals and inpatient units to encourage them to review existing service models so that they align with new models of care and are clearly focussed on a care pathway that supports focused interventions, timely and well supported discharges and develop expertise and innovation in community settings rather than hospital.

Community Living

Care and support providers will need to continue to ensure that they have well trained and supported staff so that they can build confident, consistent and competent staff teams to support the individuals in each of the 5 cohorts. They will also need to ensure that staff have effective skills in positive behavioural support and active support, to build on individuals' strengths and independence and deescalate behaviour that may challenge. Providers will also to ensure that they are able to recruit an increasing number of appropriate staff to support people to live in the community, adopt a proportionate and positive approach to risk taking, develop crisis prevention plans and deliver responsive services that demonstrate clear outcomes and offer excellent value for money. It will also be essential for care and support providers to work in partnership with commissioners and housing providers to develop sustainable housing solutions.

During our review and scoping of day opportunities and respite services which are currently being reconfigured, we will ensure that the needs of our transforming care cohorts are fully incorporated into the service transformation plans

Wider pathway

Commissioners, the health facilitation teams and Intensive Support Teams will need to step up their approach to ensure that the wider health and social care workforce and mainstream services (including mental health inpatient units) are up-skilled in making reasonable adjustments for people with a learning disability and /or autism. The ongoing development of the wider workforce will help ensure improved access to mainstream services where appropriate, continuity of practice and enable flexibility and person centred approaches, all of which support promote equality and the implementation of this plan.

CAMHS

Commissioners will need to work with CAMHS services to identify strategies in supporting more children and young people with complex/and or intense to live at home rather than in 52-week residential placements out of area or in hospital. This will build on good practice already in place around home based intervention and behavioural support, best practice and innovation.

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

Personalised Support in Hospital and Inpatient Settings

Patients who access the Coppice acute crisis intervention service will continue to receive integrated and person centred support from IST throughout their stay to provide seamless and focused support and continuity of care.

Patients admitted to inpatient settings will have timely Care and Treatment Reviews on or shortly after admission in accordance with national and local protocols to ensure that hospital is the most appropriate setting and to make sure that patient receives both high quality and focused inpatient care, with clearly defined expected outcomes and person centred discharge planning

Person centred care and support plans will be developed with the patient and or their family during their stay and will likewise aim to ensure that care is person centred and has clear objectives which will support them to build their independence when they return to the community. Additional tools such as communication passports will also be developed as required.

We will also continue to ensure that individuals in inpatient settings have access to good quality advocacy

Quality and contract monitoring arrangements will monitor and evaluate the extent to which individuals are receiving personalised support in inpatient settings.

Personalised Support in the Community

The intensive support teams will continue to provide person centred support aimed at admission avoidance and integrated care model.

Through the provision of information, market shaping, market development and focused procurement we will aim to improve the range and choice of providers across partnership area to cater for the range of needs of those covered by this plan. We will ensure that service users get good quality information about the services available and will develop a market position statement for the partnership area with the aim of building up a strong network of providers and a common preferred provider list that details local providers that have a good track record of providing person centred care to people with behaviour that challenges and complex needs.

To complement this approach, we will continue to move towards an outcome based approach to commissioning and through our various quality assurance mechanisms focus on key outcomes such as quality of care and support, quality of life and increased independence and community participation.

Accommodation – we will aim to increase the range of accommodation options available to the individuals covered in this plan, exploring innovative and joined up solutions. We will explore shared ownership, etc.

The partnership area will continue to promote the use of personal budgets, personal Health Budgets and Integrated Personal Commissioning for people with a learning disability. An example of the local offer is attached (in this case for Milton Keynes) as appendix B.

One of the CCG areas (Luton) has become an Integrated Personal Commissioning (IPC) demonstrator site. IPC is a new initiative being piloted by NHS England to join up health and social care for those with high level, complex needs. It fits well with the transforming care agenda as it shifts power to the individuals who access health and social care, allowing them to shape services around their needs instead of fitting around standard service provisions. The goals of the programme are to create a better quality of life for those with complex needs and their carers, prevention of crises that lead to unplanned hospital and institutional care, better integration and high quality of care. IPC will involve producing one care plan which covers all the health and social care needs of the individual and an optional integrated personal budget, where appropriate, to enable those needs to be met with the services of the individual's choosing. The programme runs for three years – individuals with a learning disability and/or autism will be in a phase within the next two years. We will identify individuals who fall within the remit of this plan who would be interested in taking up IPC as part of the pilot.

We will also continue to offer personal budgets and personal health budgets across the partnership and enable and support higher uptake, working with advocacy organisations to

shared information and encourage uptake. Luton is an early adopter of personal health budgets and this experience will be shared with the partners to support successful delivery.

We will continue to support individuals to complete and update their person centred plans, health action plans and health checks to ensure the development and delivery of personalised support packages

The partnership will work with the wider learning disability workforce to raise awareness of approaches such as positive behavioural support and active support to help to develop a proactive and positive approach to working with individuals whose behaviour may become challenging.

The partnership will continue to provide advocacy support for individuals in the community to ensure that voice of the most vulnerable is heard and we will fully engage with people with a learning disability and/ or autism through the relevant partnership boards, focus groups and co-production projects to ensure they are partners in the review of existing services and the design of new services.

Advocacy service in Bedfordshire

An example of the work currently being done to improve the advocacy service within the partnership comes from Bedfordshire where BCCG, CBC and BBC are committed to providing accessible and safe services within its budget envelope and has, in partnership, redesigned the Advocacy Service model to ensure it reaches the vulnerable people it is intended for, whilst meeting its statutory obligations.

Partners have been working with the current provider, POhWER, on the service redesign for 2016/17.

The redesigned advocacy service is summarised as follows:

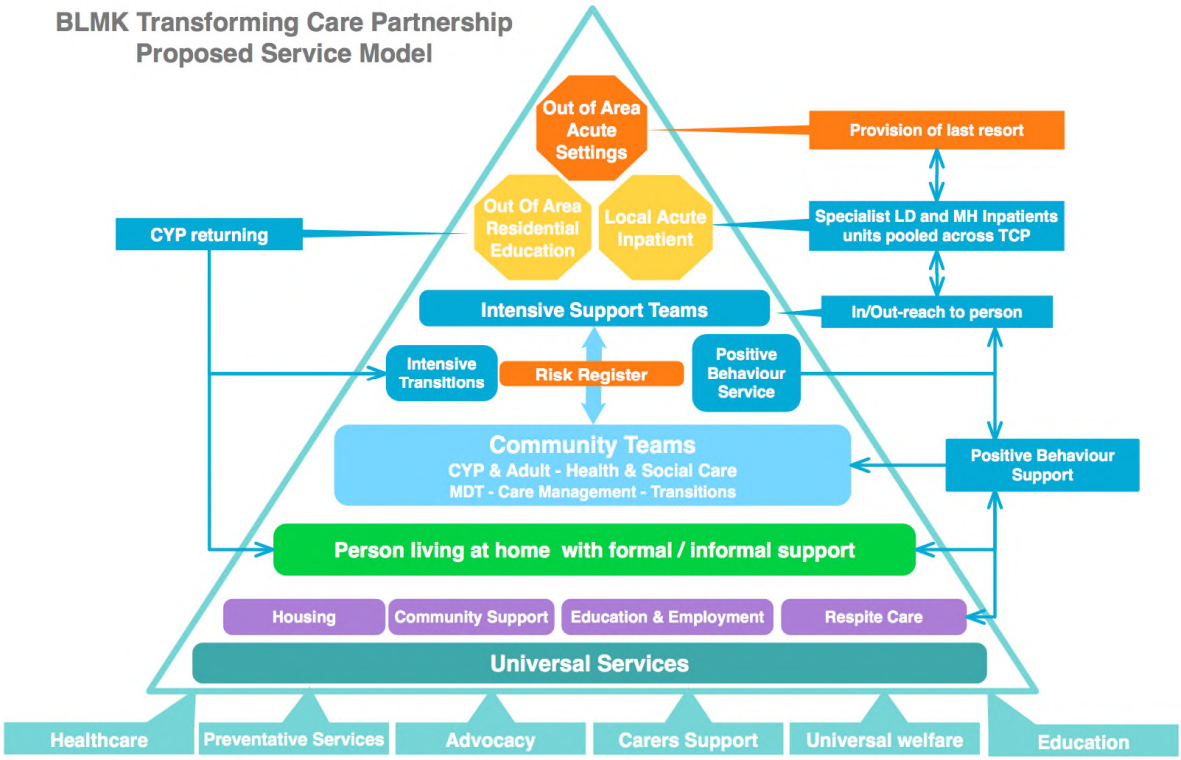
- Meets all necessary statutory requirements.
- Provides the best standards of care and support for people using our services within available financial resources.
- Ensures best value for money.
- Introduction of eligibility criteria, to ensure advocacy services are in place for vulnerable people.
- Local Authorities will work with support organisations where possible to signpost people to the most appropriate service.
- BCCG has committed additional funding to support the Care Treatment Reviews, in turn helping to keep people out of hospital as part of the Transforming Care Workstream.

It is intended that the advocacy contract will be re-tendered for 2017/18, with work beginning on the procurement of the new contract in the first quarter of 2016/17. The purpose of this is to continue to ensure best value for money whilst ensuring the service meets all statutory requirements and provides the best standards of care and support for people using the service.

What will care pathways look like?

The proposed service model is in development and will be further developed as a part of this programme; however, the current proposed model (as of 11th April 2016) is depicted in Chart 4.02 below.

Chart 4.02 Bedfordshire, Luton and Milton Keynes Transforming Care Partnership Proposed Service Model



As described previously the current configuration and alignment of services across the partnership varies both from area to area, and between children's to adult's services. Hence the proposed service model in the diagram above is not specific to one area but rather details the structure of services and interventions that can be flexed around the individual.

The proposed service model will mean the reconfiguration and development of existing community resources. The diagram above shows how the principles of Positive Behaviour Support (PBS) will move with individuals through the system and wider services.

The investment in PBS training across the partnership will help the recovery of complex individuals by enabling a more consistent approach across services. This learning will also cascade to develop services to best meet the needs of people and stop an escalation of these needs.

The aims of the model are to:

- Support people in settled accommodation as close to their informal networks as possible.
- Ensure the support they receive is positive and proactive.
- Ensure the support accessed is embedded in their community.
- Up skill the wider workforce to support lower level risk groups effectively and avoid future escalation of need.
- Further develop specialist interventions that can be applied flexibly across the system as required.

A more joined up approach both within systems, and across the wider partnership, will

enable a better understanding of those who may be at risk of admission and the adjustments and support needed for existing services to deliver individual approaches to maintain peoples wellbeing.

The aim of the model is to move away from a purely pathway approach to care and support, where people enter and leave a system, to a flexible model that can wrap around individuals and those who care for them, at times of need.

How this model will look in practice will likely continue to vary from area to area. As the partnership embeds, and strands of the plan are implemented, the consolidation of these practices will produce more joined up ways of working and drive the transformation of care across the partnership.

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

Across the partnership young people are currently referred into adult social care around the age of 16 years and this practice will continue. There are dedicated transitions workers in the community learning disability teams who work with the majority of young people transitioning through from children's services to ensure a smooth, well planned transition.

Young people (and their parents / carers) are introduced to the idea of preparing for the adulthood from the age of 14. This is a statutory obligation for young people with Statements of Special Education Needs.) Locally there are still issues in relation to young people getting the most appropriate support when they become adults and leave (educational/ residential) placements as there are not always appropriate services available locally. This is a priority need for the partnership to address. There are also still some problems for some young people who do not have a significant learning disability because it is not always clear which team is best placed to work with them. We will continue to develop a clear and effective pathway for these groups and develop appropriate local services so that young people have opportunities to return to area and receive the high quality support. We need to make sure that we are investing in the right services and building capacity to meet the needs of the growing number of young people moving into adulthood as it is projected that numbers will grow very significantly from 2020 in some parts of the partnership area.

We also need to embrace partnership working with young people, their families and carers involving them fully to make sure that we are building the most appropriate person centred services for the future. We will also review existing resources accessed by young people to make sure that they are person centred and enable people to gain independence and meet their individual goals.

How will you commission services differently?

Across the partnership there will be an increased focus on outcomes when commissioning services, notably around the quality of care and support, and the quality of life enjoyed by those with a learning disability and/or autism, and their family and carers.

The partnership will develop a joint market position statement and strategy and engage in collaborative commissioning to establish a common preferred provider list (PPL/AQP) and undertake shared procurement exercises where this is beneficial. This way of working will help form a "critical mass" of people in need of specific services which will encourage providers to establish themselves within the locality and create some degree of "economy of scale" This will help overcome some of the problems previously experienced in

commissioning services.

The TCP and commissioners will need to work with the independent and third sector to ensure there is a vibrant and high quality market to support the needs of people with complex needs. As different models of care emerge local commissioners will need to explore opportunities to commission services in different ways to fit people's needs with a range of providers.

Greater understanding of the children's and autism population will mean commissioning arrangements may need to change. Market development activities will be required where providers do not currently have the capability required.

The increase in complexity of needs and also the increased use of personal budgets and personal health budgets means that a small niche of providers is likely to be required to address some of the accommodation requirements. Therefore, commissioning mechanisms, as well as market development activities, are likely to need and encourage a much smaller type of provider.

Luton and Milton Keynes have pooled budgets in place across their CCG's and Councils. These arrangements will continue.

Bedfordshire do not have a pooled budget arrangement for learning disabilities, however there is a S117 Protocol in use between Bedfordshire CCG, Central Bedfordshire and Bedford Borough Council.

The purpose of this protocol is to:

- Establish a locally-agreed shared understanding between the responsible authorities in Bedfordshire, of their obligations under Section 117;
- Provide guidance to practitioners responsible for the delivery of Section 117 Aftercare in Bedfordshire, and;
- Ensure the consistency and quality of aftercare services provided under Section 117 across Bedfordshire.

Funding for Section 117 aftercare is a joint responsibility of Bedford Borough Council or Central Bedfordshire Council and Bedfordshire Clinical Commissioning Group. Funding responsibility is determined by the primary mental health need of the patient and the nature of the service provided. There are three possible options for funding arrangements and these include shared funding, Bedfordshire Clinical Commissioning Group funding where the individual is assessed to have a Primary Health Need (PHN) and Local Authority funded care.

If a patient is assessed to have both social care and health care needs under Section 117 then funding is shared between Bedford Borough Council or Central Bedfordshire Council and Bedfordshire Clinical Commissioning Group on a 50:50 basis, e.g. a joint package of funding whereby Bedford Borough Council or Central Bedfordshire Council pays for accommodation and personal care support services and Bedfordshire Clinical Commissioning Group pays for additional therapeutic services or other healthcare support/interventions.

In June 2014 the Joint Improvement Programme audited Bedfordshire as a site in relation to their Transforming Care programme of work. A report was produced detailing the outcome of the audit and a number of recommendations were identified. The report states that BCCG and BBC / CBC are working together '*excellently'* and have developed *'high level of trust and confidence in each other'* but the formal financial planning and joint funding approaches

are *'relatively underdeveloped'.* The report went on to further describe:

> *'Progress had generally been made because a few people got together, decided to do something, and persuaded other people to let them get on with it. Generating a sense of shared ownership – rather than a written document – was often the starting point. Whilst it is good to encourage this sense of 'entrepreneurship', it means there is always a risk that work will stop if some key people leave or the organisations decide to withdraw support. Also, it means that different people may have different understandings of what the work is about and what it is trying to achieve'.*

A recommendation was to develop a local joint commissioning protocol in place of pooled budget arrangements to enhance the current joint working and commissioning arrangements. The key principles for this joint commissioning protocol are:

- document the key working principles
- document the processes already in place to commission joint packages of care for people with learning disability with complex needs between BCCG and BBC
- define the locally agreed shared understanding between the responsible authorities
- ensure continuity of care in the absence of key individuals and to thereby minimise risks to patients
- formalise the escalation routes in the event of disagreements

Case study: How innovative commissioning enabled three Bedfordshire patients to step down into supported living in the community

In December 2014 Bedfordshire CCG was served notice by an independent hospital that required three patients to be moved from the provision within a number of weeks. There was no provision identified locally for this cohort of patients and they all presented with behaviour described as challenging.

The CCG waivered a procurement process enabling the commissioner to approach three providers requesting that they submit plans as to how they would provide care and support to these three individuals based on their assessed level need.

The multi-disciplinary team (MDT) within the hospital setting made recommendations and the level of staff support was 3:1 in the community for these patients.

One of the three providers presented a plan whereby they would purchase an identified property within the patients Local Authority area and convert the property into seven one-bedroom apartments. The apartments would have their own front door however the scheme would have shared living space both inside the property and outside the property to enable integration for those who wanted to socialise. This would also enable floating staff support so that there would be flexibility within the service to manage unplanned situations should they arise.

The three patients had to be discharged from the hospital due to closure and an interim provision was set up as the scheme was not ready. This required the provider, commissioner and care coordinator to work with a registered social landlord where an old bungalow was converted into living areas for the three patients whilst the scheme was being purchased and built. One of the patients had not left the hospital building for over a year

and a full CPA, MCA and BI was carried out. The outcome was that the patient was sedated and conveyed via secure ambulance to the interim premise with a medical team on board. The patient would challenge if attempts were made for him to leave the site. All patients were discharged successfully into the interim placement which was a supported living scheme whilst the actual scheme was built.

The patients and their families were heavily involved in the design of the apartments and they were purpose built for the individuals with the support of occupational therapists (OT's) to enable reasonable adjustments to be made that were bespoke to the individual.

The patients moved into their new home in March 2016 and the patient who previously required a secure ambulance and sedatives, was conveyed to his new home in his hire vehicle with no PRN medication administered.

The scheme is fully operational now and individuals who are placed out of area in specialist residential / educational placements and who were placed out of area as there was no provision locally that could meet their needs are now being assessed for a placement within this new scheme.

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

Changes to the local NHS estate

As explained in Section 2 there is limited NHS estate relevant to this plan in the BLMK footprint and therefore there are no real opportunities for recycling of capital receipts.

The limited local specialist learning disability inpatient unit provision will be reviewed across the partnership. It is anticipated that there will be a small increase in local NHS acute crisis provision. We expect that that by moving to this model we shall see:

- Focussed intervention at times of crisis
- Inpatient care closer to home
- A long term reduction in the net number of inpatients placements across the partnership (including placements in independent hospitals)
- A reduced length of stay (for current acute model average length of stay is seven weeks and we would expect this to align across the partnership)
- Improved quality assurance and AIMS LD accredited service provision.
- Increased local ownership across the partnership.
- Improved discharge and transition planning for a partnership provision.

Changes to the wider housing base

As identified in earlier sections of this plan suitable and readily available housing and accommodation are currently in short supply for the five cohorts of individuals within the remit of this plan and will be required to prevent delayed discharges and enable more people with live in the community within the BLMK area

We plan to work in partnership with the housing departments of four unitary authorities within the partnership to review the existing housing strategies for vulnerable people (including those in the five identified cohorts). We will feed into this review the anticipated demand generated by the transforming care agenda over the next five years. It is likely that registered housing providers and private landlords/ developers will have a significant role to play in meeting future housing need and we will ensure that anticipated demand is also reflected in the market position statement developed across the partnership area.

There are significant challenges in sourcing sustainable and affordable housing solutions,

particularly in view of rising housing prices, rent levels, uncertainty about future housing benefit and grant funding. For new developments. At a local level a good deal of work has already been initiated to engage with both council housing departments and registered housing providers to raise awareness of housing need related to transforming care and to start to find solutions in meeting it. We will need to take a range of approaches if we are going to be successful in meeting the significant new housing need generated by this plan, these are likely to include:

- Working with housing departments and registered housing providers to include the needs of the five cohorts in any potential Homes and Communities Agency (HCA) development bids
- Woking with Local Authority housing departments to purchase specific properties or renovate existing buildings as part of an invest to save programme
- Working with registered housing providers who may be able source suitable accommodation in the private rental market or be in a position to purchase suitable properties.
- Exploring potential options for individuals to have shared or full property ownership
- Working in partnership with care and support providers who may have existing relationships with housing providers.
- Where appropriate supporting individuals to assess general needs housing through choice based letting
- Applying for capital investment available as part of this transformation programme.

In relation to children transitioning to adulthood, during the phase 1 stage of our programme we intend to scope the need for children and young people approaching adulthood with a view to forecast for the next five years (2020/2021) We will ascertain the need for both accommodation and support across the TCP footprint; and work in partnership with both housing and care providers to meet it. We anticipate applying for capital funding to help meet building costs as part of this plan. The expected outcome will contribute towards enhancing community capacity that will support more people to remain independent and avoid hospital admission.

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

It is not anticipated that resettlement will be a significant issue for the BLMK partnership; however, we are awaiting confirmation of the final settlement from NHS England Specialised Commissioning.

The BLMK partnership has relatively few hospital placements that have in place for over 5 years, it also has low numbers of placements that have lasted 2-5 years

Table 4.01 Numbers of hospital placements lasting 2 years or more (CCG and NHS England Specialised Commissioning) as of 11th April 2016.

Area	Number of people who have been in hospital 2-5 years	Number of people who have been in hospital 5 years	Total
CCG	4	8	12
NHS Specialised Commissioning	4	5	9
Total	8	13	21

Individuals leaving hospital after a period of 5 years from the 1st April will be entitled to a financial "dowry", the exact details of which will be determined at a local level. The BLMK partnership will explore the possibility of taking a common approach to this. The partnership is also aware that there is a small complex cohort of individuals who are likely to have been in hospital for a significant length of time currently funded by specialised commissioning that are not yet allocated to a CCG. Risks around potential increase in patient numbers linked to this cohort are recorded as part of the risk register (section 5 – Delivery).

The BLMK partnership fully recognises that individuals who will be resettled after being in hospital even after several years are likely to have very specific and/ or complex needs. Resettlement will need to be well planned, person-centred, and care and accommodation may be of a much bespoke nature. Additional support may be required for the transitional period whilst the individual settles into the community and it will be essential that both patients (and their families) to have access to high quality advocacy throughout the resettlement process.

Overall, based on previous resettlement experience commissioners and practitioners will need to be mindful of the following challenges ensuring that relevant risks are carefully managed and mitigated both at an individual and local level, housing related issues will need to feed into any emerging housing strategies:

- Potential culture clashes and differences in ethos between the outgoing inpatient provider and incoming community provider which may lead to tensions, resistance and mistrust
- Accommodation- there may be issues around void underwriting as funders may not be willing to underwrite the risk that a placement in the community fails
- High rental charges for the types of properties required may not always be covered by housing benefit threatening the sustainability of a placement
- The types of property required may be in short supply/ not readily available.
- Budget holders may need to agree duplication/ double funding in the transition period.
- Patient willingness to move/ or otherwise
- Expectations and concerns of patient and family members.

Case Example

Please note all personal information including the name of the patient has been changed in order to maintain confidentiality.

John is a resident within the BLMK area, placed within hospital following a break down in his care and support. He was placed in an independent hospital in order to address his mental ill health. John was identified as someone who could eventually be supported in the community in a supported living environment. Following meetings with John and his care team a potential provider was identified to work with him. Accommodation was identified and the provider began the process of working with John in his current placement. This meant meeting with him and taking him out for the day, as part of the transition plan John was supported to travel back to his home area and view the accommodation and provide feedback in relation to the furniture and layout of his flat.

John was also provided with support from his local community team who continued to visit him and work with him and his transition team. After nearly three years in hospital John was supported to return back to his original area. At first he required a high degree of input and

support 24 hours a day, over the following months this reduced as he became settled and further engaged with community services and support from his family.

In the two years since John has returned to the community his reliance on services has dramatically reduced with the cost of his care reducing from £112,116 a year to an annual cost of £30,756.

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

This joint transformation plan will link closely with the following existing strategies and plans and across the partnership area: -

- Local Transformation Plans for Children and Young People's Health and Wellbeing
- Local action plans under the Mental Health Crisis Concordat
- The 'local offer' for personal health budgets, and Integrated Personal Commissioning (combining health and social care)
- Local Autism Strategies (Bedfordshire, Luton and Milton Keynes)
- The roll out of education, health and care plans
- CAMHS Mental Health and Wellbeing strategies for Bedford Borough and Central Bedfordshire

The joint Transforming Care plan supports the Joint Health and Wellbeing Strategies for all of the partners, e.g. the Milton Keynes Joint Health and Wellbeing strategy 2015-18, and in particular 'starting well: giving every child the best chance in life' and 'living well: working with communities to live longer and healthier lives'.

This joint transformation plan references and supports the:

- Local Children and Young Peoples Mental health and Wellbeing Pathway.
- The Local action plans under the Mental Health Crisis Concordat
- The 'local offer' for personal health budgets, and Integrated Personal Commissioning (combining health and social care)

We will ensure that strategic links are made with the boards, implementation groups and work streams overseeing all of the above to ensure that plans fully join up, make the best use of resources and support integrated service delivery for people with a learning disability and / or autism. In phase one (2016/17) of our delivery we will develop and implement a consultation and engagement plan to ensure this happens.

Any additional information

5.Delivery

Plans need to include key milestone dates and a risk register

Phase 1 sees the development of the work packages as part of a programme management function that will reflect upon the following work streams as illustrated earlier in this document:

- **Workforce development & training** – the development of a workforce able to deal with the changing service and commissioner requirements. This is a major work stream which will commence in 2016-17 with a workforce review and skills mix analysis
- **Finance and activity** – which will need to develop financial and activity baselines to inform the business case and on-going reporting
- **Pathways & Clinical model** – we will establish a clinical reference group who will ensure the clinical model and pathway work is all clinically sound, safe and of high quality
- **Communication, Service user Engagement and co-production** – we will share information with our service users across the 3 years of the programme and consult with people who use services and work together with them from the start to the end of the programme.
- **Commissioning – market, provider and accommodation development** – this will focus on the development of integrated commissioning & personal (health) budgets; market management including housing; forecasting/modelling demand and measurement of success; the development of a procurement strategy for the partnership and ultimately the development of a joint preferred provider list.

Attached is the BLMK road map demonstrating

- Key work streams
- Key activities and steps
- Key milestones

Key activities to date include:

December 2015:

- Organisational / governance arrangements (mobilise 'partnerships') agreed and confirmed
- Senior Responsible Officer SRO and deputy from health and social care appointed
- Lead CCG (for host finance arrangements) agreed
- Involvement and engagement with NHS England specialised commissioners agreed
- Launch or 'go-live' date for partnership (where not already working together formally) agreed
- Outline scope of transformation plan and timescale for local delivery (includes publishing meeting dates for governing board) agreed

January to March 2016:

- First governing board meeting
- Work streams and leads identified, route map developed
- First and second cut transformation plans submitted 8th February and 14th March. Local assurance of plan coordinated through NHS England with stakeholders
- Plan finalised following regional and national moderation and feedback within March 2016

April 2016

- Final plan submission 11th April
- Begin to implement plans

Across the partnership, there are a number of areas where there is agreement to a single shared work-stream or plan for all partners. In some instances, the delivery of these common plans will be through local resources where in other areas it will be delivered through shared resources or a single service jointly commissioned by partners. There is also agreement across partners that there are areas where there will be separate plans that will be delivered locally. Across all plans, work-streams and deliverables, all partners will share good practice and successes to assure the best support and outcomes can be assured to all those suffering or at risk. The role of the Partnership board is to assure the delivery of all these plans regardless of whether they are locally or jointly commissioned and delivered.

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

The key enablers particularly at this initial stage of the project are the Directors of Nursing (DON's) and Directors of Adult Social Services (DASS's).

Local resource across the partnership has not yet been identified for the long term plans; however the TCP have taken take responsibility for identifying key area leads to progress and take forward each identified work stream listed within the plan.

The Partnership has defined one overall programme of work. An interim programme manager is in place for the development of the partnerships Transforming Care plan. A programme manager will be appointed for the delivery of the overall programme for the partnership. It is recognised, however, that in a number of areas the work that will be delivered will be delivered by different projects or programmes across the partnership.

Table 5.01 sets out the identified individuals leading each of the work-streams inside the programme and key team members. The partnership is in the process of identifying and assigning leads to the Pathways and Clinical Model work stream and also the Workforce Development and Training work stream.

Table 5.01 Breakdown of work streams and work stream leads for the BLMK TCP Transforming Care Programme.

Work-stream	Work-stream lead	Team
Communication, Service user Engagement and co-production	Lisa Levy	David Pennington (Milton Keynes); Bridget Moffat (Luton); Kaysie Conroy (Bedfordshire)
Commissioning-market, provider and accommodation development	Bridget Moffat	Robin Goold (Milton Keynes); Michelle Bailey/Mary Bennis (Luton); Kaysie Conroy (Bedfordshire)
Finance and activity	Liz Cox	David Pennington (Milton Keynes); Bridget Moffat (Luton); Kaysie Conroy (Bedfordshire)
Pathways & Clinical Model	TBC	Fiona West (Childrens Milton Keynes), Amanda Griffiths (Milton Keynes), Service

		Manager TBC (Luton), Ops Manager TBC (Bedfordshire). Trish Brodie (Provider – ELFT)
Work Force Development and training	TBC	Robin Goold (Milton Keynes), Bridget Moffat (Luton), Kaysie Conroy (Bedfordshire)

There are area leads across the local authorities/CCGs. These are David Pennington (Milton Keynes); Bridget Moffat (Luton) and Kaysie Conroy (Bedfordshire). Additionally, within each organisation there is a single lead for each organisation who attends the Programme team meetings. Finally, within each organisation, there is a project team that oversees and delivers the work locally.

Additional key enablers include specifically the community teams' local practitioners, care managers, and social workers.

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

Please refer to overview of the service model described earlier in the template, section 4 which describes the three proposed phases over the next three years and the attached route map.

The next key milestone is for the plan to be taken through the formal governance processes of the various partners for approval of the plan and associated templates by the end of July 2015.

What are the risks, assumptions, issues and dependencies?

The key risks, issues and dependencies for the BLMK programme are set out in table 5.02 below. The partnership is newly formed and covers four local authorities and three CCGs. The governance of the programme is therefore complex which the partnership recognises and acknowledges the risks that this raises. The most significant risks and constraints concern capacity, complexity and finance. The Programme Management Office will ensure adequate rigour is in place to manage these risks The programme risk register will be developed further as plans are progressed in more detail.

Table 5.02 Risk register for the BLMK TCP Transforming Care Programme as of 16th April 2016.

a result of….	There is a risk that….	With the result that…	RAG Rating	Mitigation and Controls in place	RAG Rating
A number of LD in-patients currently being unallocated to CCG areas	Specialised Commissioning will allocate an unknown number to BLMK	Costs will rise for either the in-patient budget or for the transition of patients back to the community		- Maintain close communications with NHS England in relation to the numbers and costs of patients - Challenge appropriately to ensure CCGs only takes responsibility for their own patients	
An shortage of housing stock in BLMK	insufficient, appropriate housing will be available for LD patients	patients will not be able to be transferred from in patient units back to the community		- Scope current provision - Work closely with local authority and private providers across the partnership to develop shared and innovative thinking in relation to accommodation	
Difficulties with recruitment and retention of suitably qualified staff	it will be difficult to appropriately staff the community services	patients will not be able to be transferred from in patient units back to the community or will not be able to be supported in the community and will need admission to hospital		- Undertake skills audit as part of workforce work stream - Consider training requirements as part of the plan	

The partnership financial position	the organisation is unable to support the required level of transition funding	the transition from hospital bed provision to enhanced community provision will be delayed		- Maintain close communication with NHS England in relation to transformation and capital funds available - Project team to work closely with CCG finance teams to ensure full understanding of plans and financial implications - Approved business case	
Multiple partners engaged in this process	difficulties agreeing and engaging	impact on the quality of life on those people who are to be supported to live in the local community		Plan is realistic and the setup of Memorandum of Understanding between partners will facilitate joint agreement and working.	

Dependencies

Successful delivery of this programme is dependent on a number of work streams and other plans. Robust programme management will support the partnership to manage these dependencies. The dependencies identified to date are listed below:

- Mental Health & Learning Disability Programme Boards
- Children & Young People Programme Boards
- Care Pathway & Primary Care Programme Boards
- Primary & secondary care health services
- Children & Young People services
- Older People Mental Health services
- Education
- Transformation plans e.g. CAHMS
- Health & Well Being strategies
- Private providers

Constraints

Project constraints that might restrict the delivery of this programme will continue to be identified and documented throughout the life of the programme. To date those identified, include:

- Transforming Care timescales and reporting requirements
- Financial constraints including the ongoing significant cuts to local authority budgets
- Capacity for delivery
- Recruitment and retention of a suitably skilled workforce

Assumptions
There are certain assumptions that have been made which will assist in the development of the risk management plans for this programme. To date these have been identified as:

- The newly formed partnership will continue to develop successfully, effective relationships can be formed and the Memorandum of Understanding (MoU) can be agreed.
- The provider market can be developed across the partnership
- An appropriately skilled workforce can be developed
- The new model will be affordable given the constraints detailed in the risk register and elsewhere in this plan and the finance and activity templates.

What risk mitigations do you have in place?

We have mitigated this by the CCG Senior Responsible Officer's working with partners and our boards to receive an agreement in principle to the plan subject to going through partners' governance and obtaining political sign off.

A robust risk management strategy is essential for successful delivery of the programme. The programme risk management is an iterative process, managed by the PMO ensuring that

- A risk register is maintained
- Risks are identified and analysed
- Identified risks have mitigation plans developed
- Risks are tracked and reported

The risk register detailed in the previous section shows current mitigations against the key risks.

The mitigations on relation to this plan can broadly be grouped as

- Governance – ensuring plans are signed off by appropriate bodies
- Communication – partnership working and an agreed communication plan are essential
- Sound financial planning and distribution of resources
- Workforce planning

Any additional information

Due to the short timescales for the joint draft plan and bid process, the details contained in this document and appendices have not been reviewed. A thorough assurance and governance process within each of the represented organisations is ongoing. Costs are indicative of the work required. Further assurance work will continue to test the financial assumptions and review the finances in more detail and taking into account NHSE financial guidance as this becomes available.

6.Finances

Please complete the activity and finance template to set this out (attached as

an annex).

These are detailed in the relevant section of the Finance and Activity spreadsheet. Work is ongoing for both transformation and capital bids and will continue with the support of the NHSE Transforming Care team. The following sections will be contained within the spreadsheet; however, they are difficult to read and a copy is provided here.

Item	Costing assumptions	Item Cost (£)
TCP Project management	Priority 1 - employment of a Project management support across the TC partnership to co-ordinate the joint work and engagement with all of our stakeholders. This role will include the formulation of work packages, scoping of our services, and co-ordination of the central project plan. These costs are based on the recruitment and on costs of a mid-range band 7 and a mid-range band 4 to provide admin support. This is 2 WTE over the 3-year period.	£217,524
Workforce development in Positive Behaviour Support	Priority 2 - Provision of a "train the trainers" programme that will develop the skills of the workforce to coach their teams and those that they support in the implementation of Positive Behaviour support programmes. This programme will also support practitioner in the formulation of challenging behaviour management plans. This programme is a three-day course for practitioners, with a cohort of 16, we will run the course four times across the partnership. During early stages of project consider format of training due to risk of trained trainers leaving - consider provision through external provider. Over the first two years of the project.	£16,940
Client engagement	Priority 3 - Develop experts by experience with support for transport, Care and Treatment Reviews, advocacy and easy read materials over three years	£11,000
Engagement events and facilitation	Priority 4 - For clients, carers, providers and commissioners - workshops over three years	£65,000
Increase capacity of IST	Priority 5 - Intensive support team - clinical nurse * 4 over three years	£768,000
Communications	Priority 6 - Consultations, communication updates, design and production of easy to read and access materials over three years	£20,000
Care Treatment Reviews (CTRs)	Priority 7 - Additional resource to undertake CTRs (especially NHSE clients) - 30 inpatients CTRs + 12 blue light over three years	£45,000
Social supervisor training	Priority 8 - Provision of training for our current care co-ordinators across the footprint in order that they can undertake the legal requirements of managing patients discharged from the Mental Health Act who are subject to MHA conditions. It is a requirement of the legislation to have a suitably qualified person to manage these individuals and report to the home office. The course is two days, and will be run four times across the partnership for cohorts of up to twenty-five individuals. This cost does not include the backfill costs for the individuals attending or further supervision for those undertaking the role. Focused during the first two years	£15,200
Evaluation	Priority 9 - Support expertise, e.g. university for evaluation of pilots and programme. Focused 17/18 and 18/19.	£20,000
Employment of architect	Priority 10 - For redevelopment of units providing specialist capacity/support - feasibility stages over the three years of project.	£60,000
	Total	**£1,238,664**

Please describe match funding here. Please provide as much detail as possible, breaking down contributions by source and financial year (2016/17, 2017/18 or 2018/19)

The TC partnership has invested in intensive support teams across the footprint. These services are tasked with reducing hospital admissions, and supporting people within the community.

For Milton Keynes the closure three years ago (2013) of our learning disability inpatient unit (Oakwood) identified monies to be transferred from inpatient services to the community (£162K) this currently supports 4 FTE (2 outreach nurses and 3 support workers) within our Community Support and Intervention Team (CSIT). This contribution to the transforming care programme is anticipated to continue for the next three years.

For Beds and Luton, the Intensive Support Team (IST) is commissioned at £1.1M, this supports the reduction in hospital stay and supporting more people in the community during episodes of crisis. this contribution to the transforming care programme is committed for the next seven years and makes up part of the contract with services.

Priority shown above relates to priority for funding purposes. Investment requested at this stage is c.£412k 2016/17, c.£422k 2017/18, c.£406k 2018/19. Total £1.3M.

Match funding comes from across the partners to the TCP and includes funding for adult intensive support team, additional staff capacity undertaking CTRs, in-house estates and communications support, in house programme leadership and project management, management and finance resource, GP sessional time and local authority advocacy support. Total far exceeding £1.3M per annum. In addition, there will be some savings from inpatient to in area community settings which can be reinvested. Further work will need to be done once client needs/packages have been appropriately costed.

Note that other requirements are anticipated as a result of the review and scoping work due to take place during the first phases of the project, e.g. increased forensic support offer. These will be costed as a part of these "scoping" pieces of work.

End of planning template

Annex A – Developing a basket of quality of care indicators

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

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

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

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

Indicator No.	Indicator	Source	Measurement[3]
1	Proportion of inpatient population with learning a disability or autism who have a person-centred care plan,	Mental Health Services Data Set (MHSDS)	Average census calculation applied to: • Denominator: inpatient person-days for patients identified as having a learning disability or autism. • Numerator: person days in denominator where the

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

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

	updated in the last 12 months, and local care co-ordinator		following two characteristics are met: (1). Face to face contact event with a staff member flagged as the current Care Co-ordinator (MHD_CareCoordinator_Flag) in preceding 28 days; and 2. Care review (Event record with MHD_EventType 'Review') within the preceding 12 months.
2	Proportion of people receiving social care primarily because of a learning disability who receive direct payments (fully or in part) or a personal managed budget (Not possible to include people with autism but not learning disability in this indicator)	Short and Long Term Support statistics	This indicator can only be produced for upper tier local authority geography. Denominator: Sum of clients accessing long term support, community services only funded by full or part direct payments, managed personal budget or commissioned support only. Numerator: all those in the denominator excluding those on commissioned support only. Recommended threshold: This figure should be greater than 60%.
3	Proportion of people with a learning disability or autism readmitted within a specified period of discharge from hospital	Hospital Episodes Statistics (HES) and Assuring Transformation datasets. Readmission following discharge with HES main specialty - Psychiatry of Learning Disabilities or	HES is the longest established and most reliable indicator of the fact of admission and readmission. • Denominator: discharges (not including transfers or deaths) from inpatient care where the person is identified as having a learning disability or autism • Numerator: admissions to psychiatric inpatient care within specified period The consultation took 90 days as the specified period for readmission. We would recommend that this period should be reviewed in light of emerging readmission patterns. Particular attention should be paid to whether a distinct group of rapid readmissions is apparent.

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

	crisis plan	from the fields CRISISCREATE and CRISISUPDATE)	identified as having a learning disability or autism or with a responsible clinician assignment of a person with specialty Psychiatry of Learning Disabilities • Numerator: person days in denominator where there is a current crisis plan