Transforming Care Appendices

Appendix One – Partnership Joint Planning NHS England Submission

Appendix Two – Headline Plan

Appendix Three – NHS England Target Service Model

Appendix Four – Make-up of the Partnership Programme Board

APPENDIX ONE – JOINT PLANNING TEMPLATE

Introduction

- **Purpose**

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

- **Aims of the plan**

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

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

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

- **National principles**

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

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

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

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

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

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

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

Summary of the planning template

Executive Introduction

The ambitions of Transforming Care expressed in the introductory purpose and aims of this planning template are focused on reducing the numbers of people and closing in-patient facilities. The Essex TC Partnership will deliver on the targets and recognise that more must and will be done to help these vulnerable people who are either at risk of or already living a life that is over-reliant upon in-patient care. This is the continued and appropriate response to the horrific abuse that took place at Winterbourne View.

The Partnership also has shared ambitions to address the broader inequality and poor experiences that people with a lower level of Learning Disability can also suffer. All people with Learning Disability, including those with or at risk of developing Challenging Behaviours have the right to lead a fulfilling life in the chosen house and location of their choice and be able to access mainstream health and care services and participate fully in broader society. Whilst society, the statutory providers and communities across Essex have made significant progress in this respect across the Partnership localities, there remains more that has to be and will be done.

In June 2015 the Pan Essex Clinical Commissioning Groups and Local Authority constituents of the Partnership, consisting of 7 CCGs and 3 LAs, initiated the programme to work together to address these issues and deliver the right outcomes for these cohorts of people. The initial focus of the work was to collaboratively commission and re-procure specialist health care provision that is currently commissioned on North and South Essex footprints. The ambition was to use the re-procurement to transform the broader system.

Following the publication of Building the Right Support, the Partnership Board approved in December 2015, that the work should be re-scoped to include appropriate consideration of children and young people as part of the agenda. There Board also approved that the procurement process should be delayed by approximately 9 months to allow earlier transformation of the system enabled by the Transformation Funding that is being made available by NHS England.

This plan therefore sets out the broadest ambition across the Partnership, including alignment to the Transforming Care expectations. This broader story fits less straightforwardly into this planning template, but the changes, principles and levers for change remain constant across both of these agendas. It is about placing the service user at the heart of identifying the support that they require, providing flexibility and choice and adopting principles of prevention and integrated funding arrangements for the system and individual; the responsibility is to assure that the community is able to support people and their carers' and families to achieve the right and equal outcomes to which they aspire.

There is a shared ambition across the Partnership to achieve these outcomes and we are increasingly confident that the partnership is growing together and will address and resolve the difficult issues and challenges that we are facing. At the same time, much of the delivery and implementation will continue to be led locally and have accountability to those sovereign organisations – indeed for the best outcomes this has to be rooted in and led from within the community itself. The Board is clear on the dual role to drive those areas where there is shared delivery and to provide shared assurance and visibility of the changes that are required locally; both within individual organisations but also across the local health and care partnerships.

The headline plan is based upon the following very broad phases of work:

- Firstly, a review of the pathways and identification of the issues for all of the five cohorts – across both children and adults. It is expected that this will lead to three types of projects both locally and across the Partnership as follows
    - definition and implementation of the improvements that can be delivered through short-term tactical re-commissioning with current providers

- agreement upon and implementation of the necessary actions to deliver the step changes in terms of workforce development, personal health budgets and market management
- definition, planning and implementation of the service areas and additional capacity that are set out in the transformation bids

- Secondly, the procurement of Specialist LD health capability – that will deliver a sustainable transformation in the system for Adults. The detailed plans for a sustainable system that provides support to children and young people, and their families including those going through transitions, will also be developed and ready for implementation during this phase of work.

The strength in our partnership we believe is that we are starting to work closely and transparently together where we believe that this will deliver the right economies of scale and allow access to the right expertise; whilst at the same time assuring and supporting each other in delivering excellent support, managing and developing our markets and enabling equality of outcomes in our localities. Indeed in this document we demonstrate the emerging clarity across the partnership of where things will be best delivered together, where success demands local delivery and clarity and ability to manage the interfaces between the two.

This document provides clarity to NHS England of the progress and plans. Equally importantly for the partnership this document will be used to support the completion of the understanding phase of the work. This draft document provides an opportunity to clarify the shared understanding to date, to re-affirm the commitments thus far and to agree the next steps to complete the full picture in time for the final submission in early April 2016.

Planning template

1. Mobilise communities

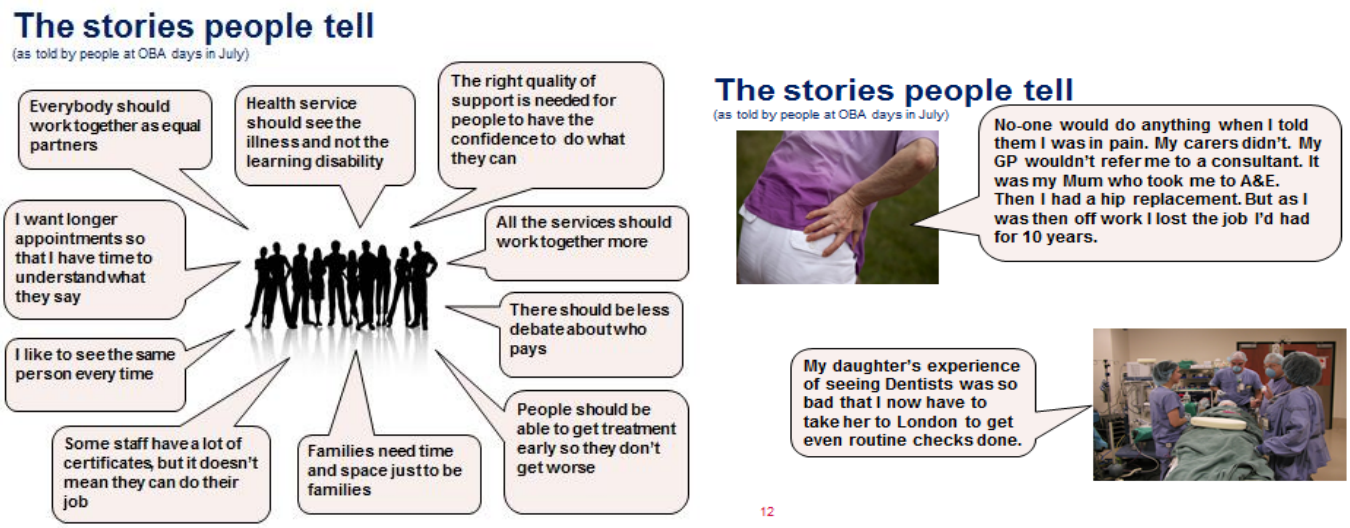
Governance and stakeholder arrangements

1.1 Describe the health and care economy covered by the plan

Guidance notes; consider the following: current providers, statutory, independent and voluntary sector contracts. Collaborative commissioning arrangements, key commissioning blocks (block contracts, geographical boundaries, provider relationships)

All communities are diverse places and the greatest strength of the Essex partnership is our ability to recognise and harness these qualities. As statutory agencies we have an obligation to help build and support our communities and the services available to provide the right support and ensure equality of access and outcomes for all.
Essex is a large County with a total population of 1.75 million and a diversity of population ethnically, financially and in terms of social and health need - as richly diverse as anywhere in the UK.

The health and care economy across Essex covered by this plan is complex, led by the 10 constituent members of the Partnership – the 7 Clinical Commissioning Groups and the 3 Local Authorities – and NHS England Specialist Commissioning. The economy consists of a highly diverse and large number of overlapping services, organisations, pathways, processes and governance structures. The impact of this complexity is most clearly articulated by those who access and consume the services. The quotations below are the result of one of the very initial engagements with service users back in Summer 2015. It is these voices that will help hold the Partnership to account to deliver the expectations of these cohorts of people and the ambitions of the Partnership and national programme.

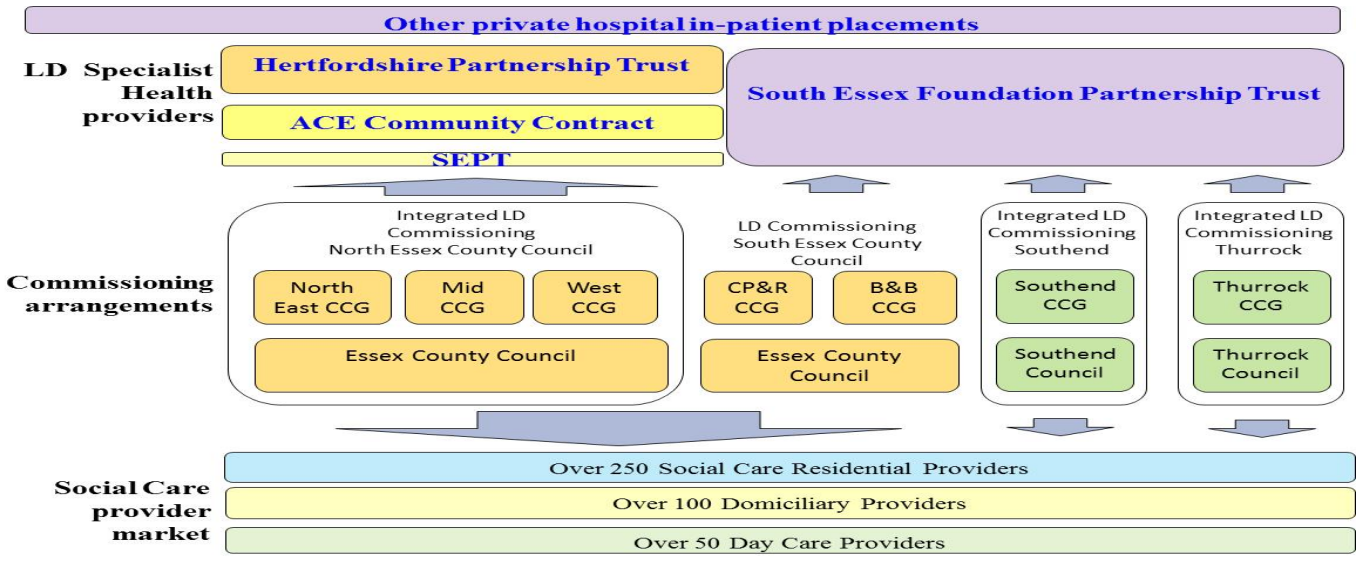


There is a sense of frustration and confusion for service users and their families; the complexity of the system that can translate into a confused offer and poor experiences, delivered variously within the Community, at scale across the Partnership and unfortunately also relying upon some use of out of area placements. At the same time, like all complex sets of systems, the health and care economy across Essex also has history; there are three Local Authorities and 7 CCGs, alongside Specialist Commissioning which brings a further set of changing governance and delivery history. Delivering the ambitions that the partnership is signing up to will be challenging; this would be true even without the significant additional pressures that include the Success Regime, the debates and plans on Devolution and the financial strains faced by all.

The overview of the current health and care economy is provided by the two overview diagrams below. These set out firstly an overview structurally of the current health and care economy for Adults and their families, followed by an overview of the economy that supports children and their families / carers. Further explanation is included under each diagram; additional detail is then included in section 2.3 of this document.

Adults

The diagram below provides an overview of the current health and care economy pan Essex for Adults with a Learning Disability. The Partnership has developed a detailed common understanding of the system that supports the Adult Learning Disability population across our communities and there is an emerging agreement between all partners about the challenges faced, the potential opportunities to improve outcomes for this population and a headline timeline ambition for the order in which some of the challenges will be addressed.



LD Specialist Health Providers
There are two sets of contracted providers across the Partnership; those contracts that have been commissioned together by the three CCGs in North Essex and a single contract in South Essex. The contract in South Essex is a joint contract for both Mental Health and Learning Disability. In addition, there are approximately 5 other private providers of in-patient care across the County with a capacity of approximately 100 beds.

Both the contracts in North and South Essex are block contracts that are based upon a risk share between the CCGs. These include 2 Assessment and Treatment units. There is recognition of the opportunity and a shared ambition by all partners to move to a single provider for these services. Particularly in the North of the County this will simplify the system and better aligns the reducing volume of bed places to the economies of scale for a provider. The spot purchase arrangements are commissioned through a team that is jointly funded by all the CCGs, but the costs of these placements are separate. At this stage the exact approach to the delivery of the spot placements remains unresolved; the plan is that this will be addressed as the partnership moves towards the procurement process.

Mental Health providers
SEPT MH Trust provide secondary and primary MH services across South Essex. They are commissioned by the 4 CCGs and 3 LA's via section 75 agreements. In north Essex NEPFT provide secondary MH health services commissioned by the 3 CCG's and ECC also via a Section 75 agreement. Primary care (IAPT) is provided by Herts PFT across North Essex.

CAMHS (Child and Adolescent MH) is provided by NELFT across Essex Southend and Thurrock.

Social Care provider market
There are a very broad range of providers across the region providing a range of services that Adults with a Learning Disability access or receive. Contractually, there are a number of these that are delivered in-house by the Local Authorities and a very fragmented provider market; there are over 250 residential care providers, 100 domiciliary care providers and in excess of 50 day care providers. The market for services to support people with behaviours that challenge is less fragmented, but remains diverse and developing. The private sector and in-house providers are commissioned through a mixture of spot and block framework arrangements. Through or alongside the delivery of this plan, a significant number of these are being or will be re-commissioned, which will provide the opportunity to strengthen the expectations for suppliers and hold them to account; including the right contracting mechanisms to assure reasonable adjustments. The partnership also recognises the need to assure the greatest level of joined-up commissioning across the health and social care provider space to ensure that the right health diagnosis and support expertise can be made available to people living inside community placements to minimise the need for in-patient episodes in all but the most very extreme cases.

From a housing perspective, the two unitary councils have the strategic housing leads in their localities where this is the responsibility of the 14 District councils across the County Council. The range and diversity of housing providers and housing provision reflects the size and socio-demographic variations across the County; the price of housing, land and rents provides the extreme range that would be expected. For Adults with complex needs there are an increasing number of examples of more innovative housing offers, but these remain the exception rather than an adequate supply; the partnership has started to explore how they might work together and where they might work apart but to similar strategies to look to develop the availability, capacity and flexibility of differing housing offers to better reflect the needs and ambitions of the Adult with Disability population.

Commissioning arrangements
Southend-on-Sea has an Integrated Commissioning Team which is developing integrated commissioning strategies for the population of Southend-on-Sea including for people with Learning Disabilities and Autism. The integrating element is a team structure and line management responsibility with joint reporting to the Director of People at Southend-on Sea Borough Council and the Accountable Officer of Southend CCG through an Assistant Director for Health and Social Care. The plans are for this to continue to develop through the lifetime of this plan.

In North Essex, there is a single integrated commissioning team for Learning Disability that is jointly funded by Essex County Council and the three North Essex CCGs. This is governed by a Section 75 agreement with the team hosted by Essex County Council; discussions are progressing for this to be renewed for a further year from April 2016. Alongside the plan to jointly procure a single LD Specialist health provider across the partnership, there is a recognised opportunity for these commissioning arrangements to either be disbanded or to broaden to encompass the two CCGs in South Essex with co-terminus boundaries to Essex county Council. The plan is that these decisions will be taken during 2016, for implementation of the agreed solution in 2017.
The agreement in Thurrock is to move towards integrated arrangements between the council and CCG in the next 18 months.

All 7 of the CCGs jointly fund a Placement function that spot purchases and places people into in-patient settings where this is required; this function manages spot placements for both Adults with Disability and the broader Older People cohort. The expenditure budget (rather than staffing budget) for this placement team is a risk share between the North CCGs, but is a separate budget for each of the 4 South Essex CCGs.

Adult Challenging Behaviour Cohort
The above documents the care and health economy for those whose primary diagnosis is Learning Disability. The five defined cohorts that relate to Challenging Behaviour, however, include those individuals who have a primary diagnosis that is LD / Autism and may also have a mental health condition. The broad range of suppliers across the five Adult cohorts are broadly similar with two notable differences: firstly that people who would need to access a Mental Health service would be supported by the Mental Health providers which again are currently commissioned separately across North and South Essex. The second difference is that there are separate providers for Adults across Autism.

Children
The agreed scope of the partnership in defining the programme and assuring progress for children and Young People relates solely to those children and young people known to display or be at risk of developing behaviours that may challenge services or others. Across the Partnership there are in excess of 9,000 children with a statement of education need (not all have been transitioned to EHC plans), but the scope of this work pertains solely to those already at the top end of need (and their families) where there is an existing or risk of sets of behaviours that may place them or others at risk.

The health and care economy across Essex is complex for Adults with a Learning Disability and those Adults at risk of offending or challenging behaviours (including those with Autism or a Mental health condition). For children and young people (and their families / carers) displaying offending or challenging behaviours or at risk of such, the health and care economy is even more complex. The SEND reforms through the 2014 Childrens and Families Act, alongside continued change to the roles and interface between councils and schools have further altered the dynamics and market for services that were already fairly complex.

The work to embed this new system is being led locally by Local Authorities and their CCG partners, alongside the very broad range of health and other specialist provides; this work is delivered working closely with schools, clusters of schools and academies. The voice, expectations and best outcomes for the children and their families remain important in this setting as they are also for Adults. All have made progress in addressing these challenges; plans and ambitions are clear at a local level and demonstrate significant success. There is recognition broadly that the challenges faced separately inside these organisations are similar for all.

The System offer
The current system for a family with a child with complex needs is in itself complex due to the number of agencies and varying responsibilities and eligibility they have from 0 – transition (now 25 if they have an Education Health Care Plan or are looked after).
All children and parents in early years have access to a health visitor and access to primary care regardless of the specific needs of the child; where a child is identified as having a disability, illness or condition it is at this point that the parent needs to receive the appropriate advice and information including pre-birth and maternity.

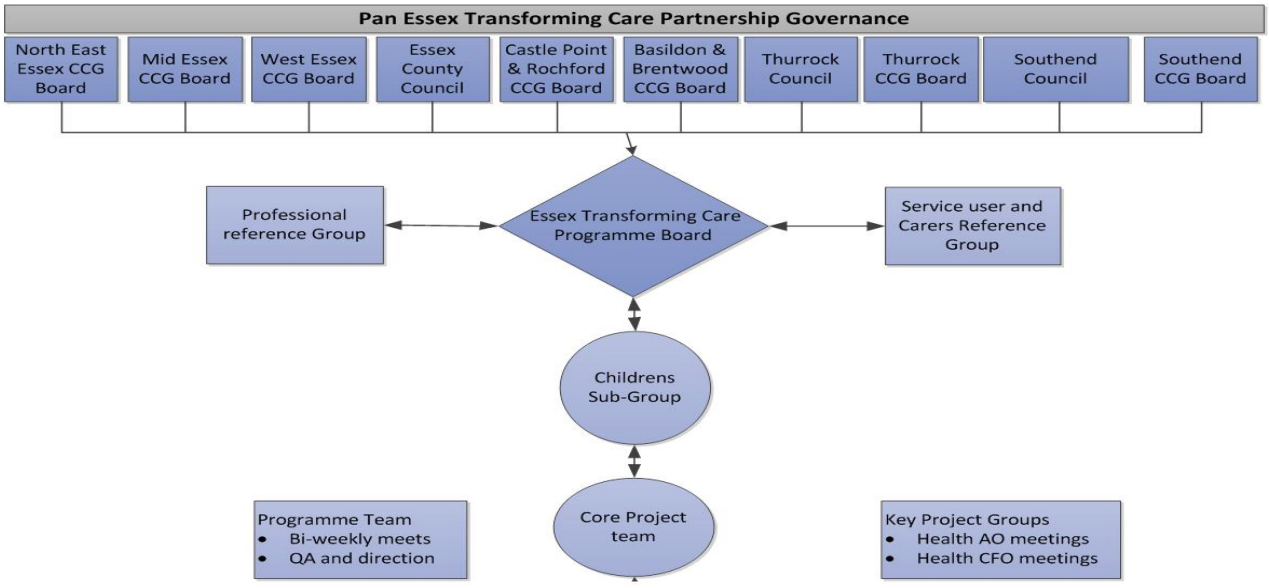
All children and their families access health and education, but for those young people with complex needs this may also include a range of services and interventions such as; specialist health provision via paediatric services and Emotional Wellbeing Mental Health Services (EWMHS) including specialist tier 4 in-patient beds; specialist education support through arising from their special educational needs or specialist schooling including residential schooling; social care support including looked after provision and for some with high risk behaviours Youth Offending Services; and access to third sector provision. Current pathways can be confusing and difficult to navigate.

As a TC Partnership, the childrens sub-group will develop a shared understanding of these issues and challenges as they pertain to children displaying or at risk of displaying self-injurious or challenging behaviours that may place others at risk. Currently the estimates are that there are over 350 children who fall into this cohort; across Essex County Council a significant number of these are currently educated out of County, which is not true for children in Thurrock and Southend. There are a number of very highly recognised special schools across the partnership h plans for over 250 additional special school places to come on stream locally in the next 3 years, including week-day boarding arrangements.

The ambition is that the sub-group will report back with a detailed and shared understanding of the current population dynamics and demographics, a more clearly defined picture of the current economy and to identify where and whether closer working may be beneficial in assuring and accelerating the changes and improvements required. Through this document further information is provided that demonstrates this progress in particular in offering a greater understanding of the numbers of the children and the number residential school placements locally and out of area. This work continues to develop this robust baseline to provide a meaningful and credible starting point to move forward and address the opportunities to improve adequate, appropriate and responsive support for children as children; and in preparing for adulthood.

1.2 Describe governance arrangements for this transformation programme

The following diagram provides an overview of the programme governance and the range of reference groups that form the broader programme management and delivery capability. To date the programme board has met seven times, both prior to and following the publication of the national plan; the professional reference group have met monthly since January; the first workshops and engagement has been delivered with a broad range of service users and their advocates and carers with the first Pan-Essex service user and family carers reference group delivered in March.



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

Southend-on-Sea Council	Simon Leftley, Director of Adult and Director of Childrens Services. SRO
Southend CCG	Melanie Craig, Accountable Officer. Deputy SRO
Castlepoint and Roachford CCG	Margaret Hathaway, Chief Financial Officer Finance Lead South Essex
Thurrock CCG	Mark Tebbs, Director of Commissioning
Thurrock Council	Roger Harris, Director of Adults and Housing Services
Basildon and Brentwood CCG	William Guy, Director of Commissioning
Essex County Council	Nick Presmeg, Director of Commissioning
Mid-Essex CCG,	Carol Anderson, Chief Nurse Quality lead North Essex
North-East Essex CCG	Kate Vaughton, Chief Operating Officer
West Essex CCG	Dean Westcott, Chief Financial Officer and North Essex Finance Lead
South Essex Quality Lead	Linda Dowse, Director of Nursing
Chair of the professional Service Reference Group	Christina Collins, Senior Practitioner, Challenging Behaviour Team, Essex County Council
Chair of the Service and carer reference group	Dave Cope (family carer – currently acting) Robert Estabrook (service user – currently acting)
Specialist Commissioning, NHS England	Karen Lockett, NHS England Anu Babu, head of Finance, Specialist Commissioning, NHS England

Governance across a complex multi-agency partnership is always involved, but the rules as regards decision-making from a project perspective are clear and well understood by all. The members of the Programme Board have delegated responsibility for their organisations for some decisions, which will include for example some decisions with regards to changes to pathways and processes. The individuals attending the Board have been chosen to provide broad coverage across a range of domains including Childrens Services (both Health and Local Authorities), Housing, Commissioning, Patient Safety and Finance. At the same time, there are a number of areas and challenges within the programme where the way forward is as much about co-ordination, assurance and delivery within individual organisations and partnerships as it is about a joined-up view of the broadest system / offer across the Partnership. Thus for example a number of the key partners report locally as well as more broadly within the programme governance. A number of examples are included below.

Service Users and Co-Production

The service user and carer reference group has been set up to assure linkages into the board, but more importantly to ensure that this is informed by and led by both the LD Partnership Boards and Autism Partnership Boards at a local level. The service user and carer reference group is not something that sits separately from the broader local accountability back to service users, but merely provides the process to consolidate and report into the Programme Board and feedback from the board to those groups.

The same philosophy is informing the design of a similar approach to co-production and service user engagement across Childrens and Transitions; similar to the LD and Autism Partnership boards, groups such as Families Acting for Change in Essex (FACE) are being engaged to embed co-production in to the plan.

Local Decision-Making and engagement

In the same way that service user engagement and co-production remains embedded in local accountability,

the police, housing and employment links similarly are represented on the above local Partnership Boards. Essex police, for example, play a key role in responding to a range of incidents within the Communities. Any changes or improvements identified through the programme to the response or support required by the Police will be taken forward to the police for input and discussion to allow these decisions to be taken forward. In particular, the partnership is keen to commission a new Community Forensics service and engagement has started through the appropriate local channels to identify how this might dovetail / sit alongside the existing community forensics liaison and diversion service that exists in certain communities across the force boundaries.

From a communications perspective, these key stakeholders and the key messages and channels for engaging and communicating with them will be managed accordingly, both through local engagement, but also through broader the core communications work-stream.

Whilst the board provides the appropriate channel for a number of decisions, the more strategic decisions with regards to any pooled funding, procurement or integrated commissioning for example will be taken through the membership boards of the CCGS, the Local Authorities and Health and Well Being Boards. The TCP Board will recommend that these decisions are put to local decision-making bodies, but these decisions remain local sovereign accountability. It is the co-ordination, timing and management of the detailed processes that can be complex, but as statutory public organisations investing public funds visibility is paramount.

Service Provider Reference Group

The plan agreed by the Partnership is that a key phase of the approach will be a procurement to deliver a new specialist health provider towards the end of 2017. This approach is necessary to deliver the target changes in services and the reductions in the bed base; financially there is no sustainable alternative. Therefore the programme approach to service engagement has two core phases

- Phase one is to work alongside current providers to deliver a number of improvements during 2016 and 2017. This work will engage current specialist health providers as suppliers to this project board; it will also include social care providers and social workers and could valuably include voluntary sector providers. The ambition is to agree commissioning intentions for April 2016 to be delivered through SDIP in the next 12-18 months
- Phase two will be a re-procurement. Input from the market and current providers will be encouraged in exploring the issues and opportunities prior to the start of the procurement process. However at that stage, suppliers will not be able to contribute to the process to avoid any legal challenge to the procurement itself.

The provider reference group has met three times to review and acknowledge the current baseline as regards the current health and care economy across the five cohorts and identify some of the key themes that will underpin any changes that may be required. The provider reference group includes representatives from the specialist health suppliers and the social care workforces with the Chair of the professional reference group attending the TCP Board. The next phase is to identify future pathways for each of the five cohorts that will be defined through a series of workshops attended by both service users and the professional reference group. Further information covering this approach is included under the section on co-production in this document.

Since the submission in February, further discussions with both the Mental Health providers and the LD Specialist Health providers have received further updates and engagement. Updates on the programme are a standing item on contract meetings with the specialist LD health suppliers.

At this stage the Board is confident that it has the right representation to drive the programme. As the childrens' sub-group makes recommendations then any necessary changes will be implemented as necessary. The Partnership has significant experience and learnt valuable lessons in managing these decision-making processes through complex programmes such as the CAHMS project.

1.3 Describe stakeholder engagement arrangements

Guidance notes; who has been involved to date and how? Who will be involved in future and how?

It is important to explain how people with lived experience of services, including their families/carers, are

being engaged.

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

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

- All 7 of the CCGs have briefed and approved the project through their Clinical Executives
- All three Health and Well Being Boards have been briefed and have similarly approved the project
- Cabinet member briefings have been completed with the lead members in all three authorities
- The three North Essex CCGs have formally approved to extend their current LD specialist health contract to align to the commitment by partners to procure a single provider for 2017
- Current commissioned LD specialist health providers in both North and South Essex were made aware of the programme of work through commissioning intentions in both April 2015 and November 2015. These key partners have also been informed of the governance arrangements for the programme and Transforming updates are a formal standing agenda item at regular review meetings
- The Essex County Council, Thurrock and Southend LD Partnership boards have been briefed and engaged in the project. The first two service and carer user reference group meetings have been delivered covering North Essex only at this stage, but the first official pan Essex service user and carer reference group is planned for end of February
- A professional reference group has been defined, the terms of reference have been agreed and are include in the appendix and the group has now met three times since the first meeting on 21 January 2016
- There have been cascaded messages through the three council Adult Operations and now the commercial functions to create the correct awareness and visibility of the programme.

At this stage there has been as yet no formal communication broader communication to the broadest social care and independent health care provider market. A small working group has been brought together with a brief to define and plan for some initial briefings to this broadest market planned for June or July once the plan itself has been taken through the CCG Boards and the necessary Local Authority approval processes.

The above demonstrates the commitment that the partnership has made to working in partnership and the progress to date; at the same time, the partnership recognises that the challenges go far beyond this initial set of engagement. The detailed communications plan is now under detailed documentation, based upon the principles and the headline timeframes set out below.

The communications and engagement plan is one part of the programme and runs in parallel to support the development of the detailed plan and the subsequent implementation. The scope of the communications and engagement work includes;

- Creating accessible information and progress briefings for professionals and local people
- Managing meetings and other channels for contributions from stakeholders
- Managing key relationships including media handling
- Supporting the programme to keep on track
- Ensuring that the programme complies with statutory duties including the duty to consult and public sector equality duty.

The communications and engagement is planned for delivery through three distinct phases, each of which will require slightly different messages for the different stakeholder groups;

- Development phase
- Awareness phase
- Implementation phase

The plan is being driven by the communications group that are leading the work-stream, working within the governance structure of the programme.

Objectives

The overarching objective is to embed timely and effective communications and engagement into the Transforming Care programme. This will be essential given the ambition of the plans. Other specific objectives are:

- To ensure that plans are well understood locally and have demonstrative support from stakeholders
- To ensure that service user, professional and public perspectives inform decisions about future service design and delivery and that there is evidence from these audiences and other stakeholders
- To strengthen key relationships involved in securing health and care services to support a successful process for system redesign and delivery.

Principles

Through the initial outline of the communications plan that was approved at the TC Board in March, all partners have agreed to work together to ensure:

- Openness and transparency in decision-making
- Meaningful engagement with all stakeholders
- Timely information and responses to communications needs
- Sensitivity and cooperation, particularly when dealing with challenging issues
- Effective internal communications
- Genuine coproduction
- Commitment to confidentiality where required particularly regarding procurement.

Applying these principles requires a robust and well-managed process with explicit plans, dates and channels of communication. A joint protocol for devolved action and consistent messages will be developed and agreed. This will be supported by core materials, identified leaders and spokespeople.

Approach

The proposed approach to delivering the communications and engagement plan has three strategic work streams.

1. Communications and engagement to support the change process. This will be an ongoing programme throughout the life of the Transforming Care Plan and will be led by the communications and engagement group.
2. Support to coproduction, both short term for the plan and long term to establish and embed a sustainable engagement model, led by the coproduction/ service user reference group but supported by the communications group.
3. Communications and engagement to support the procurement process including market work with the existing and emerging provider landscape.

Actions and Deliverables

Phase 1 – Development

- Establish communications and engagement group to lead the development and delivery of this plan
- Establish a work programme with clearly defined local and pan Essex responsibilities
- Establish infrastructure and systems for communications and engagement to include stakeholder

map, channels for distribution, use of digital technologies, feedback processes
- Preparation and distribution of initial stakeholder briefing to include summary of plan, process for delivery of plan, opportunities for discussion, key stakeholders meetings
- Set up regular programme of briefings and updates.

Phase 1 to be completed by end of May 2016.

Phase 2 – Awareness

The detail will be determined by phase 1 but will include;
- Publication of a communications and engagement toolkit and range of support materials.
- Programme of meetings/ workshops
- Channels between various programme elements eg service user group, professional reference group established and published

Phase 3 – Implementation

To be determined by phase 2.

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

Two tools to help areas assess levels of co-production can be accessed here and here.

The Partnership and all of the partners have a very strong shared commitment to the importance of co-production across the programme. Both Thurrock and Southend Councils have well established LD Partnership Boards whilst across Essex there is a Peoples' Parliament that provides this local service user leadership.

Through the early phases of the programme in Essex that started in May 2015, initial workshops engaged with service users to start to define the scope, types of services required and the approach to measuring success for a new specialist LD Health contract. The information below plays back this early progress and demonstrates the commitment that is being made to engage the service users. To date, this has included

- two large scale events based on the Outcomes Based Accountability model which over 60 people attended. These included people who use services, families, health and social care providers, and commissioners. Output from these events is included in the appendices. In addition the second event focused on how the group define and might measure success to inform the draft measures included in this document under section 3.2. These outputs will be built upon and further defined as the new arrangements progress

- Consulted upon the draft system model that the TC Partnership has defined. This focused on the success criteria and subsequent sessions were planned to engage in more detailed exploration of whether the emerging changes to services (new services and those to be changed) will deliver what is important to them. They understand that they have a remit which is not just about working together to design the new local model, but also to be involved in any new service procurements and in the monitoring of services once they are in place.

Following the agreement to broaden the scope of that initial work to align to the broader TC programme, the the group has been reconstituted to include members of the Southend and Thurrock LD Partnership Boards and the Essex Peoples' parliament. The first meeting of these new arrangements was held during March. The purpose of the reference group will be to gather the feedback and any recommendations made by the local Partnership Boards and Essex Peoples' Parliament. The chair of the reference group will be invited to attend the TC Partnership board to represent these views. This process will ensure continued leadership of the agenda by the LD Partnership board locally, but provide the process to provide representation and a

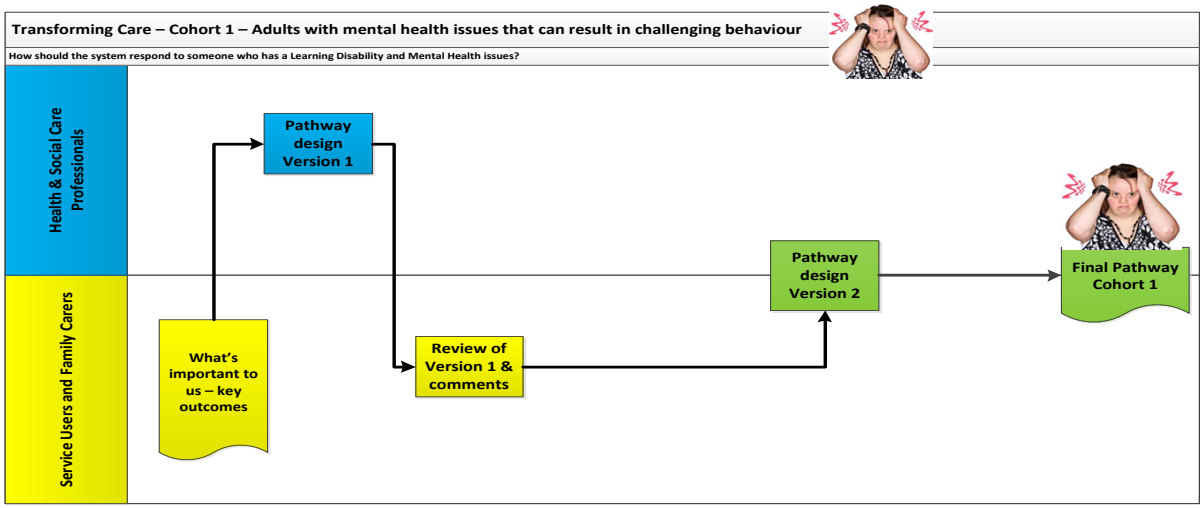
voice through to the TC Partnership Board.

The agreed approach to the next phase of work alongside the service users is to undertake some more detailed engagement with each of the five Challenging behaviour cohorts to identify headline pathways and outcomes for each cohort. The partnership has agreed that the shared ambitions demand recognition of a sixth cohort, which is the rest of the Adult community with Learning Disabilities to identify the broader reasonable adjustments which they have the right to expect to allow access to mainstream health, care, employment, housing and community services in general to achieve their personal ambitions and aspirations. This sixth cohort is important to understand these broader transformation changes required outside the more easily defined targets related to in-patient reductions.

The diagram below sets out the overview of this planned approach, which looks to dovetail and bring together both the service user reference group and the professional reference group in support of each cohort – recognising that some of the professionals skills-sets and experiences will differ for the different cohorts.

The engagement up to now and through the CTRs completed to date, have afforded a wealth of understanding about what is important to people and this will be used alongside work already done by the Service User and Families Reference Group to start this pathway design process. The new pathways will provide both

- identification of both the short-term changes / improvements to be delivered working alongside the current providers; and
- also provide the blueprint for the pathways to be taken through the procurement process from the end of the current calendar year.



This process will be followed for each cohort, with the people involved having direct experience of the pathway concerned (either lived experience or as professionals). As such it will require the Project Team to co-ordinate a wide number of people across both groups to ensure that the right people are in the room for each aspect of the design work, including those from mainstream health or Criminal Justice System services not currently represented in the Professionals Reference Group.

Further engagement is also planned with the Autism Partnership Boards to ensure that we are all working together on this agenda and establish where any separate or different engagement / co-production may be necessary to ensure appropriate insight and understanding.

Co-production for Childrens

The plans for establishing the detailed approach to co-production across the children work-stream have not been agreed. It recognised by all that the CTRs to date will provide a critical starting point for the learning and insight into the issues. These case studies are under development with the ambition to seek consent with these families to engage with them and the professionals who worked with them through these

traumatic experiences. Whilst the CTR itself is triggered at a moment in time, the aspiration is to seek the right opportunity to take a broader ethnographic perspective on a decade or even longer period of time to better understand what could and should have been different to have prevented these outcomes.

It is also clear that these same perspectives might valuably be sought from adults and their carers who have gone through these experiences and ended up in an in-patient setting, to similarly understand where different support or a different set of experiences may have prevented the calamitous outcomes. Ideally, examples of positive outcomes may also be explored to identify where similar levels of risk and similar contextual settings have resulted in less disastrous outcomes; this will help establish a set of views on where and what positive input may made the difference. As these plans become more clearly defined, they will be shared with NHS England.

These plans for co-production across both children and Adults build upon a strong network and history of engagement across Essex and we are confident that the approach will help local users to feel properly consulted, engaged, valued and supported in realising their ambitions for their lives.

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

Any additional information

2.Understanding the status quo

Baseline assessment of needs and services

2.1 Provide detail of the population / demographics

Guidance notes; This is a plan for a very heterogeneous group of people. What are the different cohorts? Consider the 5 needs groupings described in the national service model. Ensure that all your information on the different cohorts reflects children and young people who have these needs, including those who are in residential schools out of area.

As of 2014, there are estimated to be 32,724 adults 18+ living with a learning disability in Essex, Southend-on-Sea & Thurrock. Of this population 6,744 adults are expected to have a moderate or severe learning disability and it is this cohort, which is most likely to require specialist learning disability health and social care services.

Estimates suggest that the number of adults whose behaviour challenges services across the partnership is between 251 (Emerson et. al) and 472 (Lowe et.al). In an audit completed in 2013, 275 adults using "specialist" services for adults with behaviour that challenges were identified across the Essex LA footprint. Our information systems and data recording are not sophisticated enough at this stage to break this number down into the five cohorts described in Building the Right Support. Including the right coding into database modules going forward will be addressed.

The population of adults using specialist learning disability services is increasing by approximately 2.8% per annum (ECC). For people with behaviours that challenge the number is growing by between 11 and 13 each year, a higher growth rate (4%) than the general learning disability population. This could be due to improved identification of this group from the focus in "Transforming Care". These increases themselves constitute a case for change; at a time of decreasing financial resources it is critical to properly extrapolate future demand and properly evaluate the impact of the proposed changes to services to demonstrate the return on investment for both the care and health systems.

The in-patient population as at December 2015 consisted of:

- 19 people in CCG funded local Assessment and Treatment Units (inc. 3 in longer term "rehabilitation" beds.)

- 14 in CCG funded Independent Hospital placements.
- 5 in CCG funded mainstream Mental Health units.
- 28 people in NHSE funded Secure services
- 3 people in NHSE funded CAMHS services

6 of the CCG funded people and 7 of the NHSE funded people have been in hospital for more than 5 years.

The suggested in-patient population from Building the Right Support should be 10-15 inpatients per million in CCG funded beds (14.5 to 22 placements) –therefore a reduction of between 14 and 22 people is required; and 20-25 inpatients per million in NHSE funded Secure beds (29-36 placements) – there are currently 31 placements including CAMHS.

We are also aware of over 150 young people with a statement that indicates either learning disability or autism within 38 and 52 week residential placements, and these are a high risk group in terms of potentially requiring in-patient services in the future. The following table provides an indication of the children identified as potentially being at risk of developing or already displaying challenging behaviours. This analysis will continue to be refined – as it does not yet include the de-duplication of those that are attending residential or weekly boarding school placements.

Age	**TOTALS**	**Key risk**	
		Autism	LD and social/ emotional / mental health
0-4	11	3	8
5-11	122	43	79
12-16	169	53	116
16+	71	37	34
TOTALS	**373**	**136**	**237**

2.2 Analysis of inpatient usage by people from Transforming Care Partnership

Guidance notes; Set out patient flows work, any other complications / geographical / organisational considerations? (e.g. importer / exporter relationships)?

NHSE Funded Secure Services
As at the 31st December 2015 there were 28 people in Low and Medium Secure Services funded by NHSE. Since 1st January 2014 there have been 7 adults discharged from secure services to community based settings and 6 people have stepped down to CCG funded locked rehabilitation services. In the same time period there have been 6 adult admissions to secure services. This represents a net decrease of 7 people at an estimated saving to NHSE of £1,050,000 and an additional cost pressure to local authorities and CCGs of £610,000 and £780,000 respectively.

As at 31 March 2016, there are 3 children and young people in Tier 4 CAMH services. Since 1st January 2014 there have been 3 discharges from CAMH services and 5 admissions.

CCG Funded In-Patient Services (Independent Hospital placements and people who have been in Assessment and Treatment services for over 12 months).
As at the 31st December 2015 there were 11 people in IPH placements and 4 people in local Assessment and Treatment Units who have been an in-patient for over 12 months.

Since 1st January 2014 there have been 7 adults discharged from long stay CCG funded services to community placements. This includes Independent Hospital placements and people who have been in Assessment and Treatment services for over 12 months. However there have been 6 transfers in from secure services and 1 person who has now been in an Assessment and Treatment bed for over 12 months. This represents no net movement.

Assessment and Treatment Beds (Stays for less than 12 months):
North Essex:
As at the 31st December 2015 there were 7 people in A&T beds who had been there for less than 12 months.
There were 18 admissions and 18 discharges from A&T beds in 2014/15. In the first 3 quarters of 2015/16 there have already been 20 admissions and 20 discharges. There is greater demand on the system but people are moving through at a slightly quicker rate.

Mainstream Mental Health Services:
North-Essex: In the in-patient audit there were 5 patients with LD / Autism identified in mainstream mental health services. Four were admitted before 1st January 2015.

Whilst not universally true of all areas, Essex is a net importer of adults with Challenging Behaviour. At a school level, it is believed that it is significantly above average with regards to the percentage of children who are educated in out of County residential establishments.

Summary:

Compared to other areas Essex has relatively low numbers of people in Secure services. This is part represents the local success of the Transforming Care programme as a number have either moved to the community or transitioned to less restrictive CCG funded local locked rehabilitation services.

However this has had an impact on our local CCG commissioned in-patient numbers which are higher than we would like – in part due to the numbers that have transferred from Secure and the avoidance of admissions to Secure services. The next phase of our programme aims to reduce these numbers by half the current levels over the next 3 years – however this will require significant investment in housing and support services in the community to achieve this.

We are also experiencing an increasing complexity in young people with learning disabilities – in particular young males with severe learning disability and autism that present considerable challenges to services. The targets for the Essex partnership are therefore considerably ambitious as they involve reducing the in-patient population considerably over a period when demand for very specialist services is increasing.

2.3 Describe the current system

Guidance notes; How is the system currently performing against current national outcome measures?; How are the needs of the five cohorts set out above currently being catered for? What services are already in place?; What is the current care model, and what are the challenges within it?; Who is providing those services? What is the provider base?;How are those providers currently commissioned/contracted, by which commissioner(s)?

Summary
In terms of the targets for in-patient populations the Pan Essex partnership falls within the levels described in Building the Right Support for NHSE Secure placements, but above the levels for CCG funded placements. In part this reflects previous successes in supporting people to progress from secure services but as a result over 15% of our locally funded CCG placements are from people who have progressed to less restrictive environments.

Probably the greatest challenge to the partnership is how we continue to reduce our in patient population without increasing our reliance on residential care placements and moving people from one institutional environment to another. Our current social care market is over reliant on specialist residential care providers and it is difficult to control the quality of this market because providers are able to attract placements from other areas if the local partnership does not use them. Therefore the development of specialist housing where people are tenants or part owners, and their care is separate to their accommodation will be a key element of our plan.

A further challenge to the partnership is the over-supply of Independent Sector hospital beds within the area. The local partnership uses only 10% of these beds, so we are both a net importer of social care and

hospital placements. For some people within these hospitals they have lost links to their local communities and view Essex as their home which places additional demands on local services.

Current Provision

Secure Services

There are 47 Low Secure beds located within the partnership (at one hospital in North-East Essex.) The partnership only uses 6 of these beds and we are a net importer of people to this area. All but two of the people placed in Low and Medium Secure services are within the Eastern Region.

Independent Hospitals

There are five independent hospitals within the partnership with a total of 105 beds. Three of these hospitals (93 beds) are within North-East Essex. The partnership only uses 10 of these beds and we are a net importer of people to this area.

Assessment and Treatment Units

There are 13 Assessment and Treatment Beds across 2 sites. In addition there are 3 longer term rehabilitation beds on these sites. Assessment and Treatment services are provided in North Essex by Hertfordshire Partnership Trust (HPFT) at their site in Lexden, Colchester. In South Essex including Southend and Thurrock these services are provided by South Essex Partnership University NHS Foundation Trust (SEPT) at their site in Billericay.

Specialist NHS Community Based Services

Specialist learning disability community based health services are provided in north Essex by HPFT and ACE (with some Allied Health services being provided by SEPT in West Essex); and in south Essex including Southend and Thurrock by SEPT. Both areas have an Intensive Support Service - the north service operates 8 to 8 Monday to Friday and 9-5 weekends and the south service only operates during the week). Both areas provide a health facilitation service.

Assessment and Care Management Services

Essex County Council has a dedicated Complex Behaviour Team to work with adults with learning disabilities with behaviours deemed to be challenging. The team consists of a Team Manager, 2 Senior Practitioners and 3 Social Workers, and has capacity to provide person centred planning and co-ordinate the support for 125 people. In addition all three local authorities have locality based social work teams. Some are co-located with specialist health colleagues Southend); in other areas (Essex) the links between social work teams and specialist health is not as strong and this is an area the partnership would want to address.

Essex also has a Behaviour Advisory Team which specialise in undertaking Comprehensive Behaviour Assessments to inform support plans and service design for people with behaviours deemed to be challenging. The team consists of a Team Manager (shared with Out of County and Sensory / HIV Teams); 5 practitioners and 2 facilitators focused on adults and 2 practitioners focused on children and young people.

Social Care funded Residential Services

We estimate* that Essex County Councils spends £19.5 million per annum on 170 residential care placements for adults with learning disabilities whose behaviour is deemed to be challenging. The spend is with 41 providers, however over half the placements (86) and nearly half the expenditure (£9.4m) is with just 4 providers.

Market trends indicate that as occupancy rates decline in residential care homes, organisations (for profit) are seeking to re-position their services towards complex care and services for people with behaviours deemed to be challenging, which is viewed as the most sustainable and defensible segment of the market. (LaingBusisson[9]). Anecdotal information from the ECC Commercial function supports this reporting a growth in residential providers offering services for people with behaviours deemed to be challenging. However there are concerns that some providers entering this market segment do not have the required value base, skills or expertise.

An analysis of residential care admissions between February 2012 and January 2013 identified that seventeen people with behaviours deemed to be challenging were admitted to registered care during that 12

month period.

Social Care funded non-residential services

We estimate* that Essex County Councils spends £4.2 million per annum on non-residential services for 37 adults with learning disabilities whose behaviour is deemed to be challenging. The spend is with 11 providers, however the majority of placements (28) and almost all of the expenditure (£3.4m) is with just 4 providers.

In addition we estimate* that 14 adults with learning disabilities whose behaviour is deemed to be challenging are receiving direct payments to purchase their own care and support at a total cost of £300k per annum.

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

Guidance notes: Provide a summary of existing estate data by property; describe what the existing estate from which the client group are supported is and how fit for purpose/how settled the accommodation is;

Where the NHS has an existing interest in a property, confirm whether the associated capital grant agreement (CGA) and (where appropriate) legal charge is held by NHS England[2] or the Department of Health / Secretary of State for Health (DH/SoS).

The work to determine and identify the options for the current estate is a piece of work that has started recently and is a priority for the subsequent submission in March.
Our experience in managing the re-settlement of people into the community is that ensuring and securing the most appropriate housing for people is the most complex element; it is also arguably the most critical. These same challenges are true for those with moderate learning difficulties but who present very low risk of escalation in an in-patient setting. All of the 10 commissioning partners sign up to the principle that wherever practical and possible that someone's home should be distinct and separate from their care. Across a housing market as competitive as Essex, the challenges to managing and delivering these outcomes are significant.

There are four key strands to establishing the plan and strategy for estates and housing, as follows

- Identification and implementation of a number of accommodation solutions to a small number of the current in-patient cohort who are ready to move into the Community. A new facility in the Braintree area has been successfully completed to provide five living spaces for a number of these individual complex
- Identifying the existing NHS interests invested into housing and also into any other community based facilities and establish the nature of these legal charges. Appropriate requests have been made with NHS property estates to identify the precise nature of these interests and the necessary information as regards any community assets is being clarified.
- Establish any broader NHS estate across existing NHS providers and establish the plans for what any assets that might be included within the scope of a procurement exercise.
- Outside these strands of work, there are separate strategies and approaches across the three local authorities to look to create the predicted forecast requirement of appropriate housing stock. As unitary authorities, the levers differ for Southend and Thurrock compared to the County Council, but discussions have started to ensure that these can be progressed to work in mutually beneficial ways. The financial return to a private sector landlord to date has proven less secure for appropriately modified and flexible schemes and hence more innovative grant schemes will be required. Careful consideration will also be required to assure availability and flexibility of the care and health requirements for individuals that may benefit from and wish to live in similar housing offers; the support has to be available and flexible without becoming fixed whilst maintain the desired split between the home and the care.

[2] Where the original CGA and/or property charge is in the name of a Health Authority, NHS Primary Care Trust or NHS Property Services Ltd, these organisations have now been succeeded as holder of the relevant CGAs and property charges by NHS England.

In terms of the timeframes, the ambition is to ensure that an agreed plan across these domains is complete and approved before the end of June. This will not stand in the way of progress against the first strand, but resolving these capital schemes and developments is a medium and long-term timeframe to ensure that the next 2-5 years can start to release results inside the market.

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

Guidance notes; In line with the service model, this should include how more can be done to ensure individuals are at the centre of their own packages of care and support and how systems and processes can be made more person-centred.

The case for change is to address three core agendas / issues that represent failings in the system, namely

- The continued response to the scandal at Winterbourne View and the Transforming Care programme nationally
- The continued inequality and poor experiences that the broadest LD population continue to suffer and experience
- The constrained finances driven by increasing demand and reduced resources.

Both the starting point and the core definition of success are the rights, experiences and outcomes for those individuals and their carers. The process of transformation will also place the individuals and their carers at the centre of defining their packages and ensure these are coherent and joined-up at the point of receipt / consumption.

Transforming Care

The Partnership wholly endorses the introduction included within the national plan in October 2015; for a minority of children, young people and adults with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition, the health and care system remains too reliant on inpatient care. This is undoubtedly one of the key reasons that change is necessary.

Health and broader inequalities

At the same time, many Adults with lower levels of Learning Disability continue to struggle to access and consume mainstream services and society; the impact is that many do not lead as healthy and independent lives as they aspire to and compared to their non-disabled peers. Evidence and examples of these challenges are included in reports such as

- The Michael Report: *Healthcare for All* (2008)
- Mencap report: *74 Lives and Counting* (2012)
- *Mid Staffordshire NHS Foundation Trust Public Inquiry report* (February 2013),
- *Confidential Inquiry into Premature Deaths of People with a Learning Disability*: 2013 (University of Bristol; Improving Health and Lives Learning Disability Public Health Observatory).

Financial Constraints

At the same time as addressing the fact that people with LD and people with Challenging Behaviour including those that may have a Mental Health Condition can suffer these inequitable outcomes, both the health and social care systems face unprecedented financial pressures due both to the increasing number and also complexity of this cohort and constrained budgets. As these demand and financial pressures intensify, the assumption is that the current system will continue to respond in the same way as historically, with the following implications

1. People will continue to experience poor outcomes and express dissatisfaction with the fragmentation of the current offer that is based upon single agency rather than holistic person-centred solutions
2. This fragmented service offer will become more inefficient and ineffective as joint working and the needs and experiences of users are further de-prioritised by stretched providers – providers will focus ever more strictly upon individual thresholds and responsibilities thus increasing the gaps between services
3. The focus of service delivery will continue to be on protecting stand-alone budgets rather than focusing on holistic service user outcomes that may deliver lower total-cost solutions
4. Cost-shunting will continue and become more intense, increasing the costs of these processes and

continuing to delay appropriate support for service users.

The case for children mirrors many of these dynamics; legislative and policy changes provide the opportunity to address these across the childrens arena. At the same time, the evidence and commitment is re-enforced through the examples and insight that has syatyed to emerge through the CTRs to date. There is a duality of focus as regards the temporal scope of the challenge, but both align to the needs, outcomes and experiences of the individuals and their carers.

- In the immediate and short-term to assure the best for the child through their childhood
- Over the longer-term to assure the right preparation for adulthood, to assure the greatest independence, prosperity and health through their adult life.

The approach is that of an all-age pathway, accepting the financial budgeting for this eventuality remains as yet an aspiration given the complexity this creates within a single council organisation, let alone the broader challenge this presents to a multi-agency partnership.

There have been many policy and practice approaches over the years that aimed to promote the equality of opportunity and tackle the health inequalities of people with a learning disability, autism, mental health conditions and behaviours that challenge. Policies such as Every Child Matters and more recently the Send reforms and Preparing Young people for Adulthood within the Children and Families Act places specific focus on the need for early intervention and prevention to enable children, young people and their families to receive the right support as early as possible to enable the better outcomes into adolescence and adulthood.
The experiences of the young adults at Winterbourne view sent a public reality check of the existing 'system' and of the circumstances and risks that people most vulnerable face when living within an institution setting as Dr Mansell identified years previously and has since unfortunately been repeated.
There is evidence to demonstrate that children and young people who spent the majority of their lives in residential school settings their connectivity with their families and their local communities were significantly impacted, resulting in the residential school status being perceived as their home running the risk of being ill-equipped for adult life beyond the institutionalised setting.

Transforming care has acknowledged the need to be inclusive of children and young people in the development of a future service model / system in considering the current and future needs of people with a learning disability, autism, with mental health and behaviours that challenge in order to prevent them following a path into adulthood that is restrictive and minimises positive life outcomes. However there are models that successfully pull together the complexity of the whole system that a child / young person and their families need to engage with in their lives. At the same time, the

However practitioners and parents supporting young people with a learning disability and autism with MH and behaviours that challenge often describe a lack of consistent and proactive interventions that enable the parent to feel empowered to manage challenging situations, often describing the need to search or 'fight' for the right support.
Such messages have been reflected in examples provided in the Early Intervention Project by The Council for Disabled Children and The Challenging Behaviour Foundation who promote person centred early intervention approaches and coordination to support the prevention of the escalation of need, something that NICE Guidelines for Autism: recognition, referral and diagnosis of children and young people on the autism spectrum (NICE clinical guideline 128) and Autism in under 19s: support and management NICE guidelines [CG170](due to be reviewed this year) that also recognise the importance of accessing a diagnosis assessment in order to effectively determine needs and make the appropriate meaningful reasonably adjusted interventions.

How can the current model of care be improved – Adults?
The partnership has identified and agreed a number of headline improvements to the current models of care for both the identified Challenging Behaviour 5 cohorts that are detailed in the national model, as well as the broader range of people with Learning Disability. The following provides a summary of the key improvements and changes required to deliver the improved outcomes and experiences expected. Further definition of how these will drive the better outcomes are included in Section 4.1 below.

Some of these improvements will be delivered in the coming months through re-commissioning and pathway redesign that can be influenced or delivered through existing arrangements. Similarly the bids that the Partnership will be making to the national programme will provide the opportunity to implement some of the

missing services and capability required.

Other improvements, however, require a more fundamental financial investment and service transformation; these can only be delivered through the right joint investments between health and social care locally and across the partnership. The plan is that the changes implemented both through the national bids and through the initial re-commissioning will provide the evidence for the risks and rewards between health and care as we move towards strategic re-procurement. These changes will therefore be delivered through a partnership business case and a planned procurement of a single specialist LD health provider targeted during 2017.

The key changes identified that underpin the vision for how services will work in the future are

- Better integration between health and care – in every sense, but with the objective of improving both the experience and outcome for the service user and their needs. This means that assessment and care management professionals should work more closely together through Multi—Disciplinary teams and more joined-up care co-ordination, but also that commissioning and funding, at both a system and individual personal level, should be more joined up. At a system level it this procedural integration of how services are defined and consumed by the user and their carers that will ensure seamless experience, allow the right and early response to need and address any disincentives in the system that exist for providers
- Improved visibility of those suffering from or at risk of Challenging Behaviour including those with Autism or a Mental Health Condition. The definition and awareness across all service domains as well as the ability to record or assess for the risk of CB needs to be significantly enhanced
- Improved transition and planning for adulthood whilst in childhood; this must start from the ambitions and the capability of the individual to develop the right plans and strategies and support for the individual, recognising and planning for the key life events that can destabilise and unsettle people
- Improved workforce development to assure that all professionals and services provided across the system are able to make the right reasonable adjustments to enable safe and efficient access to mainstream society, community services and healthcare where and when they are required
- Improved and transparent measurement of success (based upon the things that are identified as valuable to those with LD and / or CB) to identify and communicate awareness of those services that deliver best outcomes. In this respect personal budgets will drive this process
- Increased use of personal budgets and personal health budgets that will ensure that individuals identify and access the support that they need. This cultural shift will drive services to respond to need and will drive integration of budgets as consumers pull on the services they value; this will therefore by definition be about the outcomes that individuals seek to achieve and ensure that the system is person-centred and focused on their experience rather than designed around service constraints
- Investment into the community to deliver and stimulate the right preventative services where necessary, but also to ensure that young people in particular, but also adults can receive the support closer to home and feel services are wrapped around them inside their community. Key changes included within the future model include increased assertive outreach, with a particular focus on positive behaviour support for children and their families, to engage earlier and within communities to prevent escalation.

How can the current model of care be improved – Children?

The following set out the emerging fundamental Principles, where all interventions should reflect

- Person Centred approaches
- Outcome focused interventions
- Reasonable adjustments to access to mainstream and universal services
- A focus on prevention / early intervention and health and wellbeing
- Transparent information including accessing diagnostic pathways set out within the local offer
- Responsive approaches preventing escalation and predicting escalating needs
- Least restrictive options and sustaining family life wherever possible
- Promoting resilience for the family and the child

- Maximising independence for the child and young person in preparation for adulthood
- Easily accessible, co-located services delivering co-ordinated care
- Co-production with children and young people and their carers.

The childrens sub-group has defined a framework depicting a generic good practice model, which is outlined in section 4.1 of this document. This model does not represent a proposed future model per se, but offers a framework against which to identify opportunities for improvement or gaps in the current service offer; it is these changes or improvements that will become the partnership plan.

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

The baseline Transforming Care Partnership investment in services was £101,413,044 in 2015/16 supporting an inpatient population of 73 (as at 31/03/2016) and 1,116 community based packages of care.

3.Develop your vision for the future

Vision, strategy and outcomes

3.1 Describe your aspirations for 2018/19.

Guidance notes; This should include, as a minimum, an articulation of:

- *Improved quality of care*
- *Improved quality of life*
- *Reduced reliance on inpatient services*

The aspirations of individuals and families for their own lives should be central to this.

The Partnership aspiration is that, in line with the national plan published in October 2015, all people with a Learning Disability will be living in a home within their community, and able to develop and maintain relationships, and get the support they need to live healthy, safe and rewarding lives. This ambition relates to the entirety of the cohorts covered by this plan, namely

- The five higher risk Challenging Behaviour cohorts defined within the national service model – including those with Autism and / or a Mental Health condition. This also relates to both children and young people that fall into this cohort
- All people with a Learning Disability and in particular their ability to gain and secure equal access to mainstream services and society and hence leading equally healthy and fulfilling lives as their non-Disabled neighbours.

For the Partnership the ultimate definition of success is that individuals and families will be realising their own aspiration for their lives. Our aspirations can therefore be described as:-

Improved quality of care

In terms of quality of care, the aspiration is that in 3 years time we will have

- a healthy and well managed market of health and social care providers invested in high quality personalised support, with an asset based, progression and enablement approach to all support provided
- workforce across both providers and internal care management and delivery functions that understand how to identify people that may not be able to self-advocate as ably as their non-Disabled peers or neighbours and able to provide the right support and make the right referrals where any additional support is required
- an understanding about what works and have defined an approach that will allow providers subsequently to be contracted to deliver individual and population level outcomes. This may provide the opportunity to move to capitated budgeting
- clear, differentiated, and accessible integrated pathways of support that focus on prevention and

early intervention, and which place the individual and their family central to their delivery
- integrated operation / assessment and care management teams across health and social care (at a local authority level), with a single point of access
- a co-produced strategy in place to address the health in-equalities faced by people and their poor experiences of mainstream health provision, based on data collated from using the HEF, LD SAF and other local information
- a culture whereby individuals and their families are seen as equal partners with health, social care and provider staff, in the planning and delivery of support
- addressed disincentives within the system that result in cost shunting and ineffective use of resources, through the development of pooled funding and integrated commissioning arrangements
- procured a single LD Specialist Healthcare contracts across the partnership.

Improved quality of life

In terms of improved quality of life, our aspirations include that in three years' time people and families will

- have individualised planning based on lifetime outcomes and costs, resulting in one plan and one budget per person (irrespective of funding streams)
- have a named person responsible for their care co-ordination
- have increased control over their support arrangements through increased use of Personal Budgets/Personal Health Budgets with a range of deployment routes
- have person-centred and personalised solutions that can be applied across a wide economy of provision, extending into the private and voluntary sectors and other community based assets
- feel well supported where they have a caring role, and able to sustain this for as long is appropriate for them and their family member; for them to also have a life of their own
- be able to live in appropriate accommodation, that maximises their security of tenure, and enables them to maintain their life style, occupation and relationships despite any issues that may arise. For people to live in residential care only when this is agreed to be the best option.
- have in place a strategy for addressing their needs where they may come into contact with the Criminal Justice System in order to reduce risks and support people to remain safely within their local community
- in place a specialist team able to address the needs of people who may or have come into contact with the Criminal Justice System.

Reduced reliance of inpatient care

- For no-one without a certifiable need, to be admitted into Assessment and Treatment
- For all the people currently seen as requiring re-settlement from long stays in hospital to be living in appropriate community settings and leading good quality lives
- To have used the re-commissioning of the Specialist Healthcare Contract to consolidate current provision across the county, to reduce and re-design beds and help release resources for new community provision
- To have redirected spend into the expansion of community services which enable people to be safely supported where they are living. This will include a 24hr Intensive Support and Rapid Support Service to prevent crises from occurring or to respond quickly if they do with an integrated response. It will also include a Positive Behaviour Support Service.
- For the impact of the risk registers to be seen in the pro-active preventative work being done to avoid crises from occurring and managing them if they do.
- To have provided a safe alternative to hospital for people who, for whatever reason, are not able to remain in their current accommodation and do not need hospital treatment.
- To have ensured that there is partnership working with providers and families that helps sustain individuals and families in difficult times.
- For there to be differentiated pathways for those with mental health issues to those with neurodevelopmental issues. For those with mental health issues this will focus on the maintenance of good health and recovery during periods of ill health. For people with neurodevelopmental issues this will focus on developing a sound understanding of the person and using techniques such as Positive Behaviour Support to ensure they live a high quality life.
- For people with mental health issues who require admission, to be receiving high quality assessment and treatment, that enables them to recover and return home within the shortest period of time.

- For people to be able to access the specialist help they need locally.
- For fewer people to require admission into NHSE secure hospital provision, but if they do for this to be a smooth transfer, for a limited time, with contact maintained to ensure discharge planning begins as soon as possible.
- For there to be close working with Transitions Services to enable the early planning for young people moving into adult services, and ensuring the continuity of their EHC Plan (where appropriate) into adult life.

From a system perspective, beyond the three year period, we will be able to better manage demand within the system within the constrained resources available, whilst delivering improved outcomes. A number of the longer-term ambitions include

- Improved preventative capability that will reverse the current trend of increasing numbers of people currently assessed as Challenging Behaviour. We will have evidence of those services that make a difference and will have integrated some investment decisions with associated and agreed risk share arrangements at a local level between health and care
- an all age approach that budgets for support for children based upon the return on investment that this can deliver for the life that they will lead as an adult – both in terms of increasing their independence, their health and their contribution to society, but also financially
- an increased awareness of the risk factors that can increase the likelihood that someone may become assessed as falling within the cohort of Challenging Behaviour.

At this stage, these ambitions remain aspirational. The first phase of the programme is focused on some shorter-term changes that may deliver transformational outcomes for a small number of individuals; this is not to underestimate the importance of these changes, but it does not represent a transformation of the system for all people with a Learning Disability. Over the next 6 months, as these shorter-term changes, for example implementation of the community forensics service and planned resettlement of those currently in an in-patient placement are completed, the focus will shift to the definition of these measures of success and identifying how these might be articulated both as SMART measures, but also how they relate to the broader cohort of over 6,000 Adults with a Learning Disability and over 7,000 children with Education, Health or Care plans.

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

Guidance notes;

Transforming care partnerships should select indicators that they believe to be appropriate for their plans.

However, areas should be aware that nationally:

- *To monitor reduced reliance on inpatient services, we will use the Assuring Transformation data set*
- *To monitor quality of life, we are minded to make use of the Health Equality Framework[3]*
- *To monitor quality of care, we are supporting the development of a basket of indicators (see Annex A); exploring how to measure progress in uptake of personal budgets (including direct payments), personal health budgets and, where appropriate, integrated budgets; and strongly support the use by local commissioners of quality checker schemes and Always Events*

The Partnership has significant ambition and is increasingly clear on how it will measure and demonstrate success. The measures will continue to be co-produced with the Project Team and attached Reference Groups (both service user and family, and professionals), building on the initial engagement that was undertaken in Summer 2015. Although this related at that stage to the work focused solely on the procurement in the North of a Specialist Healthcare Contract. The measures relate to specific areas of the system model that was developed and have been brought together under a range of indicators that are 'The things we can count' and 'What we should experience' (in the form of 'I statements').

[3] http://www.ndti.org.uk/publications/other-publications/the-health-equality-framework-and-commissioning-guide1/

Responsibility and accountability for delivery of these outcomes will continue to be held at a local level. Some of the delivery infrastructure and mechanisms may be shared (in particular the health resources that might be included within critical and crises response teams, forensic community capability and the crises / crash pad accommodation for example), but the majority of the resource must remain at a local level. The role of the Partnership Board, therefore, is about the visibility and assurance of delivery and performance.

'The things we can count':-
[Nb these can be subdivided into in-patients and people in the community]

Quality of care

- Proportion of eligible people with an Annual Health Check and Health Action Plan. Proportion of HAPs which can evidence follow through on the actions
- Proportion of eligible people who take up national screening and vaccination offers
- Proportion of people with a current HEF. Proportion of individuals with a HEF where there is evidence of reduced health in-equalities as a result of support/service interventions
- Life expectancy in relation to local, county and national levels (NB this is a long term indicator)
- Individual, service and population level outcomes forming part of the KPIs for the new Specialist Healthcare Contract
- Proportion of social care providers who meet the quality standards within their (new) contracts
- The presence of integrated pathways for the named cohorts of people.

Quality of life

- Proportion of people with a single, integrated, person-centred support plan based on lifetime outcomes which has been reviewed within the last 12 months. Proportion which can evidence achievement of agreed outcomes within the last 12 months.
- Proportion of people with a named care co-ordinator.
- Proportion of people with social care support in receipt of a PB deployed: through a DP; an ISF; or a managed PB.
- Number/proportion of people with health support in receipt of a PHB.
- Number of people with an integrated health and social care PB. Number deployed:- through a DP; an ISF; or a managed PB.
- Proportion of people living in settled accommodation suited to their needs.
    - Proportion of people living in residential care
    - Proportion of people living in supported living, shared lives etc
    - Proportion of people living with family carers
- Proportion of people who return to where they were previously living following a hospital admission (as appropriate).
- Proportion of people in employment.
- Number/proportion of people in contact with the Criminal Justice System.

Reduced reliance on inpatient care

- Number of beds per 1000 head of population for Assessment and Treatment (for people with mental health issues), and for Short to Medium Term Rehabilitation (people with neurological disorders).
- Transforming Care Assurance Data.
- Number of family or social care breakdowns that result in changed accommodation or hospital admission.
- Waiting times for new psychiatric referrals for people with a learning disability or autism.
- Proportion of people with learning disability or autism for whom there is a crisis plan. Proportion of people on the risk register who have a crisis plan.

- Number/proportion of admissions that are 'un-planned', ie an unknown crisis.
- Number/proportion of people requiring use of the temporary/crisis accommodation. The average length of stay. The number who return to their previous accommodation (where appropriate). The number who move into new accommodation (as appropriate).

'What we should experience':

It is envisaged that these will be measured through a series of activities focused on what service users and families say of their experience (surveys etc), together with formal quality assurance delivered by providers, the commissioners of services and schemes such as quality checkers.
They would be looking to assess against:
Transforming Care 'I statements'
TLAP 'I statements'
Pan-Essex 'I statements' as developed by the local reference groups.
Examples include – for the Temporary/Crisis Accommodation:

- I do not have to be admitted to hospital just because of my behaviour.
- There is somewhere suitable for me to go if and when I need it.
- There is somewhere for me to go if I am ready to leave hospital but my permanent home is not yet ready.
- I am supported to maintain my relationships and community networks (as appropriate).
- The staff have the right skills to support me. They are there when I need them.

3.3 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.

The programme will

- Reduce the numbers of people in in-patient settings through investing into community capability and capacity to be able to support people in the community who were previously deemed as too complex and / or dangerous
- Improve the health outcomes for all people with LD through ensuring equality of access and reasonable adjustments are delivered across all mainstream health
- Improve the life chances and involvement and contribution to society for people with a Learning Disability - through assuring that they feel valued and included members of society
- Reverse the trend that demonstrates increasing numbers of people with a diagnosis of Challenging behaviour. Better understanding of the risks and increased awareness of this by professionals – both within the children and Adult populations – will allow earlier intervention and prevention.

To achieve these outcomes across all cohorts covered by the plan, the core principles that underpin the redesign of the pathways, services and system are:

- Placing service users / consumers at the heart of the service offer, ensuring that they are able to use integrated personal budgets / service funds to access the support that individuals and families seek. Redesign is based not upon the needs of the service to be more efficient, but on the ambitions and support requirements of the individuals, their carers and families
- Reduced reliance on in-patient care – and ensuring that any episode of in-patient care is focused on assessment and defined treatment to move to a planned return to a community placement. It is the continued monitoring of the success of treatment that is perhaps important that provides a focus on the move-on. Accordingly, the planned reductions in commissioned beds are targeted less on assessment and treatment, but more on rehabilitation and low secure beds
- Continuing to improve our approach to Care and Treatment and Reviews to provide the integrated and also the independent challenge to planned and progress for the treatments
- A belief that the right place for people with Learning Disability is to be living in their chosen home in their community. The requirement is to deliver person-centred services that are wrapped around those that need support to keep them able to live healthy, independent and fulfilled lives

- Placing service users / consumers and their families and carers at the heart of system and service redesign and continuous improvement processes. Success is about achieving their ambitions, expectations and rights
- Clearly defined measures of success, consulted upon and informed by service users / consumers and transparency about the performance of and the value placed on services. This will encourage choice and target personal budgets and personal health budgets towards those services that make a difference for people
- Supporting and developing the workforce and capability of all providers and professionals within the system; whilst also developing the market and holding providers to account to deliver what they are commissioned to provide
- Where the specifications for services are common across all partners, then the ambition is to look to commission at scale to achieve best value
- Contracts should be of sufficient size and longevity to incentivise providers to invest and develop services
- Improved take up and greater value placed upon health checks and health action plans
- Seeking to address any disincentives in the system that can drive poor experiences and poor outcomes for service users where service providers seek to shunt responsibility and hence cost across to other providers. The approach is to ensure that suppliers are held to account to their responsibilities
- Alignment and visibility across key related agendas – mainly Autism, Mental health, Learning Disability and the mainstream cohorts across both children and adults. Transition that works is key
- Ensuring most appropriate resources are available for care planning and coordination; based not upon funding streams but expertise and the choice of the individual consumers
- Integrated commissioning and funding arrangements for the system and for individuals' budgets – whilst ensuring that the commissioning arrangements recognise the sovereignty and accountability locally. It is this accountability and locality that helps to keep people in familiar and safe surroundings that will provide the self-fulfilling prophecy that they live their life within that community

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

The revenue and capital funding requirement in the next 3 years is as follow:

	2016/17 £	2017/18 £	2018/19 £
Essex Transforming Care Partnership	**101,530,726**	**103,183,427**	**104,851,538**
NHS England Revenue Funding	**4,141,666**	**1,928,334**	
Total Revenue Funding	**105,672,392**	**105,111,761**	**104,851,538**
NHS England Capital Funding Support	**2,116,000**	**1,100,000**	

The detailed analysis of investment is included in the Finance and Activity, and Transformation funding tabs.

At this stage, the data is submitted with the following caveats:

- Further modelling is required for a number of reasons – most importantly to more clearly establish the cohort of people currently at risk of escalating into in-patient settings – both as children and adults
- The plans are being submitted for formal governance across the organisations during May and June. The Local Authority budget setting processes will complete by December
- The exact nature of the dowry and the nature of the relationship with Specialist Commissioning needs to be further defined as this will impact the flow of funding

- The timeframes will continue to be updated, but these are based upon initial plans and best estimates at this stage
- The changes being defined through the Success Regime and the resource implications continue to change the personnel involved in the programme which inevitably causes a shift in dynamic.

4.Implementation planning

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

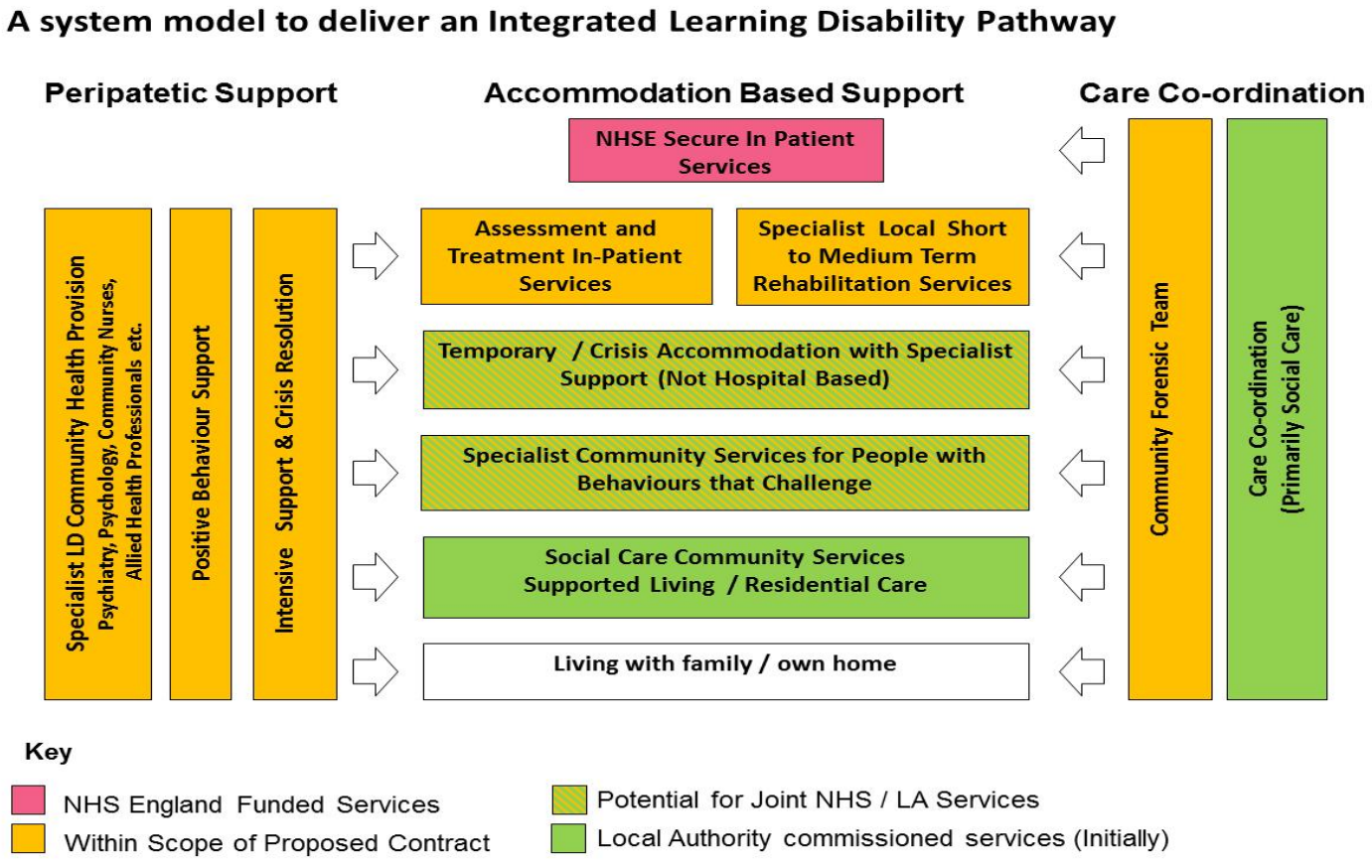
4.1 Overview of your new model of care

Guidance notes; How will the service model meet the needs of all patient groups, including children, young adults, and those in contact with the criminal justice system?

The following diagram provides an overview of the headline agreed model. This has been endorsed by the Partnership for further detailed development with in particular further definition of those service offers that are currently not available – mainly a forensic community capability and crisis accommodation.

Further information is included in the appendices; this section describes: Model objectives; Scope issues; Monitoring, performance and resources; Model focus and interdependence; Model flexibility; How the model meets the needs of the 5 cohorts described in Building the Right Support.

The main feature of the model is the development of effective and preventative local services that stop people moving away from their home and community to further away/hospital provision. Locality is the emphasis, with specialist services commissioned collaboratively where this is necessary and delivers benefits. A person centred approach needs to be in evidence at each stage.



Model objectives

The core model and the activity that underlies it is designed to:

- Reduce behaviour that challenges and prevent escalation to inpatients from local/community based services.
- Deliver effective emergency crisis intervention that prevents escalation in individual cases and support a preventative local system
- Provide for appropriate settings away from people's homes that best meet needs and circumstances. The whole system will both prevent escalation and encourage de-escalation – i.e. moving from inpatient to community based provision.

In many ways the structure of the model responds to needs of people in the system now by achieving the right and appropriate support. It is a solution which we think is sustainable and which will reduce the number of beds in the system

Over the medium to longer term (the 3 year horizon) the model will evolve to increasingly take account of choice and personalisation. This process will subtly change the model as the tranches in the programme proceed. Commissioning will become less 'done for' people and more driven by users themselves. Within each of the components of the model we are planning to achieve market sustainability and innovation, reflected in the core model design and associated bids that help us achieve the benefits of the model.

Over the longer term we expect a further step change in bed usage through improvements for pathways for children and young people, which will include appropriate assessment and risk based intervention. The Transforming Care Board will have a line of sight to these pathways and related developments, ensuring responsiveness and early interventions across the Pan Essex area.

Model flexibility

The core model is a Pan Essex vision/high level blueprint. It is not a fixed model but can be changed as tranches of the programme progress. It provides real direction for a 3 year programme of plans and the benefits achieved by those plans, although there may be local variations in the final model achieved because of differing structures of provision and community need across the Pan Essex area and the dynamics in the system brought about be Integrated Budgets and choice. Working towards the model over the next 3 years is a process of progressive and measurable change overseen by the Transforming Care Partnership Board. The programme plan will deliver this change.

Scope issues

The Transforming Care Boards has a developing line of sight to enable collaboration in commissioning specialist services and is also able to see when other collaborative endevours can improve outcomes for all people with Learning Disabilities and Autism. For instance, through influencing the development of an Integrated Personal Budget Offer.

<u>Prevention</u>

The 5 cohorts are a very small proportion of people in relation to the whole population of people with Learning Disabilities and Autism Spectrum Conditions. Through the lifetime of this plan and beyond, the size of the 5 cohorts where challenging behaviour has already been identified, will reduce further through better prevention in the whole system. We also expect the severity of episodes to reduce as the whole system becomes more attuned to positive behaviour support and is more responsive and person centred.

We think that best practice reflects consideration of the 5 cohorts. Measuring the impact on these cohorts of interventions will provide increased evidence for sustaining the momentum of change but we do consider the wider learning disability and autism population.

The Transforming Care Partnership will have a line of sight of the 'whole system' including how local services work together to prevent challenging behaviour arising, assuring locally that broader reasonable adjustments are made and that people with Learning Disabilities have equal access to health services

compared to the rest of the population. Most activities here will be the domain of the Learning Disability Partnership Board and the Autism Partnership Board under Health and Wellbeing Boards but again with a line of sight. This includes Annual Health Checks which are likely to be influenced by local community approaches with GPs identifying with the communities of which they are a part. This community factor is likely to be a critical factor in achieving equality for people with Learning Disability and which is situated at the base of health pathways.

In addition and also at the local level, are supported living providers, residential care providers, short breaks, employment support, advocacy – all components which are part of a local offer in the communities and neighbourhoods where people live and are part of, but which also are under the line of sight of the Transforming Care Partnership Board.

Housing and accommodation

Line of sight for the Transforming Care Partnership Board will also include housing, and indeed Local Authorities already want to respond to people's desire of where and how they might want to live. This is beyond 'accommodation' provision but a complete range of housing choice for people, and a well-planned offer can reduce the need for public sector provision through innovative funding. Innovative housing options could Transform Care and the experience of it. Part of the commitment in developing the model is about achieving a sustainable mixed economy of accommodation/housing relating to risk and choice for all people with autism and learning disabilities not just within the 5 cohorts, although these are particularly important to this core plan.

Learning Disability Partnership Boards and Autism Partnership Boards

Successful communities based on Health and Wellbeing footprint areas and with flourishing Learning Disability Partnership Boards and Autism Partnership Boards will be the main drivers improving the quality of life for people with Learning Disabilities and Autism. The Transforming Care Board will recognise this root of equality and citizenship in communities and play a part in strengthening this where it can.

When people with Learning Disabilities presented as self –advocates and representing people with a Learning Disability telling it like it is about Annual Health Checks, the Health and Wellbeing Board listens and improvements were made.

Monitoring/Performance/Resources

The Transforming Care Board will monitor system wide performance in order to assure itself about appropriate system activity. (See Quality of Care and Quality of Life domains in Section 3).

It will not make resource decisions as this is not a part of its role and decision making depends on local and wider pooling decisions yet to be determined. Local Authority resources (including social care resources) and community assets far outweigh NHS resources for people with Learning Disabilities and autism.

One of the core ambitions is to reduce the numbers of in-patient beds commissioned and the monitoring of performance will support this, enabling the shift to more responsive and integrated community prevention. Including investment in community crisis aspects and increasingly effective and incentivised local provision. The 'Reduced Reliance on Inpatient Beds' domain, described on Page.19 of this document will help to measure progress towards these objectives.

The mechanisms for achieving cost and quality objectives are the model's structural elements and also cultural and practice change which will be encouraged by commissioners and also commissioned support services such as positive behaviour support. We think that the weight of the impact of change is as much about culture and practice as it is about structure. Interactions will be person centred, both within and between organisations. Monitoring will include these aspects and commissioning for outcomes will be a part.

We will seek to focus the Personal Health Budgets offer at first on Cohort 5 (The resettlement cohort, who have complex needs) whilst considering widening it to a single Learning Disability Offer across the Pan Essex area. We will also consider the feasibility of a wider integrated personal budgets offer which would

include health and social care and possibly widen to include other sector resources. Economies of scale across the area are likely to enable us to do this. Again, it can be a line of site and monitoring issue for the Transforming Care Partnership. (The TCP will seek to use its resources to learn from IPC pilots). Personalisation may also help to influence the wider use of community assets, bringing more non-public sector resources into the system. The monitoring of the development of personal budget and the strategic influence of the partnership are important to achieving effective change.

Model focus and interdependencies: Mental Health/Mainstream Services

More cost effective provision with quality improvements will be attained through effective provision of mental health services that are reasonably adjusted to meet the needs of people with a Learning Disability and Autism Spectrum Conditions. Whilst Mental Health services are outside this core model it is important that pathways available enable people to have the most appropriate care. Learning Disability specialist teams within the core model will be well placed to influence the development of reasonable adjustments in mainstream service although improvement should be generated by those areas without assistance, such is the expectation person centred responsiveness. Despite expectations people with Learning Disabilities and autism do not get the same access to provision that people without do, and this is where the Health Equalities framework is recognised by the Partnership as bringing a focus to the issues involved. An important component might be the addition of a new role which is the subject of a bid under Transforming Care: Learning Disability and Autism Learning Disabilities Nurse. This is essentially about influencing Mental Health provision to reasonably adjust (This is a role that is akin to the Learning Disabilities Acute Hospital Nurse, which have proven to be successful in achieving change in provision in the acute sector).

Aspects of integration with Mental Health services:

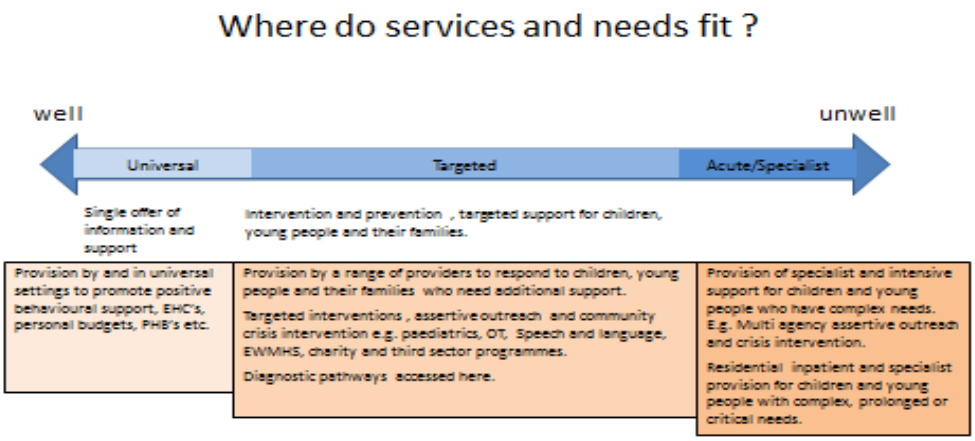
Reasonable adjustments are likely to take place in Mental Health Crisis Support and other mainstream services. There may be also be particular benefits from 'higher-level' Mental Health specialist expertise for people with Learning Disabilities which may presently be denied because they are only in less accessible Mental Health Services.. A potential example is that of Personal Disorder. With equal access to appropriate services quality and cost improvements may follow and local commissioners have begun to have these discussions. Gates and inappropriate criteria will need to be amended to allow this.

Model focus and interdependencies: Children and young people

The focus of the core model presented is the 5 cohorts in relation to Adults. However, links are made to potential activity along the life-cycle including children and young people. The Transforming Care Board knows that prevention for children and young people is a main factor in reducing behaviour that challenges and therefore will align activity where collaboration will do this.

The following provides a theoretical good practice model that has been developed by the childrens sub-group. This does not set out a target model at this stage, but rather provides a common baseline and a common language to ensure a focus on on the underlying, common principles which underpin should underpin models of care so that we have a common language to discuss and share best practice. The output from the reviews will be identified gaps and / or improvements at a local level that will be brought together across the partnership to identify and agree where and what will be progressed locally and reported to the Partnership Board and those areas where additional value will be derived through working together.

Example: Service Model Approach
Note: This does not take into account the existing service provision available across the region. Work will need to take place to carry out a full gaps analysis and identification of current pathways and positive practice **specifically for families and children with a LD, Autism, mental health and behaviours that challenge and who may also have physical and sensory needs.**



A) Universal Offer
Children and young people with complex needs will be identified at the earliest point and services working at a universal level will be respond appropriately by:
1. Providing appropriate support, information and advice
2.Listening to the views, wishes and feelings of the child and parent and young person
3. Ensuring that universal services will be accessible to children and young people with complex needs
4 Having local knowledge to signpost families and CYP to the appropriate services and opportunities within their own communities
5. Navigating and completing referrals with targeted services as indicated
6. Supporting opportunities to build a network of informal and formal support to reduce isolation
7.Enabling access to positive and personalised parental training and behavioural support building confidence, resilience and skills to manage behaviours that challenge
8. Ensuring the development of a co-ordinated programme of co-produced support.

B) Targeted Services
The services should offer transparent access for assessment and review, access to diagnostic pathways. Early intervention and targeted support should be available for all ages where required through a coordinated multi-agency approach including health, social care and education.

Health and Behaviour support – identified services should have a clear responsibility for assessing the causes of challenging behaviour and the development of behaviour support and risk stratification plan. This will include consideration of all factors which might affect behaviour that could include; developmental issues, sensory and physical needs including illness, relationships with others and factors in a child's environments. The objective is to work alongside the whole family and other carers to put the Behaviour Support Plan into practice in a consistent way. Training for universal services to ensure behaviour plans can be shared appropriately and followed would help to improve access and outcomes for CYP with complex needs.

When a child and young person presents with emerging mental health and psychological or behavioural distress, timely access to support services should be available. These could include Paediatrics, Occupational Therapy, Speech and Language and EWMH's Services, depending on needs and not reliant or waiting on a formal diagnosis to be made. Specific support networks and advice should be available for families in dealing with issues such as sleep, toileting and eating in order to provide them with the confidence, skills and support to maintain their family unit wherever possible.

The development of peer and support opportunities for families to establish a network of informal support can be crucial in minimising isolation and emotional distress. In addition to this direct support for individual families is the building of a wider community support network. This network will include opportunities through

working with community assets and voluntary organisations, to consider a range of issues such as sensory adaptations, equipment and spaces that can support inclusion and community engagement. This will promote a positive culture of equality and demonstrate inclusion at the earliest point for the young person.

Pre-School/School/College/Employment/Community support.
Early education and childcare pre-school groups**,** and services such as Portage can enable all those supporting learning and development to implement a consistent behaviour support plan within the educational setting. Children with complex needs may be identified through Early Support Programmes or Education Health and Care assessments and plans prior to school, to determine the most appropriate transition to education.

Education, Health and Care Plans ensure that the services and resources are developed though a family centred multi agency approach in co-production with the child/young person and parent/carer. The child's /young person's and their family's aspirations provide the focus with outcomes developed together. Information about Personal Budgets / PHBs is available to the family and young person to allow personalised solutions to a variety of issues.
A co-produced transition plan that supports the young person and their family to prepare for adulthood, inclusive of local education, employment, health needs and life choices. This is an ongoing process building on the support in place over time for the young person with a focus on their aspirations and desired outcomes.
Clear links with adult services to support complex family units to provide a holistic family support offer including other young people in the house hold who are considered as young carers or are impacted on by the environment.

C) SPECIALIST SERVICE
A small cohort of children and young people will require a level of specialist support due to the complexity of their needs and the challenges that these needs present. It is anticipated that with the appropriate provision of responsive targeted preventative support through an early intervention approach, the numbers accessing specialist provision will reduce, however for some, a specialist and intensive support offer may be required. These specialist services should at the outset always be seen as a crisis and short-term intervention to support a return to targeted rather than more specialist services.

These interventions may include

- Young people in need of specialist hospital provision CAMH's tier 4 currently funded by NHSE and are often in placements away from their local community and family.
- Young people who are on the autistic spectrum or have moderate to mild learning disability and who may have in addition, undisclosed mental health or substance issues and could find themselves at risk of offending and accessing young offender's institutions
- Young people who have behaviours that are difficult to manage in their family setting and who may find themselves in a specialist residential school away from their local community. For some of these children/young people the Local Authority may become the legal guardian. For some children/young people parents may agree to voluntary accommodation under S20 of the Children Act 1989, or the Local Authority may need to share Parental Responsibility via a Care Order under S31.

The availability of these and potentially other services Every effort to prevent long term institutionalisation should be taken through more targeted assertive outreach models and community crisis intervention.

The specialist offer

Multi agency assertive outreach team
To provide targeted coordinated support to the young person & family across MH, Autism and LD interventions, minimising the risk escalation and family breakdown and the use of institutional provision, to also develop the resettlement plan from institutional settings and provide transitional support.
Crisis intervention
Short term placements including family at critical risk of breakdown, targeted interventions for the young person and family intervention, court liaison and diversion, specialist foster placements. Continuity of care and treatment coordination is paramount – the judgement must to be to focus on specialist intervention into specific areas whilst maintain the continuity in other areas of life that remain stable – it is possible that wholesale change of care, housing, treatment and environment may further de-stabilise.
Critical Support
The provision of appropriate in patient support for young people with significant risks associated with their mental health, within a regional footprint, inclusive of the accessibility of young people who have autism and a learning disability.

Alignment with Children and Young People's pathways

The incidence of challenging behaviour throughout each stage of life will be influenced by the structure of provision and joint working approaches encouraged by the Children's and Families Act. This includes diagnosis and assessment and service provision.

Transforming Care will require, for children and young people. the early development of Care and Treatment Reviews (CTRs) next to Education, Health and Care Plans, and a clear strategy in relation to risk of behaviour that challenges. This means that where there is risk, an improved balance of Education, Health and Social Care services (including behaviour support services) should be developed to reduce that risk. More effective activity might relate to people in CAMHS Tier 4 and those in 52 week residential provision and CTR's will be a useful mechanism to achieve this. Pathways will be aligned to 'Preparing for Adulthood' which means for instance an alignment of roles of a range of providers, including to help people get jobs. The range contained in the 'local offer' for children and young people (in the context of the Children Act'), will continue to be enhanced.

In some areas, transition protocols will be better developed than in other areas (but all areas will seek development in accordance with the principles of effective Transition Planning in supporting documents for the Children's and Families Act.) This is again a 'line of sight' issue for the Transforming Care Board in relation to the activities of its partners and this line of sight will include the early years.

We have a number of bids that support and strengthen our approach for children and young people and which will help to reduce both 52 week residential school accommodation and therefore prevent children going on to hospital provision when they become adults.

These include:

- Children at risk prevention co-ordinators
- Behaviour support for children and families
- Children and families Learning Disability Community Services (Including assessment and diagnostics
- A shared capability for the delivery of CTRs, which include children and young people.

Model focus and interdependencies. Autism Spectrum Conditions including Aspergers

The models target is Learning Disabilities and autism. Autism covers a range of conditions including aspergers, which can be overlooked. We want to make sure that this does not happen in Pan Essex based on an equality and invest to save basis. To do this we have made a bid for all age diagnosis.

Model focus and interdependencies. Care Act developments with regard to prevention.

Alignment with Care Act developments:

An example directly relevant to people with Learning Disabilities and Autism is that of the provision of aids and adaptations enabling people to have independence in their own home potentially before behaviour that challenges arises. The width of this potential 'offer' relates to the local alignment of health and social care activity in relation to risk. Areas within 'Pan Essex' are developing this and again there should be a line of site of innovative approaches so that all areas might benefit. Aids and adaptations might also be commissioned by specialist teams to better meet needs and with less resources and allowing people to continue to live at home.

How the Model meets the needs of the 5 cohorts described in the template

We acknowledge that at present we do not know the numbers of individuals within each of the cohorts, adults or children, and therefore it is likely that more evidence, based on development of relevant data structures, within organisations, will be required as the programme progresses.

Areas will be differentially sighted on existing data categories such as high functioning autism/aspergers, which means that the Transforming Care Partnership Board will also be differentially sighted. We recognise across Pan Essex, a requirement to measure numbers in these cohorts to inform the specifics of the core model in relation to the vision, and to test the impact of our intervention in pathways.

In relation to each of the 5 cohorts

Cohort 1:
LD and Autism with MH

Adults: We will develop protocols between 'mainstream' mental health services and Learning Disability Services. This will enable allocation to services that will be in the best interests of the patient. The alignment of Mental Health and Learning Disability Services is critical to reducing behaviour that challenges as it gives a flexible person centred approach. All services, including Liaison and Diversion services will be sensitive to conditions and refer appropriately. The flexibility of services to respond, based on the persons centred need, indicates the required acknowledgement and flexibility within the present Pan-Essex Mental Health Review. (Again this is about lines of sight that enable the Transforming Care Board to influence the wider health economy in relation to this cohort.).

Children and young people: We plan to identify current practice in relation to Mental Health and Learning Disability services including through CAMHS tiers (Including Tier 4). Analysis of lifecycle trajectories may be required with best practice paediatric diagnosis and support. Again allocation to services depends on the best interests of the person and we will seek to influence this on a local and Pan Essex basis. Care and Treatment Reviews will also be applied to make sure that risk is dealt with. The Transforming Care Board will seek assurance for this.

Cohort 2:
LD and Autism:
Adults: These groups (LD and Autism Spectrum Conditions) are central to the core model. A significant causal element of behaviour that challenges (where mental health is not involved) is likely to be a lack of reasonable adjustments and a lack of positive behaviour support. Therefore system wide reasonable adjustments and the continuous improvement in all pathways, including appropriate training interventions are important for this group. The role of specialist nurses in influencing the wider system is key and their influence is recognised in the development of the core model. In addition the specialist teams, where integrated across health and social care will provide a better and more effective service. (This is a flexibility enabled by the model)
Children and young people: In many ways the actions for this Cohort are similar to those in Cohort 1. It is about achieving system wide early identification and achieving effective support in Education, Health and Care. Within the 18-25 year range there is scope in all areas for the closer alignment of services between children's and adult's services so that they are seamless. Reasonable adjustments should also be developed for children and young people.

Cohort 3:
Specific Risky Behaviour including fire starting and sexually inappropriate behaviour.

Adults: We consider that the development of expertise within Community Offender Services will help guide the support offered to individuals and provide an expert view of how risk can be mitigated in settings. Again this is part of the core model. A critical link will be those referred from the Criminal Justice System who might be subject to some form of specification for instance in relation to accommodation. Such a service will help provide the optimum response to such needs.

Children and young people: The Transforming Care Partnership Board would need to develop a clear understanding of provision in relation to the development of risky behaviour through the lifecycle. We may consider commissioning the development of relevant expertise within the Community Offender Service but would need first to consider existing engagement structures through Youth Offending Teams. (YOTs). We do consider that local pathway integration in relation the early years is critical to preventing problems before they become worse. These aspects are already being tackled locally.

Cohort 4:
Low level risky behaviour often by those not known to services

Adults: Implementation of the core model and community wide reasonable adjustments will help prevent behaviour that challenges. Reasonable adjustments are the subject of both the Learning Disability Partnership Board and of local responses to 'Think Autism', in the context of Autism Partnership Boards and their fulfilment of the expectation in relevant I Statements. It is also important that preventative approaches and pathways in relation to the Care Act given access to relevant support.

A main point of entry into services for people whose behaviour challenges is through low level offending via Local liaison and Diversion schemes (which already exists in South Essex as one of 10 'Bradley Report' pilots). We envisage developing closer relationships between services and the Community Offending Service may play a part in this. This will prevent further escalation within the Criminal Justice System, including to secure services.

Children and young people: Intervention from the early years are particularly important for this cohort. Existing and future targeted interventions are important in relation to troubled families, who may have children at risk/in this cohort. This requires whole systems responses from an early age. The context, including deprivation and the social determinants of health are particularly important for those with mild learning disabilities and autism, as causal factor and improving local environments is already the thrust of local area policies, overseen by Health and Wellbeing Boards.

Cohort 5:
Resettlement

This is primarily relevant to Adults and is about the development of innovative housing/accommodation and

effective resettlement and discharge processes. It relates to those being discharged through the CTR processes and perhaps to some of the local authority out of area placements who might benefit from joint provision.

In relation to this cohort we aim to commission a new accommodation offer of 16 units across Pan Essex. To achieve the balance of risk sustainability and choice, and we are making a bid as part of Transforming Care to do this. We are seeking capital to invest to develop a sustainable model with Housing Associations, which would enable the setting of competitively attractive (for providers) and affordable rents (for consumers) on a supported living basis to achieve this. We think that the offer will likely be attractive for people in this cohort and other cohorts such as those placed out of the area and are therefore likely to be sustainable. The accommodation offer would meet the needs of people with Learning Disabilities, Autism and those with Challenging Behaviour. (Making the bid is also about recognising the difficult market conditions for the housing market).

4.2 What new services will you commission?

Community forensic services

Community forensic Services will be focused on enabling both resettlement of the in-patient cohort that require case managed forensic support in the community, whilst also providing the same case management for those who need it who are already living in the community.

There is no provision within the Pan Essex area for this. It is important that these services relate to the 5 Challenging Behaviour Cohorts and that service interfaces and pathways are designed with this in mind. There are interface requirements for all cohorts but particularly for:

- Cohort 4 (Where people might not be known to services)
- Cohort 3 (Where expertise and input is required for specifically risk and offending behaviour such as sexually inappropriate behaviour).

The ambition is to implement an interim service, which will form part of the future procured services through the planned process through 2017.

Interfaces, roles and pathways

We will consider how we can make sure that pathways are effective and that roles are clearly defined with regard to specialist LD services and the Commuity Forensics service. Early research to understand the models and the parameters of this development is required. There are likely to be new challenges and referral patterns in relation to the existing Liaison and Diversion services (at all levels: Police Station; Courts and Prison), from the Criminal Justice System. Getting these linkages right is critical in preventing escalation within the Criminal Justice System and the potential high level cross over to secure units. These linkages also present a critical element where the appropriate reasonable adjustments and training are required to ensure that communication and responses are appropriate to the understanding and communication of individuals.

Supported living and residential services

- Local supported living and residential services will reduce behaviour that challenges and be incentivised to do so through effective local and system wide commissioning. This requires closer and focused commissioning around a clear concept of risk and behaviour that challenges. It also requires the development of greater local networking between providers to access available support. This local organic market development of mutual provider support is a key part of our plans because it may foster innovative local approaches between providers and networks of interest.

  Particular emphasis will be given to the practices recommended in 'Ensuring Quality Services', which emphasis positive behaviour support. Organisations will be encouraged to become learning organisations and encouraged further to meet some of the targets described in the Learning Disabilities Self-Assessment Framework.

  In addition, in geographical areas where this is necessary, specialist challenging behaviour services will be commissioned, and effective networks between providers developed, including with Specialist

Learning Disabilities described below. (These are often the subject of Framework Agreements).

Market analysis and emerging market positions statements across the Partnership will on the back of the Care Act drive transformation across residential provision with a changed emphasis on ordinary residence. The partnership broadly has historically been a net importer of people with social care needs. 'Repatriation' of people as planned might increase the number of beds available in the short term which could be used for other functions such as crisis / intermediate beds (which are recognised within the model).

These market adjustments are part of the commissioning landscape which local commissioners could make use of and the Transforming Care Partnership Board would have a line of sight of in order to plan for such facilities where they have Pan Essex relevance.

Specialist Learning Disability Health Services

- Existing specialist health services will place more emphasis on preventing escalation to inpatient services, including Assessment and Treatment. They will be encouraged further to support person centred prevention in the local network of providers, including Supported Living Provider and Residential Providers. They will be incentivised to do this progressively to enable an increasing shift to community based provision, potentially changing the structure of those services if it increasingly achieves the outcomes that people desire.

  The Transforming Care Partnership Board and the unity of commissioning messages brings with it the critical advantage of clear and structured messages to providers. This will be enhanced by a well-structured single contract. (Also a specification in our model)

  Local development will differ, dependent on achieving the best outcomes for adults with Learning Disabilities. For instance: Community Teams for People with Learning Disabilities teams will change in relation to their composition across health and social care depending on local ambitions and opportunities for enhanced collaboration across health and social care. Teams and communities work best and achieve better outcomes where people know each other. Health and Wellbeing Board provide the context for this to happen.

  These teams will also respond flexibly to people's needs wherever they live.

Crisis Support

Whilst there is a limited crisis support service now, this should be strengthened, with a clearer specification around the mutually reinforcing roles of:

- Crisis response. Which responds quickly to a crisis and refers urgently to appropriate settings.
- Assertive outreach. Which stabilise the environment and context that minimises the escalation of behaviour that challenges.

Crisis Support is a service that will be available 24/7. It will prevent escalation and enable more people to remain in the place they live. This function is critical to reduce the demand for inpatient beds and also includes the provision of Crash Pads (and short and medium term accommodation) enabling an effective short term stay so that issues can be resolved. These will be clearly differentiated from Assessment and Treatment services, which will have a clear assessment and treatment function. The existence of 'Crash Pads' also enables a more appropriate focus of Assessment and Treatment. Some people who will benefit from this accommodation will be detained under the mental health act, but again they should be suitable for people with different condition including autism and behaviour that challenges.

These services will network effectively with supported living and residential care providers and other settings to make sure that support offered is timely and effective. This aspect of service is akin the development of positive behaviour support, which exists as a service to improve capacity. (See below).

Assessment and Treatment
A more focused service looking to provide a short term intervention, focused on the assessment and the treatment, alongside discharge planning and clarity of target process and timeframes for the return to the community setting.

Resettlement options
The development of these services relates specifically to Cohort (5). These are individuals who have been in inpatient services and may find it difficult to settle into other options and which is described above. Appropriate support provision will be available such as support from Community Offender Services where required and the wider model enables this.
Resettlement is a process that is underway so it is important that we understand what best supports people. However we can make no easy assumptions about groups – the best support is always person centred.

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

There is agreement that success will include commissioning fewer high cost/high dependency beds, based upon investment into the right resettlement options and the right community capability. To achieve the new model will require

- A reduction in high, medium and low secure accommodation. These are presently commissioned by NHS England. Although the national target indicated a potential increase in these beds for the Pan-Essex area, we think that are model and approach with local innovation and support will enable us to reduce this costly bed based.
- A reduction in CCG commissioned inpatient beds (from the independent sector) potentially matched by changes in the function of those beds, to relate more to local communities. A reduction in CCG beds is signalled as a target in Building the Right Support for 'Pan Essex' and we envisage a potential change in function of these beds.
- A potential reduction in Assessment and Treatment beds which are likely to be centralised on a Pan-Essex basis and under a single contract.

The Partnership board is resolved to move to a single specialist LD health provider. At this stage, the exact scope and sets of services to be procured are undecided, but the expectation is that this will provide some economies, in moving from three current providers across the partnership to a single one. This procurement may also provide an opportunity to sharpen the nature of the relationship between the current assessment and treatment provision and the broader range of mainly spot purchased rehabilitation placements as well as those placements requiring higher levels of secure accommodation that are commissioned by specialist commissioning. There may be opportunities to make greater use of the range of expertise required across the five cohorts and these various in-patient settings to assure more rigorous application of a three-step process of assessment, treatment and discharge planning.

Success will also require improved prevention to identify those at risk and provide the right community capability to better manage behaviours that would otherwise escalate into the need for in-patient settings. This is particularly important with regards to the approach, support and care offered to children and their families. More defined proposals will emerge as the childrens sub-group complete their initial assessment and recommendations. With regards to children, the ambition would be that 52 week placements are a last resort for these and indeed all cohorts; the ambition is to also ensure reductions in the numbers of these placements that made out of the area.

The ambition is to ensure a move away from homogenous services towards support and capacity that is more personalised and tailored to the ambitions and expectations of consumers. Broader application of personal and personal health budgets will itself start to drive investment into valued and beneficial services and support, stimulating and driving the market. Over time, the ambition is to have better insight, both internally to commissioners and transparently to the market and consumers, of those services that are valued by the communities they serve and that make a difference. Over time commissioning will be towards those services that work and hence those that have no evidence base for better outcomes can be de-commissioned.

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

Independent hospitals

Independent hospitals will be encouraged to make more direct community links and more emphasis will placed on a pathways that achieve rapid and supported discharge. This is dependent on the systems elements described above which support people in the community. It is essential that the independent sector as a whole considers the likelihood of a reduction in the overall bed base. Commissioners, should monitor the outcomes of different pathways and their cost and quality implications. This may change the required bed base to shift towards, Short and Medium Term Beds specified in the model. Other aspect such as the Care Act, in terms of Ordinary Residence Status and Commissioning Responsibility will increasingly emphasise locality and community, changing the relationship between capacity and utilisation possibly lowering the price of a stay.

LD Specialist Health

There are two key changes envisaged

- Firstly, as mentioned in the previous section, a move towards crises response within communities rather than in-patient settings
- Secondly, that there will be closer working between health and social care operations at a local level. A move towards multi-disciplinary teams at a local level to support seamless pathways, shared visibility of those at risk and ability to utilise the most appropriate resources for care management with different cases.

Commissioning Medium and Low Secure provision

From April 2016, the commissioning of medium and low secure provision will pass to the CCGs from NHS England. This will create new commissioning challenges but new opportunities for service development and innovation. It will create new possibilities and the development of new pathways. Our developing model will need to take account of this, particularly as it will change the quantum of resources to be deployed locally and which the Transforming Care Board will have a clear line of sight of. This new responsibility will need a set of metrics aligned to local community systems. There are many potential alignments including with the Criminal Justice System. (This will put an emphasis on ongoing system design as part of the developing programme).

Preparing for Adulthood

Although the childrens sub-group have not yet defined plans for what will change, there is a recognition of the need for greater proactivity in preparing for adulthood. This does not mean increased investment, but demands sharpening of the transition protocols and the need for Adult services to reach into earlier support and planning with young people as they move through adolescence. Preparing for adulthood should again be an integrated set of engagements and interventions, that build upon aspirations and ambitions for the young person, but that also take a holistic view of housing, health and care and that make the greatest use possible of mainstream services.

Mainstream provision

A fundamental ambition is to help develop the health and social care workforce particularly in mainstream to be able to make reasonable adjustments for people with a Learning Disability (recognising that there will be pockets of excellence). The ongoing development of the whole workforce help to ensure the continuity of practice whatever the specifics of organisational structure that exist and enables flexibility and person centred approaches.

Positive Behaviour Support

Positive Behaviour Support is the provision of a service that helps to achieve good outcomes because it works with people's strengths and seeks to encourage, and is not punitive. It is included here, as it is a component option/support for service provision. However, the development of positive behaviour support

does not require a service in all geographical areas but will require all services to apply its principles, which for some might be a change. The principles and relevant interventions relate to the whole lifecycle. (See the NHS England publication 'Ensuring Quality Services').

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

Guidance notes; Areas should look to set out, how their reforms will encourage the uptake of and what year on year progress they expect to make in:

- *Personal budgets (including direct payments)*
- *Personal Health Budgets*
- *Where appropriate, integrated budgets*

It should be noted that children and young people with a learning disability who are eligible for an Education, Health and Care plan should also be considered for a personal health budget, particularly for those in transition and those in 52-week placements.
This process aligns with the 'local offer' areas are developing for personal health budgets and integrated personal commissioning (combining health and social care) in March.

A pathway is already in place and embedded in the Continuing Care and Continuing Healthcare services, and work is on-going to increase the uptake of PHBs by the people eligible for this funding across all CCGs. The TCP Board has also approved the proposal for an initial PHB offer that delivers the same offer for an identified cohort of people and this has subsequently also been formally approved through the sovereign CCG boards. This represents a significant step forward in agreeing a single offer.

Furthermore, this approach is not only approval of the scope of the PHB offer, but more importantly addresses the complexities about the support and implementation and it was agreed that there needs to be a single oversight, management and coordination function across the partnership.

The oversight of the implementation will be managed by the Individual Placement Team (IPT) that is a shared function. The scope of the PHB offer is focused on those people who are looking to be resettled out of long-term in-patient settings; this provides the greatest opportunity for take-up as these people were placed usually into those placements by IPT who also support the resettlement process and hence provide the interface with the service user.

The proposal is for this initial offer to be made to people who are currently receiving their service via the Individual Placement Team with a view to scaling up the approach once the learning from this has been disseminated and work has been done within the provider market.
This proposal has been developed in light of the opportunity presented by the spot purchasing arrangements and knowledge of people who it is felt would benefit from a PHB and are at appropriate stages in their individual journeys for the introduction of a PHB not to be disruptive. It also helps address the need to personalise the approach for people with some of the most complex needs with learning to be gained from how this can then be used to help others with similar needs gain greater control over their lives and planning of their support.
In addition to this, work is being planned for how the existing provider market will be supported to understand the personalisation agenda and how they can move to being able to offer PHBs within their services. This approach recognises that the current Specialist Healthcare provision is block funded, and although beginning to develop the processes for personalisation (eg building a costed menu of services/health outcomes) can be undertaken through the use of contractual incentives within existing contracts, more significant progress can best be achieved through the re-commissioning of the provision which is underway.
It is anticipated that this re-commissioning of Specialist Healthcare provision will also enable the development of Integrated PBs in line with the ambition of the wider Pan-Essex programme of work to have one plan and one budget per person. This will then be available to people who do not fall within the cohorts of Transforming Care, but for whom this degree of choice and control is important to deliver.

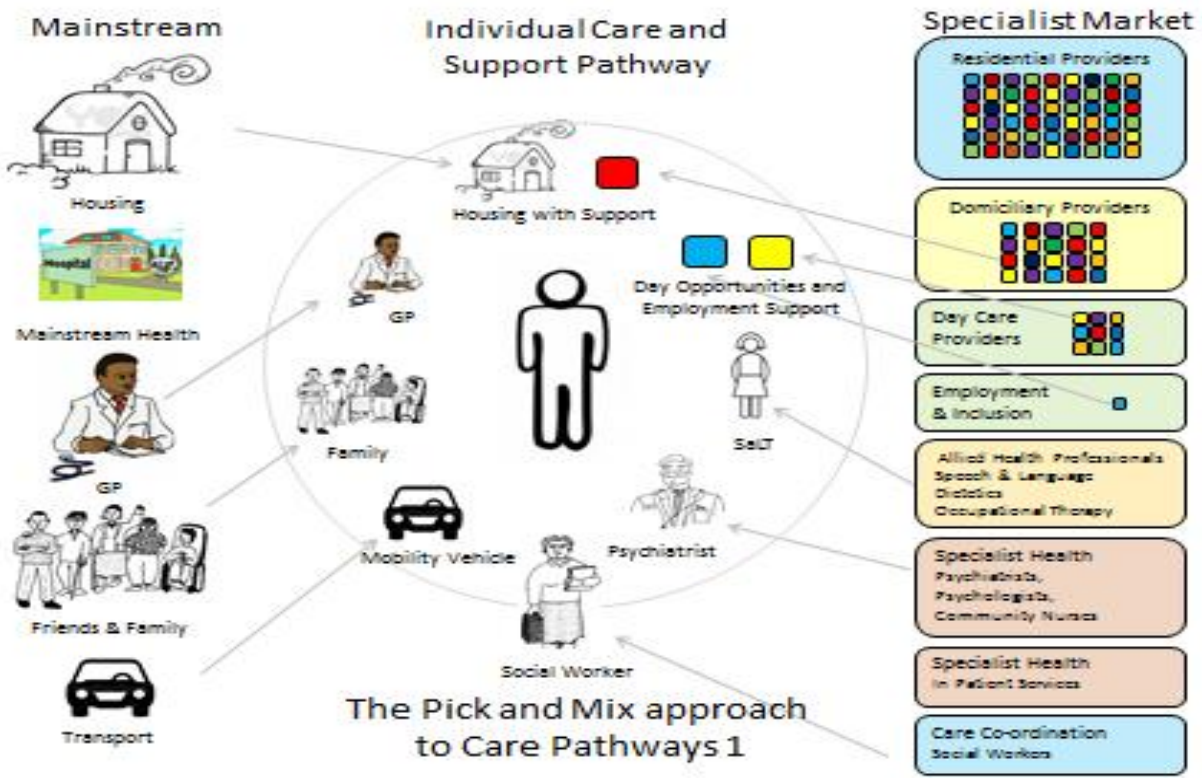
4.6 What will care pathways look like?

Guidance notes; Consider planned, proactive and co-ordinated care.

Two of the key attributes of care pathways will be that they will be

- co-ordinated to avoid delays and ensure seamless experiences; and
- "pulled" by the needs of users rather than "pushed" by providers.

The following diagram provides an overview of how it is envisaged that this might work – where the care co-ordination ensures that the right blend of services and support are available wrapped around individuals and their families within their communities. It is the clarity of the responsibility for the role of care co-ordination that is critical, alongside services that are responsive, that rely upon risk of escalation rather than threshold and that can be flexibly delivered into community and care placements.



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

Guidance notes; Consider what will be different for children and young people going through transition, including those in 52-week placements.

It is acknowledged by the Partnership that the existing arrangements for transition are not adequate. The system can sometimes become pre-occupied on the complexity from a financial and organisation perspective of transitioning the budget from "childrens" to adult "services"; Consequently, many young people and their families find that at a crucial point in time they are left with no or very little community support and a lack of continuity of care. The shift towards personal budgets and personal health budgets and the language of preparation for adulthood is helpful in ensuring a focus on the experience and lifelong implication on the individual. The partnership is fully committed to improving the transition process to ensure improved quality of care and to reduce the risk of disengagement with services.

During 2016/17 the partnership will review existing transition protocols in each locality and shift the emphasis to the focus on preparing for adulthood; from a partnership perspective it will demand common principles to avoid the need for those services commissioned at scale to have different pathways and rules at different Local Authority levels. It is not envisaged there will be a single protocol, but there will be close

working to share best practice; the protocols will address amongst others the following groups of vulnerable young people;

- Children looked after
- Care leavers
- Young people entering or leaving inpatient care
- Young people entering or leaving prison
- Young offenders
- Young people with neurodevelopmental disorders
- Children subject to a protection plan or a Child in Need
- Children receiving education in a 52 week residential setting.

The protocol will include the following key principles;

- Planning must commence at least 6 months prior to a young person turning 18.
- Planning for a young person with severe learning disability should be considered from 14
- Each young person will have a formal transition plan developed with their involvement
- Planning must be multi agency
- Plan must identify alternatives to statutory services if a young person falls below the threshold for adult services
- Plans will include the arrangements for follow up and monitoring of those leaving services.

Many of the children at risk of developing Challenging Behaviours, either as a child or adulthood, are known to multiple agencies and the recognition of this "shared customer" at the critical transition stage will drive improvements in care co-ordination, care planning and joined-up delivery.

4.8 How will you commission services differently?

Guidance notes; Include new arrangements for, where appropriate, aligning or pooling budgets, changes as to how commissioning arrangements will change e.g. exploring capitated budgets with providers in the area

Across the partnership there are a range of established and developing integrated commissioning arrangements between social care and health at the local level. The expectation is that at a local level these will continue to become more robust, build increasing trust between the local partners and move to making pooled investment decisions to deliver better health and social outcomes for their communities. Integrated local oversight and local operational commissioning, alongside improved visibility and better understanding of the most appropriate resources to provide care co-ordination will remain critical at a local level.

At a shared and strategic level, there are also a range of existing shared contractual and strategic commissioning arrangements between all partners; in particular for example, all partners have recently procured a transformed service for CAHMS with shared contractual and reporting mechanisms in place and working well. Even more importantly, the CCG partners already jointly fund the Individual Placement Team whose role is increasing given the responsibility to oversee the implementation of the new PHB offer. The interface between IPT and the separate integrated commissioning arrangements locally requires further clarification. Similarly, the options for how to best interface and work alongside Specialist Commissioning remain unclear and unresolved and should offer the opportunity to ensure that greatest use is made of community- based health and care professionals to increase the skills and success at maintaining people within a community based setting.

Historically, the partnership has had a range of contracts and integrated commissioning with associated risk-share arrangements split between North and South Essex. There is agreement between partners that this no longer has any relevance for this cohort. The plan is that these and other existing models across the partnership will be reviewed to identify the most appropriate arrangements both locally and across the Partnership – the ambition is to agree these arrangements for April 2017, but recognising that some will happen more quickly than others.

The agreed move towards a single LD specialist Health provider and a shared model for the critical and

crises response elements of support for these cohorts presents significant challenges to the partnership. In particular understanding and clearly establishing the benefit of what is currently perceived to be differing levels of investment between the North and South. There is increased confidence that this transparent understanding of current expenditure will be completed in the next 3 months. At this stage the methodology for evaluating the benefits of differing levels of investment has not been agreed, but is critical to build the agreed business case for the necessary shared investments. A number of the bids for transformation funding through the TC programme will deliver new capability funded externally (with matched funding) that will provide an excellent opportunity to demonstrate the benefits to all partners of these new service offers.

In terms of pooled or aligned budgets there are also a range of existing examples across the partnership - both across the CCGs and also increasingly some successful examples of pooled budgets between health and social care locally; again CAHMS demonstrates an agreed risk-share between all 10 partners. The ambition for the partnership over the next 2 years is to pool budgets locally and bring these pooled arrangements together to procure a single provider of LD specialist health. The partnership is very encouraged by the ambition expressed by NHS England that the current function for specialist commissioning will also become a pooled responsibility between partners – recognising that there will be no funding related to the placements budgets.

The challenges to agree the share of the necessary investments and the approach to sharing the risks and rewards of these investments at both local and partnership level will be significant. However there is recognition and ambition across the partnership to incrementally address these opportunities for larger-scale procurement and pooling funding locally (and where it makes sense across the partnership) to address the health and social care needs of the cohorts. For service users their health and independence are inextricably linked and it is recognised by the partnership particularly at a time of strained budgets that traditional silo-based funding does not provide the right flexibility and person-centred response that delivers demonstrably improved outcomes and experiences.

Whilst an option to move to capitated budgets has been discussed and the merits recognised, particularly for the adult rather than child and young person cohort, there is no plan at this stage to engage with the market on this basis through any imminent procurement process.

Finally, the arrangements for integrated commissioning around children are recognised as more complex, but also in need of resolution. There are no plans for the timeframe within which these may be resolved at a local level; over the next 3-6 months these discussions alongside schools and special schools will start to play out the implications and opportunities.

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

Guidance notes: This should differentiate between the need for new capital investment and any potential recycled capital receipts (subject to approval) from the sale of unused or unsuitable property held under existing NHS capital grant agreements and/or associated legal charges. Set out the future accommodation requirements for children transitioning to adults if appropriate.

The first changes that will be delivered will be through the proposed capital bids for transformation funding. These will provide some crises housing accommodation – this approach will provide some emergency local / community options that provide the appropriate response without having to resort to inpatient settings. The intention is to deliver this earlier in the models development whilst the planning still requires formulation with key partnerships including people who have experience of needing crisis resources and the local area foot prints for accessibility.

The ambition is for this to “pump prime” and stimulate the market to recognise the need for broader flexibility and variety in the range of housing options available. This is about flexible use of community resources that can respond to individuals changing needs which may be aligned with the local housing stock with the joint investment across health and social care potentially using existing capital receipts where appropriate or capital investment

The other sets of changes relate to the right support for transitional arrangements for young people returning home from out of area and separately those resettling our intention is that we will have non hospital settings

that will enable the assessment of needs and skills in an outcome focuses way that will provide the required transitional support and enable the development of independent living skills. The investment and use of capital is still to be determined.

Indicatively, the aspiration is to deliver in excess of 350 new housing units to address the shortage of suitable units across the county for people with learning disabilities generally. The demand for specialist housing is driven by more than 260 people each year (in two distinct groups; those aged between 18 years to 24 years and the over 45's who have previously lived with their parents), who now seek help from the Council. Some of these are people with complex challenging behaviours for whom the planned new schemes can provide appropriate accommodation.
However there are a small number of people with the most complex needs, often as a result of prolonged hospital stays or multiple placement breakdowns, who need bespoke accommodation solutions. In these cases individualised solutions are developed based on comprehensive person centred support planning including environmental considerations. Plans to date for some of the people identified within the Resettlement Cohort include the purchase of adjoining properties to facilitate conversion of one into a single occupancy unit, and building from scratch on purchased or available land.

The bids made through this plan will provide some pump priming capability, but a very small percentage of the required investments. The evidence demonstrates that the current expectations

4.10 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?

The proposed bid for TC funds nationally will, if the bid is successful, deliver additional capacity role and additional expertise to help drive improvements in resettlement. It is an example of a critical interface between the locality / community (where someone will be resettled) and the management of that process given that it will start from a placement that was commissioned and placed through a shared capability. It is recognised that the interface in particular between Specialist Commissioning and local health and care commissioners offers significant opportunity to bring increased clarity with respect to the more detailed care co-ordination that is necessary to deliver successful resettlement.

Similarly from a childrens perspective greater focus is required on the planned resettlement for those in a 5 week residential school placement to plan for the resettlement into what is essentially a new community. Even those in a 38 week local boarding placement will benefit from specific planning.

The challenges are not insignificant across these in-patient and residential resettlements in moving from an institution (back) into a community, but there is a shared recognition of these issues, including the following

- Transition: challenge of inpatient and community provision and culture clash. This had led to mistrust and resistance/defensiveness
- Housing – void underwriting. Funders are not necessarily willing to underwrite the risk that a placement in the community fails leaving providers with empty properties.
- Housing benefit thresholds and ceiling may not meet high rent costs in some areas
- Availability of suitable properties, especially where adaptations/special requirement are needs which might include proximity to neighbours, ramps etc., suitability for conversion
- The need for large properties to take into account the need for carer to be able to have office and sleeping space
- Duplication/double funding during transition period
- MHA Tribunal processes in conflict with CTR outcomes.
- Responsible commissioner guidance and incentives to place out of area.
- Patient willingness to move/or otherwise
- Expectations of patient and family in relation to above
- Availability of section 117 aftercare plans.

At this stage, the solutions and even the plan to resolve these problems is unclear. Further conversation

with Specialist Commissioning is necessary.

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

Guidance notes; How does it fit with:

- *Local Transformation Plans for Children and Young People's Health and Wellbeing*
- *Local action plans under the Mental Health Crisis Concordat*
- *The 'local offer' for personal health budgets, and Integrated Personal Commissioning (combining health and social care)*
- *Work to implement the Autism Act 2009 and recently refreshed statutory guidance*
- *The roll out of education, health and care plans*

Alignment with these and indeed other key priority agendas is essential in formulating and delivering a sustainable, joined up approach in local areas. In order to maintain oversight of the alignment of how such key agendas are embedded within the Transforming Care Plan each local area will maintain its accountability to the agendas, with assurance provided to the Transforming Care Board.

Fit with local transformation plans for children and young peoples' health and well being

The ambition detailed throughout this transformation plan is completely aligned to **'Open Up, Reach Out"** – the transformation plan for the emotional wellbeing and mental health of children and young people in Southend, Essex and Thurrock. Both plans cover the same geographical footprint and have been developed by the same constituent partners i.e. 7 CCGs and 3 local authorities. Partners have also ensured cross representation on the governance structures for both strategic planning workstreams.

National evidence suggests that children with learning disabilities are up to 6 times more likely to have mental health problems than other children and more than 40% of families with children with learning disabilities feel that they do not receive sufficient help from services. The JSNA for children's emotional wellbeing and mental health identified children with learning disabilities and difficulties, developmental disorders and children in special schools as one of four main groups of children with a greater risk of developing mental health problems.

Key service gaps identified in 'Open Up, Reach Out" included:

- Behaviour management, notably help to manage violent behaviour at home
- Services for children with learning disabilities
- Lack of clear pathways for autistic spectrum disorders and ADHD
- Limited services for children with development disorders

The childrens sub-group has initiated reviews across all three Local Authority areas, based upon the three tier, universal, targeted and special service model outlined. A key focus is the alignment of this universal local offer and the alignment with Education, Health and Care plans and referral pathways through schools, childrens centres, health visitors and other available community based services. At differing ages, there is also a requirement for different nature of parental support (the parent of a 16 year old needs different support from the parent of a 3 year old).

Fit with local action plans under the Mental Health Crisis Concordat

Mental Health is recognised across the Transforming Care partnership to be a key priority. It is recognised that people on the autistic spectrum have increased likelihood of episodes of mental distress and that all too often mental and emotional wellbeing of people with a learning disability can be missed.

The Transforming Care plan identifies with the range of work currently underway that supports the mental wellbeing and the appropriate support in the provision of manging mental health and treatment.

Pan Essex Partnership approach
The Police & Crime Commissioners' office led by Morris Mason the Assistant Chief Constable Essex Police, in collaboration with the safeguarding hub; coordinate the Pan Essex development and implementation of the Concordat. Through this forum the agreement was to have three action plans in the region namely North Essex, South West Essex and South East Essex.
The implementation deliverables under this mandate are:

- Improve baseline and demographic data
- Undertake a training needs audit
- Enhance partner agency communication and information sharing
- Commission robustly to allow earlier intervention and responsive crisis services
- Promote access to support before the crisis point
- Facilitate urgent and emergency access to care
- Enhance quality of treatment and care when in crisis
- Ensure Recovery and staying well preventing future crisis

The partners are undertaking abroad and far-reaching review of Mental Health provision and support across the area. This provides the unique opportunity to review the current Mental Health Crisis Concordats, within which the recognition of the need to include people on the autistic spectrum and a learning disability in minimising the escalation of crisis through the appropriate approach and management of the partnership includes training. This also relates to the implementation of the Autism Strategy and Guidance in building awareness and embedding reasonable adjustments, this is particularly pertinent of the appropriate approaches during periods of distress (overwhelmed) minimising inappropriate contact with the police, Criminal Justice system and mental health services. Three groups across Pan Essex are progressing to evidence the delivery of the Crisis Care Concordat mandate to include:

- All action plans will be updated to reflect clear protocols for people with Learning Disabilities
- Any service review will undertake a comprehensive EQIA to ensure that people with Learning Disabilities have equitable and appropriate access to service
- Public facing first response agencies e.g. the police and other partners have adequate training or apply the guidance on responding to people with mental ill health or learning disabilities to minimise inappropriate or disproportionate use of the Mental Health Act.
- Explore commissioning of crisis houses and other intermediate care to provide intensive support when needed and minimise need for hospital admission as a default position
- Crisis plans for people with Learning Disabilities that define early warning signs and clear coping strategies

Where an assessment of the persons mental health is at a crisis point currently there is not a 24/7 provision and consideration of the review of the Crisis Home Treatment Team in Mental Health could be extended to urgent crisis assessment people with a learning disability with the appropriate skill base.

The Partnership are currently reviewing mental health services which also provides an ideal opportunity to review and reinforce the Greenlight tool kit and the requirements of the Autism Statutory guidance in making reasonable adjustments to enable equal access to mainstream mental health services where, reducing the risk of specialised commissioning of autism provision due to a lack of local appropriate support.

Within the forming service model and the associated bids a key focus has been focused on the prevention of crisis and crisis support within the community.
We recognise that there are thresholds of risk and crisis and therefore providing a range of approaches in a community setting that is right for the individual in a timely manner we believe will prevent escalating need through a personalised responsive approach for example assertive outreach, behavioural support and 'crash pads' that individuals could access or where appropriate families could access to provide the intervention required within the home, previously residential, respite or hospital settings would be used.

<u>Considerations for the Essex implementation plans</u>

As the three working groups progress work to evidence delivery of the Crisis Care Concordat mandate:

- All action plans will be updated to reflect clear protocols for people with Learning Disabilities
- Any service review will undertake a comprehensive EQIA to ensure that people with Learning

Disabilities have equitable and appropriate access to service

- Public facing first response agencies e.g. the police and other partners have adequate training or apply the guidance on responding to people with mental ill health or learning disabilities to minimise inappropriate or disproportionate use of the Mental Health Act.
- Explore commissioning of crisis houses and other intermediate care to provide intensive support when needed and minimise need for hospital admission as a default position
- Crisis plans for people with Learning Disabilities that define early warning signs and clear coping strategies.

Fit with the 'local offer' for personal health budgets, and Integrated Personal Commissioning (combining health and social care)

The Partnership has agreed that the initial local offer for budgets for Integrated Personal Commissioning will be a uniform offer across Essex. This is under development and will be decided and communicated to service users by the end of March. In the first instance this may be a limited cohort that will receive the opportunity at the outset, but the final plans will identify the timescale for this to be extended and rolled out across increasing numbers of service users.

At this stage, the proposal is to bring specific focus to facilitate the transition of people in hospital to the Community in a person-centred way including the use of personal health budgets and where appropriate integrated personal budgets.
There may also be an opportunity to bring a similar focus for children and young people during transition either into Adults or from health into a care setting.

Fit with Autism Act 09, Autism Strategy and Statutory Guidance 2015

The partnership is committed to the inclusion of all the cohorts identified within Transforming Care and will ensure that the future service model and any service provision is autism appropriate across the spectrum where appropriate and as such autism is mentioned within the alignment of all the aligned plans

Key to our governance arrangements is the alignment with the local area partnership boards and autism partnership boards. As previously mentioned working with the local partnerships is key to supporting the effective implementation of the autism strategy.

Our ambition is to enable people with autism to have a fulfilling and rewarding life accessing the appropriate support that is meaningful and preventative. Key to this is ensuring that assessors are trained and are able to make the reasonable adjustments required throughout the process from first contact.

In addition the development of accessible Autism Diagnostic Pathways across children's and adults is an area we are exploring in partnership with the local areas to consider how this could be coproduced and locally applied.

The forming service model will have further engagement inclusive of people on the autistic spectrum.
The bids in particular the resettlement and the risk of offending community service teams are envisaged to include a specific emphasis on the understanding of risk and approaches in working with people who have a history of offending and are high in the functioning autism spectrum.

Fit to the roll out of education, health and care plans

Each local partnership is embedding the transition from Statements to EHC Plans. Transforming Care has a specific focus on the defined cohorts and this will provide an opportunity to target review and drive further progress in EHC implementation.
For children's services the undertaking of EHC plans and the alignment with Transforming Care is recognised as a priority. Particularly in considering the appropriate support required in order to minimise the risk of breakdown at school, college, exclusion and the provision of the right support locally and minimising the requirement for residential schools or school away from their community, inclusive of those young

people and children on the autistic spectrum.

There is recognition by all partners and organisations of the need for a focus on transition (and lifelong planning) with the commitment to ensuring the effective transition for all young people. This includes a very specific and high-risk specific focus on those young people who are placed in residential schools and in patient settings to receive the appropriate targeted support to enable their resettlement back into their local community; inclusive of the identification of appropriate support and funding inclusive of the provision of personal health budgets.

Each locality is currently reviewing their governance to ensure that there is appropriate line of sight and collaborative working across children and adults in order to ensure that both agendas are effectively aligned.

Included in the proposed areas for transformation is a need for greater capacity around CTRs children in hospital settings. This provides an opportunity to ensure renewed focus on seeking to support the undertaking of CTRs for including the alignment with EHC in the bids.

Any additional information

5.Delivery

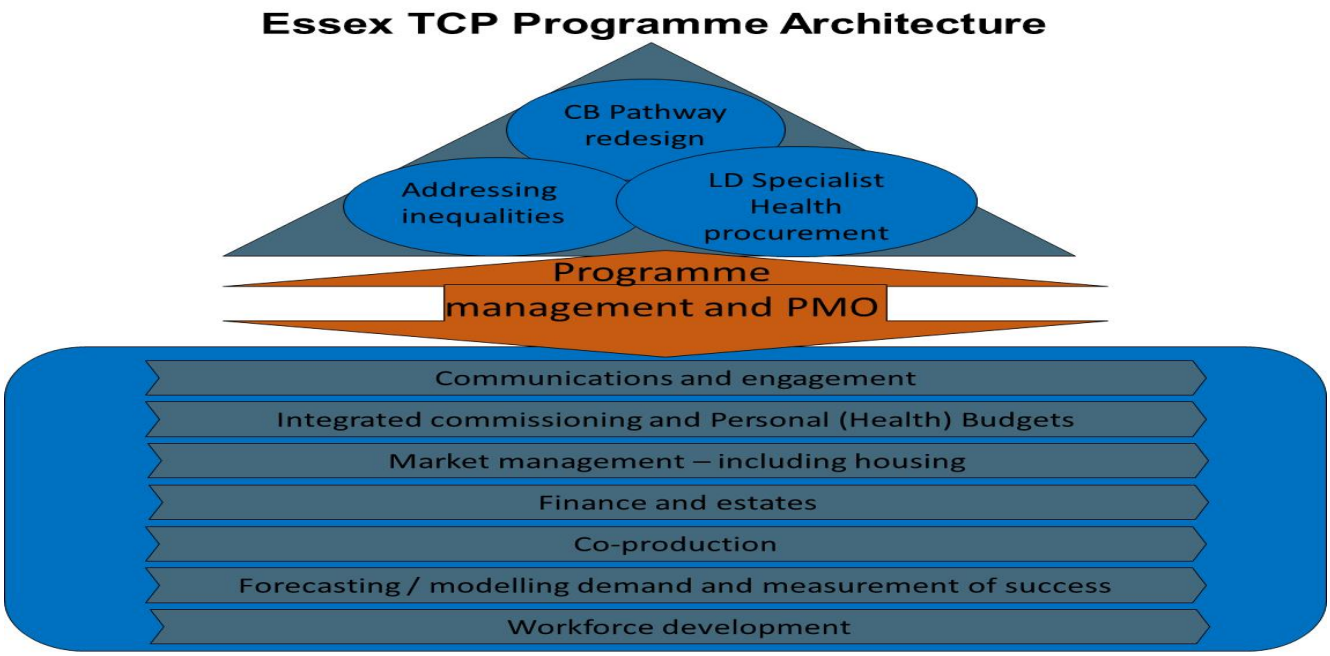
Plans need to include key milestone dates and a risk register

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

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

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

The following diagram provides an overview of the architecture for the programme, which will be delivered through a small number of highly related, but none-the-less separately defined projects. All of these projects are supported by a set of common workstreams – that will help manage the dependencies between the projects. A more detailed definition of these workstreams is included below, that also recognises the elements where there will be separate plans / approaches locally versus a single approach across or plan across the Partnership.



There are three projects within the programme:

- A project to redesign and implement improvements to the pathways for those at risk of or already displaying challenging behaviours, across adults and children. This will lead to changes that can be implemented quickly and also to new changes that will need to be implemented over a longer period of time. These changes will demand changes to contracts, pathways, reasonable adjustments, the markets for housing, care and health
- A second project to address the broader inequalities and in particular health inequalities that people with Learning Disability can sometimes experiences. This will again require some broader measurements of success and changes to pathways, systems and processes
- A third projects is then the procurement of a single LD specialist health provider across the Partnership. Alongside this process, the contractual mechanisms with the social care market will also need refinement to align the mechanisms and the pathways with the new arrangements for the contracted LD specialist health services.

To deliver these projects, there are a number of common work-streams as set out in the diagram. Further detail is set out in the table below that more clearly articulates the deliverables within each workstream and how this relates to the individual projects. The most detailed view of these The appendices provide the detailed definition of these work plans, the key deliverables and related product descriptions. Over the coming months, these will continue to be refined and approved by the Partnership board allowing the quick wins to be delivered early during spring 2016.

5.2 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

The Partnership has defined one Programme of work and the appointed Programme Manager is Sallie Mills-Lewis. Sallie was the Programme Manager on the recent and successful procurement of a single CAHMS service across the same ten partners that are members of the TCP. It is recognised, however, that in a number of areas the work that will be delivered will be delivered by different projects or programmes across the partnership. Thus for example, the definition of the Market Position Statement that includes the necessary recognition and approach to delivering reasonable adjustments will be documented by each individual Local Authority – such as through an existing Care Act Implementation Programme.

In responding to this question, the information provided provides the key resources and oversight. Further detail can be provided as necessary. The following tables set out the identified individuals leading each of the work-streams inside the programme.

Work-stream	Work-stream lead	Other resources
Communications and engagement	Sallie Mills-Lewis, Programme Manager	
Integrated Commissioning and PHB	Mark Tebbs, Integrated Commissioning Director, Thurrock CCG	
Market Management including housing	Phil Brown, Integrated Commissioning Manager, Essex County Council and North Essex CCGs	
Finance and Estates	Margaret Hathaway, Director of Finance, CPR CCG	
Co-Production	Rosemary Leak, Integrated Commissioning Manager, Essex County Council and North Essex CCGs and Glyn Jones, Integrated Commissioning Manager, Southend Council	
Forecast / Modelling Demand and Measurement of Success	Phil Brown, Integrated Commissioning Manager, Essex County Council and North Essex CCGs	
Work Force Development	Esther Beaumont, Commercial Team manager, Essex County Council	

Within each organisation there is a single lead for each organisation who attends the Programme team meetings. At this stage, the contact into Specialist Commissioning is led by Jackie Bland from the Individual Placement Team; as the interface and process for commissioning and care co-ordination for those people currently placed by specialist commissioning becomes clear, we hope to work more closely with NHS England to implement these improvements.

The make-up of the programme team is listed below, which is followed by a table that sets out the roles as related into other parts of their organisations and the workstream to ensure the alignment to other strategies and plans.

Role	Names
Commissioners	Mark Tebbs, William Guy, Hugh Johnston, Glyn Jones, Catherine Wilson, Steve Allen, Sipho Mlambo, Jane Itangata, Phil Brown, Rosemary Leak
Quality and patient safety	Amanda Murphy, CP&R Quality and Patient Safety Manager
Programme management and Project Management	Sallie MillsLewis Simon Dickinson Zandrea Stewart
Commercial	Esther Beaumont, Essex County Council
Finance and estates / property	Charles McNair Richard Nartey, NELSCU
Procurement	Attain
Comms / Engagement	Sallie Mills Lewis
Specialist Commissioning	Jackie Bland
Workforce development	TBA

The final table below, then sets out the clarity of the responsibility for each individual in communicating across the workstream and into the contacts for that area inside each of the 10 organisations or into broader shared operational capability.

	Project team members (attend fortnightly meeting)	**Key board link (ensure named person is briefed prior to board)**	**Key links (attend and support key meetings/ forums)**	**Key Organisations (support communication and governance)**	**Key resource link (resources part of delivery of work to be mobilised as required)**
Programme Director	Sallie	Melanie and Claire	Essex AO's	Southend	
Deputy Programme Director	Simon	Nick Presmeg	Essex DoSC	NA	NA
Subject Expert	Zandrea	Simon Leftley	Clinical Reference Group	SBC	Glyn
Commissioners	Phil	Steve Allen	NA	NEE, Mid and West	TBC
	Rosemary			ECC	TBC
	Catherine	Roger Harris	Service User Reference Group	TBC	Kelly
	Mark	Mandy Ansell	South Essex DoC	TCCG & BBCCG	Jane and Alfie
	Hugh	Melanie	Clinical Leads (GP's)	SCCG	TBC
Finance lead	Charles	Margaret	Essex CFO's	NA	CCG and LA finance leads
Quality lead	Amanda	Linda Dowse	Essex DON's	CPR CCG	TBC
Commercial support	Sarah	Margaret	LA procurement / commercial teams	NA	Attain TBC
PMO support	Anjali Patel				
Admin	Various				

5.3 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

The route map below provides an overview of the timeframes for a number of key milestones across the key work-streams. There are a number of constraints and dependencies that are included in the subsequent section. In particular the key risk relates to the resources constraints related to the Success Regime, but similarly the need for continued clarity about financial matters such as the Who Pays guidance, the transformation funding and greater detail with regards to the nature of the interface with specialist commissioning.

The key targets at this stage are

- Implementation of community forensics service – to be implemented during Autumn 2016, subject to agreed Transformation funding
- Start of the LD Specialist health procurement process – before the end of the 2016 calendar year
- Completion of the CB pathway redesign project – Autumn 2016, with implementation phase over the next 2 years as
- Completion of the baseline, including QoL and QoS targets – end of Spring 2016.

The target dates for the plan to be taken through formal CCG Board governance are set out in the table below. These are target dates at this stage.

Organisation	**Date**
West Essex CCG	26 May
Castepoint and Rochford CCG	26 May
Basildon and Brentwood CCG	26 May
North east Essex CCG	31 May
Southend CCG	2 June
Mid Essex CCG	9 June, 9 June
Thurrock CCG	22 June

Route Map: *<TCP Area Name>*

Date last updated: 30/11/2015

Deliverables	Leads	Quarter 4			2016/17				2017/18				Notes
		Jan-16	Feb-16	Mar-16	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
1) Pathways and care-cordination													
Challenging behaviour Cohorts - Adults				Review of CB cohort pathways - Adults		Recommend improvements	Implementation of improvements through local re-commissioning						Need to quickly identify any opportunities that may create changes for SEPT and include as SDIP in March
						Implementation of shared Forensic Service, CTR improvements, crisis support		Phased go-live of shared capability					
Challenging behaviour Cohorts - Children and Transitions			Childrens sub-group - overview and headline plan		Review of CB cohort pathways - Children				Implementation of improvements through local re-commissioning				
2) Communications and Engagement													
Communications plan			Develop Communications Plan			Launch TC Plan							
Service User Engagement / Co-Production		Refine and approve updated approach and plan for co-production / service user											
3) Integrated Commissioning, increased personalisation and PHB / PBs													
Integrated Commissioning				Re-sign Section 75 in North Essex	Evaluate local and shared commissioning options			Phased implementation of new integrated commisisoning arrangements locally, but also elements of shared commissioning / contract management pan Essex					Keep aligned to emerging work in Success regime about consolidated commissioning
Personal Budgets and Personal Health Budgets				Agree headline plan for LD PHB		Phased roll out of PHB opportunities to all LD cohorts							
Local Offer and PHB for Children							Identify and roll out opportunties for PB and PHB across childrens at risk of CB						
4) Market Management, workforce development													
Housing					Gap analysis	Implementation planning		Phased crash pads and specialist housing implementation					
Market development				Market Position Statements	Gap analysis								
Workforce Development			Identify workforce development themes		Roll out workforce development								
Community inclusion - including employment													
Health equalities				Baseline - to understand current incidents / issues and impacts / implications		Agreement on opportunities	Local and where appropriate shared implementation of improvements around health access						
Quality assurance of market / providers				Define approach to Quality assurance		Engagement / consultation	Implement new QA approach						
5) Finance and Estates													
Estates			Complete estates baseline			Future estate plan / vision							Align to estates work in Success regime
Finance			Complete financial baseline										
Business cases			Complete capital and revenue TC bids			Specialist health procurement business case							
Procurement					Agree procurement route	Specification and decisions	Procurement				Award new contract		
6) Data Capture, demand modelling and measurement of success													
Demand modelling		Complete TC templates	Terms of reference for demand	Identify patterns / pathways (childrens +	Build 3-5 year forecast demand model	Agreed demand model							
Measurement of success			Agree indicators to be used that will measure success		Baseline current performance		Implement monthly reporting / tracking						
7)Governance													
Sign off by CCG Boards and Local Authorities				Sign off the TC Plan		Sign off Procurement							TC sign off by boards for single procurement process, the financial princples / implications, target bed reductions, single PHB offer and childrens
8) Key Meetings: Board/National/Regional and Events													
TCP Board Meeting		29th	20th										
Area Learning Disability Network Meeting													
NHS England Good Practice Events				10th - London			8th - Birmingham						

5.4 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 risks, issues and dependencies for the programme are set out below. The aspirations of the partnership are significant, but there are also significant constraints and risks that all partners recognise – the most pressing of which are about capacity and the range of competing priorities that all partners face across all fronts. The Project Management Office provides the necessary rigour and control to the management of this significant programme.

Risk	Impact	L	I
Ambition and definition of the programme becomes solely focused on those in in-patient settings. This is easy to count and will become an increasing pressure.	Focus will end up solely on solutions for current in-patients, rather than system change to prevent escalation – both children and Adults. This would not address significant issues that broader LD population face, including health inequalities.	H	H
Scale and scope of the programme is not fully recognised and inadequate resources and commitment by organisations and sponsors	Focus of programme will inevitably shift to the easy to count issue – of in-patient beds. The result is that no system transformation happens and forecast demand continues to grow and broader health and life inequalities continue	H	H
Insufficient resources are made available to progress the project. There is huge pressure for resource across the system – on Success Regime, Mental Health review and financial resolving financial pressures	Multi-agency projects that go slowly tend to fail and become overtaken by internal agency pressures / issues. Programme will focus on minimum requirement – that of current in-patient numbers. End result may be more dysfunctional system and increased cost shunt.	H	H
Unable to secure accurate and trusted data about current baseline	Delays the programme and decisions made upon assumptions / perceptions rather than accurate and detailed data Lack of trust in the data means that agencies do not buy into the benefits (and risks of non-delivery).	H	M
Defining, agreeing and implementing risk share may prove too complex – driven by lack of data and broader financial pressures	Without pooled fund, the project becomes more incremental than transformational and the debates about funding continue to be individual by individual negotiation rather than system models.	M	M

Arrangements with NHS England Specialist Commissioning do not become clear quickly enough and do not allow system-wide flexibility of resources.	Difficult to plan transformation without clarity of the proposed model for future NHSE SC. System will remain about "cost shunt" at one end of the system.	M	M
There is a perception of differential investment levels in North and South Essex	This may make conversations about the funding of any shared risks very sensitive and difficult. May therefore point to the need for more complicated funding arrangements.	M	M
Ambitions for speed and degree of change may differ between agencies	May make agreement difficult to reach and hence slow down the process.	H	M
New model may create financial pressures / be seen as unaffordable and the return on investment / risk-reward model may not create compelling case for investment	The solution will become commissioned for current capability and will constrain rather than enable transformation. Will also escalate the tensions and discussions about affordability and cost shunt between partners.	M	M
Scale of change in other areas, alongside devolution and NHS Success Regime stretches capacity of sponsors to address complex issues	Project is delayed or progresses without resolving the systemic issues and hence achieves little more than a short-term reduction in bed numbers – not changing forecast demand and not addressing broader health and life inequalities.	M	M

These risks are the risks to the project. The project is very resource intensive and hence brings significant conflict and pressure with ongoing operational responsibilities that are focused more upon the immediate and urgent need for resolution of problems. These operational pressures will always take precedence; the risks to ongoing service delivery in reality are therefore mitigated through slippage to this programme.

The dependencies are identified below. At this stage these have only been agreed and communicated within the Programme Board, project team and their commissioning organisations. As the first project to review the pathways for the five CB cohorts is started, then current providers that play a role will be engaged and will recognise and help manage the risks, issues and dependencies.

- The Care Act – and implementation in each locality
- Overlaps with OAMH services supporting people with LD
- Mainstream MH services and the broader MH review
- Mainstream primary and secondary health care services
- LD general (ie non CB) Day Opportunities, Employment Services, Supported Living, Domiciliary Care, Residential Care, Short-breaks
- Mainstream family carer support
- Advocacy support (inc IMCAs)
- Children and young people's services

- Children and Adults Autism Partnership Boards and their action plans
- Transition Services
- Mental Health Crisis Concordat
- Local Autism Strategy.

Constraints

There are a number of constraints that will provide external influence over the project, including:

- Transforming Care timescales and reporting requirements
- NHS Success Regime
- The Mental Health review
- The need to procure new contract in North Essex
- Broader operational pressures.

Assumptions

- Governance arrangements enable timely decision-making across the whole system
- There is a market available and able to deliver the new model
- The new model will be affordable. It is recognised that the first iteration of the model will be unaffordable; the plan in reality is to identify the level of funding available across health and care in about 5 years' time (2020) and then identify the level of investment required in transformation in the next five years to achieve that sustainable level of expenditure at the same time as achieving the target outcomes.

5.5 What risk mitigations do you have in place?

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

Broadly the mitigation of risk is through three broad approaches.

- Collection of additional evidence as regards pathways, detailed data and forecasting demand. This will provide the evidence to address those risks that relate to inadequate resources or inadequate engagement / capacity.
- Secondly investment into appropriate planning. The philosophy is that of "measure twice and cut once" – appropriate time, modelling and planning is necessary to ensure a real understanding of impact that services might have on outcomes. It is robust benefits realisation modelling.
- Finally investment into adequate and well managed communications. This will address those risks that relate to engagement with other programmes and service domains and management of key dependencies.

Further dialogue with NHS England would be valued as the Success Regime continues to create significant constraints as regards capacity.

Any additional information

6.Finances

Transformation bids

Introduction

This section provides the context to the Transforming Care bids that have been submitted through the required template. These investments are fundamental to deliver the ambitions to which the Essex Partnership aspires. The funding will support two key outcomes

- Firstly it will deliver the necessary support and capability across the system that will enable the planned step-down and resettlement of the current in-patient cohort
- Secondly, it will also deliver the necessary services and increased capacity to better manage and prevent the current forecast numbers of both adults and children that would otherwise escalate into in-patient settings in the future. This is across all three age profiles (already adults, currently children but at risk of escalating when they become adults and children at risk of escalating imminently) and across these five cohorts.

In terms of sustainability, the plan set out and approved by the Partnership is that the new and changed services that will be funded through the transformation funding will in the future be procured from the market (currently planned for completion towards the end of 2017/2018). However without significant investment, the system cannot deliver against the shared NHS and Essex aspirations; the system is under significant strains and needs the additional capacity to deliver the continue to support the current level of demand, to deliver the target re-settlements and to deliver a step-change in terms of prevention and longer-term transformation.

Key themes to these bids

In identifying, defining and agreeing these areas, there are a number of key themes or principles, as follows

- It is clear how this capability fits to the target system model; over the medium term, therefore, it is clear how the capability will become part of a sustainable and transformed system
- The identified service and capital requirements will address the known gaps in the current level and type of provision
- It is clear how this will support and allow delivery of the targets that have been approved by the partners
- In terms of sustainability, the investments are not simply to put in place the capability to step down the current cohort. The approach will deliver the necessary step down, but all of the bids also reflect an element of market stimulation / role modelling to develop the type of housing and service capability sought for the future
- Delivering a separation of “home” from “support” to allow progression and create stability for service users and their families and carers; where

support is not working or no longer required, then people do not have to leave their homes

- The bids reflect the needs of the five cohorts within Transforming care; the services and capacity sought are flexible and will meet the individual needs of the cohorts and individuals
- Furthermore the bids address both the required capability and capacity to resettle current in-patients, but more importantly to provide the additional capacity to start to address the problems related to the lack of investment into the right capability to properly prepare children for adulthood
- That the market for housing / accommodation across Essex is fast-moving (many of the previously planned schemes don't come to fruition as housing providers see quicker returns elsewhere), but also extremely costly
- The longest-term ambitions recognise the continued financial strains across the system and the model and approach to investment for these bids and the proposed future model are all built upon the principles of assuring best use of both health and social care resources
- Perhaps most critically, these proposals recognise the broader health and economy and the range of programmes across the Partners including in particular the Success regime and the Mental Health review
- Of the identified cohort for resettlement about 20% have been in in-patient settings for longer than 5 years; 80% of people to be re-settled therefore need to be support by local rather than dowry funding.

The bids have an element of prioritisation, accepting that capital and revenue requirements may need to be separated in the planned submission in March 2016. The indicative prioritisation reflects the completing pressures across a variety of issues, including

- Some changes and capacity will take time to come on stream – would need to balance those areas that can be implemented more quickly (such as additional care co-ordination expertise) with those areas that may be more fundamental longer-term but will require longer to bring on stream (diagnosis and capacity for Community Learning Disability for Children and Families)
- The balance between prevention and resettlement and similarly the balance between supporting Adults and supporting Children and families
- The need to secure the right pump-priming and market development changes versus the need to plug the gaps that exist within the current system (such as Community Forensic services).

It is also at this stage unresolved how certain services will be "secured / delivered" with regards to whether this is something that is commissioned through current providers or how this might sit alongside the current providers.

The priority relates to the funding and commissioning of a Community Forensics service. Information on this is below.

Community Learning Disability Forensic and At Risk of Offending Team

Background:

Delivering the "*Transforming Care*" programme for learning disabilities is one of the nine "must do's" for every local system described in "*Delivering the Forward View".* Key to this is implementing enhanced community services and reducing in-patient capacity. A joint health and social care Transforming Care Partnership Board has been established across Southend, Essex, and Thurrock to deliver these changes, and is tasked with reducing the number of in patients with learning disabilities by 40 per cent over the next three years.

Context:

This proposal has come about due to the need to discharge a number of people with learning disabilities who are a risk of engaging in offending behaviour from in-patient services, and to safely manage and support them in the community. There is also a need to avoid admissions of people with learning disabilities who are known to engage in risky behaviours and may be at risk of contact with the criminal justice system. A study found that in a known population of adults with learning disabilities, 26% showed risky behaviours that could be construed as offences, nearly 10% had a history of contact with the criminal justice system and just under 4% had either a history of or a current criminal conviction. (McBrien *et al.,* 2003)

Demand:

There are two methodologies for estimating demand for this type of service. A bottom up approach aggregating known information about our current population; and a top down approach through applying estimated prevalence rates.

Known Information: Through the Care and Treatment Reviews that have taken place for every in-patient with a learning disability, there are 19 people who would benefit from a service such as this. In addition the Essex CCGs are spot purchasing a Forensic risk assessment and treatment programme for 8 people currently living in the community.

Applying prevalence rates: Various studies have been undertaken in the prevalence of offending behaviour in the learning disability population. Estimates range from between 2 and 10% (e.g. Lyall
et al., 1995; McBrien *et al.,* 2003; McNulty,*et al.,* 1995). A study undertaken in 2008 focussed on behaviours that often lead to restrictions being placed on individuals with significant implications for individuals, communities and services alike – the population most likely to need a specialist service such as the one proposed. It found prevalence rates of around 3.6% of the known LD population – which equates to a potential demand from 243 people across the Partnership.

Gap Analysis:

Historically people with learning disabilities who have engaged in offending behaviour that had significant implications for individual and communities would be placed in a specialist hospital to "manage their risks". Across the partnership there are currently 40 adults placed in Low and Medium Secure Services, and 43 adults placed in "locked rehabilitation services. Care and Treatment Reviews undertaken for these individuals has indicated that 19 people could be discharged if specialist Community Forensic capability were in place.
In addition Forensic Assessments and Treatment programmes are spot-purchased by CCGs for eight people currently living in the community. Their treatment programmes are delivered in London and there are challenges in transporting for people to access these therapies. These services do not provide on-going care co-ordination and active risk management – an essential component of the required service.

Proposed Service Model:

The service would support:

- People with learning disabilities / autism being discharged from hospital with a forensic history and active risk profile
- People with learning disabilities / autism currently in the community with a forensic history and active risk profile

- People with learning disabilities / autism currently living in the community who are at risk of engaging in offending behaviours

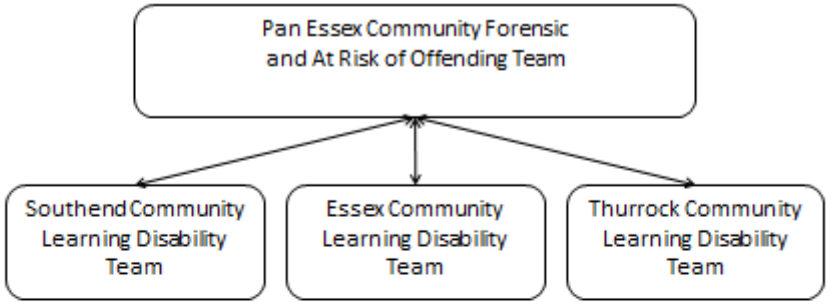
The service will offer the following:

- Forensic risk assessment and management;
- Early intervention and advice, where risk behaviour is evident, but no offence has taken place;
- Medication management for treatment-resistant conditions;
- Liaison, advice and joint working with the local legal system, including police, MAPPA, probation service and the MDO panel;
- Consultancy advice and support to mainstream forensic services, who could be in a position to support some people with learning disabilities;
- Advice and support and training to specialist learning disability services on the safe management of people in the community;
- Individual and group offence specific interventions aimed at reducing offending (including sexual offences; violent and aggressive offences and fire setting).

In it's pilot phase the service will deliver three main elements:

1. Manage a caseload of 20 high risk individuals. This will include Initial Assessment; Forensic Risk Assessment; Offence Specific Interventions; On-going multi-agency working; and On-going Case Management, Maintenance and Review.
2. Provide additional support and expertise to existing care co-ordinators and social care providers for an additional 30 people for people whose risks are less than in the first group.
3. Deliver a rolling programme of Offence Specific support programmes (e.g SOTSEC programme for sexual offenders.) There will be four programmes per annum with a minimum of six people attending each session.

The service will consist of a core team including Psychiatry, Clinical Psychology, Clinical Nurse Specialists and Occupational Therapy. As such it will link closely and support existing community learning disability specialist health teams and social work teams. Local authority social work functions (i.e Social Supervisor) will continue to be provided by the three local authorities during the pilot period but be supported by the Community Forensic Team.

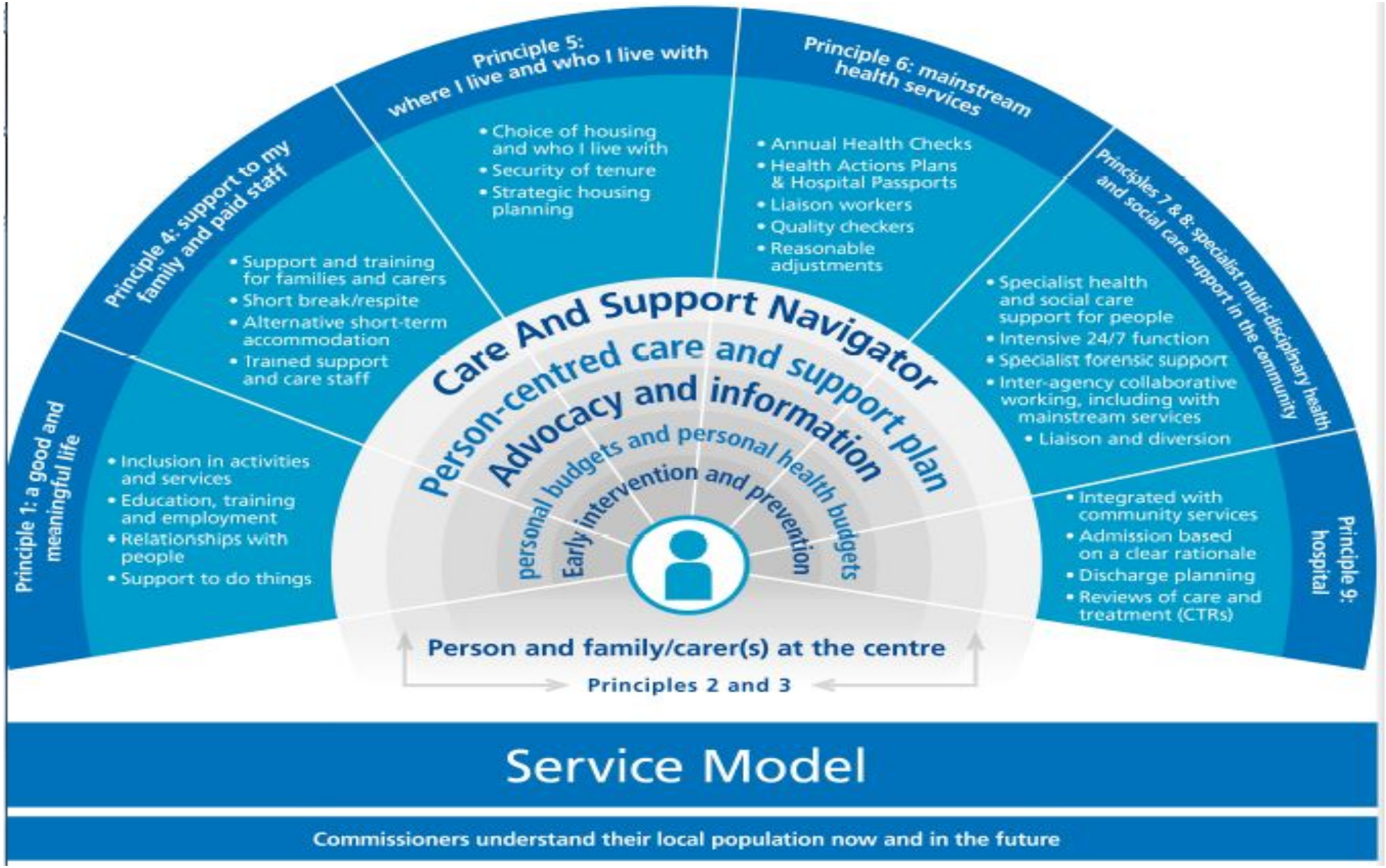


Please complete the activity and finance template to set this out (attached as an annex).
End of planning template

APPENDIX TWO – HEADLINE THREE YEAR PLAN

Deliverables	Leads	Quarter 4			2016/17				2017/18				Notes
		Jan-16	Feb-16	Mar-16	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
1) Pathways and care-cordination													
Challenging behaviour Cohorts - Adults	Simon			Review of CB cohort pathways - Adults		Recommend improvements	Implementation of improvements through local re-commissioning						Need to quickly identify any opportunities that may create changes for SEPT and include as SDIP in March
						Implementation of shared Forensic Service, CTR improvements, crisis support		Phased go-live of shared capability					
Challenging behaviour Cohorts - Children and Transitions	Sallie		Childrens sub-group - overview and headline plan		Review of CB cohort pathways - Children				Implementation of improvements through local re-commissioning				
2) Communications and Engagement													
Communications plan	Sallie		Develop Communications Plan			Launch TC Plan							
Service User Engagement / Co-Production	Rosemary	Refine and approve updated approach and plan for co-production / service user											
3) Integrated Commissioning, increased personalisation and PHB / PBs													
Integrated Commissioning	Mark Tebbs			Re-sign Section 75 in North Essex	Evaluate local and shared commissioning options			Phased implementation of new integrated commisisoning arrangements locally, but also elements of shared commissioning / contract management pan Essex					Keep aligned to emerging work in Success regime about consolidated commissioning
Personal Budgets and Personal Health Budgets	Sallie			Agree headline plan for LD PHB		Phased roll out of PHB opportunities to all LD cohorts							
Local Offer and PHB for Children	???						Identify and roll out opportunties for PB and PHB across childrens at risk of CB						
4) Market Management, workforce development													
Housing	???				Gap analysis	Implementation planning		Phased crash pads and specialist housing implementation					
Market development	???			Market Position Statements	Gap analysis								
Workforce Development	???		Identify workforce development themes		Roll out workforce development								
Community inclusion - including employment	???												
Health equalities	???			Baseline - to understand current incidents / issues and impacts / implications		Agreement on opportunities	Local and where appropriate shared implementation of improvements around health access						
Quality assurance of market / providers	???			Define approach to Quality assurance		Engagement / consultation	Implement new QA approach						
5) Finance and Estates													
Estates	Richard		Complete estates baseline			Future estate plan / vision							Align to estates work in Success regime
Finance	Richard		Complete financial baseline										
Business cases	Richard		Complete capital and revenue TC bids			Specialist health procurement business case							
Procurement	Sarah				Agree procurement route	Specification and decisions	Procurement				Award new contract		
6) Data Capture, demand modelling and measurement of success													
Demand modelling	Richard	Complete TC templates	Terms of reference for demand	Identify patterns / pathways (childrens +	Build 3-5 year forecast demand model	Agreed demand model							
Measurement of success	Simon		Agree indicators to be used that will measure success		Baseline current performance		Implement monthly reporting / tracking						
7)Governance													
Sign off by CCG Boards and Local Authorities				Sign off the TC Plan		Sign off Procurement							TC sign off by boards for single procurement process, the financial princples / implications, target bed reductions, single PHB offer and childrens

APPENDIX THREE – NHS ENGLAND Target Service Model



APPENDIX FOUR – Make-up of the Partnership Programme Board

Organisation	Board Member
Southend-on-Sea Council	Simon Leftley, Director of Adult and Director of Childrens Services. SRO
Southend CCG	Melanie Craig, Accountable Officer. Deputy SRO
Castlepoint and Rochford CCG	Margaret Hathaway, Chief Financial Officer Finance Lead South Essex
Thurrock CCG	Mark Tebbs, Director of Commissioning
Thurrock Council	Roger Harris, Director of Adults and Housing Services
Basildon and Brentwood CCG	William Guy, Director of Transformation
Essex County Council	Nick Presmeg, Director of Commissioning
Mid-Essex CCG,	Carol Anderson, Chief Nurse Quality lead North Essex
North-East Essex CCG	Kate Vaughton, Chief Operating Officer
West Essex CCG	Dean Westcott, Chief Financial Officer and North Essex Finance Lead
South Essex Quality Lead	Linda Dowse, Director of Nursing
Chair of the professional Service Reference Group	Christina Collins, Senior Practitioner, Challenging Behaviour Team, Essex County Council
Chair of the Service and carer reference group	Dave Cope (family carer – currently acting) Robert Estabrook (service user – currently acting)
Specialist Commissioning, NHS England	Karen Lockett, NHS England Anu Babu, head of Finance, Specialist Commissioning, NHS England