Appendix 1 (to HWBB June 2016)

NHS England

NHS Telford and Wrekin Clinical Commissioning Group

Telford & Wrekin Council

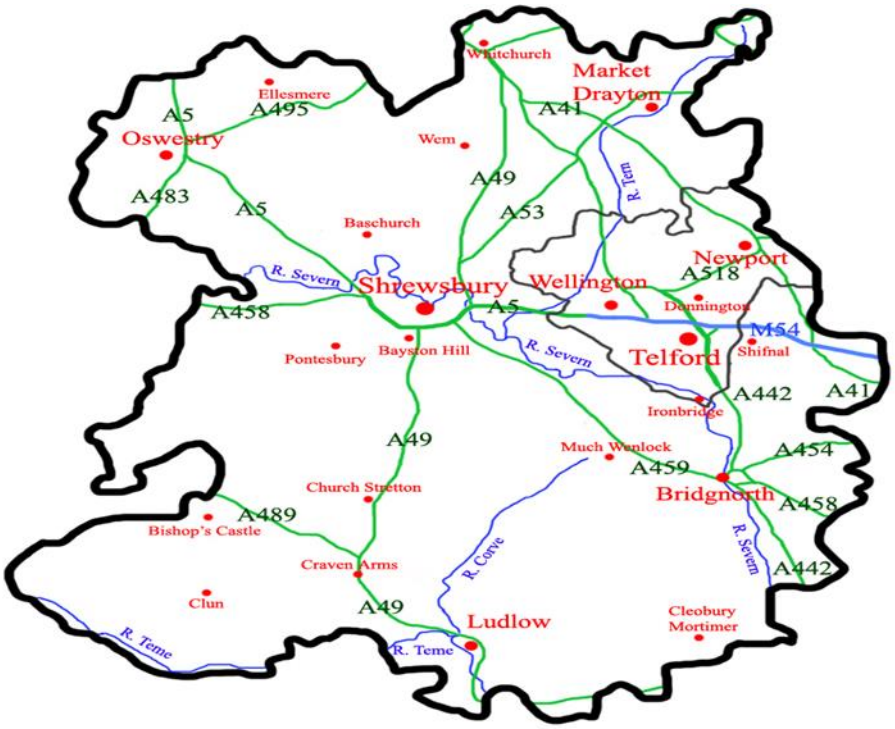
a co-operative council

Shropshire Council

NHS Shropshire Clinical Commissioning Group

Transforming Care Partnership

Shropshire Footprint



April 2016

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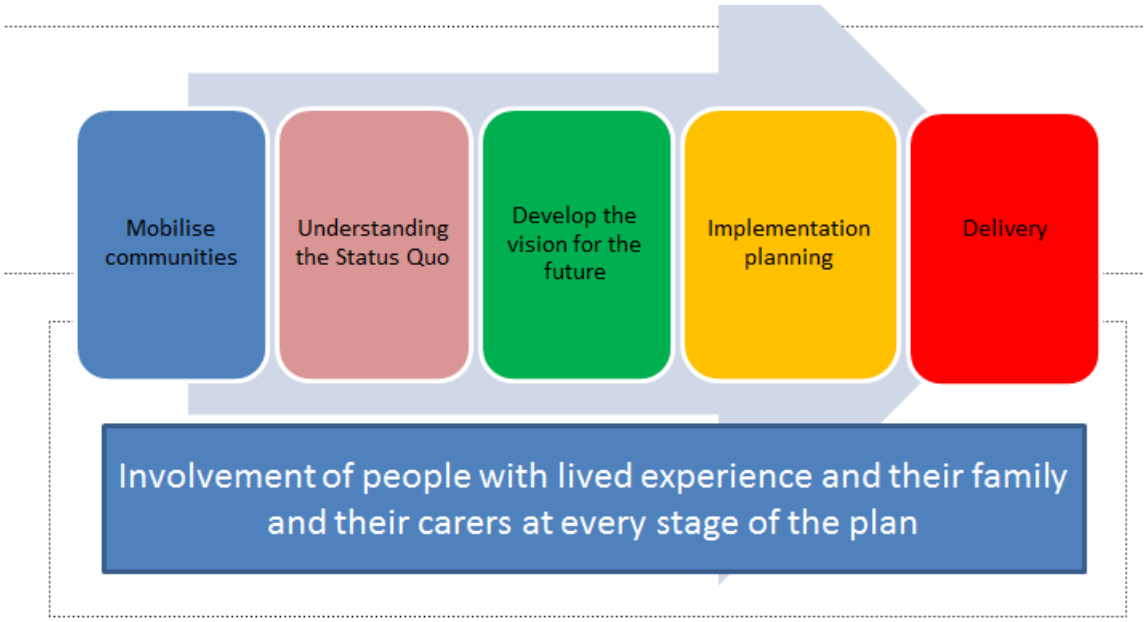
Appendices

Acronyms/Glossary	Meaning
TCP	Transforming Care Partnership
SC	Shropshire Council
TWC	Telford and Wrekin Council
SCCG	Shropshire Clinical Commissioning Group
TWCCG	Telford and Wrekin Clinical Commissioning Group
SC, TWC, SCCG & TWCCG	The Authorities
LD	Individuals referred to throughout all have a learning disability and/or Autism, and all are able to exhibit behaviours which challenge. For ease, the term used throughout the document is Learning Disability, abbreviated to LD.
EbE	Experts by Experience
NHSe	NHS England
RSL	Registered Social Landlord
LA	Local Authority
DOLs	Deprivation of Liberty
ADASS	Director of Adult Social Services
OSCA	Oswestry and Shropshire Citizen Advocacy
SSSFT	South Staffordshire and Shropshire NHS Foundation Trust
SPIC	Shropshire Partners in Care
ASC	Adult Social Care
CB	Challenging behaviour
CJS	Criminal Justice System
CTR	Care and Treatment Review
CHC	Continuing Health Care

This template as laid out in the following sections. In addition there are Appendices which provide more detail for specific areas for the plan. These provide information that will support the implementation and delivery part of the plan. Each section has been colour coded to aid the reader.



Planning template

1. Mobilise communities

Governance and stakeholder arrangements

Describe the health and care economy covered by the plan

Introduction

Transforming Care Partnership (TCP) plan covers the Shropshire Footprint (Telford and Wrekin and Shropshire). It includes four statutory organisations:

- Shropshire Council (SC)
- Telford and Wrekin Council (TWC)
- Shropshire Clinical Commissioning Group (SCCG), and
- Telford and Wrekin Clinical Commissioning Group (TWCCG).

Collectively, throughout the report they are referred to as the Organisations.

The plan sets the context for this Programme of work, planned for July 2016 – March 2019 (33 months). Although the Programme will formally end at this time, the work of TCP will be ongoing within the footprint area. It is expected to take a further two years to fully 'bed in' the changes to culture, behaviours and beliefs so as to ensure the model way of working is sustainable and continues to evolve.

The Programme is about integration and new ways of working. The integration is between the Organisations. New ways of working is an approach to successfully meet the needs of five cohorts of people described in the service model.

The common features of the five cohorts is that the individuals referred to all have a learning disability and/or Autism, and all are able to exhibit behaviours which challenge. For ease, the term used throughout the document is Learning Disability, abbreviated to LD.

At the heart of the process of integration is a person centred approach to supporting people with LD, wherever they are – be that living at home, in the community, in hospital or specialist hospital care.

Background

Who we are:-

The Shropshire footprint covers two local authorities (Shropshire County and Telford and Wrekin) and two CCGs (Shropshire and Telford and Wrekin). It covers a population of

- 472,700 (Shropshire 306,100 (8% increase from 2001); T&W 166,600 (5% increase from 2001)

NHS provision for health care includes:-

- 62 General practices (NHS)
- One mental health trust that also supports adults with learning disabilities (FT) including one unit providing respite for individuals with complex needs
- One community trust that supports CAMHS, CAMHS LD and children neuro- development service (NHS)
- One acute trust covering two hospitals across the locality (NHS)
- Four community hospitals
- Two mental health trusts that sit outside of the footprint that support autism diagnosis.
- Two complex care teams based in CCGs
- Autism hub (joint funded- third sector)
- Continuing health care for complex patients (joint funded in some cases- independent sector)

- Small community unit for people with behaviour that challenges (independent sector joint funded)

Social care provision includes:-

- Information, advice and guidance (third sector)
- Advocacy
- Care packages
- Personal budgets and direct payments
- Accommodation commissioned via block contracts, individual/shared living; supported living; shared lives and foster carers. (N.B. During 2016-17, some changes to existing accommodation for named individuals with learning disabilities and with behaviour which can challenge will be consulted on, with the intention of providing accommodation that is better suited to the needs of the individuals and thereby providing an overall 'better quality of life').
- Day time activities accessible by all
- Some services receive support from the councils.
- Advocacy service (Taking Part and OSCA)
- Information, advice and guidance provided by a consortium of third sector providers.
- Various services which provide activities during the day time are from both the private and voluntary sector.

Education via two local authorities includes:-

- One school specifically for autism (Queensway)
- One large special school (Severndale) with a satellite in Pontesbury
- Two residential schools (Cruckton Hall and Overely)
- Several smaller special schools (Haughton, Old Hall, Southall, The Bridge and Mount Gilbert
- Mainstream children's services

How we work together:-
Collaborative commissioning arrangements are not in existence across the four Organisations. Coterminous local authorities and CCGs, have worked together to support joint funding and care packages.

Contracting with the local authorities is undertaken via block contracts and/or via individual packages. Non NHS providers are supported by Shropshire Partners in Care (SPIC) an overarching organisation to which most providers are affiliated. NHS contacts are mainly via a block with the trusts or via individual packages of care for complex patients.

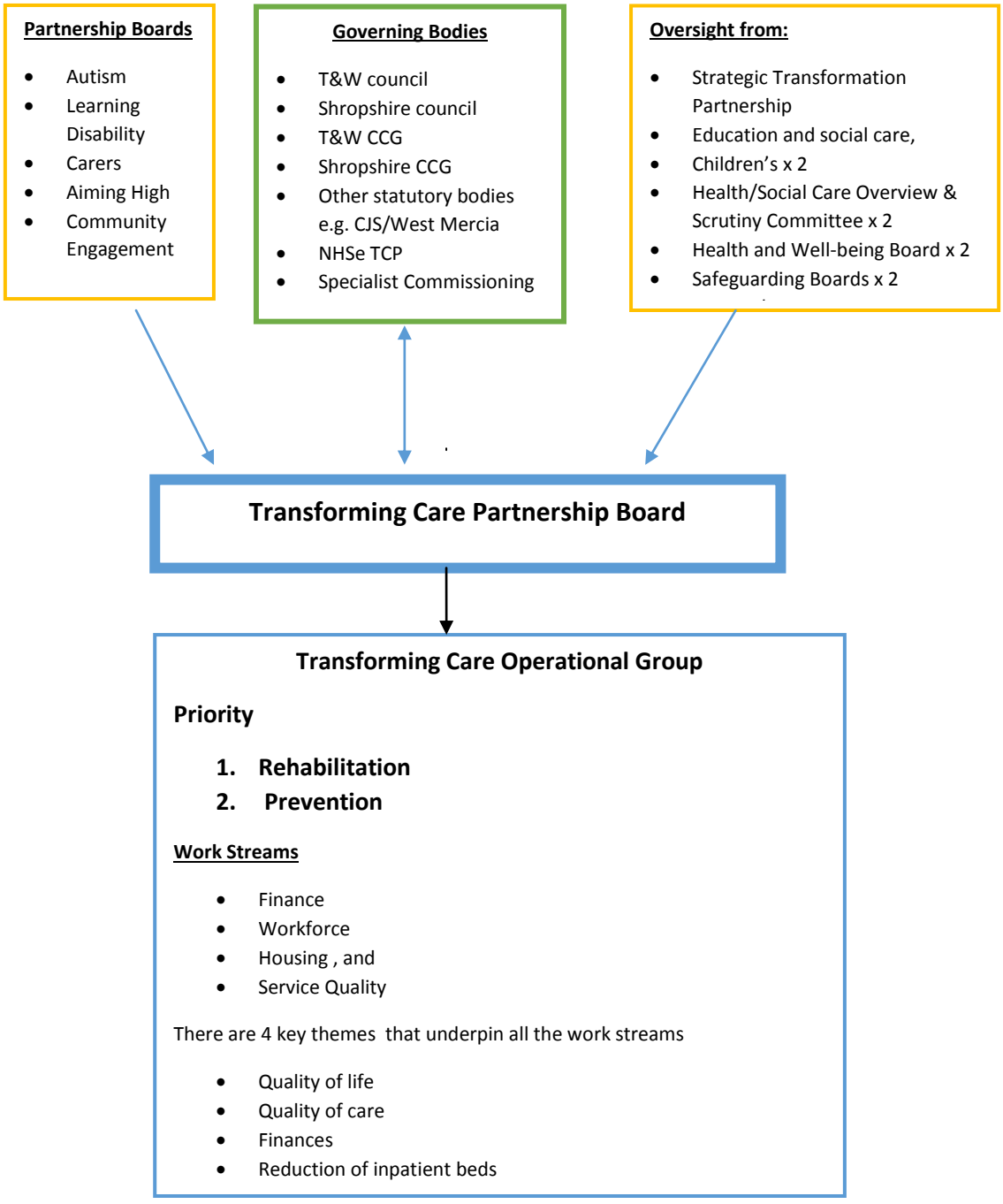
Relationships with individual commissioning organisations and providers are positive. Local authorities have good relationships with care organisations including those providing packages in homes and those providing accommodation. NHS provider relationships are developing a stronger footing as substantive posts have now been filled after 2 years of instability in commissioning in the CCGs.

Relationships between service users and carers and commissioners are strong with very proactive carers Boards, one of which was Highly commended in the 2015 HSJ Commissioning for carer's award.

Describe governance arrangements for this transformation programme

See illustration, below.

Shropshire Transforming care partnership governance structure



This plan will be ratified at the following board meetings:-

Date	Authority	Meeting
26th April	T&W CCG	PPQ
10th May	T&W CCG	Board
15 June	T&W/Shropshire	H&WBB
27th April	Shropshire CCG	QPR, 1 – 5pm
4th May	Shropshire CCG	Clinical Advisory Panel
10th June	Shropshire CCG	Board meeting (private

Whilst the action plans will be monitored via the TCP regular updates will be provided to the organisations.

Describe stakeholder engagement arrangements

The TCP:-
The core membership of the TCP Board are health and social care commissioning representatives of:

- Shropshire CCG
- Telford & Wrekin CCG
- Shropshire Council
- Telford & Wrekin Council
- NHS England Specialised Commissioning
- Supported by representative from NHSE Transforming Care Project Team.

Representatives will continue to be involved to oversee the development and monitoring of the plan and action plan. The TCP board is overseen by the following bodies:-

- Governing Bodies – providing strategic oversight
- Partnership Boards – will be informed and consulted with, as necessary.

A Transforming Care Operational Group – will be responsible for implementation of the Action Plan Leads will be allocated work streams on the different sections of the Action Plan. Service users and carers will be represented on the group.

The lead for the programme and SRO is the Director of Adult Social Care for Telford and Wrekin council. Deputy SRO is the Chief Nurse and Director of Quality for Shropshire CCG. This level of input from the organisations ensures high level commitment and the ability to share and influence across the footprint.

Service users and carers:-
There are two LD Partnership Boards within the footprint and both have had agenda items regarding the Transforming Care agenda. Both groups have had the opportunity to input into the early discussions of the plan. The Transforming care agenda will inform a large part of the work of these boards over the next 3 years.
In addition each individual organisation has well established and on going means of engaging with service users and carers. These will continue and will feed into TCP action plans.

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

Discussions have taken place with Taking Part and an Expert by Experience, who sits on national boards linked to Valuing People and Learning Disability/family carers. In addition discussions have also taken place with six carers as part of developing this plan. As TCP moves forward, more work will take place to develop the TCP using a co-production approach. Further details can be found in Appendix 1.

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

Baseline commissioned beds/patients are as follows:-
NHSe specialist commissioning- 16adults and 3 children (as at 31/03/16)
CCG commissioned beds/patients- 7 adults (as at 31/03/16)
Target 2019:-
NHSe reduction from 49.46 to 23.43

CCG reduction from 18.22 to 13.03

2.Understanding the status quo

Baseline assessment of needs and services

Provide detail of the population / demographics

Work is still taking place to fully understand the population covered by programme. The TCP is an all age programme. There is substantial information held about children, both in social care and education and those not known the health or social services which needs further work to collate.
In writing the TCP we have gathered information and data from a range of sources. Key local information is used to routinely inform service improvements and design, including:

- data collected as part of the JSNA
- public health data
- social care data
- service provider data including hospital admissions, and
- Information and feedback from stakeholders and service users.

However, as recognised in the descriptions of the 'cohorts', some people are not know to services. This means that some of the plans put forward in the template may change in the future.

Nationally produced data, and information from neighbouring and comparator areas is also used by commissioners to inform service design and improvements. A summary of the key data is provided in this section.

Prevalence data would indicate the following for the total footprint of the TCP:- (for further detail see Appendix 1)

Learning disabilities prevalence					
Years	**2014**	**2015**	**2020**	**2025**	**2030**
18-64	6,843	6,839	6,760	6,689	6,562
65 plus	2,039	2,093	2,360	2,603	2,924
challenging behaviour	127	127	126	124	122

Autism by prevalence					
Year	**2014**	**2015**	**2020**	**2025**	**2030**
18-64	2,851	2,850	2,817	2,792	2,730
65 plus	915	940	1060	1178	1329
Totals	**3,766**	**3,790**	**3,877**	**3,970**	**4,059**

Locally Quality and Outcomes Framework (QoF) data for 2013-14 states that adult (18+) prevalence of learning disability on GP practice registers is :-

- 0.6% of the Shropshire
- 0.4% for Telford and Wrekin.

This accounts for 1,412 adults in Shropshire and 586 adults in Telford and Wrekin, giving a total of 1,998. However, QoF data only includes people registered as having learning disabilities and is most likely to

include people with moderate to profound learning disabilities.

The 5 cohorts:- *Children, young people or adults with a learning disability and/or autism who:*

1. Have a mental health condition such as severe anxiety, depression, or a psychotic illness, and those with personality disorders, which may result in them displaying behaviour that challenges.
    - In the final quarter of 2015/16- 3 patients were supported in an inpatient mental health unit. There is no local data on those people with LD supported by community mental health teams.

2. Who display self-injurious or aggressive behaviour, not related to severe mental ill health, some of whom will have a specific neuro-developmental syndrome and where there may be an increased likelihood of developing behaviour that challenges.
    - Throughout 2015/16---10 patients supported in inpatient beds

3. Display risky behaviours which may put themselves or others at risk and which could lead to contact with the criminal justice system (this could include things like fire-setting, abusive or aggressive or sexually inappropriate behaviour).
    - There is lack of clarity regarding the numbers in those cohort but it likely to be those CAMHS (2) in transition and specialised commissioning (14) in inpatient beds

4. Have lower level support needs and who may not traditionally be known to health and social care services, from disadvantaged backgrounds (e.g. social disadvantage, substance abuse, troubled family backgrounds) who display behaviour that challenges, including behaviours which may lead to contact with the criminal justice system.
    - This information is currently held by a range of statutory authorities and will be collated across the footprint in due course

5. Have been in hospital settings for a very long period of time, having not been discharged when NHS campuses or long-stay hospitals were closed.
    - Specialised commissioning- 2 dowry patients

Further details of employment status, Section 136 detentions, cares information and local authority information can be found in Appendix 2.

Analysis of inpatient usage by people from Transforming Care Partnership

NHSe specialised commissioning beds

Ref	Location	Status	Daily rate	Assumed date of move into community
Adults				
1	Brooklands, Birmingham	Low	£480.00	Mar-17
2	Ashley House	Low	£480.00	Sep-17
3	St. Andrews, Birmingham	Low	£480.00	Mar-17
4	St. Andrews, Birmingham	Low	£480.00	Sep-17
5	St, Andrews, Nottingham	Medium	£525.00	24 Months
6	St Johns House	Medium	£525.00	24 Months

7	Brooklands	Low	£480.00	Mar-17
8	Brooklands	Medium	£525.00	Sep-17
9	Ashley House	Low	£480.00	Sep-17
10	Ashley House	Low	£480.00	Mar-17
11	Ellesmere	Low	£480.00	Mar-18
12	Ellesmere	Low	£480.00	Mar-18
13	Stockton Hall	Medium	£525.00	Consider LSU next 3- 6 months
14	St Andrews, Nottingham	Medium	£525.00	Admitted to MSU 7/1/16. 24 months +
15	Stockton Hall	Medium	£525.00	
16	St John's PIC, Norfolk	Medium	£525.00	
CAMHs				
17	Alpha Hospitals Sheffield	CAMHs	£770.00	3 to 6 months
18	CWPT - Brooklands Hospital	CAMHs	£770.00	within 12 months
19	St. George's	CAMHs	£770.00	Within near future

CCG commissioned beds

No	Unit non NHS	Type of bed	No. of beds	Cost per day	No of beds commissioned by CCG
1	Annesley House	Locked rehab	2	£392.50	Spot purchased
2	Hunter Combe, Birmingham,	Locked rehab	1	£392.50	Spot purchased
3	Denshell- Wast Hills	Sec 3 treatment	1	£392.50	Spot purchased
4	Ballington House	Sec 3 Treatment	1	£392.50	Spot purchased
5	Brooklands-Birmingham	Informal admission complex care with mental health needs	1	£392.50	Spot purchased
6	Redwoods	Mental health acute	1	£347.21	Cost and volume

The footprint has repatriated many patients over the years back to the locality and has utilised few specialist LD beds out of area. The partners have many years of experience of repatriation of complex patients which it will utilise to bring the NHSe patients back to the area.

Describe the current system

The local foot print has high levels of specialised commissioned beds- 42 per 1,000,000 which is one of the highest in the region. For CCG commissioned beds the figure is 21 per 1,000,000.

Historically, there was no specialist long stay hospital in the Shropshire region. Thus, we exported people to other locations including St Margaret's, Lee Castle and Stallington. During the 1980/1990's many people were repatriated 'back home' and continue to live in area.

We have a plethora of commissioned services to support people with learning disabilities and these are described in more detail in Appendix 2
High level view of current system and flows:-

- Cohort 1- Any patients with mental health needs have access to a liaison nurse who attends

the local mental health hospital to ensure patients are reviewed and discharged as soon as possible. A recent 'Greenlight' toolkit audit showed a 37% reduction in Length of stay for people with LD and 90% reduction in incidents that harm since the introduction of LD care plans at the local mental health hospital.

- Cohort 1, 2 and 3-Robust systems and processes are now in place to ensure the continued safety and appropriateness of placements to meet individual needs, with the local mental health trust and CaMHS LD team. Meeting with commissioners and Complex Care Managers occur on a monthly basis to review the Care and Treatment Reviews and People at Risk of Admission (PARA) children and adult registers. There is an agreement in place across all stakeholders to encompass the sharing of information about all people with a learning disability and/or autism who are 'of concern' or 'at risk' of being admitted.
- Cohort- 4-Support is provided from a range of statutory services including children's' social services; looked after children; children in need; CAMHS; education services and criminal justice system including youth offending, targeted youth support, community cohesion, diversion & liaison and substance misuse.
- Cohort 5- these patients are managed by NHSE and there has been limited contact over the past few years with local commissioners regarding these patients until they are ready to step down.

Other services commissioned across the footprint to support all cohorts are:-
Health

- Spot purchasing of complex care beds as required
- Beds in a mental health hospitals- as required
- Continuing Health Care funding (see details in Appendix 1)
- Prison in reach service
- Forensic mental health team
- Psychology services
- Inter disciplinary team working to support people in their own home
- Community unit for people with behaviours that challenge (4 beds)
- NHS respite for people with learning disabilities and complex needs
- Intensive support team for people with behaviours that challenge
- Community LD service (nursing)
- Care packages- individual and bespoke
- Personal health budgets- children and adults on CHC
- CAMHS includes neuro development pathway
- CAMHS Learning disabilities
- CAMHS LD psychology
- Child development centres
- Occupational therapy to support named individuals
- Community paediatrics
- Continence team
- Annual health checks- acute liaison nurse and primary care facilitators support this work
- Learning disabilities dentistry service
- Out of hours provider (non specialist)

Local authority

- Supported living
- Personal budgets and direct payments

- Shared lives
- Single point of Access to care services for adults and children's
- Support sessions
- Autism HUBs- peer and advice support for adults with autism
- Leisure services run specific groups for people with LD including keep fit, cinema other recreational schemes
- Schools-one large specialist schools catering for all types of disability. Several smaller schools/ special schools supporting those in 1 of the 5 cohorts.
- Further education including one specialist residential college
- Employment- both local authorities have specific schemes to support people with learning disabilities into employment. (Further data included with Appendix 1)
- Housing working with social landlords: - Bromford; Sanctuary; Wrekin; Bournville.

Police-

- Hate crime: safe place scheme set up to support people with LD who may be subject to hate crime. Equality and diversity officer in place to support vulnerable adults including those with a learning disability
- Probation service
- Youth offending service

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

The overall estate for people with learning disability are provided through a range of accommodation comprising of

Health

- Dedicated specialist non NHS community based accommodation- Church parade- Community based 4 bedded unit providing support for people with behaviours that challenge- Rented from private sector-**fit for purpose for Telford and Wrekin. Insufficient supply for whole footprint.**
- There are no specialist learning disability hospital beds in the footprint.
- No intermediate care provision to prevent general hospital admission for physical health needs.
- Oak House provides 10 beds for LD for assessment and treatment for people with physical health needs and LD. **Not fit for purpose** for those with behaviours that challenge.

Local authority

- Residential- block contracts across footprint area-private and voluntary sector –**not all are fit for individual needs of** those with behaviours that challenge.
- Supported living- **Fit for purpose** as matched to individual needs **but insufficient supply.**
- Tenancy- with care packages to support- **Fit for purpose** as matched to individual needs **but insufficient supply.**

NHS has no existing interest in a property.

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

What have service services/ carers told us about the current system?

Consultations have taken place on a 1:1 basis with several carers. In response to a range of questions the following comments were made:

There is an overall support for TCP and the principle of normalisation. The carers recognised the importance of sufficient resources to deliver community based support across all sectors (health, social

care, police and education) and across the footprint. The view is that an all age strategy offers opportunities for earlier detection and intervention. Carers felt the silos of the cohorts did not reflect the multiple needs of individuals who sometimes span more than one descriptor. This is significant when considering the needs of more complex individuals. Carers recognised that some individuals who are institutionalised into receiving care and support would need time to gain confidence in making decisions/choices.

Where there is support for PB/PHB it was also perceived as something that requires thought and planning. It may not always be welcomed. Co-production was welcomed and a recognition that one size does not 'fit all'.

Carers were keen to support the progress and welcome oversight from other existing partnership boards (Carers, LD) and they welcome ongoing engagement. Carers request that professionals keep them updated on progress in a timely manner and provide ongoing reassurance to quell concerns about isolation and being left to cope.

Workforce and housing were seen as critical elements of the TCP. It is essential staff have the right skills but even more importantly the right values to support individuals, and accommodation must match the needs of individuals. One size does not fit all.

Where individuals can progress towards employment and engage in activities, more should be done to help this happen. Concerns included being valued, listened to and the ongoing discrimination against people with learning disabilities.

Respite was seen as a critical element of support for carers and felt that this must be supported; otherwise individuals will go into institutionalised care.

This following section describes the issues and concerns that impact on the vision the TCP wishes to provide for people.

<u>Workforce</u>

Health

- A deficit in knowledge, skills and competency of health staff as illustrated in the Confidential Enquiry into Premature deaths of people with learning disabilities (CIPOLD)
- Lack of specialist LD workforce
- Lack of training places for LD workforce
- Difficulties with recruitment and retention
- Lack of research and evidence base of interventions
- Insufficient expertise within mental health workforce to support LD and autism

Local authority

- Lack of dedicated specialist social workers and commissioners
- Difficulties with recruitment and retention of skilled social workers and care staff
- Locally there is a small pool to recruit from

<u>Communication</u>

- Services are not joined up with little communication between NHSE specialised commissioning and CCGs/Local authorities.
- This is the first opportunity for the Organisations to work collaborative at a strategic and operational level on a programme of work. Processes, policies and agreements need to be developed to ensure transparent communications.

<u>Engagement</u>

- Whilst there is a real engagement with service users and carers it is not true coproduction across the adults and children's services

- Carers have told us that the system needs to be more joined up so if it doesn't work it can 'react' to support people better

Estates

- Insufficient supply of required accommodation (see section above)
- Accommodation needs to focus on supported living with less emphasis on residential care and block contracts

Finance and activity

- There is no understanding regarding the impact on each other's budgets and no way of sharing risks.
- Local councils are severely challenged by austerity measures
- CCGs are facing significant financial challenges

System Service model

- There is no articulated service model
- Lack of clear pathways- for example into criminal justice system
- Lack of clear roles and responsibilities
- Duplication of workload
- CAMHS services are not commissioned to provide a proactive model to support the reduction of crisis.
- Community nursing teams are just changing to develop an Intensive Support Team and this needs time to embed and ensure pathways are in place.
- CTR process needs more time to embed to ensure proactive consistent management of patients
- Too many patients in specialised commissioned beds out of area.
- We are not clear about the number of carers in our footprint supporting people with LD(only 28% of those people receiving LA care have details of a carer)

The system can be improved by the articulation of a new model of care and principles to underpin the model. This new model will require additional pump priming monies to develop services in the community before repatriation of patients closer to home.
The following changes in service provision will improve the offer to local patients and carers:-

- The change of service specifications for community teams, CAMHS LD, neuro developmental service (0-25);
- The re procurement of CAMHS
- Focus of accommodation to supported living and individual commissioning of care
- Increased use of personal health budgets
- Improved transition pathway to adult services
- Closer working with specialised commission, police and criminal justice system.
- Bespoke local support to the management of people with behaviours that challenge, and
- Develop a range of respite options to support both carers and service users.

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

Any additional information

Total spend across the footprint 2015/16
CCGs **£13,235,625**
NHSe **£3,744,900**

Local authority **£15,896,479**
Shropshire total **£32,877,004**

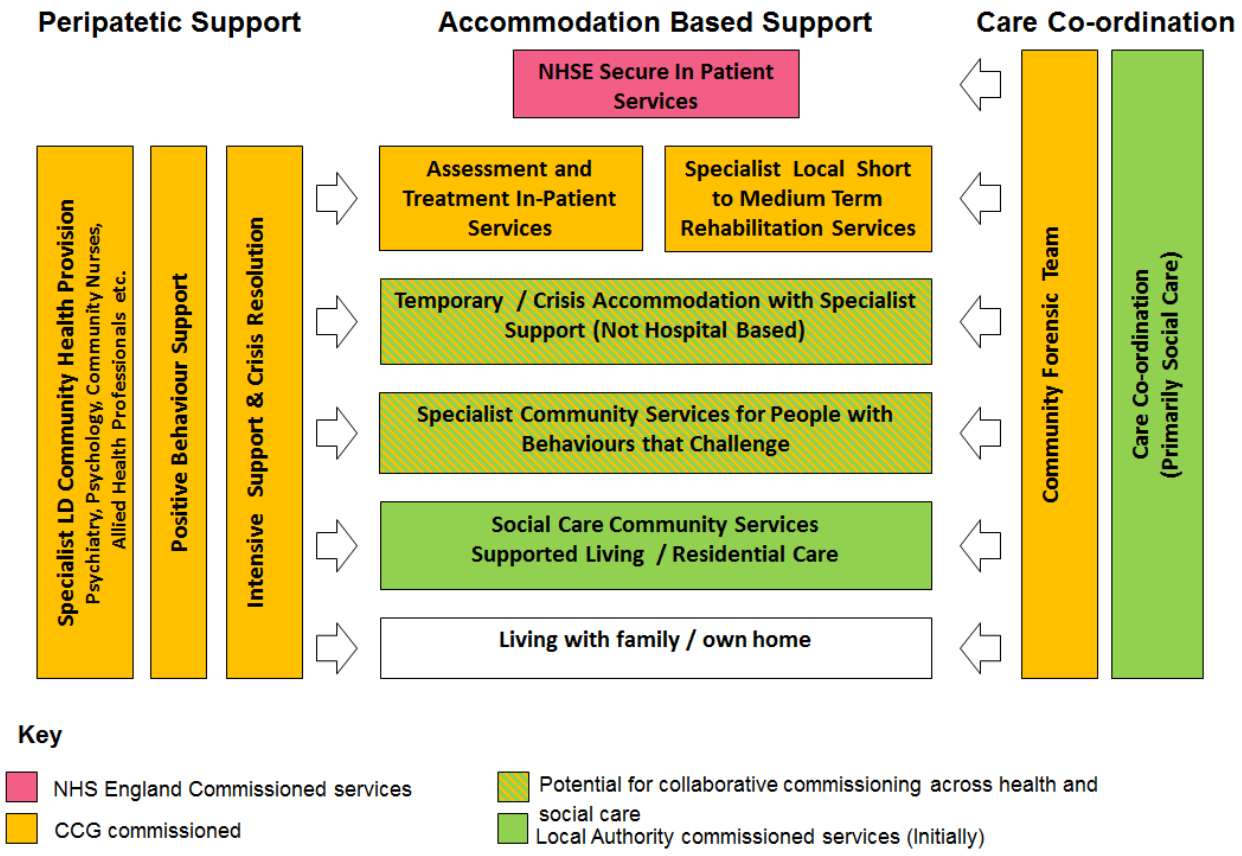
3.Develop your vision for the future

Vision, strategy and outcomes

Describe your aspirations for 2018/19.

By 2018/19 the TCP will ensure the provision of a fully integrated system across the Shropshire footprint for people of all ages with learning disabilities.

A system model to deliver an Integrated Learning Disability Pathway



The vision will be that people with LD/Autism with behaviours that challenge will be supported to have a good and meaningful life.

We will aim to:-
Provide proactive support to manage people in their own homes where possible. Care will be provided on an individual basis with bespoke plans for each person. It will be a rare occurrence for an individual to be admitted to a hospital for care to manage their challenging behaviour. Where this does occur it will be a managed process with plans to support the patient back at home as soon as possible. Universal services will be supported to manage people with learning disabilities whose behaviour challenges so they can remain part of our local communities.

We will ensure all organisations sign up to key principles across the TCP area:-

Respect- All people with LD will be treated with respect and valued as part of our communities.

This means that……

- Aspirations of individuals and families for their own lives will be central to all care.
- People who want to be in touch with family members will be able to do so.
- People with learning disabilities will not be ghettoised into long stay units run by health or social care, in area or out of area.
- Individuals will not be bullied, and will not be afraid. They will be in environments which are conducive to supporting them and giving them a greater sense of choice and control over their own lives.
- Carers will feel assured that their family member is being cared for and not subject to abuse of any kind.
- Individuals will be able to express themselves, feel valued and enjoy their lives.
- The health and well-being of individuals will be proactively managed.
- Locally people will be able to access flexible and diverse support services which match their needs.
- Whenever possible and appropriate, individuals will purchase the care and support they require through personal budgets and personal health budgets.
- The statutory organisations will 'take a step back', as individuals are enabled to lead their own lives.

To achieve the quality of life, quality of care and reduce reliance on inpatient services the TCP will adopt the national service model principles. (See Appendix 4)

To achieve this vision the TCP will:-

Improve quality of life by

- Greater awareness amongst the general public of LD and how to interact with people with a LD to reduce discrimination and prejudice
- Community services leisure, recreational, transport etc will understand support and accept people with LD in the community and make reasonable adjustments.
- Public health prevention programmes will have clear consideration for people with LD therefore reducing health inequalities
- Universal services will support early identification of risks which could develop into behaviours that challenge
- Parenting support is available to support positive behaviours.
- This will be measured by positive feedback from service users, cares and experts by experience that services feel safe, supportive and enabling.
-

Improve Quality of care by

- A Transformed 0-25 emotional health and wellbeing service with capacity to provide proactive support at an early stage and throughout the tiers.
- Realignment of the neuro development pathway to ensure timely diagnosis and support for both children and adults
- Ensuring all people with LD from age 14 shall have an annual health check, health action plan and a hospital passport
- When people with LD are admitted to a general hospital the liaison workers will support them and the staff to make reasonable adjustments
- General health and social care services staff will feel confident and have the required skills and competencies to make a positive difference to the life of individuals
- Across education, social care, criminal justice, independent sector and voluntary sector

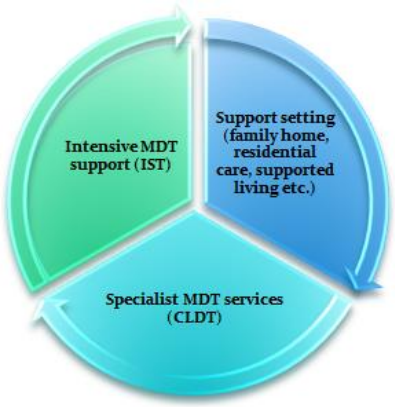
staff are aware of their role supporting and mitigating risks of challenging behaviour

- Specialist health practitioners are commissioned to support people with LD and mental health issues to manage and/or prevent escalation of behaviours that challenge.
- All people with LD will have the opportunity to hold a personal budget and/or personal health budget.
- Where advocacy is required it will be independent to the service provider.
- A sufficient suite of accommodation to match the diverse needs of the LD population that are fit for purpose
- There will be a sustainable 'market diversity' of quality providers of care for people with LD
- Employment support services will have the skills to support people with LD
- A range of alternatives for respite and short term breaks

Reduce inpatient bed usage

- A clear crisis pathway will be developed with relevant services in place

Future model – Intensive Support



- A robust, consistent Care and Treatment Review process that has access to fast track, with flexible interventions being delivered at the right place and at the right time, to avoid, where possible, admission to a hospital bed. Where admission does occur, discharge process shall be commenced immediately
- Where a safe place/support is required we will have access to community facilities in the form of step up /step down to provide fast access to the right support for as short duration as appropriate.
- Whilst we plan to reduce inpatient beds by 50% on occasions where inpatient facility is required the location will be 'as close to home' as possible and the response time will reflect the needs of the patient. (Parity of Esteem)
- A clear pathway will be developed into and out of Forensic services with clear communication including risk mitigation plans.

How will improvement against each of these domains be measured?

To ensure we know that we have achieved our vision of a good and meaningful life we will develop outcome measures that can be monitored and where we can target improvements.

These will be focused on the three priority areas:-

Improved Quality of Life measures will be developed alongside service users and family carers to ensure we measure what is important to them for their quality of life and wellbeing. It is anticipated that these

will be coproduced in Quarter 3 of 2016/17 and may include:-

Person centred planning

- Evidence of people's involvement in care planning, support and interventions/

Respite/Short breaks - including in the home

- Access to short break facilities (measure, total number, LOS)

Improvement in people's experience

- Activities and services (such as early years services, education, employment, social and sports/leisure activities)
- Education, training and employment
- Housing / accommodation measure
- Spiritual and cultural care
- Experience of clients, carers and families

Improved health outcomes

- Improvement in people feeling safe
- Improvement in people having choice and control
- Equitable outcomes
- Number of clients who have an annual health check
- Number of clients who have a Health Action Plan.

Improved Quality of care a basket of measures will be developed from the following:-

- the Health Equality Framework which looks at the five main determinants of health inequality commonly experienced by people with learning disabilities:
    - Social determinants
    - Genetic and biological determinants
    - Communication difficulties and reduced health literacy
    - Personal health behaviour and lifestyle risks
    - Deficiencies in access to and quality of health provision
- Proportion of people receiving social care primarily because of a learning disability who receive direct payments (full or in part) or a personal managed budget. (excludes people with autism but not learning disability)
- Proportion of inpatient population with a learning disability and/or autism who have a person-centred care plan, updated in the last 12 months and local care co-coordinator. Ideally, a co-production approach will be used.
- Proportion of people with a learning disability or autism readmitted within a specified period of discharge from hospital
- Proportion of people with a learning disability receiving an annual health check (again, excludes people with autism who do not have a learning disability)
- Waiting times for new psychiatric referral for people with a learning disability or autism
- Proportion of looked after people with learning disability or autism for whom there is a crisis plan.
- Uptake of personal budgets/personal health budgets
- Quality monitoring visits
- Contract reviews (of providers)
- Workforce trained to minimum standard (basic) increasing linked to functionality (existing and recruited, over the duration of the project)

- Training provided to carers

Personal budgets

- Number of people with personal budgets
- Number of people with personal health budget
- Number of people with joint/integrated personal budgets
- Number of people with Direct Payments

Reduced inpatient bed usage will be measured through monitoring and recording of data including the following categories:

- Active risk register for children, young people and adults
- Reduced reliance on inpatient care (Assuring Transformation data set), specifically monitoring the:
    - CTR activity for both adults and children including 6 monthly CTRs and blue lights
    - Number of children and young people in inpatient facilities
    - Number of adults in inpatient facilities
    - Number of clients with a person centred care & crisis plan
    - Number of clients with a named liaison worker
    - Reason for admission
    - location (in or out of area);
    - age,
    - duration of stay
- Number of beds per 1,000 head of population for Assessment and Treatment (for people with mental health issues), and for Short to Medium Term Rehabilitation (people with neurological disorders).

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.

Described in Section 3 and in Appendix 4

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

Any additional information

1. Key Assumptions

In completing the submission template the following assumptions have been made.

- No % inflationary uplift applied so the submission is based on single year cost basis (2015/16) - Increases for inflation etc will be dealt with through normal routes with associated pressures managed via a risk share agreement that the partnership will develop.
- In calculating average annual costs per community provision package for CCGs and Local Government, existing package cost details have been used with outlier costs excluded to avoid a distortion of the true 'average'
- When attributing inpatients moving in to community provision, the 10 transfers from NHS England have been attributed for planning purposes to the Local Authority funded packages line (at £183,294 per package) rather than the CCG or Joint Funded packages lines (at £138,557 and £179,911 respectively). Actual funding arrangements will be determined based on the individual patient needs at point of transfer.

- Actions relating to repatriation will commence in 2017/18, at the earliest. If new build and planning development is required, this may slip further towards 2018/19.
- Costs in the 'Finance and Activity' page reflect expected recurrent costs and therefore exclude all non-recurrent costs of implementing transformation, particularly the dual costs associated with named individuals to support repatriation. These costs form part of the non-recurrent transformation funding bid
- Transformation Funding 'bid' assumes a need for cost cover from Quarter 4 of 2016/17

2. Identified Risks

Finance representatives from all 4 partner organisations met on Wednesday 18th May 2016 to review the finance template and to identify risks inherent in both the drafted submission and overall process. Following this meeting the partnership was represented at the NHS England Finance Modelling Workshop on 19th May 2016 where some of these risks were aired and some mitigations identified. A summary of identified risks and mitigations is set out below:

2.1 NHS England unable to confirm final number of inpatients attributable to the Partnership

NHS England have confirmed that we will not know the final numbers for the potential specialised services inpatient transfers until at least August and so there will inevitably be future iterations of our returns.

In addition there are patients identified that don't have a CCG of origin and there is currently no clarity on how these patients will be 'allocated' to CCGs.

At the workshop on 19th May 2016 it was recognised that Boards are being asked to sign up to a process in June with a great deal of unknown risk – it was accepted that this was not going to work and this is to be formally raised at the TCP Board meeting on 20th May 2016.

The 26th May 2016 submission should therefore be seen as a final draft (as opposed to final) with a further review later in the year.

2.2 Basis of Dowry calculation and funding

To date there has been no clarity about how dowry funding is to be calculated. If dowries are based on actual costs of individual patients then there is no financial risk to the local partnership.

If however a dowry is calculated based on the average NHS England inpatient cost there is then a risk that actual costs of a patient are greater (or less) than the actual funding received.

Information to date has identified potentially three patients qualifying for a dowry that are attributed to the partnership.

2.3 Calculation of CCG and Local Government Average Community Provision Package cost

The finance template requires CCGs and local authorities to calculate and then use average costs of community provision as a basis for estimating future costs.

Earlier versions of the finance template used simple average calculations (total costs of patient packages divided by number of patients).

During the discussion amongst finance representatives on 18th May it was recognised that given the small numbers of patients involved a single package that was significantly different to other package costs in the relevant category could materially distort the average calculation. Consequently the average package calculations have been reviewed and outlier package costs (particularly where the outlier is a very low cost) have been removed from the calculation so that the partnership overall position is protected.

2.4 Funding arrangements for inpatients transferring in to the Community

The key assumptions section identifies that inpatients transferring from NHS England to a community based provision have been attributed for planning purposes to the Local Authority funded package line. This should not be seen as a prejudgement on the appropriate needs and associated funding of the individuals who will be transferred but more a practical recognition that in order to protect the overall partnership position the package should be reflected in the highest cost range as a means of recognising that the patients concerned will have highly complex (and costly) package requirements.

2.5 Receipt of NHS England savings in to the partnership

To date the process for transferring the NHS England 'savings' back in to the local health and social care economy have been unclear. At the Workshop held on 19th May2016 it was confirmed that:

- NHSE would not try to take savings from the budgets before transfer to CCGs.
- The funding transferred from NHSE to CCGs will be Recurrent.
- The mechanism for actioning this transfer from NHSE has yet to be agreed although it was indicated at the workshop that the mechanism should be agreed by the summer.

2.6 Funding of additional recurrent infrastructure to support transferring patients

There is a local concern that there will need to be additional infrastructure to support transferring patients. Whilst some of these costs may well be built in to the individual package costs that are put in place, an additional resource has been added in to years 2 and 3 to provide additional contingency for these costs totalling £140k in year 2 and increasing to £300k in year 3 (and recurrently thereafter)

2.7 Transfer process is not cost neutral

The final draft of the finance template submission shows that there is an additional cost between 15/16 and the end of year 3 of £734.6k (equivalent to 2.19% of total expected costs in year 3). This represents a predicted cost pressure to the local health and social care economy. This position also assumes that the NHS England savings in full are transferred into the economy. However, the NHSe draft paper (May 2016) *Transferring Care: Budget Alignment (With TCPS) states:*

> *"A reduced specialised commissioning budget would continue to be used to fund reduced activity in secure inpatient care, and larger CCGH budgets would be used to fund increased activity in community forensic services. The quantum of budget transfer will be for local negotiation, but should be proportionate to the shift in service activity agreed in the plan".* (page 3, para 6)", and
>
> *"Demand for secure LD/ASD services from one TCP (particularly the smaller TCPs) is likely to be highly volatile. Whilst the intention behind enabling TCPs to see the notional budget allocated to patients from their area is to encourage them to reduce demand for secure services, it is likely that there will be some natural volatility in demand which it will be difficult to impossible for them to control. That is partly why the proposal is for budgets to be managed at hub level, with the risk pooled across several TCPs".* (page 4, para 13)

These two extracts cause further concern. The first para indicates a limitation on how the funding transferred from specialist commissioning to local CCGs can be used. And, the second para reflects the reality facing the Shropshire footprint, as a small TCP, with one CCG in special financial measures.

This gap is based on a variety of assumptions (not least the calculation of the average cost of community based packages) and whether there is a cost pressure or not will only be known for certainty when individual transfers and associated package costs are confirmed.

When the scale of this gap was shared with NHS England at the workshop they did not appear to be overly concerned with this as a submission conclusion, but were keen to stress that there won't be any more money and the partnership will need to recycle costs locally to fit within the assumed cost neutral envelope. Locally, there is a risk as the additional costs cannot be recycled or absorbed.

An option to be explored over the coming months that may assist in the management of the overall cost position is the potential to develop a pooled budget across the partnership, alternatively there was discussion at the workshop about whether forming a larger TCP footprint with neighbouring health and social care economies may be a better way of managing any financial pressure. Locally, there is no appetite for merger with Staffordshire TCP.

4.Implementation planning

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

Overview of your new model of care

The new model of care is based on a fundamental paradigm shift in culture and practice which will impact on organisations, providers, communities, and individuals. This is an all age programme of care involving supporting local people, rather than promoting a dependency on institutional care. It will encompass all elements of service that people with LD may come into contact with for example Criminal justice system, police and probation.

This is a large piece of work and will exceed the timeline set by NHSE thereby ensuring changes are embedded into the culture of the footprint. It will impact on all elements of commissioning and operational delivery ultimately generating efficiencies.

What new services will you commission?

- Intensive support team to provide support in a crisis
- Additional accommodation in relation to named people, if required
- Additional buildings to support the delivery of specialist health care.
- Commissioning flexible arrangements for care and support in the community
- Support to establish micro-enterprises for individuals or small groups

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

- Complex care beds out of area will be reduced.
- In-patient services provided by Independent providers/companies
- A reduction in residential services

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

- Review service specification for the community unit for managing people with challenging behaviour to ensure it provides short term support with outreach function.
- Community LD team service specification to ensure proactive support for people with behaviours that challenge
- Advocacy related specifically to supporting this project (i.e. over and above the limited criteria for advocacy, as defined in the Care Act 2014)
- Ensure capacity meets the demand in community based health support
- Local support and treatment services redesigned to support clear pathways for planned, crisis, and emergency care.
- Increased employment opportunities support for those who are able to progress towards employment, and wish to do so
- 'Care work force development' is commissioned to ensure staff working with the client groups identified is competent, skilled and flexible.
- Access to low level preventative services has a clear pathway for people with LD to ensure equity of access.
- An increased range and variety of activities including outside activities, particularly for people on the autistic spectrum.
- As the number of personal health budgets increase providers will need to consider their approach to market share and sustainability.
- individuals will be encouraged to have personal budgets and take more control of their lives
- All service specifications will be reviewed and clear outcome measures developed. All block

contracts will be reviewed

- Increased capacity to provide support to family carers
- A range of Short term breaks (not respite) will be commissioned for individuals
- Day services will reflect the benefits of individuals receiving bespoke and tailored support matched to their own needs.

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

This will be an area of development, as we promote greater use of PB/PHBs. The councils have experience in PBs and this knowledge will be shared with CCGs. It is anticipated that systems and processes to manage both PH and PHBs will be integrated across organisations by the end of the programme. A PHB project will be set up within the service model work stream.
The model for developing supported living will increase peoples confidence in managing their own affairs and therefore their confidence to manage a PH or PHB, The emphasis on prevention and enablement will support this direction of travel. As we work in co-production of care packages, with service users and carers they will also grow in confidence in managing their own affairs.

SEND
Locally the SEND framework became operational on the 1st September, 2014. Within the new process the right to an Education Health and Care Plan (EHC) now exists from the age of 0-25 and will be determined through a single multi-agency resource allocation panel as part of the assessment process. It places duties on health services to work with local authorities in order to provide the health component of the EHC Plan. This includes the provision of a personal health budget where applicable.
Children with special educational needs and EHC plans in receipt of NHS funded care are also to be included within the plan. The full extent of the needs will be established to articulate the number of children who are eligible and the type and cost of care currently being provide

What will care pathways look like?

Planned, proactive and co-ordinated pathways will form part of the systems/ service model work stream, which will be co-produced throughout development and implementation of the following:
<u>Health care pathways</u>
<u>Specifically linked to the repatriation of current out of are patients:</u>
A Clinical Reference Task and Finish Group will be established involving the main provider (South Staffordshire and Shropshire NHS Foundation Trust), CCGs and council representatives. For the duration of actual repatriation. The Group will meet on a regular basis and the following will happen

- Clinical advise to ensure the right support is in place and all steps occur in a timely manner, based on the needs of the individual
- All changes occur is a way that maintains the safety of the individual and others
- All parts of the pathway for individuals will be risk assessed and mitigation will occur.
- Individuals will receive support from local health care providers as required, including GPs, community based and specialist services.
- Most importantly, repatriation will be person centred and time will be taken to ensure:
    - Planning of an appropriate package of care with funding in place – this will include double funding for staff for the duration of transition
    - Involvement of the named individual with advocacy support, as required
    - When appropriate and requested, the involvement of named family carers.
- If there is a need for crisis support during the period of change this will be provided in the

community setting

- If re-admission to impatient services is required, this will be to Redwood.
- A review will take place to learn any lessons that could have prevented or negated the need for admission, if it seems to be linked to the process of transition.

Social care pathways

- Linked to repatriation, some named individuals may require limited support from health and be ready to progress into social care support.
- Individuals will be assessed to determine the type of support required in relation to housing, engagement and staff support.
- Wherever possible, individuals will be supported to move into supported housing or shared lives.
- The intention will be to support the person to remain in the community and avoid re-admission into health care.
- If staffing levels are higher at the outset, the provider will be expected to work in a manner which leads to reduction in support within a reasonable timescale.

Planning to avoid admissions into in-patient services

- Both to support repatriation and to prevent out of area placements in the future, more work will take place to support and stimulate market growth for this particular group of individuals.
- In growing the market, the paramount issue will be to take a person centred, bottom up approach, ensuring the safety of named individuals and those in the community.
- Individuals will require different environments and different opportunities. Some individuals will require a comprehensive programme of activities throughout the week, whilst others may be more content to be able to spend time by themselves, with less intrusive support and in their own space.

Working with schools to develop a Pathway

- We will establish stronger links with schools/special schools
- Support identification of potential for challenging behaviours at the earliest point
- Ensure sufficient, appropriate support is offered, e.g. therapeutic services
- Work to mitigate or stabilise at the earliest possible time.

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

- Both councils have systems in place to support transition and we aim to work within those structures.
- The dedicated social workers will work closely with the Transition teams, especially post 16, to ensure the support needed by individuals is identified and put in place at the right time.
- As TCP improves the sharing of information more accurate planning will take place.
- Transition can cause stress which impacts on the family, sometimes leading to family breakdown. We will support families to 'stay together' by providing support to the whole family.
- CAMHS service will become 0-25 years' service to ensure transition is undertaken later giving more time for the person to mature and time for transition

How will you commission services differently?

We will commission services across the whole footprint instead of 4 different organisations.
We will share skills and expertise in commissioning and contracting
The organisations within the TCP footprint will review the options for aligning budgets to ensure risks are shared
Where we have a provider working across more than our footprint we will ensure we have strong communications and may develop services together in the best interests of patients.

We will explore capitated budgets or year of care across NHS provision with our provider.

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

- New development of dedicated specialist non NHS community based accommodation for Shropshire-need **new capital investment**
- **Capital required** to redevelop/ refurbish community unit to be able to support physical health needs of those with LD and behaviours that challenge
- Increased capacity for Supported living- already in discussion with local housing providers
- Increased capacity for Tenancy- new builds in development- high capital costs for those with behaviours that challenge.

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?

At this moment in time we understand there are a very small number of people in this category – possibly only 2 people. We do not know which of those people will return to Shropshire or, based on clinical assessment may need to remain in in-patient beds.
When we are informed, we will develop bespoke packages of care. A named member of staff will support the transition planning including working with providers and other key stakeholders. Double funding is likely to be required for some period during the transition.

- Detailed discussions will take place about each proposed resettlement, with support from independent advocates for individuals and if required, for carers.
- Whilst following a clear pathway to support resettlement, there will be flexibility to deliver bespoke packages of care.
- The programme to resettle people who are in long stay, out of area placements will be planned during 2016-17 and occur during 2017-2019.
- The TCP Board will maintain an overview of the planned resettlement programme.
- The ALD Co-ordinator post will maintain a detailed management plan to support all elements of transition.
- Funding will be available including double staffing during the actual period of transition
- Reviews post transition will occur on a regular and frequent basis to ensure a point of stability is achieved.
- Monthly joint communications prior to resettlement.

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

Many of the key representatives on the TCP board are also part of the other transformation groups/board. These include:-

- CAMHS transformation
- Mental health crisis concordat
- PHB development
- Autism commissioning

This cross cover ensures that plans fit together and are coordinated.

Any additional information

5.Delivery

The TCP Operational Board will oversee the work of the TCP Work Streams.
This TCP Board will select one of its members to chair the Operational Board. Discussions will take place prior to appointing chairs to the work streams to ensure good representation from the Authorities and other key stakeholder groups. Chairs of each work stream will attend meetings. The Operational Board will be central to taking the work of TCP forward.
The new model of service delivery will be integrated, encompassing all ages and sectors. There will be a central hub to co-ordinate and plan programme development.

Key partners will have agreed and signed up to Terms of Reference, protocols to support interaction and collaboration. Most importantly, they will understand:

- Where they fit into the partnership
- What the other parts of the partnership are (other operational stakeholders)
- What they are expected to contribute, (how, when, where etc)
- What others are expected to contribute, (how, when, where etc)

This is fundamentally important. Experience has taught us that simply making assumptions about these things leads to break down of progress and outcomes.

In the main, we will seek to work through existing structures and systems, engaging with existing post-holders with functions which overlap with the TCP agenda (e.g. transition teams, reviewing teams). However, there will be a need to create some new posts. Our intention will be to keep this to a minimum.

- A Project Manager who works across the Shropshire Footprint
- Specialist social work posts (estimates at the moment of between 2 – 4 posts – new posts) who each carry a maximum of 15 – 20 active case loads at any point in time.
- Additional Transition support worker(s) to deal with additional demand

The intention will be to keep the TCP team focused. The major principles to inform work undertaken at an operational level will be both prevention and enablement. A key area of work in the delivery of this new way of working will be the service user and carer input, which will ensure services do improve both the quality of life and quality of care for service users and their families.

We recognise the opportunity presented by TCP being an all age Programme enabling work across sectors, agencies and providers. If incidents of potential risk can be highlighted at an early stage and preventative support introduced in a timely manner, we hope to avoid family breakdown and escalation of challenging behaviours. Based on experience, we anticipate a critical area of focus will be around the later stages of transition from children's to adult services.

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

To implement our vision we have agreed the following work streams to drive forward delivery. Each work stream will have a clear focus on finance, quality of life, quality of care and a reduction
Of inpatient beds. Each work steam will have service user/carer representatives to ensure there is a clear challenge to professionals and to develop the things that really matter to the individuals we commission services for.
Workstream delivery/action plans below will be re-written by July 2016, to reflect the re-modelled governance structure (page 6). The changes align the work of the TCP with NHSe.

No	Work stream	Project no	Descriptor- project areas	Finance	quality of life	quality of care	Reduction inpatient beds.
1	Workforce	1.1	Capacity	Y	Y	Y	Y
		1.2	Knowledge skills development	y	Y	Y	Y
		1.3	Culture and values	y	Y	Y	Y
		1.4	Explore tool to measure competencies (research)	y	Y	Y	Y
2	Strategic Communication	2.1	Governance- legal/ policy	y	Y	Y	Y
		2.2	Stakeholder awareness	y	Y	Y	Y
		2.3	Public awareness	y	Y	Y	Y
3	Engagement	3.1	Co-production development and delivery	y	Y	Y	Y
		3.2	Easy read documents	y	Y	Y	Y
4	Estates	4	Housing strategy (including new build, fit for purpose, capacity	y	Y	Y	Y
5	System service model/ comn	5.1	Good and meaningful life	y	Y	Y	Y
		5.2	Person centred, planned, proactive and coordinated	y	Y	Y	Y
		5.3	Choice and control-PHBs advocacy	y	Y	Y	Y
		5.4	Support to family and paid staff	y	Y	Y	Y
		5.5	Mainstream health services- Annual health checks, health action plans, hospital passports	y	Y	Y	Y
		5.6	Specialist health and support in community	y	Y	Y	Y
		5.7	Support to stay out of trouble	y	Y	Y	Y
		5.8	Hospital services support	y	Y	Y	Y

	Workstream One: Workforce Plan			
No	Task	Lead	Milestones	Comment
1	Establish a Work stream group	SPIC	Q2 2016/17	Additional costs for meetings, providers needing to release staff, paying EbyE and travel costs for carers
2	Establish formal links with the Skills for Care and Health and seek input - attendance	SPIC	Q2 2016/17	They may, or may not attend.
3	Agree Terms of Reference	SPIC	Q2 2016/17	Use overarching TofR, with tweaks to suit context of WFD.
4	Establish a workforce plan using the Skills for Care template	SPIC	Q2 2016/17	Work with health colleagues to link with equivalent health care template
5	Seek advice and learning from the TCP Workforce pilot	TBA by workstre	Q2 2016/17	
6	Understand and map out the existing and available workforce	As above	Q3 2016/17	Need collaboration from all relevant stakeholders
7	development needs of current workforce	SPIC	Q3 2016/17	And, what needs to be added to WFD programme specifically related to TCP
8	Access support from resources and tools produced by Skills for Health and	SPIC	Q3 2016/17	Work with commissioners who will be commissioning new service model
9	Planning and meeting needs – develop a Strategic Workforce Development	SPIC	Q3 2016/17	
10	Seek Grant funding to support development, including EU/ESF	SPIC	Ongoing	Meet objectives linked to external funding
12	Confirm workforce gaps Business case for recruitment			
12	Identidy training opportunites	TBA by workstream	Q2 2017/18	
13	Recruitment processes	TBA by workstream	Q2 2017/18	
13	Commence delivery training	TBC by workstream	Q3 2017/18	

	Work steam two:Strategic Communication			
No	Task	Lead	Milestones	Comment
1	Establish work stream steering group and get shared agreement	SRO	Q1 2016/17	Understand statutory requirements identifying shared perspectives which support integration and those which hinder and find workable solutions Timetable regular meetings/ Identify Terms of Reference
2	Agree policies/ processes in relation to finance	SRO	Q1 2016/17	Alignment across the four authorities will require detailed work to ensure the TCP progresses smoothly.
3	legal frameworks for pooled budgets	SRO	Q2 2016/17	Be clear on budgets and maintaining financial control and management Consider implications of alignment on commissioning and operations
4	Stakeholder enagement, project plan and agree target audience	SRO	Q3 2016/17 & ongoing	Understand the drivers and boundaries which operate within the two domains (CCG and social care /(children and adults))
5	Awareness raising and ongoing comms plan with stakeholders	Project manager	Q3 2016/17 & ongoing	Develop protocols to support information exchange
6	Awareness raising and ongoing comms plan for public	Project manager	Q3 2016/17 & ongoing	Communication and Engagement plan
7	Develop project plans/ identify prioities (e.g. reduce stigma)	Project manager	Q3 2016/17 & ongoing	Inform of progress and feed back - users and carers, workforce, estates, governance, commissioning, benchmarking, CJS etc

	Work stream Three: Engagement Plan			
No	Task	Lead	Milestones	Comment
1	Identify all the existing routes which are in place and can continue to be used to support communication and engagement	Project manager	Q1 2016/17	LDPB and plan to attend and keep stakeholders aware and informed Longer term, agree method of keeping the groups informed
2	Identify additional meetings to be arranged	Project manager	Q1 2016/17	On going talk with Taking Part agree how to progress, & establish co-production as 'way of working' to engage specifically with people who have LD and/or autism and behaviours which can challenge
3	work with experst by experience and carers	Project manager	Q1 2016/17	Talk with CVS / Carers PB and agree how to progress, & establish co-production as 'way of working'
4	Involve colleagues who already have contact/friendships with the individuals & who will support the process of engagement, including Taking Part.	Project manager	Q1 2016/17	
5	Establish a programme of meetings	Project manager	Q1 2016/17	
6	Seek to identify people who may be able, willing and interested in supporting the co-production approach	Project manager	Q1 2016/17	
7	Explain steps we are taking, including wanting to benchmark	Project manager	Q1 2016/17	
8	Commence programme development	Project manager	Q1 2016/17	
9	Produce programme and consult on new model	Project manager	Q2 2016/17	ensure any enagement is embedded and shared into the other work streams
10	Talk about co-production and proposal	Project manager	Q2 2016/17	a small steering sub group of some representatives (individuals and carers) to help us plan and then progress consultation
11	Develop a more comprehensive plan to support progress post December 2016.	Project manager	Q2&3 2017	
12	receive information relevant and meaningful to them	Project manager	Q3 2017	
13	Continue all aspects of engaement	Project manager	Q4 - ongoing	use feedback and support to support on going programmes, implementation, delivery and evaluation of impact

	Workstream Four: Estates Plan			
No	Task	Lead	Milestones	Comment
1	Identify named individuals to be part of Strategic Working Group	LA	Q2 2016/17	invite all relevant stakeholder orgs to join Work Stream
2	Establish a Project Group to oversee the Estates/Housing Stock and Accommodation. To remain in place for the duration of the TCP project.	LA	Q2 2016/17	
3	Terms of Reference (ToR) developed including aims, outcomes, governance, finances, links to other projects/work streams	LA	Q2 2016/17	
4	Develop a TCP Project Plan/ prioities	LA	Q2 2016/17	
5	Review/refresh the existing ALD Housing Strategies, creating a sub strategic objective around TCP covering the entire footprint..	LA	2016-2019	PID submitted to NHSe for 2017 – 2019. Planning to occur in 2016. Cover period 2016-19 for people described in the 5 cohorts;· Update to reflect changes on policy (e.g. TCP); Care Act 2014
6	Identify and map demand	LA	Q3 2016/17	
7	Assess in detail the existing supply which exists and is likely to be available across all sectors.	LA	Q4 2016/17	
8	Created Action Plan to support Strategy	LA	Q1 2017/18	
9	Identify all current Out of Area (OofA) people requiring Housing and Accommodation in the future.	LA	Q4 2016/17- Q1 2017/18	Some OofA may not want to return
12	Specifically confirm status of named individuals against the '5 cohorts' definitions.	LA	Q4 2016/17- Q1 2017/18	For repatriation, cohort 5
13	Gain understanding of the perspective of named individuals relating to their future housing and accommodation needs	LA	Q4 2016/17- Q1 2017/18	Specifically in relation to existing OofA, supported by Advocacy services and existing providers of care
14	Within the Project Plan develop a pathway to support repatriation of existing out of area placements	LA	Q4 2016/17- Q1 2017/18	a) CCG patients (12); b) Spec Commissioning (14/19); c) Local authority out of area placements (no's. TBC)
15	Understand the perspective of named carers linked to individuals due to be repatriated.	LA	Q4 2016/17- Q1 2017/18	Involve carers throughout; If families don't want to engage, involve correct statutory bodies as stated in the Care Act
16	Estates/Housing Stock and Accommodation Commissioning and procurement Strategy which is aligned to the overall learning disability strategy and reflects the current	LA	Q4 2016/17- Q1 2017/18	
10	Identification of new providers, secure housing to maximise opportinuty to meet demand	LA	Q4 2016/17- Q1 2017/18	agree standards / requirments of market management
11	Tendering work	LA	Q1 2017/18- Q3 2017/18	

project	Work stream 5- System Service model/			
No	Outcomes (tasks to be agreed with prject group)	Lead	Milestones	Comments
Have a good and meaningful life				
1	People are included in activities and services.	Local authorities	TBC with work stream	Get to know individuals. What do they like doing?
2	People have choice and control over the activities in which they participate,	Local authorities	TBC with work stream	facilitated through person-centred care and support plans/ Education, Health and Care (EHC) plans and personal budgets/personal health budgets
3	Access to education, training and employment (including supported internships) which they can access within their local area	Local authorities	TBC with work stream	
4	Training and support to mainstream service staff and/or provide support to individuals and their families/carers	Lead to be identified in each member organisatio	TBC with work stream	This enables them to participate in mainstream services, and to access education and training within local schools and colleges.Discussions with providers of education/FE about courses and support available
5	Offer good support to families/ carers, friends and others so that people are supported to take part in things they value.	identified in each member organisatio ns	TBC with work stream	
Person centered planned, procative and corodinated care and support				
6	Sophisticated risk stratification of local populations	CCG	TBC with work stream	to enable local services to anticipate and meet the needs of those people with a learning disability and/or autism.
7	Everyone will be offered a named local care and support key worker	CCG	TBC with work stream	Consistency for named person and family carers
8	People are given more choice and control over decisions to do with them and their peers,	LA & CCG	TBC with work stream	Will inculde support from independent advocates, as required.
9	Things happen in a timely manner to help stop people finding themselves in situations which lead to behaviours which challenge	LA & CCG	TBC with work stream	
Everyone has chioce and control over how their health and care needs are met				
10	Everyone receives information about their care and support in formats that they can understand.	CCG	TBC with work stream	This will apply in all circumstances – even when people lack capacity to make specific decisions, they are involved in their care and support planning discussions wherever possible and any decisions taken on their behalf will be made in their best interests.
11	The offer of personal health budgets are increased. Integrated personal budget across health and social care are developed.	CCG	TBC with work stream	Identification of TCP cohort likely to accept an offer of a PHBs
12	People are involved in deciding who provides care and support to them (recruitment), including personal care	CCG	TBC with work stream	Identification of TCP cohort likely to accept an offer of a PHBs
13	People have access to different types of independent advocacy.	CCG	TBC with work stream	Non-statutory advocacy to be increasingly offered , at key transition points including in preparation for and on leaving a specialist hospital.

Care and support in the community to reduce crisis situations				
14	Practical and emotional support and access to early intervention programmes are available	CCG	TBC with work stream	across Shropshire, including evidence-based parent training programmes, and other skills training.
15	Improved availability and access to short breaks/respite	CCG	TBC with work stream	suitable for people whose behaviour challenges at times when there is stability in the home. Different types of respite and short term breaks are available,
16	Alternative short term accommodation (for a few weeks) is available,	CCG	TBC with work stream	To be used in times of crisis or to avoid a potential crisis (eg for medication review/ changes) preventing an avoidable admission into a hospital setting
17	All paid, health and social care staff providing packages of support, to be able to deliver proactive and reactive strategies to reduce the risk of behaviour that challenges,	CCG	TBC with work stream	Staff feel confident, skilled and competent to de-escalate behaviours which challenge
18	Within Shropshire there is a clear identified list of preferred providers across health and social care,	CCG	TBC with work stream	A comprehensive list exists and is maintained by commissioner which can demonstrate minimum quality standards and competencies.
19	SPIC will, in partnership with the providers, develop competency frameworks, including requirements for staff training	SPIC/LA	TBC with work stream	Competency Framework e.g. communication and Positive Behaviour Support (PBS).
Main stream health servcies				
20	Everyone with a learning disability over the age of 14, will be offered an Annual Health Check	CCG	TBC with work stream	To inculde a Health Action Plan, which identifies how any physical and mental health needs will be met.
21	The health action plan will also include a 'Hospital Passport'	CCG	TBC with work stream	To help mainstream NHS services make the reasonable adjustments required by law (including meeting the needs of people who display behaviour that challenges) and ensure equity of health outcomes for people.
22	Review of 'liaison' workers, who have specialist knowledge and specific skills in working with people with a learning disability and/or autism which enable them to advise those services on how to make effective adjustments	CCG	TBC with work stream	Liaison workers in place with the right specialist knowledge and specific skills
23	Audit of how Shropshire Footprint NHS provider services 'quality checker' schemes are utilised to ensure that mainstream services serve them appropriately.	CCG	TBC with work stream	Improved consistency in Health Checks, to improve North/South divide
24	Audit how mainstream mental health services are meeting the needs of people with a learning disability and/or autism.	CCG	TBC with work stream	Green Light Toolkit (NDTi 2013, ring MDT together for 3 x 2 hour sessions to work through the green light toolkit together

	access specialist health and social care support in the community			
25	That everyone has readily accessible community access to integrated, community-based, specialist multidisciplinary health and social care support.	**CCG**	TBC with work stream	(including those who may have come into contact with or are at risk of coming into contact with the criminal justice system)
26	Evidence is available to demonstrate that support will be built around the needs of the individual through a **'**Collaborative Care' model,	**CCG**	TBC with work stream	combined team (e.g. all age, learning disability and autism) and that individuals receive continuity of care and support through close collaboration of services/agencies, including between specialist and mainstream services.
27	Anyone who requires additional support to prevent or manage a crisis will have access to hands-on intensive 24/7 multi-disciplinary health and social care support at home, or in other appropriate community settings,	CCG	TBC with work stream	Including schools and short break/respite settings. This support will aim to be delivered by members of highly-skilled and experienced multi-disciplinary/agency teams with specialist knowledge in managing behaviours that challenge.
28	Improved interface between specialist routine multi-disciplinary support services a	**CCG**	TBC with work stream	
29	Commissioners will ensure the availability of specialist integrated multi-disciplinary health and social care support in the community for people with a learning disability and/or autism, covering all ages.	**CCG**	TBC with work stream	
30	Commissioners will ensure this specialist health and social care support includes an intensive 24/7 support function.	**CCG**	TBC with work stream	
31	Commissioners will ensure inter-agency collaborative working, including between specialist and mainstream services	**CCG**	TBC with work stream	Specialist health and social care support is available to people.SSSFT provide a 24/7 service to support people remaining in the community
32	Understanding an asset based approach and ensuring community based services are accessible.	CCG	TBC with work stream	
	population can get the necessary support to stay out of trouble			
33	People who are at risk of coming into contact with the criminal justice system, will have access to the services aimed at preventing or reducing anti-social or 'offending' behaviour.	CJS	TBC with work stream	Commissioners expect services (including those provided by youth offending teams, liaison and diversion schemes, as well as troubled family schemes and programmes such as those for drug and alcohol misuse) to identify people with a learning disability and/or autism amongst the people they support, and to make reasonable adjustments so they can effectively support those people. This will be achieved through collaboration with specialist multi-disciplinary health and social care services for people with a learning disability and/or autism
34	Liaison and diversion schemes will seek to support people through the youth or criminal justice system 'pathway'	CJS	TBC with work stream	enabling people to exercise their rights and/or where appropriate, diverting people to appropriate support from health and social care services. Clear pathways for diversion to appropriate health and social care services will be established through local multi-agency protocols.
35	Strong links are established with all the different parts of the CJS	CJS	TBC with work stream	People receive the right support at the earliest stages to stop them becoming involved with any part of the CJS.Information on how to support and prevent links with the CJS is provided to paid carers and family carers as well as other professionals

high-quality care in hospital settings				
36	Everyone who is admitted to a hospital setting for assessment and treatment will be integrated into their broader care and support pathway,	CCG/ NHSE	TBC with wo	hospitals working closely with community mental health, learning disability/autism and other services, including those providing intensive community and/or forensic support
37	People admitted for assessment and treatment in a hospital setting will focus on proactively encouraging independence and recovery.	CCG/ NHSE	TBC with work stream	Services will seek to minimise patients' length of stay and any admissions will be supported by a clear rationale of planned assessment and treatment with measurable outcomes. Discharge planning will start from the point of admission - or earlier for a planned admission. Care and treatment should be regularly reviewed, in line with NHS England Care and Treatment Review guidance and Shropshire's local CTR policy and CPA requirements.
38	People who present an immediate risk to those around them and/or to themselves may require admission to a hospital setting when their behaviour and/or mental state is such that assessment and/or treatment is temporarily required that cannot be provided safely and effectively in the community.	CCG/ NHSE	TBC with work stream	High quality assessment and treatment in non-secure hospital services with the clear goal of returning them to live in their home will be evident.
39	Providers will make the reasonable adjustments to enable this (e.g. liaison nurses and collaborative working with learning disability and/or autism specialists).	CCG/ NHSE	TBC with work stream	
40	People whose learning disability and/or autism is more significant and who require an adapted environment and/or intensive specialist treatment and care will be admitted to a specialist unit if they require inpatient care.	CCG/ NHSE	TBC with work stream	With the right support at the right time in the community, use of inpatient services will be reduced and only for clearly defined purposes. Admission to secure inpatient services will only occur when a patient is assessed as posing a significant risk to self or others.
41	A clear consitnet CTR process in place for adults and children	CCG/ NHSE	TBC with work stream	As a result of the process all inpatient provision (secure or not) children admitted to hospital will be placed in an environment suitable for their age and must have access to education. For adults, provision of single-sex accommodation is essential

Work stream 5

Project 5.8 Hospital services

A priority for this work stream is the reduction in inpatient beds. This will have a significant impact on mainstream health services, specialist health services, hospital beds, social care and family and carers to ensure people with LD have a good and meaningful life.

Baseline Financial Figures

	Cost to CCGs (£)	Cost to NHS England (£)	Cost to local govt (£)	Total (£)
Forecast annual cost of inpatient provision used by TCP population	£1,049,672	£3,744,900		£4,794,572
Forecast annual cost of individual community support packages for former inpatients/those at risk of admission	£9,584,182		£10,174,366	£19,758,548
Forecast annual cost of community services	£2,601,771	£0	£5,722,113	£8,323,884
Total	**£13,235,625**	**£3,744,900**	**£15,896,479**	**£32,877,004**

Assumptions for in-patient discharges

Our financial plan is predicated on an assumption that actual transition will commence from April 2017, so there is time to prepare accommodation and suitable care packages. This will ensure safe, high quality discharge. We will continue to work closely with NHSe specialised commissioning for individuals whose discharge is planned before this date.

From May 2016 when NHSe specialised commissioners revert to population based commissioning, the lead from Specialised Commissioning will meet monthly with TCP clinical leads to discuss the individuals, their needs, preferences and discharge plans. This provides the opportunity to identify the level of risk of repatriation and make longer terms plans in order to keep both the individuals and communities safe.

CCGs and local authorities have not built in any additional funding requirements to support repatriation of people who have previously been the responsibility of NHSe specialist commissioning responsibility and are therefore reliant on funds following the individual. These individuals have highly complex and resource intensive needs.

Future admissions over next 3 years and link to decommissioning of in-patient beds -

Assumptions

- The CCG do not commission any inpatient beds for this cohort- they are spot purchased as required.
- As we develop more proactive community based and crisis support we will commission less in-patient beds which will have an impact on out of area providers.

Dowries

3people (Low Secure) are eligible for Dowries. Assumptions made:

- Annual revenue stream of £175,200 per patient. (Total per annum £525,600).
- At this point in time the assumption is the full cost of the current placement will be maintained at the current rate (with annual increases for inflation and fee increases from providers).
- Cost reduction will be dependent on the individual requiring less individual staff support.
- Accessing activities and engaging in the community may require further investment which will be in excess of the possible staff savings.
- This revenue stream will continue until the two people die.

Financial Risk

- Non Dowry patients- There is lack of clarity regarding how long funding from NHSe will continue into the TCP area once individuals are moved. This could have significant financial impact on the CCGs and LA circa £2.6M. Local authorities are bound by financial regulations to hold a balanced budget. Where funding ceases during the lifetime care of these individual local authorities will not have the budget to support the level of care required. This could mean cutting of other services in prevention. On this basis local authorities will not approve these plans. This impasse is likely to have a detrimental affect the partnership working across the TCP
- It is likely that the future cohort will increase in complexity. Whilst the footprint will have an increased prevention, proactive, model in place there will be some individuals who require specialist inpatient beds. The TCP is unaware of any prospective increase in baseline budgets to reflect this.
- Transport costs for the footprint will increase due to the rurality of the area. The changes in

practice will mean more staff travelling as well as individuals accessing activities and healthcare.

Section 117 aftercare

- If any of the non-dowry patients are eligible for section 117 after care, the funding details between the local authority and CCG will be calculated according to existing local policies.

Continuing Health care

- If any of the non-dowry patients are not eligible for section 117 funding, they will be assessed for CHC funding.

Investment in community infrastructure

The 2016/17 contract for LD services supports the Intensive support team and the proactive LKD team. These teams will provide support in the community for those at risk of admission and support positive behaviour management.

On the assumption of repatriation for each individual the following will need to be taken into account in order to meet the requirements of the service model:-

- Operational Staffing levels for care delivery
- Case Management
- Housing costs
- Activities
- Healthcare
- Transport
- Education
- Employment support
- Criminal justice system- police, probation etc

All of these factors require individual consideration.

Investment in individual packages of support

Based on assessment of the above factors NHSe have suggested that the transfer will be cost neutral to manage people in the community. The evidence indicates this will not be the outcome at a local level, and across the footprint, this risk cannot be mitigated.

Capital – Financial Assurance Checklist 2

Capital PID

- The Capital PID will be revisited and revised during May – June 2016.
- An updated submission will reflect cost assumptions to provide the above accommodation.
- The application PID will not require investment during 2016-17.

Capital Plans

Capital plans for 16/17 – not proposed

Capital plans for 17/18 & 18/19 will be assessed and confirmed by Autumn 2016.

Capital – community based accommodation

As an example of recent costs associated with developing provision Shropshire commissioned supported living for 9 people with complex behaviours, including repatriation from out of county settings.

- Site 1- £3.2 million including site value and development costs.
- Site 2- £370,000
- Site 3- £56,000

Review of existing estate under legal charge

NA

Work with housing organisations/local authority

Estates/Housing work stream to be established.

Unused/vacant properties

As part of above work stream.

Raise ambition for capital plans

- The ambition for the TCPs is to have fit for purpose, community bedded accommodation to provide step up, step down facilities to support those with behaviours that challenge through escalation of physical, mental and social issues.
- Quality individual tenancies for supported living for each individual
- A range of short term/respite options including accommodation

Person centred approach

An underpinning principle of this TCP is that wherever possible housing will be community based in supported living accommodation whereby people with LD will have their own tenancy, have access to benefits and are supported to live fulfilling lives in their local community as citizens. As work progresses consideration will be given to the requirement to involve court of protection and DoLs.

Understanding the financial risk for each commissioner - how to address and mitigate

(See risk register for financial risks)

Development of a local, transparent financial model

The Shropshire footprint TCP will continue to work together to produce a transparent financial model to support TCP and has in principle agreed to align budgets. Further conversations will be undertaken after May 16 when NHSe has reverted to population commissioning, to align specialised commissioning budgets.
An invitation has been extended to Specialist Commissioning to join the Shropshire footprint TCP Board.

Provider sustainability and contracting footprints

As the footprint commissions a small number of beds from a small number of providers the impact is minimal. The repatriation of individual will support the sustainability of local providers. Our footprint for some highly complex individuals may extend into neighbouring TCP areas and the TCP is in direct conversation with them.

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

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

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

Members of the TCP Board will be assigned to a work stream and an operational lead will be responsible for co-production and implementation of the projects.

Members of the TCP are:

- Chair: Assistant Director, Early Help and Support and Statutory Director of Adult Social Services

- Deputy Chair: Director of Nursing, Quality and Patient Experience Shropshire CCG
- Risk Mitigation Lead Nurse for Vulnerable People, Nursing, Quality, Patient Safety and Experience, Shropshire Clinical Commissioning Group (CCG)
- Commissioning Specialist / Contracts Officer, T&W Council
- Assistant Director, Shropshire Council
- Head of Commissioning for Mental Health, Learning Disabilities and Children, T&W CCG
- Project Manager

Project planning monies have been agreed to support setting up of plan. Organisations have also agreed a joint post needs to be in place to move the agenda forward. This has been put into the financial bid from the TCP

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

Guidance notes; What are the timescales / lead times for each key milestone
Please either complete a route map – as attached, or some other project management tool to map milestones

Route Map: *<Shropshire TCP>*

Date last updated: 07/04/2016

Example Deliverables	Leads	2016/17						2017/18						2018/19				
		Jan-16	Mar-16	Jun-16	Sep-16	Dec-16	Marc `17	Jun-17	Sep-17	Dec-17	Mar-18	Jun-18	Sep-18	Dec-18	Notes
1) Workforce															
Develop a sustainable workforce - Capacity - Knowledge and skills devlopment - Culture and values - Explore tools to measure competencies (research)	SPIC		Establish work stream group Establish inks with skills for care and Health and seek input. Agree ToR	Workforce plan Advice and learning from workforce pilot>	Map existing workforce	Planning /engagement meetings Agree Strategy Seek grant funding	Identify Training Opportunities, plan training dates & communicate dates out	Commence to Deliver Training/ recruitment	Deliver Training	All training to be delivered					
2) Strategic Communication															
Governance	SRO		Establish work stream group Shared agreement	Policies and agreement in relation to finance	Legal framework for pooled budgets										
Stakeholder engagement	SRO		Establish work stream group	Develop project plan and agree target audience				Deliver awareness training in relation to people with LD							
Public Awareness	SRO		Establish work stream group	Develop project plans priorities e.g. reduce stigma					Public awareness launch						
3) Engagement															
Co-production development and delivery	Project Manager	Identify existing routes, enage carers. Estyablish programme	consultation on new model	Commence Programme Development	ongoing co-production			documentation shared and embedded							
Develop Easy Read documents	Project Manager		Establish work stream group	Review Current Practices	Identify Gaps	Propose New Arrangements		Produce and distribute documents							
4) Estates - Availability & Suitability															
Housing strategy	LA		Establish work stream group	Develop project plans priorities	Requirements Develop Develop / monitor Risk Registers	Agree Standards/ a pathway to support repatriation of	Identify & Map Demand Procurement Strategy			securement of new providers/ housing to meet demand	monitoring/ recruting/ implemtation processes				
5) Systems service model and commissioning															
Good and meaningful life	LA, CCG, Provider lead		Establish work stream group Agree ToR	Review Current Practices, Identify Gaps, Risk Registers	Agree pathways and establish gateways	Develop systems for indivualised care / support	Agree Service specifications	Procure/ recuit to gaps idenified							
Person centred, planned, proactive and coordinated	LA, CCG, Provider lead		Establish work stream group Agree ToR	Review Current Practices Identify Gaps Risk Registers	Agree pathways and establish gateways	Develop systems for indivualised care / support	Agree Service specifications			Procure/ recuit to gaps idenified					
Choice and control-PHBs advocacy	CCG		Establish work stream group Agree ToR	Review Current Practices Identify Gaps Risk Registers	Agree pathways and establish gateways	Develop systems for indivualised care / support	Agree Service specifications	Procure/ recuit to gaps idenified							
Support to family and paid staff	LA, CCG, Provider lead		Establish work stream group Agree ToR	Review Current Practices Identify Gaps Risk Registers	Agree pathways and establish gateways	Develop systems for indivualised care / support	Agree Service specifications	Procure/ recuit to gaps idenified							
Mainstream health services- Annual health checks, health action plans, hospital passports	CCG		Establish work stream group Agree ToR	Review Current Practices Identify Gaps Risk Registers	Develop Uniform System Approach CTRs Early interventions	Develop systems for indivualised care / support		Agree Service specifications	Procure/ recuit to gaps idenified						
Specialist health and support in community	CCG/ NHSE		Establish work stream group Agree ToR	Review Current Practices Identify Gaps Risk Registers	Agree service specifications for community integrated teams	Agree pathways and establish gateways	Agree Service specifications	Procure/ recuit to gaps idenified							
Support to stay out of trouble	CJS		Establish work stream group Agree ToR	Review Current Practices Identify Gaps Risk Registers		Develop systems for indivualised care / support		Agree pathways and establish gateways	Agree Service specifications	Procure/ recuit to gaps idenified					
Hospital services support	CCG		Establish work stream group Agree ToR	Review Current Practices Identify Gaps Risk Registers	Agree pathways and establish gateways	Develop systems for indivualised care / support	Agree Service specifications	Agree Service specifications	Procure/ recuit to gaps idenified	Procure/ recuit to gaps idenified	Procure/ recuit to gaps idenified	Procure/ recuit to gaps idenified			

Key Milestones
Steps in Process
Delivery/Target Date
Trajectory

What are the risks, assumptions, issues and dependencies?

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

The key dependencies and risks for organisations not signed up to this plan focus mainly on the criminal justice system. This includes police and probation services. The implication of managing people who are higher risk to the community will need to work through with them and pathways developed to ensure they can access crisis support quickly and easily.

Other dependences include the housing market- whilst we have providers willing to work with us to manage people with LD this may become more problematic as we bring back people who are initially at higher risk

of causing significant harm to others or property. This will require careful management on an individual basis for each client.

Whilst the local authority with their remit for education are signed up to this plan as many schools are now independent bodies we will need to work with individual schools to ensure they work with us to improve early identification and support for young people

The work involved in this plan is labour intensive and will require project management, workforce development, engagement costs and double running costs. The TCP is requesting some financial support to make this happen.

Estimated requirements for Transformation Funding:

YEAR ONE		
Programme Co-Ordination	1 WTE already paid into TCP	£0
Increase resources to manage CTR process and case management	3 case workers in Q 4 only	£37,500
Management and supervision of staff	0.2WTE manager Q4 only	£1,850
Support for care leavers and work with special schools	1 WTE case manager Q4 only	£9,375
Admin support for co-production of plan	0.5 WTE start September 16	£6,250
Workforce development - wider community	1 WTE educator in LD/autism Q4	£15,000
Advocacy/IAG/Communication	To support TCP plan, repatriation of individual, support to People at risk of admission	£21,450
Project management for capital build /estates plan	1 WTE Q4 only	£18,750
YEAR TWO		
Programme Co-Ordination	1 WTE full year effect	£50,000
Increase resources to manage CTR process and case management	3 case workers FYE	£112,500
Management and supervision of staff	0.2WTE manager FYE	£46,250
Support for care leavers and work with special schools	1 WTE case manager FYE	£60,000
Admin support for co-production of plan	0.5 WTE FYE	£22,000
Workforce development	01 E educator in LD/autism FYE	£43,200
Advocacy/IAG/Communication	To support TCP plan, repatriation of individual, support to People at risk of admission	£21,450
Project management fro capital build /estates plan	1 WTE FYE	£75,000
YEAR THREE		
As above year two	FYE	£430,400
		£970,976

Match Funding

The Shropshire TCP will match fund this bid by the following:-

Service/ support for TCP Plan implementation	**Total cost of Service applicable to TCP plan**
Commission managers 1* day per week 4 organisations at Band 8a	£43,986
Criminal justice system 20% LD	£82,837
Outreach behaviour support team	£421,747
Community LD (50% challenging behaviour)	£1,231,938
IAPT -Wellbeing services 10%	£280,249
Admitted care 10% Cluster 8 activity	£4,236
Non admitted care 10% of Cluster 8	£222,561
TOTAL 2016/17 (Year 1)	£2,287,553
TOTAL 2017/18 (Year 2)	£2,287,553
TOTAL 2018/19 (Year 3)	£2,287,553
Contributions by Organisation	
Shropshire CCG	£1,449,578
Telford & Wrekin CCG	£815,982
Shropshire Local Authority	£10,997
Telford and Wrekin Local Authority	£10,997
Total	£2,287,553
All identified matched funding is incorporated in to existing 2016/17 budgets and none is dependent on planned future investments	

What risk mitigations do you have in place?

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

Risk Register

These scores are based on the interpretation of NHS risk registering scoring criteria. They are not reflective of Local Authorities level of concern in relation to the financial risks.

Risk mitigation scores will be identified within the work stream individual risk registers.

Category of Risk (e.g. financial, reputational	**Risk Include any assumptions made**	**Impact 1 - 5**	**likelihood 1 - 5**	**Risk Score 1.25**	**Mitigation Actions**
Finance	At the outset, the project will be high cost. Cost savings will only be	3	3	9	Cannot mitigate without additional, **sustainable** revenue investment to underpin a Paradigm shift in service delivery. The cost neutrality described in the WebEx

	achieved in the much longer term and not within 3 years				conference phone call **must be the reality** for local CCGs and councils as well as NHSe.
	Shropshire footprint has low 'Dowry numbers'	3	3	9	Full Dowry monies paid, with no local reduction
	Austerity measures mean fall in annual revenue to maintain existing services to ALD, and unable to accommodate growth from this project.	3	3	9	TCP prevention is resourced sufficiently to counter Austerity.
	Lack of detailed financial planning to inform assumptions	3	3	9	Information passed to TCP areas in a timely manner.
	Lack of resource to support the wide cohort of potential clients defined in the Service model, including those with potential to enter CJS.	3	3	9	NHSe/ADDASS confirm funding to underpin Programme implementation, ultimately leading to reduced costs
	Lack of detailed knowledge about the cases held by specialist commissioning which limits future planning	3	3	9	Information is shared and is comprehensive
	Level of historical disconnection between council, CCG and specialist commissioning cannot be fully addressed within the available short timescale	3	3	9	Communication improves
	Require clarification on funding mechanisms for new clients who would previously have been admitted to in-patients beds by either the CCG or specialist commissioning.	3	3	9	CCG funding able to flow into community easily
	Claw back of funds from specialist commissioning to support local involvement and attendance at case meetings.	3	3	9	Need to receive assurance this wont happen
Develop personal-ised models and impact on take up of PHB	NHS still gaining knowledge and understanding of personal health budgets RISK CCGs will have to identify funding to pay for PHBs.	2	2	4	CCGs learn from councils Councils undertake management of PHBs (at a cost) to support CCGs CCGs indicate intention to decommission services from existing block contracts to provide revenue to support PHBs
Estates	Suite of appropriate buildings to provide the right services and/or accommodation when needed.	2	3	6	Clear information of how to match the needs of the individual with the right accommodation,
Project Focus	The project is multi-faceted – requiring collaboration across organisational and professional boundaries	2	2	4	Senior Project Co-ordinator appointed from Transformational Funding Time is given to support under-pinning the project with

	a) Four main statutory authorities b) Private and voluntary sector c) Family carers and experts by experience				firm foundations Familiarisation between stakeholders and understanding the complexity of the tasks. Developing a matrix approach and understanding the interchangeable elements which impact on each other.
Programme Board Membership	Ability to establish appropriate levels of stakeholders on the Board RISK: Not having suitable stakeholders and thus not having intended levels of views and options	1	2	2	Ensure stakeholders are selected on basis of compatibility and contribution Ensure meetings are timetabled in on a regular basis, convenient time and location. Ensure support is available to members, as required. Produce information in accessible formats. Have pre-and post .meetings with experts be experience (with advocacy support)
Building costs and/or building adaptations	Plans to develop any new build must be based on accurate assessment of future need RISK Need to ensure time for all aspects of developing new build including, in summary: • purchase of land • commissioning of build to a design which is 'fit for purpose' and therefore higher spec than ordinary accommodation • commissioning of providers • Cost of building development • If PFI, managing the cost • Councils and CCGs not able to underwrite, nor cover any associated costs	3	3	9	Detailed information available to support planning assumptions and business planning. Grant application via PID approved by NHSe.
Reputation	Funding restrictions across the local health and social care economy may result in limited delivery of Transformational plan Timescales available to fully develop the plan have been limited. Elected members will wish to assure local communities that TCP is affordable at a time of austerity. Reputational damage Limited consultation Elected members are	1	2	2	Further information is provided by NHSe, the financial plan submitted in February can be reviewed Some engagement has taken place with named individuals. More work will be planned from July, onwards and be ongoing Elected members are given written and formal assurance that all costs associated with TCP are resourced directly and on an ongoing basis through savings achieved by reduction in in-patient beds.

	compromised due to failure to deliver programme at a cost neutral position.				
Safety/ Safe guarding	Information provided by NHSe spec comm is not detailed. This means repatriation plans cannot be risk assessed from the safeguarding perspective. Client and community safety is paramount RISK Discharge planning cannot take place When discharges occur, they are not safe.	2	2	4	Detailed information is gathered through CTRs involving CCGs and social care as discharge is planned for Discharge is risk assessed in terms of safeguarding of the individual and community

Risk Matrix

Risk Matrix		Likelihood				
		1	2	3	4	5
		Rare	Unlikely	Possible	Likely	Almost certain
Impact	5 Catastrophic	5	10	15	20	25
	4 Major	4	8	12	16	20
	3 Moderate	3	6	9	12	15
	2 Minor	2	4	6	8	10
	1 Negligible	1	2	3	4	5

6.Finances

Financial assumptions

The following financial assumptions are outlined in the Excel spreadsheet and 'pasted' here, for information.

Additional information

Assumptions:-

Assumptions:-
No % inflationary uplift applied so this sheet is based on single year cost basis (2015/16)- Increases for inflation etc will be dealt with through normal routes with associated pressures managed via a risk share agreement that the partnership will develop.
10 patients transferring from NHSE beds to community based provision have packages of care in community- costs assumed at the present highest cost package of care to allow for complexity and risk.
Additional cost between 15/16 and end of yr 3 is £735k. This represents a cost pressure to the local health and social care economy after an assumption that the NHS England savings in full are transferred into the economy . This additional cost pressure cannot currently be mitigated. If the money transferred into the economy is only targeted

to support ***'increased activity in community forensic services'*** the risk to councils will increase further. This will increase the level of un-mitigated risk. (NHSe Transforming Care: Budget Alignment (with TCPS) report 09/05/2016.

Actions relating to repatriation will commence in 2017/18, at the earliest. If new build and planning development is required, this may slip further towards 2018/19.
Please note, costs in 'Finance and Activity' page exclude all costs of implementing transformation, particularly the dual costs associated with named individuals to support repatriation.
CAPITAL FUNDING:-The forecast capital investment for 15-16 is £541K, which excludes the value of land. Of the £541K, £165k relates to capital project which commenced in 14/15 and completed in 15/16. The total overall value of this project is £2.275m (including value of land at £375k).

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

End of planning template

Appendix 1 Engagement

Who	How	Next steps
People with learning disabilities and/or autism	Engagement post Mansell 2 and remains ongoing, but not as structured and focussed as required	Establish key people who can support co-production of TCP and help to 'take it wider' to other people who use services now, or may do in the future. Engage as experts by experience to support quality monitoring (learn from Gloucester Voices)
Family carers	Attended T&W Carers Partnership Board Met with four carers (see information below (page xxx)	Carers are a priority in TCP. Respite must be provided Establish links with Foster Carers and Shared Lives to maintain family links as individuals leave home
Learning Disability Partnership Boards (Shropshire and Telford & Wrekin)	Attended meetings of both LDPB in February and March.	Keep informed.
Health Commissioners (CCG and NHS England),	Attendance at TCP Board meetings Ongoing informal support outside meetings	TBC
NHS Providers	Meetings with SSSFT	Establish stronger links with: • SaTH • Shrop Com • GPs • Screening services • Therapeutic services • Audiology • Dentistry To better understand issues, challenges, boundaries etc and how to address the same. And, within SSSFT: • Psychiatry

		• Psychology • SALT • Physiotherapy
Clinicians		
Safeguarding	Adult safeguarding	Widen to include children's safeguarding Agree on nature and level of engagement and information sharing.
Local Authority Commissioners	Adult and Children's + Education	Ongoing. As information becomes clearer on repatriation, ensure commissioners are informed and engaged in a timely manner
Managers	• Service Delivery Managers • Operational Team Leaders • Attended briefing meetings • Ongoing conversations	Involve in case management, as required and especially at time of discharge for people due returning to area. Establish stronger links with managers from Children's services in context of TCP.
Social Care Providers	Meeting with SPIC (Shropshire Partners in Care)	Continue to work with SPIC Also, SPIC to lead on Workforce Development
CAMHS	To be confirmed	
Adult Mental Health Service Providers	To be confirmed	
Third Sector Services	Meeting with Community Voluntary Services Strong support to carers Visit to the Autism Hub (run by CVS)	Maintain contact and sharing confirmation Increase role and contribution of the voluntary sector to support TCP in the community
Education Providers	Meeting with Mount Gilbert (T&W) Severndale (Shropshire)	Establish pilot to focus on schools and TCP. Two models operating in the two areas. Identify good practice and roll out Engage schools at the centre of the service model, interfacing with all domains
Housing Commissioners and Providers (builders and developers)	Initial conversations with commissioners	During 2016-17, firm up future demand and develop plan (see below, page xxx) Through Housing commissioners, progress work with builders and developers
Youth Offending Services	Initial conversations	More engagement to occur and clearer plans for future collaboration developed.

Criminal Justice System including police and probation services	Represented on both LDPBs Links via commissioning (how strong are they)	Establish good, sustainable working relationship with relevant stakeholders (include all) Involve in Governance Lead on West Mercia/CJS work stream
Advocacy services	Taking Part	Support ongoing engagement, co-production and Easy Read (including of the TCP plan to go on website)

<u>Future co-production – additional detail.</u>

- In meeting Co-production the TCP will strive to deliver public services in an equal and reciprocal relationship between professionals, people using services, their families and their neighbours.
- Where activities are co-produced services and neighbourhoods will become far more effective agents of change.
- In order to achieve full co-production, we need to ensure services and local people can work together in a genuine partnership to design and deliver services and support. This TCP footprint has made excellent steps in the start of this journey.
- The TCP will ensure that any Co-production will not just be about asking people what they think and all those involved will contribute their gifts and skills as well as insights based on experience
- Any Experts by experience who support co-production will be paid
- Co-production will aim to shift perception from individuals being seen as 'problems' to problem solvers
- Starting this co-production with children and young people through the Health Champions roles has already shown positive results in Shropshire on young people's confidence and self-esteem.
- **Write to Know** is a group focusing on checking information and paperwork that is sent out locally and nationally by public bodies and organisations who offer services.
- **Right to Speak** collects information and issues from Shropshire to raise and feedback at the partnership board.
- **Taking Part** supports speaking up groups in Shropshire services.
- These 'speak out' groups have worked with Manchester University research team twice. They worked in partnership with the University and OSCA about the choices people make when thinking, what is important to them when using their personnel budgets.
- The 'speak out' group have said "*It's important to us that Shropshire LA and CCG group listen to us. We think we have a lot to offer and can help other groups.*
- *We want professionals, carers and everyone to remember: Get it right for us; get it right for all!"*
- Co-production will be included in the Communication and Engagement workstream.
- We propose to form a small sub-group of four people with learning disabilities (and experience of assessment and treatment/in-patient services) and four carers.
- Advocacy support will be provided, as required.

The sub-group will help with ongoing communication and engagement with a wider representation of people with learning disabilities and family carers. We believe this approach will work, but it needs to be:

a) confirmed by others who will be involved, and
b) If the model does not work, we will change accordingly.

Overall, the biggest changes we wish to achieve are a shift in power & control, from statutory organisations to individuals themselves and where appropriate, carers.
We will also manage risk, safeguarding individuals and others in the community

APPENDIX 2

Population Data and information

People aged 18 and over predicted to have a learning disability T&W

	2014	2015	2020	2025	2030
People aged 18-24 predicted to have a learning disability	420	422	389	379	413
People aged 25-34 predicted to have a learning disability	533	530	535	525	496
People aged 35-44 predicted to have a learning disability	540	533	515	529	538
People aged 45-54 predicted to have a learning disability	573	579	552	491	479
People aged 55-64 predicted to have a learning disability	438	440	484	530	505
Total population aged 18-64 predicted to have a learning disability	2,504	2,505	2,476	2,454	2,430
People aged 65-74 predicted to have a learning disability	346	355	387	384	423
People aged 75-84 predicted to have a learning disability	166	172	212	266	289
People aged 85 and over predicted to have a	55	57	71	93	124

learning disability

Total population aged 65 and over predicted to have a learning disability	568	585	670	743	835

Comment: *Overall, the numbers of people with learning disabilities between ages 18 – 64 is due to decline slightly by 2030, (74 people), whereas the number of people over 65 predicted to have a learning disability aged over 65 shows an increase of 267 people.*

People aged 18-64 predicted to have a moderate or severe learning disability and be living with a parent, by age, projected to 2030 T&W

	2014	2015	2020	2025	2030
People aged 18-24 predicted to be living with a parent	64	65	60	60	65
People aged 25-34 predicted to be living with a parent	59	59	59	58	55
People aged 35-44 predicted to be living with a parent	53	52	51	52	53
People aged 45-54 predicted to be living with a parent	30	30	28	25	25
People aged 55-64 predicted to be living with a parent	9	9	10	10	9
Total population aged 18-64 predicted to be living with a parent	214	214	207	205	207

Comment: *The prediction of numbers of people with moderate to severe learning disability shows little change with an overall reduction of 7 people. This prediction is likely to inaccurate. The increased use of Tenancies, Supported Living/Tenancies and Shared Lives is likely to mean this is under forecasting of predicted prevalence.*

People aged 18-64 predicted to have a moderate or severe learning disability, and hence likely to be in receipt of services, by age T&W

	2014	2015	2020	2025	2030
People aged 18-24 predicted to have a moderate or severe learning disability	97	98	90	89	98
People aged 25-34 predicted to have a moderate or severe learning disability	114	114	115	113	106
People aged 35-44 predicted to have a moderate or severe learning disability	136	134	129	133	135
People aged 45-54 predicted to have a moderate or severe learning disability	129	130	124	111	109
People aged 55-64 predicted to have a moderate or severe learning disability	95	95	106	115	108
Total population aged 18-64 predicted to have a moderate or severe learning disability	571	571	564	561	557
People aged 65-74 predicted to have a moderate or severe learning disability	57	58	62	62	69
People aged 75-84 predicted to have a moderate or severe learning disability	17	18	22	28	29
People aged 85 and over predicted to have a moderate or severe learning disability	5	5	7	9	11
Total population aged 65 and over predicted to have a moderate or severe learning disability	79	81	91	98	110

Comment: This table gives the number of people with moderate or severe learning disabilities. Therefore, the numbers are lower than the total learning disability population. The assumption is that these people will be in receipt of services. Again, the numbers reduce for people between the age of 18 – 64 (reduction of 14 people), and increase for people over 65 (31 people) by 2030. Due to changes introduced with the Care Act, prevention and enablement and austerity, it is likely that numbers in receipt of services will in fact slow down and reduce beyond the level predicted.

People aged 18-64 with a learning disability, predicted to display challenging behaviour, by age, projected to 2030 T&W

	2014	2015	2020	2025	2030
People aged 18-24 with a learning disability, predicted to display challenging behaviour	7	7	6	6	7

People aged 25-34 with a learning disability, predicted to display challenging behaviour	10	10	10	9	9
People aged 35-44 with a learning disability, predicted to display challenging behaviour	10	10	9	10	10
People aged 45-54 with a learning disability, predicted to display challenging behaviour	11	11	11	9	9
People aged 55-64 with a learning disability, predicted to display challenging behaviour	9	9	10	10	10
Total population aged 18-64 with a learning disability, predicted to display challenging behaviour	46	46	46	45	45

Comment: This table shows the numbers of adults predicted to display challenging behaviour as being low and remaining the same, with a slight decrease of 1. This information is odd. Current information from social services and CCG evidence higher numbers. This may be around classification criteria used by those predicting prevalence. However, if this is the data accessed by NHSe to inform anticipated demand, it may be a serious point of discrepancy.

People aged 18-64 predicted to have autistic spectrum disorders by age and gender, projected to 2030 T&W (1st table – males; 2nd table – females)

Males T&W	2014	2015	2020	2025	2030
Males aged 18-24 predicted to have autistic spectrum disorders	148	148	135	131	146
Males aged 25-34 predicted to have autistic spectrum disorders	193	193	196	196	184
Males aged 35-44 predicted to have autistic spectrum disorders	200	198	187	193	198
Males aged 45-54 predicted to have autistic spectrum disorders	221	225	214	189	180
Males aged 55-64 predicted to have autistic spectrum disorders	169	169	187	205	196
Total males aged 18-64 predicted to have autistic spectrum disorders	931	932	920	914	904

Females T&W	2014	2015	2020	2025	2030
Females aged 18-24 predicted to have autistic	15	15	14	14	15

spectrum disorders					
Females aged 25-34 predicted to have autistic spectrum disorders	22	21	21	21	19
Females aged 35-44 predicted to have autistic spectrum disorders	22	21	21	21	21
Females aged 45-54 predicted to have autistic spectrum disorders	25	25	23	21	20
Females aged 55-64 predicted to have autistic spectrum disorders	20	20	22	24	22
Total females aged 18-64 predicted to have autistic spectrum disorders	102	102	101	100	98

Comment: The two tables above predict as overall fall in the number of people expected to have autistic spectrum disorders. Again, this seems at odds with evidence of growth in numbers of people diagnosed on the spectrum. Further information is needed to drill down into the numbers overall and understand which of these people also have a learning disability, and/or challenging behaviour and any associated issues of mental health.

Males T&W	**2014**	**2015**	**2020**	**2025**	**2030**
Males aged 65-74 predicted to have autistic spectrum disorders	140	144	151	151	169
Males aged 75 and over predicted to have autistic spectrum disorders	85	88	113	146	164
Total males aged 65+ predicted to have autistic spectrum disorders	225	232	265	297	333

Females T&W	**2014**	**2015**	**2020**	**2025**	**2030**
Females aged 75 and over predicted to have autistic spectrum disorders	17	17	19	19	21
Females aged 75 and over predicted to have autistic spectrum disorders	13	14	16	20	2/3
Total females aged 65+ predicted to have autistic spectrum disorders	30	31	35	38	43

Comment: Overall, this table shows growth for both males and females and at a slightly higher rate for females. This probably reflects an increase in number of older people seeking a diagnosis.

Shropshire data

People aged 18-64 predicted to have a learning disability, by age Shropshire

Shropshire data	2014	2015	2020	2025	2030
People aged 18-24 predicted to have a learning disability	615	604	529	511	547
People aged 25-34 predicted to have a learning disability	819	827	857	819	757
People aged 35-44 predicted to have a learning disability	881	869	830	887	922
People aged 45-54 predicted to have a learning disability	1,094	1,093	1,020	893	859
People aged 55-64 predicted to have a learning disability	929	941	1,048	1,124	1,047
Total population aged 18-64 predicted to have a learning disability	**4,339**	**4,334**	**4,284**	**4,235**	**4,132**

People aged 65 and over predicted to have a learning disability, by age Shropshire

Shropshire data	2014	2015	2020	2025	2030
People aged 65-74 predicted to have a learning disability	842	861	911	895	1,001
People aged 75-84 predicted to have a learning disability	450	461	554	679	718

Shropshire data

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People aged 65-74 predicted to have a learning disability	842	861	911	895	1,001
People aged 75-84 predicted to have a learning disability	450	461	554	679	718
People aged 85 and over predicted to have a learning disability	179	187	225	286	370
Total population aged 65 and over predicted to have a learning disability	**1,471**	**1,508**	**1,690**	**1,860**	**2,089**

People aged 18-64 with a learning disability, predicted to display challenging behaviour, by age, projected to 2030

Shropshire data	2014	2015	2020	2025	2030
People aged 18-24 with a learning disability, predicted to display challenging behaviour	10	10	9	9	9
People aged 25-34 with a learning disability, predicted to display challenging behaviour	15	15	15	15	14
People aged 35-44 with a learning disability, predicted to display challenging behaviour	16	16	15	16	17
People aged 45-54 with a learning disability, predicted to display challenging behaviour	21	21	20	17	16
People aged 55-64 with a learning disability, predicted to display challenging behaviour	18	19	21	22	21
Total population aged 18-64 with a learning disability, predicted to display challenging behaviour	**81**	**81**	**80**	**79**	**77**

Figures may not sum due to rounding

Figures may not sum due to rounding
Crown copyright 2014

LD - Living with a parent

People aged 18-64 predicted to have a moderate or severe learning disability and be living with a parent, by age, projected to 2030 Shropshire

Shropshire data	2014	2015	2020	2025	2030
People aged 18-24 predicted to be living with a parent	94	93	82	81	87
People aged 25-34 predicted to be living with a parent	91	92	95	90	84
People aged 35-44 predicted to be living with a parent	86	85	81	87	90
People aged 45-54 predicted to be living with a parent	56	56	51	45	45
People aged 55-64 predicted to be living with a parent	18	18	21	21	19
Total population aged 18-64 predicted to be living with a parent	**344**	**343**	**330**	**324**	**325**

Figures may not sum due to rounding

Shropshire data	2014	2015	2020	2025	2030
People aged 65-74 predicted to have a learning disability	842	861	911	895	1,001
People aged 75-84 predicted to have a learning disability	450	461	554	679	718
People aged 85 and over predicted to have a learning disability	179	187	225	286	370
Total population aged 65 and over predicted to have a learning disability	**1,471**	**1,508**	**1,690**	**1,860**	**2,089**

Figures may not sum due to rounding

Autistic spectrum disorders
People aged 18-64 predicted to have autistic spectrum disorders, by age and gender, projected to 2030

Autistic spectrum disorders by gender Shropshire data	2014	2015	2020	2025	2030
Males aged 18-24 predicted to have autistic spectrum disorders	225	220	193	187	202
Males aged 25-34 predicted to have autistic spectrum disorders	310	311	328	311	286
Males aged 35-44 predicted to have autistic spectrum disorders	322	319	304	328	344
Males aged 45-54 predicted to have autistic spectrum disorders	423	423	385	337	322
Males aged 55-64 predicted to have autistic spectrum disorders	362	367	412	443	407
Total males aged 18-64 predicted to have autistic spectrum disorders Shropshire data	**1,642**	**1,640**	**1,622**	**1,606**	**1,561**
Females aged 18-24 predicted to have autistic spectrum disorders	20	20	18	17	18
Females aged 25-34 predicted to have autistic spectrum disorders	32	32	32	31	29
Females aged 35-44 predicted to have autistic spectrum disorders	36	35	34	35	36
Females aged 45-54 predicted to have autistic spectrum disorders	47	47	44	38	37
Females aged 55-64 predicted to have autistic spectrum disorders	42	42	46	50	47
Total females aged 18-64 predicted to have autistic spectrum disorders	**176**	**176**	**174**	**172**	**167**

Custody-*Please note this information does include people with LD but they are not highlighted so we do not understand at this time the impact on the report*

Section 136 total Detentions in Custody/Redwoods Centre

	2010-11	2011-12	2012-13	2013-14	2014-15
Shrewsbury Custody	168	96	101	84	16
Malinsgate Custody	103	27	36	27	6
Wellington Custody	0	12	13	0	0
Total Custody	271	135	150	111	22

Redwoods Centre	n/a	75	178	253	244
Total	271	210	328	364	266

Section 136 Detentions – Under 18 years

	2010/11	2011/12	2012/13	2013/14	2014/15
Shrewsbury Custody	9	7	6	4	1
Malinsgate Custody	6	5	3	0	0
Wellington Custody	0	1	3	0	0
Total Custody	15	13	12	4	1
Redwoods Centre	n/a	7	12	21	14
Total	15	20	24	25	15

Employment support information

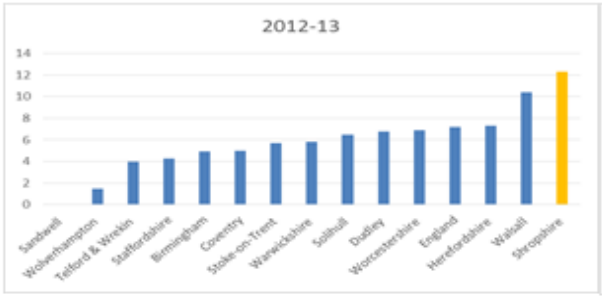
Data from ASCOF (T&W)

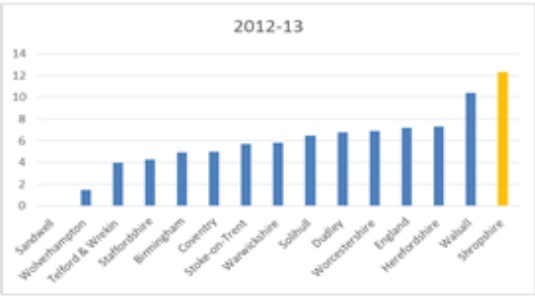
1E - ALD Employment		1G - ALD Settled Accommodation	
In employment	7	**Settled Accommodation**	135
Not in employment	138	**Unsettled Accommodation**	48
Not reviewed/ Captured this year	168	**Not reviewed/ Captured this year**	197
Not recorded	79	**Not recorded**	12
Total	392	**Total**	392
Performance	1.8%	**Performance**	34.4%

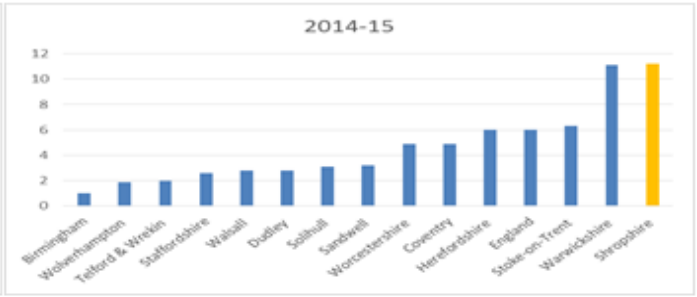
Programme	No. of people referred	No.'s in paid employment	% of sustained jobs at 13 weeks
SC LD employment	43	75	61%
SC / CCG MH employment	147	72	82%

Enable Performance Data 2015 – 16 (April to now)

Programme Shropshire	Referred since 01/04/15	People supported	Work placements	Into paid employment
Council LD	39	166	N/A	57
Council / CCG MH	94	270	N/A	45
DWP LD	52	52	N/A	13
DWP MH	77	101	N/A	22
Supported Internships	5	5	5	0







Telford and Wrekin Council – Employment Support

Data gathered internally by TWC Employment services indicates that 586 people with Asperger's, Autism, Behavioural/Emotional and Social Difficulties, Moderate Learning Difficulties and Severe Learning Difficulties receive support from Telford and Wrekin council. A 5 of these people also have behaviours which can challenge.

Team Name	Asperger's	Autistic Spectrum Disorder	Behaviour/ Emotional/ Social Dif	Moderate Learning Difficulties	Severe Learning Difficulties
Business Support	0	7	46	57	3
EEAST	20	21	8	85	4
Future Focus	0	23	124	129	18
Job Box	2	3	10	12	2
Job Box Outreach	0	1	1	8	0
Skills Delivery Area	0	0	2	0	0
Total:	**22**	**55**	**191**	**291**	**27**

Appendix 3 Services in place

Health the Shropshire footprint has :-	
Acute hospitals	Two main hospital sites. Royal Shrewsbury Hospital (RSH) in Shrewsbury and the Princes Royal Hospital (PRH) in Telford and Wrekin. Discussions continue about alternative options on where services are best located and both areas campaign vigorously to retain the hospitals
Community hospitals	Shropshire Community Health NHS Trust runs four community hospitals: Bishops Castle, Whitchurch, Ludlow and Bridgnorth. There are four Minor Injuries Units in the county. They are at: Whitchurch, Ludlow and Bridgnorth Community Hospitals and Oswestry Health Centre Both CCG's commission SCHT and SSSFT to provide services for people with learning disabilities. <u>Shropshire and South Staffordshire Foundation Trust:</u>

Mental health and learning disabilities	SSSFT provides mental health, learning disability and specialist children's services across South Staffordshire and mental health and learning disability services in Shropshire, Telford & Wrekin and Powys. A range of community and outpatient services are offered as well as specialist inpatient and day care for people with severe learning disabilities and challenging behaviour South Staffordshire and Shropshire NHS Trust (SSSFT) SSSFT headquarters is in Stafford. It is commissioned by the CCGs through a NHS Standard contract. The organisation covers the following regions: • South Staffordshire, • Shropshire, • Telford & Wrekin, and • Powys.
Community learning disabilities services	Within SSSFT, the Specialist Learning Disabilities Directorate provides the following: ➢ Community Learning Disabilities Health Teams (East Staffordshire, South Staffordshire, Shropshire, Telford and Wrekin) ➢ Challenging behaviour service (Shropshire & Telford and Wrekin) The SSSFT Challenging behaviour team is located at Mytton Oak, RSH and Diamond Jubilee, Telford. Services include: nursing, psychology, psychiatry The focus of the directorate is to provide person centred, evidence based and outcome focussed specialist health care in the community. In response to this it has developed a clinical approach designed to ensure the best quality services possible. This includes: Clinical Effectiveness Groups (CEGS) x 4: Physical health, Mental health, Autistic spectrum disorders and Positive behavioural support. Intake pathway: a new pathway to ensure a robust and consistent multi-disciplinary approach to identifying eligibility for and assessing, intervening and evaluating the needs of people referred to its services. Introduced the Health Equalities Framework to review the impact of health inequalities on people who have learning disabilities. Involving people who use services and family carers: An inclusive interview process for all new staff. They now facilitate a discussion group prior to interviews which involves people with learning disabilities, family carers and team members. Their views are included in the interview panel's final decision making process. In 2013/14 a comprehensive clinical review led to service reconfiguration to ensure services fit with: • changing demographics, • the national vision for healthcare for people who have learning disabilities, • the evidence around best practice and high quality services. Outcomes from the review included:

	• specialist nurses working in Telford and Wrekin were transferred into the SSSFT from the Shropshire Community Trust • one Shropshire CLDT nurse was moved on a short term secondment to Continuing Heath Care (CHC) to support their work
Prison in reach	The Prison In-reach Service provides mental health services to a number of local prisons. The team provides an assessment and treatment service including the transfer of people with severe mental health problems to the wider NHS and interventions for those with mental health problems whilst in custody.
Substance misuse	Inclusion substance misuse services include advice, information, harm reduction interventions, recovery planning in conjunction with a range of pharmacological, psychosocial and structured treatment programs. They work with specific needs including criminal justice, mother and baby and dual diagnosis.
Forensic	Forensic mental health team provide a local, high quality, specialised and comprehensive forensic mental health service for the mentally disordered offender and others that will benefit from the service, within the West Midlands, in partnership with other agencies.
Psychological services	Psychological services are provided directly to children, adolescents, young adults, older adults, and people with physical health needs, people with learning disabilities, people with substance misuse problems, and people who have committed criminal offences. Specialist psychological practitioners work within the clinical teams across our services
Community services (universal) and children	Shropshire Community Health NHS works closely with people with Learning Disabilities, their families and carers to ensure that they are actively involved in the planning and decision making of care delivery. They strive to ensure people with learning disabilities have access to the same community health services as everyone else. There aim is to ensure that the needs, choices and preferences of this group are understood and that services are available to reflect individual choices. SCHT have a mission that people with learning disabilities will be valued equally, participate fully in their communities and be treated with dignity and respect. Implementing all appropriate measures to ensure all people with learning disabilities accessing services have effective person-centred care, with reasonable individual adjustments delivered by staff with an enabling and positive attitude.
Inter disciplinary team	SCHT Inter Disciplinary Teams (IDT's) comprise community nurses, occupational therapists and physiotherapists who work together to deliver community health services to patients in their own homes, with the aim of preventing admission, supporting early discharge from hospital and promoting maximum independence. The care provided by the

	interdisciplinary teams is for adults (over 18 year olds) living in Shropshire, Telford and Wrekin who are unable to travel to access specific health care services from their GP or other NHS health care providers. As part of the patient's care or treatment programme care is also available for parents and carers. Services are delivered in the patient's own home or usual place of re On-going review of pathways of care to improve the experience and care of people with learning disabilities takes place and assurance given to the CCG. SCHT have identified a Lead Person within the organisation and each Division with specific responsibility to monitor the services in relation to people with learning disabilities.
Child development	**Child Development Centres** (CDC's) in Shropshire and Telford and Wrekin provide assessment of children with additional needs who are under five years old. Children can attend the child development centre for assessment, diagnosis, intervention and advice for the following impairments and disabilities: •Behavioural problems •Communication and interaction problems •Delay in their development •Impaired vision or hearing •Physical disability •Severe co-ordination problems From the age of two to two and a half years of age, children can be referred for a developmental assessment. The short assessment is for children who are thought to have difficulty in only one area of their development or who need a check on their development for medical reasons. Then there is a full assessment for children who are identified as having more complex needs and, here, a broad range of professionals will see children over a number of visits. Parents are encouraged to contribute to the assessments as their knowledge of the child is much valued. The assessment will also help to decide whether the child requires any support in their future educational provision. The full assessment process will link to the Educational Health Care Plan (EHCP) to ensure a more joined up process for parents and each child. The service is currently open Monday to Friday, 09:00 - 17:00 except Bank Holidays.
Occupational therapy	**SCHT Occupational Therapy** services are provided for children with severe / specific learning difficulties and / or complex needs attending special schools in Telford (Bridge, Haughton) and Shropshire (Severndale, Shrewsbury). The children's OT team work in partnership with the child, parent, family and carers, professionals and voluntary organisations to provide interventions that maximise the individual potential of each child personally, functionally, academically and socially. The service is available for children aged between 0-18 years (19 years if in full time education) who are registered to a GP within either Shropshire or Telford and Wrekin geographical boundaries.

Community Paediatricians	**Community Paediatricians** are specialist doctors with skills and knowledge in child health and development. The service is provided primarily to children whose GP is based in Telford & Wrekin or Shropshire County. The aim is to provide care as close to home as possible so services are based in different parts of the county, including at special schools such as the Bridge and Severndale. They offer a holistic paediatric service and focus on identifying and working with others to meet each child's needs - medical, educational and social. By providing: • medical reports as part of statutory processes for children with special educational needs, looked after children and in child protection procedures • leading the multidisciplinary developmental assessments in the Child Development Centres • being trained to use the 3di Autism assessment tool • carrying out hearing tests for children with special needs (special schools and outpatients)
Continence management service	**Continence management service** is a team of specialist nurses who provide assessment for people with continence problems. Advice and support is given to clinicians involved with children who may be carers for and their parents/ carers with learning or physical disabilities who require continence management.
Children's and Special Care Dentistry	**Children's and Special Care Dentistry** service is for children and young adults with additional needs which include a physical, intellectual, medical, emotional, sensory, mental, psychological or social impairment or disability or a combination of these factors. It is only for patients who are unable to attend the dental surgery
CAMHS Learning Disability	**CAMHS Learning Disability** service works with children and young people with a learning disability aged 0-18 in Telford and Wrekin or Shropshire. They also work with young people with learning disability who have significant problems with aggression or other challenging behaviour, and who may also have a mental health diagnosis such as an eating disorder, post-traumatic stress, anxiety or obsessive problems, depression or problems with mood, hyperactivity and attention problems or behaviours which are harmful to self or others. The team accept referrals from professionals involved with a child for example GPs, Social Workers and Teachers. A referral letter is required to provide us with relevant and up-to-date information. At present, we do not accept referrals directly from parents or carers. There are 290 young people currently on the CaMHS LD case load across Shropshire and Telford & Wrekin. One person is in specialist in-patient service. 95% of the case load is young people with LD and challenging behaviour. Only 5% have co-morbid mental health problems. The developments of this service are included within the CaMHS transformational plan. Commissioners/ partners will work closely to align the plans and developments with TCP.
CAMHS LD Psychology	**CAMHS LD Psychology** is a specialist service. Before this service get involved, children and young people will often have been seen by other services, to see whether any problems can be resolved within the community, with the support of the child's school, within primary care services (such as the GP or Health Visitor), or within services that can offer

	support to parents and carers. Psychologists will provide input to children with disabilities and their families, alongside other professionals already supporting them. Psychologists are particularly interested in understanding how children and young people with learning disability manage and cope within their unique situation and environment. This means understanding their family situation, meeting with and talking to their parents at length to see how they see the current situation, and often they will meet and talk with teachers, social workers, and other professionals to help get a thorough understanding of the wider picture. Their role is to try and reach a formulation which identifies the main issues and helps explain the factors that contribute to the current situation From the 1st September 2014, new legislation required health service providers to work with Local Authorities to publish a "Local Offer" for children and young people with Special Educational Needs/Disabilities (SEND), aged 0-25. The local offer provides information on what services children, young people and their families can expect from a range of local agencies, including education, health and social care. Knowing what is out there gives people more choice and therefore more control over what support is right for each child and young person
Out of hours medical support	Out of hours • Shropdoc works across Shropshire and Telford and Wrekin. • Initially contacted to triage/ screen the need, • The local authority duty team is contacted to provide access to the Emergency Duty Team (EDT) and if required, an Approved Mental Health Practitioner (AMH). • If there is need for emergency funding out of hours, the EDT can approve this. • Referrals to the challenging behaviour service and for acute liaison all bypass the community learning disability team process. • In some cases people do not access the multi-disciplinary assessment and review process recently introduced through our Intake pathway.

<u>Local authority provision of services</u>

Education	Schools, particularly Severndale (Shropshire) is a school for children and young people are aged 3 to 19 who have a range of learning difficulties. These include moderate, severe, complex and profound learning difficulties, those with autism, complex medical conditions, physical, mobility difficulties and behavioural difficulties arising from their condition. Severndale also makes use of an external location called Tickwood Care Farm to deliver around 22 classes per week. Severndale at Mary Webb is a satellite provision catering for pupils with Moderate Learning Difficulties. The Centre is an integral part of the Mary Webb School and provides opportunities for collaborative learning and integration. The Key-stage 3 and 4 students who attend the Centre have access to specialist facilities, teaching and the social

	inclusion aspects of a mainstream secondary school. Pupils have the chances to acquire the skills, knowledge and experiences which will enable them to develop a greater understanding of themselves, and enhance their independence skills whilst accessing a range of subjects and qualifications. Derwen College (Shropshire) is a further Education College offering vocational, educational, social and personal development. The colleges has residential, a wide range day placements, a post-college living and work programme, apprenticeships and supported internships for young people with learning difficulties and disabilities. Offering places for up to 250 young people The Bridge, Southall and Mount Gilbert (Telford), although pupils defined as categorised in the cohorts (bullet points 3 & 4) may be in main stream education. Children's services Cruckton Hall and Overely School (residential)
Support services Autism	Various services which provide activities during the day time are from both the private and voluntary sector. Some services receive support from the councils. Advocacy service Let's Talk Social work advice, professional who support; Carers assessments; Peer support sessions, Autism Hub -provides peer support and social activities pre and post diagnostic support Autism Partnership Board A multi-agency meeting, Autism SAF
Inclusively Fit	A new scheme that is trying to get people with disabilities involved in sport and physical activities

Other Agencies provision of services

West Mercia Police - Hate Crime: safe place scheme:
• 200 places across Shropshire, located in over 20 towns across the Shropshire footprint. A partnership of Shropshire Council, Telford and Wrekin council, West Mercia police, Taking Part, OSCA, Shropshire disability network, Autonomy, Mencap, the VCSA and Wrekin Housing Trust. • Includes shops, community centres, libraries, within the community where someone trained will offer support and safety until additional support provided**.**
West Mercia Police:

- The equality and diversity officer for Shropshire/ Telford and Wrekin for West Mercia Police is currently recruiting new members onto their IAG,
- they currently have a couple of members who are on the Autistic spectrum and an individual with learning disabilities, and
- they plan to increase membership in relation to a wider spectrum of disability.
- the equality and diversity officer role is available to provide support and advice in situations involving all Vulnerable Adults including those with a learning disability

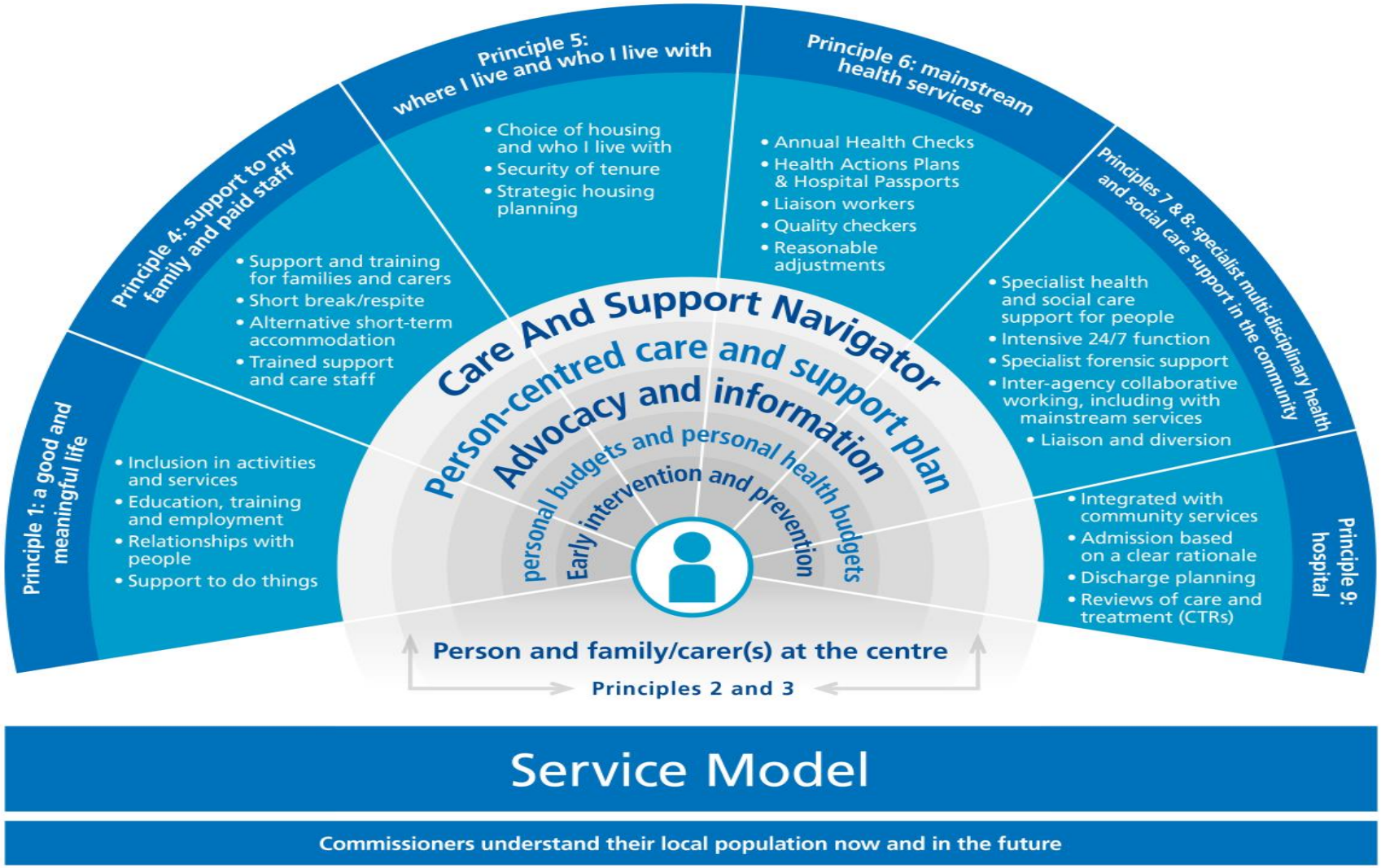
West Mercia - adjustments

- Within the police services, 'Adjustments' applies to people who have a learning disability with limited capacity and any other learning disability,
- anyone who requires an appropriate adult either to give a statement or as a suspect would be offered support
- The need for access to this service would be assessed when arrested, and also
- an officer would have to justify if an arrest was necessary or whether a voluntary attendance would be more appropriate.
- Diversion work looks at outcomes which are appropriate to the offender and the victim.
- If a prosecution is considered one of the strict legal thresholds that would need to be met is, is the prosecution in the public interest?
- This is considered in detail when dealing with an offender with Learning disabilities. The Protecting Vulnerable People unit will look at ways to deal with an outcome that could be dealt with out of court.
- This involves working with and referrals to partner agencies and programs of work which could address the offending behaviour.
- These can be formalised Conditional Cautions or Community resolutions.

Forensic Service:

- The Criminal Justice System will divert people with LD to health and social care, to prevent criminalising people with LD.
- Police will always assess capacity and request an appropriate adult for anyone with mental health need- can be family friends or social workers from local teams.
- Will require reports from psych's social workers.
- Previously a social worker which support mental health impairment team- this has not been in place for a couple of years.
- As part of this review we may consider if such a post should be reinstated, or not.

Appendix 4 Principles of care



Service Model

Commissioners understand their local population now and in the future