SWINDON & WILTSHIRE

Transforming Care Partnership

Service Model Plan

DRAFT

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Introduction

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This document is the local plan of Wiltshire and Swindon for 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). This Plan covers 2016/17, 2017/18 and 2018/19.

This plan demonstrates how Wiltshire and Swindon will fully implement the national service model (published with above document) by March 2019 reducing the use of and/or closing any inpatient beds using the national planning assumptions set out in *Building the Right Support,* 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 have been used by commissioners in producing this plan. A creative and ambitious approach has been taken, 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. It should be noted that Wiltshire and Swindon current use of beds is already much lower than the above planning assumption.

National principles

The Wiltshire and Swindon partnership have tailored the plan to the local system's health and care needs based on provider landscape and demographics and health and social care contexts. However the plan is consistent with the following principles:

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

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

b. **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 the closure of 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 Plan

1. MOBILISE COMMUNITIES

Governance and stakeholder arrangements

1a Describe the health and care economy covered by the plan

Background and national context
In 2012, following an investigation into criminal abuse at Winterbourne View Hospital, the Department of Health initiated a national programme of action "Transforming Care" to transform services for people with learning disabilities and/or autism who have mental health conditions or behaviours that are challenging. Transforming care aims to reshape services for people with learning disabilities and autism away from institutional models of care, closing some inpatient provision and strengthening the support available in the community. On 12 June 2015, Health and Wellbeing boards received a letter from NHS England, the Local Government Association (LGA), the Association of Directors of Adult Social Services (ADASS), Health Education England (HEE), Care Quality Commission (CQC) and the Department of Health which describes how they are collaborating on a cross-system Transforming Care programme.

Five 'fast track areas' (collaborations of CCGs, Local Authorities and NHS England specialised commissioners) piloted delivering Transforming Care approaches.

The National programme has been rolled out with the following timelines:

January 2016
- First Transforming Care Partnership (TCP) board meetings to take place (Wiltshire's will be 19 January 2016)

February 2016
- Draft plans to be submitted by 8th February
- NHS England and other stakeholders to undertake review and assurance of TCP plans locally

March 2016
- TCP's to revise plans according to local and regional feedback

April 2016
- Final TCP plans submitted and implementation commence

Timescales are extremely tight. However, previous consultations undertaken in Wiltshire on Winterbourne View Concordat have been used to develop the plans.

This is only the first stage and it recognised that plans and actions will change and develop and further consultation with, and the support of all stakeholders is vital.

The local context
The total population of Wiltshire and Swindon for people who have a learning disability and/or autism in 2015 is estimated at 18,136. Those individuals known to the Local authority of Wiltshire is 1,600 and Swindon is 898.

This submission provides our initial **DRAFT** Service Model plan. Swindon and Wiltshire intend to focus on further developing supporting people within their own community whilst recognising the need to work regionally with other transforming care partnerships to develop specialist services.

Over the last four years, the partners have been implementing the community based model of care concentrating on prevention, early intervention and maintaining people in their community. Closing all specialist assessment and treatment inpatients beds and only using inpatient beds when absolutely necessary. This intention has largely been realised and there are clear plans for the 7 people to move to community placement in 2016.

Wiltshire already has a strategy, with the development of a Learning Disabilities and/or Autism complex needs care pathway which has seen the roll out of the:

- Care programme approach (CPA),
- An intensive support service
- Development of specialist housing a support options, moving people on from inpatient placements.

Swindon is developing plans to consider a multi-disciplinary intensive support service to support adults with a learning disability and for those with behaviours that may challenge. Further exploration of the Swindon Autism Diagnostic Service to see if this could be developed and expanded. More robust preparation and support planning to be undertaken for complex cases under the Commissioning Around The Individual process to ensure appropriate provisions and outcomes are achieved. Planning Live events for young people entering into the transition period, achieving better outcomes for entering adult services. Further development of a wide range of housing options, core and cluster models to allow for appropriate support in a personalised way.

Swindon and Wiltshire Partnership

There is agreement to collaborate for knowledge sharing and work towards the same strategic vision rather than having a set solution in place across the geography to deliver care, but a joint model of care has not been fully ruled out.

Most of this plan therefore concentrates on implementing the new models of care across Swindon and Wiltshire, and a sharing of best practise. The plan also recognises the need to work with our regional partners to develop care pathways for people who may need low and medium secure settings, keeping them close to home.

The Swindon and Wiltshire plan

Swindon and Wiltshire's local plan to implement Transforming Care was signed off by Health and Wellbeing Boards and local CCG and Local Authority Governing Bodies in January 2016. The intentions outlined in the plan are echoed in commissioning intentions of local CCGs and in wider strategies for learning disabilities and autism locally.

Within this plan Wiltshire and Swindon aim that care and support should be:

- Closer to home
- In line with best practice models of care
- Personalised and responsive to individual needs over time
- Based on individuals' and families' wishes
- Value for money

The set of criteria against which we will measure our success:

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

The plan builds on the work already undertaken under the Winterbourne View Concordat and is based on the 9 core principles set out with the Transforming Care National Service Model. See section 5 for more details on a how this partnership is going to deliver.

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

- **Phase 1:** Setting up and embedding intensive support services. Setting up a transitions team to assist the move of any patients from hospital into community settings. In Wiltshire we have set-up a bespoke residential community based option known as 'The Daisy', which will help to prevent unnecessary inpatient admissions. In addition these teams will prevent avoidable admissions, working with families and carers and providers to provide specialist support around challenging behaviours, and supporting mainstream services to provide reasonable access. Robustly working on our data to ensure its validity and aid accurate and effective planning for Phase 2 and 3 to inform any regional commissioning outside of this partnership.

- **Phase 2:** Building on the experience of implementing Phase 1 look to extend the scope to include people with Autism who do not have a learning disability, and or whether a separate service is required, working together across the region if appropriate to commission the required service.

- **Phase 3:** Building the capacity and capability of the market for community services, commissioning of regional forensic, specialist medium and low secure services if required by the partnership by 2018/19.

Delivering this transformation requires significant implementation effort, and a programme to

achieve it will be place for at least the next eighteen months, delivering the 9 core principles through specific work streams to be decided by the Service Model Partnership board.

1b Governance

In addition to NHS England, there are two Clinical Commissioning Groups (CCGs) and two Local Authorities who commission care for the population in this area. At this stage, the plan for transforming services in Swindon and Wiltshire primarily focuses on their own geographical areas. This programme will report into the Transformation Care Partnership Board which in turn reports into Joint Commissioning Boards and Health and Wellbeing Boards.

Who are the key partners to this plan and do they endorse it?

How Swindon and Wiltshire integrate in the delivery of the programme has yet to be determined. For example, Wiltshire already has an intensive support team in place, but need to develop how it meets the wider requirements of Transforming Care. The options for how the three areas may collaborate are:

- **Option 1:** One model of care implemented through shared teams across the geography
- **Option 2:** One model of care implemented through separate teams across the geography
- **Option 3:** Individual models of care for Swindon and Wiltshire and knowledge sharing of expertise across the geography

As work begins and information and ideas shared a way forward will be agreed as to which option will be adopted and a plan implemented.

Finances

The development of the financial plan to support the delivery of the model is at a very high level stage currently, and requires more detailed development with the 2 CCGs and Local Authorities in particular around plans for matched funding.

Decreasing NHSE specialised and CCG funded in-patient care for Swindon and Wiltshire residents might release some funding that can be re-invested in community care and support. It is more likely to be used on these individuals.

Finally, due to the short timescales for the process, the details contained in this document and appendices have been reviewed but have not undergone a thorough assurance and governance process within each of the represented organisations. Further immediate assurance work is needed to test the financial assumptions and review the finances in more detail.

To help understand the change needed across Swindon and Wiltshire, population data for Swindon and Wiltshire has been included in this plan. Inpatient and provider information has just been included for facilities outside of Swindon and Wiltshire.

1c Stakeholder engagement arrangements

Within Swindon and Wiltshire this plan has been developed with representatives from all the key commissioning and provider organisations concerned with people with a learning

disability and/or autism.
These organisations are:

- Swindon Borough Local Authority
- Wiltshire Local Authority
- Swindon CCG
- Wiltshire CCG

The scope of the Transforming Care Partnership has aimed for a whole system inclusive approach, other organisations included in this plan:

Provider Organisations:

- Avon and Wiltshire Mental health Partnership (NHS Foundation Trust)
- Great Western Hospital (NHS Foundation Trust)
- Wiltshire Council
- Swindon Borough Council
- SEQOL

Wider Involvement
In Wiltshire, service users, families and stakeholders have been engaged in the development of this plan via a stakeholder's event held during January 2016. These events were attended by individuals with Learning Disabilities (LD), carers, families (including a number of parents) as well as Third Sector representatives. The joint commissioning team from the area also attended to support and facilitate discussions. In particular the Stakeholder event looked at;

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

The outcomes and intelligence from this day, along with other consultations and engagement such as from the Winterbourne View Consultation process carried out in 2015, are incorporated throughout this Plan and will continue to be used as a check and balance as the Plan is implemented. Feedback to date;

"Those involved in the consultation shared their views and felt listened to, and are pleased their views and ideas will be incorporated in the plan. As representatives we also acknowledge the steps already taken to improve support for people at risk of needing inpatient services" Learning Disabilities Partnership Board representatives (13th January 2016)

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

Previous Transforming Care Consultation
In January 2015 Swindon and Wiltshire Local Authority together with the Clinical Commissioning Groups completed a consultation exercise with key stakeholders on how the partnership area should implement the Concordat recommendations. The consultation included separate groups with customers, their carers, carers for younger people, carers directly affected by Winterbourne View, providers and specialist health and social care workers. Those individuals and their families who have lived experience of inpatient

services have been consulted as a fundamental principle of all the work undertaken prior to this work and will continue to be throughout the next three years and beyond.

1d Describe how the plan has been co-produced with children, young people and adults with a learning disability and/or autism and families/carers

The wider roll out of the plan will see further co-production, with a wider role on the implementation group and the overseeing transforming Care Board.

We intend to fully explore the use of the co-production, self-assessment tool where appropriate and as agreed by the wider stakeholder engagement as we move forward.

Any additional information

None

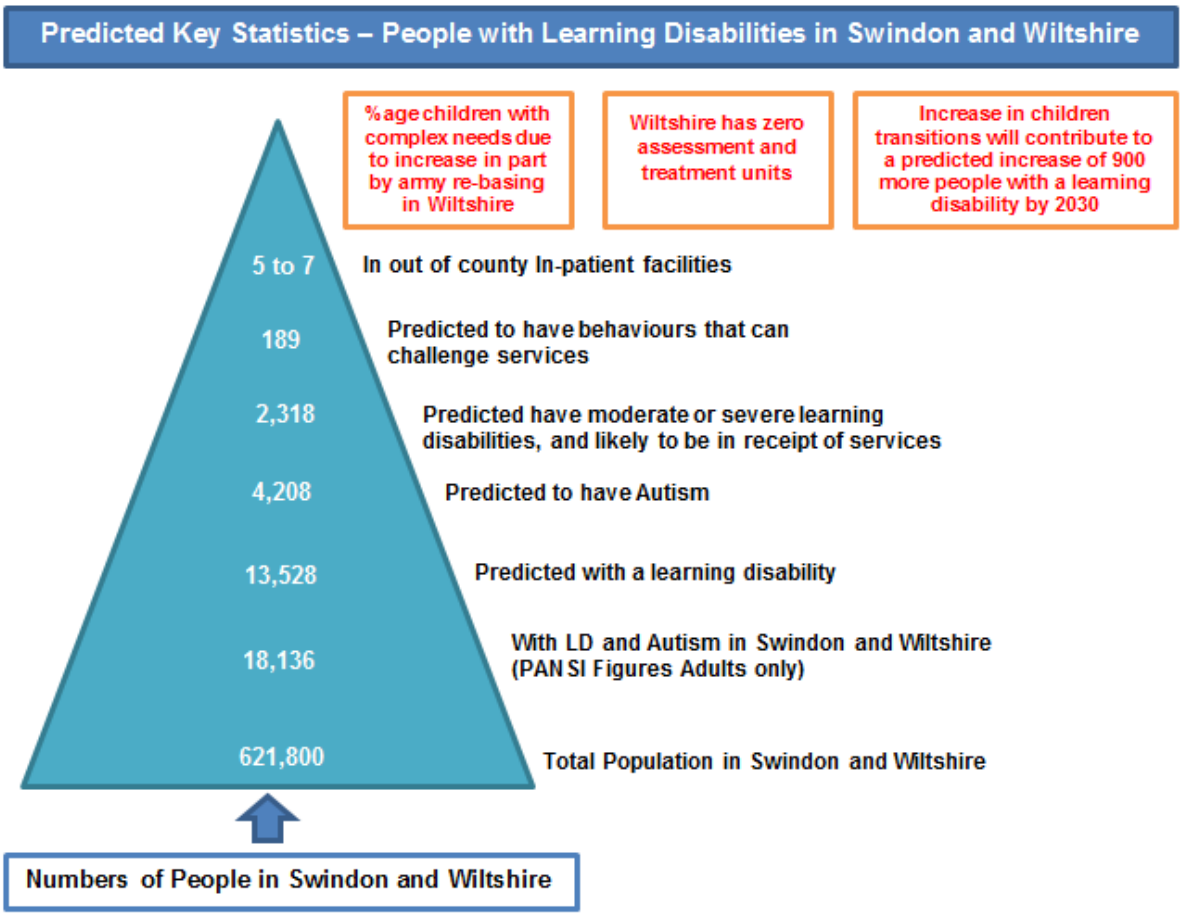
2.UNDERSTANDING THE STATUS QUO

Baseline assessment of needs and services

2a. Provide detail of the population / demographics

What is our population?
Of the 18,136 people who have a learning disability and/or autism in Swindon and Wiltshire, there is a cohort that displays behaviour that challenges, estimates for this vary. Emerson & Einfield estimate that 10-15% of the learning disability/autism population will have behaviour that challenges. For Swindon and Wiltshire this would be between 1,813 and 2,719 people. The Projecting Adult Needs and Service Information (PANSI) database estimates that 189 people with a learning disability and/or autism have behaviour that challenges in Swindon and Wiltshire (based on a prevalence rate for people with a learning disability displaying challenging behaviour of 0.045% of the population aged 5 and over).

In terms of the degree of need, 2927 or 16% of people in Swindon and Wiltshire with a learning disability and/or autism have moderate or severe learning difficulties. Statistics suggest 336 or 1-1.6% of the learning disabilities and/or autism population have profound multiple learning disabilities.



Predictive Figures broken down into area
It is estimated that 13,528 people or 2.7% of the population in Swindon and Wiltshire currently have a learning disability and/or autism (approximately 2.5% nationally).

Area	Total population	LD/autism population in area	LD/autism know to services
Wiltshire	484,400	13,907	1,600
Swindon	137,400	4,229	898
Wiltshire CCG	As above	As above	tbc
Swindon CCG	As above	As above	716
TOTAL	621,800	18,136	Est 3214

Predictive Numbers of Children
In schools the numbers of pupils with a learning disability as of January 2015 were:

Degree of learning disability	Numbers of pupils in Wiltshire (Swindon Figures to be confirmed)
SEN and ASD	451
Moderate learning disability	321
Severe learning disability	189
Profound and multiple learning disability	29

Predictive Adult Numbers
The profile across the age bands in 2015 for adults in Swindon and Wiltshire based on the 18,136 population estimate is shown in the table below:

Age band	Estimate of population in 2015 with a learning disability
18-24	636
25-34	1095
35-44	1107
45-54	1100
55-64	792

Predictive Behaviours that Challenge
The profile across the age bands in 2015 for adults in Swindon and Wiltshire based on the 18,136 population estimate is shown in the table below:

	Estimate behaviours that can challenge
18-24	24
25-34	38
35-44	41
45-54	48
55-64	38

Future
Looking forwards the numbers nationally are estimated to increase overall from 2015 to 2030. Separately in Wiltshire there is a falling trajectory with estimates for those with a learning disability and/or autism having been identified as estimated to fall from 12,155 in 2015 to 11,901 in 2030 representing a decrease of 2.1%. In Swindon there is an increase of 425 in 2015 to 2030. Overall this represents a total increase of 171 in Swindon and Wiltshire.

The number of people with a learning disability and/or autism with challenging behaviour in Swindon and Wiltshire is estimated to be 189 in 2016. Due to the increase in children transitions it is predicted that the number of cases where individuals may challenge is likely to increase. There is also anticipated to be an increase in year 9 group (age 14) from children to adult's services, which will likely impact on the complex needs individuals in the next 15 years.

Total number of people known to SEND who have behaviours that challenge is 259 in Wiltshire. This will present challenges across the health care and system as people with learning disabilities and or autism are more likely to experience age related health conditions at an earlier stage.

Finances
CCG and specialist spend refers to the cost of inpatient support as it currently stands January 2016

Category	2015/16 forecast spend	Comments
CCG Spend		
Swindon CCG	tbc	Awaiting definitive figures
Wiltshire CCG	tbc	Awaiting definitive figures
Continuing Health Care	tbc	Awaiting definitive figures
Specialist Commissioning Spend		
Low and medium Secure	tbc	Awaiting definitive figures
Local Authority Spend (LD adult and children Social spend – residential and community		
Swindon	£23M	
Wiltshire	£46M	

Patient Flow
In terms of inpatient flow, Wiltshire and Swindon is a natural grouping. There is no provision in our area for specialist inpatient beds so there are not placements made from out of county. There is a degree of flow out of the Wiltshire with 7 people currently placed out of the county in long term inpatient placements. These placements need to be validated and an appropriate /robust plan to be agreed and put in place within the next 12 months.

A new complex needs care pathway is in place reducing the need for future specialist inpatient placements which will see a reduction in the need to place people out of county, using intensive support and local generic inpatient bed usage. However, there is recognition of a need to develop specialist inpatient services, on a regional basis, closer to peoples' homes. To reduce the number of beds spot purchased out of area a collaborative effort will be required by our wider closest regional Transforming Care partnerships.

2b. Analysis of inpatient usage by people from Transforming Care Partnership

Learning disabilities NHS Assessment and Treatment inpatient beds in Swindon and Wiltshire have now closed and refocused support into a community setting. There are no private inpatient providers and no other specialist low or medium secure or forensic services. When a specialist inpatient bed is required a bed is spot purchased from a range of providers. There is currently limited provision within the South and West region, and the 7 people currently placed in specialist inpatient provision, were placed with providers many miles from their homes. (These are NHSE figures, not yet validated by CCG).

Provision	No. of Beds	No. of Beds	No. admissions and discharges

in Swindon and Wiltshire	In County	Out of County	in the last year
Swindon	0	0	0
Wiltshire	0	7	4 additional local generic inpatient now all discharged.
TOTAL	**0**	**7**	**4**

2c. Describe the current system

Currently, people with a learning disability and or Autism who at risk of admission to hospital are usually supported in the following ways:

Wiltshire - For people with a learning disability, the 24/7 Learning Disabilities Wiltshire Intensive Support Service (LD WISS) will support a person to maintain them in their community setting, with the framework of the Care Programme Approach (CPA), robust, pre authorised crisis contingency planning and positive behavioural support. If a person is at risk of an inpatient placement, the Blue Light protocol is triggered, all efforts are made to divert, considering amongst other things the specialist respite flats. The protocol is authorised to agree 72 hours of joint funding to address crisis situations and avoid an inpatient admission. If an admission is still required a local generic inpatient mental health placements will be considered and support provided by LD WISS with the care and treatment review facilitated and undertaken within 72 hours of admission. If a generic bed is not available or a specialist inpatient bed is required, it is currently spot purchased from a specialist provider.

Wiltshire CAMHS inpatient admissions are low (just 13 in 2014/15), and we will endeavour to reduce this further, including the length of stay in inpatient services by making investment in early intervention and prevention. Redesigning the child and youth mental health pathway and the service and investing in early help and counselling services. Also further enhancing our Outreach Service for Children and Adolescents which is already helping to facilitate quicker discharge by providing treatment in home settings. Strengthening support for children and young people with special educational needs and/or disabilities through our trailblazing integrated 0-25 SEND service, to include the co-location of CAMHS mental health practitioners. In addition, we have expanded our Children's Learning Disability Service with an additional investment to help improve help and care for families, including support around challenging behaviour).

The CAMHS team are also looking to strengthen transition work between CAMHS and adult services. Developing a fast track intervention scheme and integrating care and treatment reviews for those in a crisis situations The teams will be co-locating with mental health

clinician within the MASH so that specialist CAMHS are represented.

Swindon - For people with a learning disability, the community team for people with learning disabilities working closely with commissioners to support and maintain a person a community setting, with engagement from the clinical psychiatry and psychology team if appropriate. Robust planning and contingency plans are essential focusing on Positive Behaviour Support models. If this is not possible to maintain and an inpatient placement is required, the Blue Light protocol is triggered, and a spot purchased inpatient bed is procured from a specialist provider.

Further work to strengthen the transition planning between CAMHS and Adult Services in Swindon. Consideration given to a more integrated response to crisis situations and interventions using an multi-disciplinary approach.

Out of area beds are commissioned on a case by case basis using spot contracts. Low and medium secure, and CAMHS beds are commissioned through frameworks with NHS England Specialised Commissioning Units.

2d. What does the current estate look like? What are the key estates challenges, including in relation to housing for individuals?

As stated above, Swindon and Wiltshire have already closed all inpatient beds relevant to this service model plan. There is no existing estate.

2e What is the case for change? How can the current model of care be improved?

The current challenges within this baseline are:

- Robustness of data
- The population increases will put pressure on capacity
- The ageing population will require more proactive support, integrated around co-morbidities that are more common in later life.
- There is a lack of joined up commissioning and working across the forensic pathway for people with learning disability and or autism.

To address these challenges, the following needs to be put in place:

- A system wide approach across specialised and CCG commissioning, health and social care and other services e.g. housing, for those in Swindon and Wiltshire with a learning disability and/or autism and challenging behaviours
- Care and support services need to be redesigned to minimise inpatient care so it is the best place for the person concerned e.g. crisis prevention, respite or assessment when community provision not possible, or when it is mandated by the courts
- A ‘whole life’ preventative approach needed for care and support with a much greater emphasis of addressing or reducing the impact of challenging behaviours from a young age
- Significant market development and provider liaison is required to achieve the changes required by building the skills and capacity in the market, and avoid destabilisation

The overall plan is to work towards achieving zero admissions, relying on a community and or a local generic mental health response (see section 2c). However, there is recognition that we will need to consider specialist low and medium secure services and will look to undertake work with other regional Transforming Care Partnerships to establish a better understanding of need. Currently Swindon and Wiltshire would consider;

Type of accommodation	Sept 2015 No. of beds for Swindon and Wiltshire	2020 No. of beds commissioned for Swindon and Wiltshire residents	Assumed length of stay	New/enhanced provision as a result of the model
Low and medium secure (1 CAMHS A&T)	6 (wilts)	Up to 3 spot purchased	3 months (low) and 6 months (medium)	Look to develop a regional response to this need
Locked Rehabilitation	0	0	up to 6 months	Look to develop a regional response to this need
Assessment and Treatment	0	0	up to 6 months	Community focused A&T with the support of the ISS and generic mental health inpatient services
CAMHS Adolescent beds – Learning disability only	1	1	up to 6 months	Look to develop a regional response to this need

The above figures are based on assumptions and therefore further validation and clarification of information is required

Any Additional information

None

3.DEVELOP YOUR VISION FOR THE FUTURE

3a Describe your aspirations for 2018/19.

Our aspirations:
To continue to promote prevention, early intervention and keep low or completely removed the need for admissions to hospital. The expected outcomes are:

- All will be supported to live in the community/at home, safely as a first option with good care and quality of life
- The frequency and severity of behaviours that challenge will reduce
- Fewer, or no one, will be admitted to non-secure and secure hospitals but if required it will be closer to home and delayed discharges will be minimised
- There will be fewer inpatient beds used for the Swindon and Wilshire population.

3b. How will improvement against each of these domains be measured?

The Transforming Care Partnership will use the national service indicators as follows;

- 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[2]

To monitor quality of care, the partnership will also use the basket of indicators (see Annex A). This will measure progress in uptake of personal budgets (including direct payments), personal health budgets and, where appropriate, integrated budgets; and strongly supports the use of external quality assurance and quality checker schemes.

The National Service Model also sets out nine core principles which the partnership will use to evaluate and measure progress. The nine core principles are as follow;

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

Based on the nine core principles section 5 of this plan sets out the partnerships deliverables The project board will plan and setup a monitoring process designed to

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

measure progress against these core principles (see section 5 for more details).

How will we know that we have succeeded?

We will measure our success against individual perceptions and outcomes in relation to the care and support people receive;

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

3c Principles we are using in how we offer care and support to people with a learning disability and/or autism who display behaviour that challenges:

The National Service Model sets out nine core principles which the partnership will be use to in how we make changes to improve care and support for people with learning disabilities and /or Autism who display behaviour that challenges.

To deliver this new model of care we, as the organisations commissioning and providing care and support, will also work to a wider set of overarching principles;

- Service users and their families will be at the heart of decisions about their care, providing them with more choice and control over their care including promoting a culture of positive risk taking
- We will assume a person has the mental capacity to make decisions about their care, unless it is established that they lack capacity for that specific decision – and all practicable steps will be taken to support them to make their own decisions
- We will establish the extent of a person's mental capacity as soon as there is any doubt as to whether the person has the mental capacity to make decisions
- Services will be commissioned which promote prevention, early intervention and wellbeing to support people of all ages, including children, who are at risk of developing challenging behaviours and minimise inappropriate admissions to hospital, including from the Criminal Justice System
- We will encourage the use of mainstream services as the starting point for care

and support, available and accessible for those with a learning disability and/or autism

- Where mainstream services are insufficient to meet a person's needs then we will provide access to specialist multi-disciplinary community based housing and support expertise seeking creative options and or bespoke solutions.
- We will work in partnership across health and social care commissioners to ensure people's homes are in the community
- Commissioners and providers of care and support will collaborate and share knowledge and experience to achieve the best outcomes for service users, including collaborating regionally across the wider region and with NHS England specialised commissioners where appropriate
- People involved in implementing the plan will use a problem solving 'can do' approach
- We will develop cost effective services which promote individuals independence
- We will provide support in the least restrictive setting possible that is therapeutic and safe for all. Where restrictive interventions are required they should be for the shortest time possible
- We will proactively use intelligence from a range of sources to identify and respond to commissioning gaps and to facilitate and shape the local health, social care and housing market
- We will protect those with a learning disability and/or autism from abuse and neglect wherever possible, and address safeguarding concerns as soon as they arise

Any additional information

None

4. IMPLEMENTATION PLANNING

4a Overview of your new model of care

Introduction
The Swindon and Wiltshire plan focuses on delivering and developing a model of care that embeds the nine overarching principles set out within the national service model which defines what 'good' services are for people with learning disabilities and/or autism whose behaviour challenge. In Wiltshire, the commissioning strategy has been to move towards community based support with the development of a new learning disabilities intensive support service and also a new specialist housing support option known as 'The Daisy'. This will support individuals moving back from existing in-patient provision and assist with prevention of unnecessary patient re-admissions.

Background
Swindon and Wiltshire have not had any specialist Learning Disability/Autism beds since the closure of Postern House and previously the closure of The Lanterns. Following their closure, work was carried out to identify the needs of the people within the partnership area. The closure of Postern House, A&T unit, Wiltshire released finance that was used to commission LDWISS in Wiltshire.

How is it different?
The emphasis on community provision over inpatient settings will mean that the size and extent of community provision relative to inpatient provision will be much more extensive than it is now. This community provision will be focused on three cohorts:

- **The current in-patient cohort, including those in forensic settings**
  The community provision will need to effectively accommodate those previously served by inpatient settings, so that the people concerned can improve their quality of life, and the quality of care and support is improved so that they can stay living in the community and any inpatient admissions are minimised.

- **The current community cohort**
  The community provision will need to keep people with a learning disability and/or autism living well in communities, preventing deterioration in their wellbeing and crises so that their need for inpatient services is reduced to when they are the best option for the person concerned.

- **The wider learning disability and autism population**
  This is the cohort that is currently unknown to services, with the exception of primary care. Mainstream services and community networks will need to support people with a learning disability and/or autism living well in the community without the need for specialist services for those with learning disabilities and/or autism where possible.

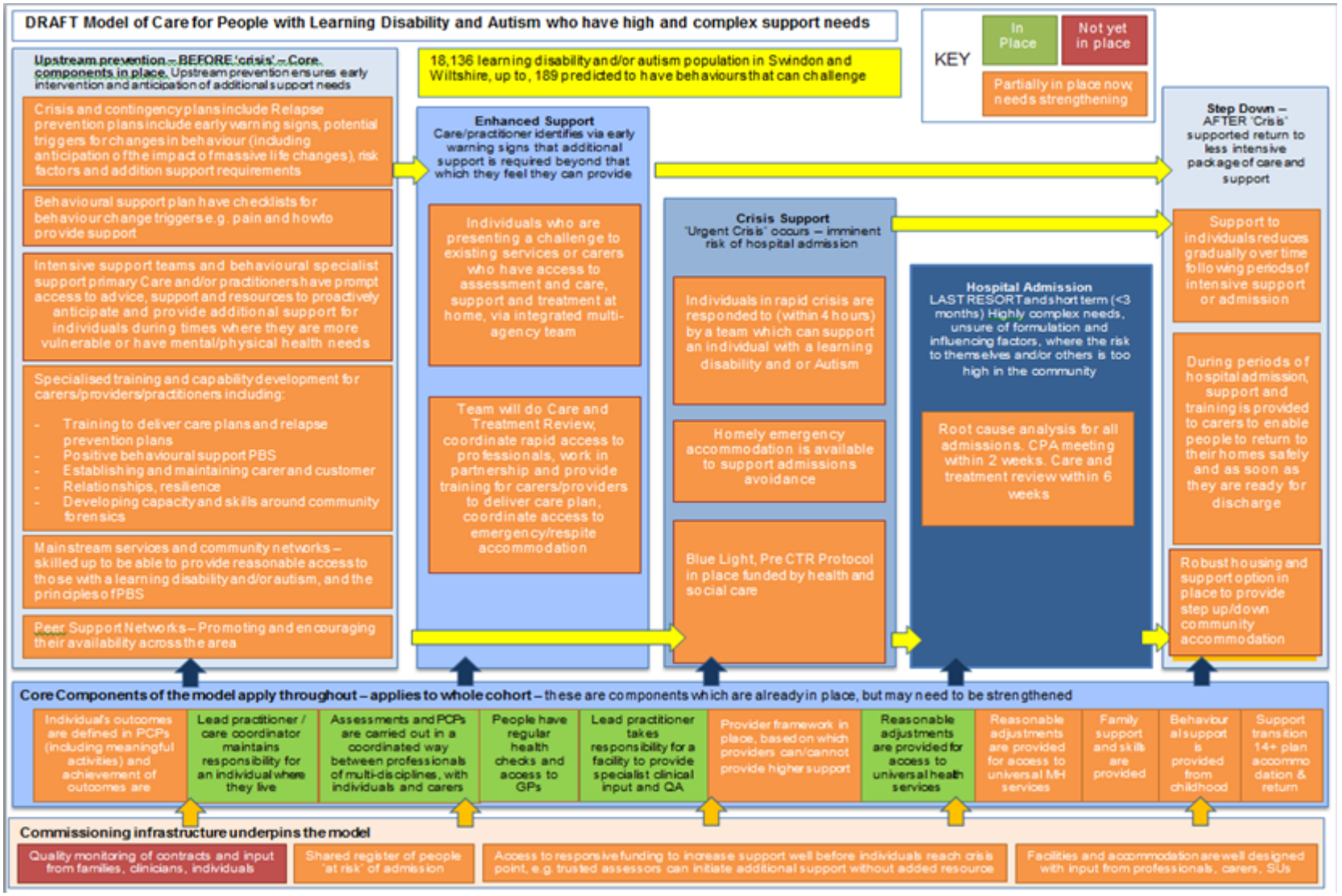
We will require a continued focus on community provision on being proactive, and preventing and intervening early to reduce need. Underlying causes of behaviours will need to be addressed so that the frequency and severity of incidents of challenging behaviour is reduced. This will be helped by effective risk stratification of the population, with a **register of those at risk of admission** being the key tool to do this.

The role of **mainstream services** and **community networks** as an important partner in achieving this is also much more of a focus. There will be an emphasis on making sure all the relevant mainstream services are accessible.

Spending extensive time in hospital often disempowers individuals. The intention is that Positive Behaviour Support approaches will be embedded at every level, commissioners and providers, and the wider mainstream services, building on and using the expertise of Swindon and Wiltshire specialist providers. This way of working will have a significant and positive impact over the next few years - not only on the individual but also on their care team, developing practical skills and resilience. In addition, there will be a **consistent approach to challenging behaviours** across all teams so that the right interventions are delivered to change behaviours. This will be done with the aim of reducing the severity and frequency of challenging behaviour and consequently the needs that need to be addressed.

What will our future system look like?

The future model of care is presented pictorially on the table below. It was developed as part of the Winterbourne View Concordat. It has been developed by Swindon and Wiltshire joint commissioning teams on behalf of the CCGs Local Authorities and providers. The transforming care partnership have implemented this concordat which has been based on robust consultation processes and is in the process of delivering a new complex needs care pathway for this group of individuals.


DRAFT Model of Care for People with Learning Disability and Autism who have high and complex support needs
KEY
In Place
Not yet in place
Partially in place now, needs strengthening
Upstream prevention – BEFORE 'crisis' – Core components in place. Upstream prevention ensures early intervention and anticipation of additional support needs
18,136 learning disability and/or autism population in Swindon and Wiltshire, up to, 189 predicted to have behaviours that can challenge
Crisis and contingency plans include Relapse prevention plans include early warning signs, potential triggers for changes in behaviour (including anticipation of the impact of massive life changes), risk factors and addition support requirements
Behavioural support plan have checklists for behaviour change triggers e.g. pain and how to provide support
Intensive support teams and behavioural specialist support primary Care and/or practitioners have prompt access to advice, support and resources to proactively anticipate and provide additional support for individuals during times where they are more vulnerable or have mental/physical health needs
Specialised training and capability development for carers/providers/practitioners including:
- Training to deliver care plans and relapse prevention plans
- Positive behavioural support PBS
- Establishing and maintaining carer and customer
- Relationships, resilience
- Developing capacity and skills around community forensics
Mainstream services and community networks – skilled up to be able to provide reasonable access to those with a learning disability and/or autism, and the principles of PBS
Peer Support Networks – Promoting and encouraging their availability across the area
Enhanced Support
Care/practitioner identifies via early warning signs that additional support is required beyond that which they feel they can provide
Individuals who are presenting a challenge to existing services or carers who have access to assessment and care, support and treatment at home, via integrated multi-agency team
Team will do Care and Treatment Review, coordinate rapid access to professionals, work in partnership and provide training for carers/providers to deliver care plan, coordinate access to emergency/respite accommodation
Crisis Support
'Urgent Crisis' occurs – imminent risk of hospital admission
Individuals in rapid crisis are responded to (within 4 hours) by a team which can support an individual with a learning disability and or Autism
Homely emergency accommodation is available to support admissions avoidance
Blue Light, Pre CTR Protocol in place funded by health and social care
Hospital Admission
LAST RESORT and short term (<3 months) Highly complex needs, unsure of formulation and influencing factors, where the risk to themselves and/or others is too high in the community
Root cause analysis for all admissions. CPA meeting within 2 weeks. Care and treatment review within 6 weeks
Step Down – AFTER 'Crisis'
supported return to less intensive package of care and support
Support to individuals reduces gradually over time following periods of intensive support or admission
During periods of hospital admission, support and training is provided to carers to enable people to return to their homes safely and as soon as they are ready for discharge
Robust housing and support option in place to provide step up/down community accommodation
Core Components of the model apply throughout – applies to whole cohort – these are components which are already in place, but may need to be strengthened
Individuals outcomes are defined in PCPs (including meaningful activities) and achievement of outcomes are
Lead practitioner / care coordinator maintains responsibility for an individual where they live
Assessments and PCPs are carried out in a coordinated way between professionals of multi-disciplines, with individuals and carers
People have regular health checks and access to GPs
Lead practitioner takes responsibility for a facility to provide specialist clinical input and QA
Provider framework in place, based on which providers can/cannot provide higher support
Reasonable adjustments are provided for access to universal health services
Reasonable adjustments are provided for access to universal MH services
Family support and skills are provided
Behavioural support is provided from childhood
Support transition 14+ plan accommodation & return
Commissioning infrastructure underpins the model
Quality monitoring of contracts and input from families, clinicians, individuals
Shared register of people 'at risk' of admission
Access to responsive funding to increase support well before individuals reach crisis point, e.g. trusted assessors can initiate additional support without added resource
Facilities and accommodation are well designed with input from professionals, carers, SUs

The Plan

Following submission of these plans discussions will be had with the regional partnerships in the South and South West to find a way to collaborate going forwards. This is primarily to address the need for **more localised specialist services**, services that are unachievable within the smaller partnerships.

The longer term care and support teams for both adults and children will address **the lower levels of complexity and challenging behaviour**, review care plans, coordinate rapid access to professionals including short-breaks accommodation, and coordinate evidence-based parenting training and practical and emotional support.

Currently in Wiltshire LDWISS is an enhanced support or crisis support function around those with a learning disability and autism who display challenging behaviours. This is planned to be developed within Swindon and is yet to be delivered for people with Autism within Wiltshire. The enhanced support and crisis support functions may be set up incrementally in order to support the wider cohort of people covered within this plan. This will enable the model to be tested and refined. The team maybe grown to support a prevention approach, working across children's and required to extend its capacity and skills to incorporate the development of community forensic provision.

An important responsibility for the Intensive Support Service will be to work closely with family and carers, and providers, including those for mainstream services, so they don't need specialist support going forward.

Mainstream services, community networks and peer support

People with a learning disability and/or autism should experience similar levels of service provided as the general population. Any new intensive support services will facilitate access through supporting staff of generic services to make reasonable adjustments so they are able to cater for those with a learning disability and/or autism, including the principles of positive behavioural support. It is envisaged that the mainstream services that may need to be supported to make these reasonable adjustments may include:

- Activities that enable people to lead a fulfilling and purposeful everyday life
- Education, training and employment services. Employment is overwhelmingly a high priority for people with a learning disability and/or autism in Swindon and Wiltshire
- Primary care
- Mainstream NHS services and mental health services, including those provided by GPs
- Services that prevent or reduce anti-social or offending behaviour
- Liaison and diversion schemes to enable people to exercise their rights and/or where appropriate diverting people to appropriate support from health and care services
- Mainstream forensic services
- Dental care
- Generic housing services
- Settled accommodation options including exploring home ownership or ensuring security of tenure
- Drugs and alcohol services
- Sensory services

In the new model there will also be a much stronger emphasis on support given by communities and networks, both community networks that are of interest to the whole population, and peer support networks around those with a learning disability and/or autism and their carers. There will be a much more systematic approach to ensuring peer network coverage for all, though recognising the necessary organic nature in which they evolve and develop if they are to be successful.

We will **promote peer networks** to be in place across Swindon and Wiltshire to establish and provide support to other individuals and their families throughout the journey from children into adulthood and into old age. Our feedback from people with a learning disability and/or autism and their families shows that these peer networks are valued by most individuals where they currently exist. The exceptions are those with autism who often don't want to be involved in social networks. Across Swindon and Wiltshire teams have been developed including Transition Link Workers or Community Connectors to work with young people and families to start looking at community options and planning about the future. It has procured 4 full time volunteers to work across learning disability on some of the softer social isolation, community engagement, vulnerability aspect. Building connections then gradually withdrawing.

Primary care

In primary care there is an additional focus on GPs identifying physical and mental health needs earlier for those with learning disabilities and/or autism. This will be partly achieved through **GP led health checks** for everyone with a learning disability over the age of 14. Each Annual Health Check will result in a **Health Action Plan integrated** into an individual's person-centred care and support plan.

Short term accommodation options

This will be required for crisis and respite. When people are placed in this accommodation it will be part of a journey of care, seamlessly integrated into community based care by the CPA care coordinators and supported by the Intensive support teams.

For crisis accommodation there is currently limited specific crisis **respite** for people with behaviours that challenge, but with the increasing numbers of people supported in the community and the increase in complexity of people being supported in the community, then capacity and capability will need to be increased. The crisis accommodation will include the following:

> **Bradbury House** – Has a specially adapted flat that can be used, when available for planned respite or crises intervention for people with learning disabilities and Autism.
>
> **Bradbury Manor** - Has a specially adapted flat that can be used, when available for planned respite or crises intervention for people with learning disabilities and Autism.
>
> **Swindon - Firethorn Close** - redesign of service to accommodate a small number of beds that could be used for crisis intervention for people with learning disabilities and Autism.

Longer term accommodation options

Longer term accommodation options, including **Supported Living**, will also need to increase capacity and capability to support the extra volume and specialist needs of people living in the community, and the support services for these need to be skilled up to be able to take on people with more complex needs and challenging behaviour, and also be based around a culture of **positive behavioural support**. Accommodation specifications will also need to be considered to ensure we have robust community accommodation to meet the needs of individuals who may display destructive behaviours. The provision of long term accommodation will move to mixed models of care including accommodation with support, moving away from 'one model fits all' and commissioning models that offer choice to customers and their carers. There are planned schemes in the pipeline and already in place to expand accommodation capacity and as part of this plan we are proposing the development of bespoke services to enable individuals currently in hospital to be discharged into the community, or those at risk of inpatient admission to be accommodated appropriately.

Hospital admission

Hospital admission will be integrated into a broader care pathway, working closely with community-based mental health and learning disability services. Hospital-based specialist services will only be used where community settings cannot deliver and only accessed after the **Blue Light Protocol** has been exhausted. The **intensive support teams** will use **generic inpatient settings** as part of a continuum of care, and will work with hospital staff from the day of admission to the day discharge, to make sure an estimated day of discharge is determined when the person is admitted and discharge planning and preparations begin from the day of admission.

Robust care plans to commence on admission to ensure that discharge preparation and planning are thorough and appropriate. Individual commissioning to be considered to ensure personalised and tailored support for discharge to community settings.

Offender Pathway

The partnership will consider an improved offender pathway to minimise in-patient admissions. Considering an admission of a person with a learning disability onto the offender pathway (specialised commissioning commissioned services) will only occur for people who are detained under Part III of the Mental Health Act 1983 (Patients Concerned in Criminal Proceedings or Under Sentence). An admission of a person with a learning disability detained under Part II of the Mental Health Act 1983 (Compulsory Admission to Hospital and Guardianship) will only occur if the referral for an admission is via the courts as part of the diverting offenders with mental health problems and/or learning disabilities within the National Conditional Cautioning Framework. Possibilities for the improved offender pathway could include:

- **Community forensic support** to police custody areas and magistrates courts
- The use of **Care and Treatment Reviews** (CTRs) before an admission
- Intensive community support services (non-secure)
- **Short break/crisis intervention** support and facilities

4b What new services will you commission?

The transforming care partnership have implemented the Winterbourne View Concordat which has been based on robust consultation processes and is in the process of delivering a new complex needs care pathway for this group of individuals. This has resulted in the following commissioning plan:

What will we commission that is different?

- **Intensive support services**
  Any services commissioned will focus initially on supporting people with learning disabilities and/or autism, and specifically the 7 existing inpatients for Wiltshire moving out to the community. The partnership will consider plans to enhance the specification for any transition team to include this cohort.
- **Community forensic services**
  To consider the options to commission forensic services.
- **Specialist Housing Options**
  As part of this work we are developing more appropriate ranges of accommodation for this. In Wiltshire we are developing 'The Daisy'. This is a housing and support option which will support people moving back from in-patient placements and also support prevention of readmission into hospital settings. This is a new specialist service which is planned to support people under the mental health act where necessary and under the least restrictive route.
- **Housing options**
  All new frameworks commissioned will look to include this cohort and existing ones will be reviewed. There will need to be work done to look at the market to ensure capacity for the Transforming Care work. This will be followed by market development activity to create a market of small niche providers, since there are few providers of this nature currently operating in the area.
- **Advocacy services**
  Advocacy services are a key enabler for the new model to help those with a learning disability and/or autism exercise choice and control over their care and support over the long term. Those with a learning disability and/or autism with behaviours that challenge may need long term advocacy support. Swindon and Wiltshire currently has an outcome based advocacy framework that would support this.

4c What services will you stop commissioning, or commission less of?

How will care settings change?
Care settings will shift further from in-patient provision to community settings. Community settings will be bolstered by teams providing community based intensive support and also consideration will be given to admission prevention (crisis) accommodation that will be for those with learning disabilities and/or autism.

Inpatient beds
As previously stated Swindon and Wiltshire do not currently commission any block funded inpatients beds for people with a learning disabilities and/or Autism. There are currently 7 Wiltshire residents, according to NHSE who are placed in inpatient out of county settings. All authorities would like to see this reduce to zero once the work already started, and further exploration and development work identified as required, is fully implemented and embedded.

4d What existing services will change or operate in a different way?

As above and in addition short term care settings such as admission prevention (crisis) accommodation and short breaks, as well as long term care settings through e.g. Supported Living, will be able to cater for those who have come into contact with the Criminal Justice system.

4e Describe how areas will encourage the uptake of more personalised support packages

Wiltshire is currently part of a regional pilot / regional commissioning which includes personal health budgets (PHB). Consideration will be giving to rolling out PHB's across the full partnership for the cohort group. See section 5 for actions.

The design of the service model plan has at its focus the individual and as such PHB's will influence the delivering of individual bespoke services for people with learning disabilities' and or Autism who have complex and challenging needs.

Swindon will work to develop personal health budgets whilst continuing to promote personal budgets and direct payments. Where cases are joint funded with Health or solely health funded, the same standards will be implemented to ensure personalised support planning is at the forefront. The Commissioning Around The Individual (CATI) process will be used in most cases to ensure individuals and family/carers have as much involvement as possible in designing the future support package and are fully part of the selection process.

4f What will care pathways look like?

See section 4a, figure 1 for more details

4g How will people be fully supported to make the transition from children's services to adult services?

The partnership will review current transitions processes and look to make changes that support people with learning disabilities and/or Autism to have a successful transition. See section 5 for actions plan.

A new transitions process is being set up and refined in Wiltshire to support people with learning disabilities and or Autism who have the most complex needs to achieve a successful transition to adult life.

Swindon has in place a Transitions Protocol which is regularly reviewed and updated. There is a dedicated transitions care management team with 4 newly appointed Transition Link Workers. The Transition Link workers will commence engagement with young people and families at the start of the transition planning process and will be the key point of contact and support throughout the move into Adult Services. We need to improve the robustness of the flow of data between children and adults services.

4h How will you commission services differently?

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

Local commissioners need to work with the independent and third sector to ensure there is a vibrant and high quality market to support the needs of people with complex needs. As the model of care is developed local commissioners will explore the opportunities to develop an integrator model to support alignment and fit of people's needs with a range of providers. Greater understanding of the children's and autism population will mean commissioning arrangements may need to change. Market development activities will be required where providers do not currently have the capability required.

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

Consideration will be given to collaborative commissioning and linked risk-sharing with other CCGs and other specialised commissioning teams. This will require the support of NHS England in the negotiations to ensure that CCGs and other specialised commissioning teams have a plan to reduce the numbers of beds they commission.

There are no current intentions in these plans to pool budgets however this is something that will be explored fully.

4i How will your local estate/housing base need to change?

The partnership will review the housing needs of people with learning disabilities and or autism who have complex and challenging needs and review the housing strategy to see if it meet the needs of this group of people. See section 5 for actions.

Swindon has a fortnightly Housing and Adult Social Care Board the meets to look at strategic need and will take exceptional cases that require a more creative option or fast track response.

4j 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?

Wiltshire currently has 7 people in long term inpatient placements. Robust plans to be put in place for all inpatient provision, subject to further data validation. Four will be moving back to their own flats in Wiltshire in 2016, one of whom has been in an inpatient placement for over 5 years. The fifth person is currently under section 37/41 and we are working with the Ministry of Justice to deliver a community placement for this individual. The other 2 are short term placements.

4k How does this transformation plan fit with other plans and models to form a

collective system response?

This plan has been developed alongside our key partners and works alongside all other plans and models within the current partnership area. However, during this work future amendments and alignments may be required.

Any additional information

None

5 DELIVERY

The delivery plan is based on the **9 Core Principles** set out in the National Service Model Plan. They are:

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

The plan is covers the **5 Cohorts** groups described within the National service Model Plan; it is children, young people or adults with a learning disability and/or autism:

1) Who have a mental health condition such as severe anxiety, depression, or a psychotic illness, and those with personality disorders, which may result in them displaying behaviour that challenges.

2) Who display self-injurious or aggressive behaviour, not related to severe mental ill health, some of whom will have a specific neuro-developmental syndrome.

3) Who display risky behaviours which may put themselves or others at risk and which could lead to contact with the criminal justice system

4) Often with lower level support needs and who may not traditionally be known to health and social care services, from disadvantaged backgrounds who display behaviour that challenges, including behaviours which may lead to contact with the criminal justice system.

5) Who have a mental health condition or display behaviour that challenges who have been in hospital settings for a very long period of time, having not been discharged when NHS campuses or long-stay hospitals were closed.

Swindon and Wiltshire Delivery Plan (Based on the 9 Core Principles set out in the National Service Model Plan)

Core Principles 1 - I have a good and meaningful everyday life.				
5a What are the programmes of change/work streams needed to implement this plan?	**5b Who is leading the delivery of each of these programmes, and what is the supporting team.**	**5c What are the key milestones – including milestones for when particular services will open/close?**	**5d What are the risks, assumptions, issues and dependencies?**	**5e What risk mitigations do you have in place?**
Strategic learning disability commissioners should work with those that commission and manage **mainstream activities/services to find ways to make them accessible**, in line with Equality Act duties. Operational commissioners will need to work with mainstream services to enable people with a **learning disability and/or autism who display behaviour that challenges** to be included. Local Authorities should **commission supported employment** services that can meet the needs of this group. Commissioners should ensure that service specifications are based on **person-centred outcomes**.	Wiltshire and Swindon - Joint Commissioning Team	Audit mainstream activities/services to assess accessibility (Date) Ensure that all new contracts for mainstream activities/services include this cohort. (Date) Ensure that Supported Employment specifications are reviewed and amended as required. (date April 2016) All new tender/specifications to include Person Centred Outcomes. (date)	**Risks:** Capacity across all areas to deliver **Assumptions:** The plan runs over a five year period to March 2020. The plan concerns individuals whether in beds or placements. **Dependencies:**- All organisations and stakeholders across the area.	Trusting relationships are required across all organisations. A single shared vision across all stakeholder organisations. All organisations sharing the same vision.

Core Principles 2 - My care and support is person-centred, planned, proactive and coordinated				
5a What are the programmes of change/work streams needed to implement this plan?	**5b Who is leading the delivery of each of these programmes, and what is the supporting team.**	**5c What are the key milestones – including milestones for when particular services will open/close?**	**5d What are the risks, assumptions, issues and dependencies?**	**5e What risk mitigations do you have in place?**
Strategic learning disability commissioners should **risk stratify their local population** of people with a learning disability and/or autism. Micro-commissioners should ensure that the person they are supporting has **a single person-centred care and support plan**, not just those on the Care Programme Approach (CPA). Commissioners should ensure that everyone is **offered a local care and support navigator or key worker**. Commissioners should ensure a **multi-disciplinary approach to EHC plans**, not leaving this only to education	Wiltshire and Swindon - Joint Commissioning Team Wiltshire and Swindon - Operational teams Wiltshire and Swindon - Operational teams Joint Children's Commissioning Team in Swindon and Wiltshire	Revise the data base to cover this cohort (date) Roll out of CPA for this cohort* (date). Roll out care coordinators, care managers and key workers for the 5 cohort groups* (date) Roll out multi-Disciplinary EHC plans for the 5 cohort groups (date)	**Risks:** Capacity across all areas to deliver **Assumptions:** The financial plan for the Partnership programme is based on a reduction in use of inpatient beds (commissioned by specialised services or the CCGs but excluding high secure beds) that releases funds for re-investment into community services.	Public and stakeholder support for the programme.

Core Principles 3 - I have choice and control over how my health and care needs are met				
5a What are the programmes of change/work streams needed to implement this plan?	**5b Who is leading the delivery of each of these programmes, and what is the supporting team.**	**5c What are the key milestones – including milestones for when particular services will open/close?**	**5d What are the risks, assumptions, issues and dependencies?**	**5e What risk mitigations do you have in place?**
Commissioners should be planning for, and delivering the offer of, **personal budgets**, personal health budgets and integrated personal budgets beyond rights guaranteed in law. By April 2016, every CCG will be expected to have **a 'local offer'** for how to expand the use of personal health budgets; this must include people with a learning disability Commissioners should work with **the local voluntary sector to consider what additional or different local services** are needed to ensure that people with personal budgets have a range of services to choose from.	Wiltshire and Swindon - Joint Commissioning Team	Roll out the PHB pilot in Wiltshire for the five cohort groups (ongoing 2016). Build up the range of LD/A specialist support providers by ensuring the support framework and training offer are robust. Put in place robust provider frameworks (April 2016).	**Risks:** Capacity across all areas to deliver **Assumptions:** Wiltshire is part of the PHB pilot, Swindon not at this time. Look to both join. Swindon will join the Training partnership to develop focus on the training needs of the 5 cohorts*. Roll out of a consistent approach to PBS across Swindon and Wiltshire.	Public and stakeholder support for the programme.

Core Principles 3 Continued - I have choice and control over how my health and care needs are met				
5a What are the programmes of change/work streams needed to implement this plan?	**5b Who is leading the delivery of each of these programmes, and what is the supporting team.**	**5c What are the key milestones – including milestones for when particular services will open/close?**	**5d What are the risks, assumptions, issues and dependencies?**	**5e What risk mitigations do you have in place?**
Commissioners should be **extending the offer of advocacy** through investment in non-statutory advocacy services and should ensure statutory and non-statutory advocacy is available to people who are leaving a hospital setting. Commissioners should ensure **that advocacy services are independent** and provided separately from care and support providers		Develop a new consistent to approach to PBS. Developing a training partnership, **champions role (summer 2016)** and **training agreement (summer 2016)** and roll out of Wiltshire and Swindon single approach to **positive behavioural support (PBS)** (Date). Review Advocacy contracts to ensure that robust statutory and non-statutory advocacy is available for the 5 cohorts (date). Review advocacy services for cohort who are in inpatient beds to ensure that robust independent statutory and non-statutory advocacy is available (date).	**Capacity and working / improving on current arrangements**	Contracts for mental health advocacy awarded from April 2016 that will be monitored Support of people with complex LD.

Core Principles 4 – My family, paid support and care staff get the help they need to support me to live in the community				
5a What are the programmes of change/work streams needed to implement this plan?	**5b Who is leading the delivery of each of these programmes, and what is the supporting team.**	**5c What are the key milestones – including milestones for when particular services will open/close?**	**5d What are the risks, assumptions, issues and dependencies?**	**5e What risk mitigations do you have in place?**
Children's and strategic learning disability commissioners should **ensure availability of early intervention programmes**, including evidence-based parent training programmes. Children's and strategic learning disability commissioners should ensure availability of a range of **support and training for families and carers**. Children's and strategic learning disability commissioners should provide flexible and **creative short break/respite** options Children's and strategic learning disability commissioners should work with their local providers to develop models of **alternative short-term accommodation.**	Wiltshire and Swindon - Joint Commissioning Team	Review early intervention programmes, and consider options to ensure access is available (date). Review and consider options for the support and training for families and carers (date). Review and consider options for the provision of flexible and **creative short break/respite** (date).	**Risks:** Capacity across all areas to deliver **Assumptions:** Access to match funding for the wider development of early intervention, crisis intervention and housing and support options. **Issues:** Swindon short breaks are looking at developing an early intervention, crisis intervention model. (dates) Wiltshire are in the process and have adapted their Children's and Adult services to offer early, crisis intervention and respite options.	Public and stakeholder support for the programme.

Core Principles 4 – My family, paid support and care staff get the help they need to support me to live in the community				
5a What are the programmes of change/work streams needed to implement this plan?	**5b Who is leading the delivery of each of these programmes, and what is the supporting team.**	**5c What are the key milestones – including milestones for when particular services will open/close?**	**5d What are the risks, assumptions, issues and dependencies?**	**5e What risk mitigations do you have in place?**
Commissioners should develop **a group of social care preferred providers** that meet the needs of people with a learning disability and/or autism. Local Authorities should develop **Market Position Statements** with an explicit focus on this group. **Transition** - There will be improved coordination between children's and adult services around the transition of children with a learning disability and/or autism, with better support to people with a learning disability and/or autism and their family and carers through this time. A simple step by **step guide** will be produced to support people and carers through the process.		Review and consider options to ensure that provider frameworks cater for the 5 cohort groups (date). Redraft Market Position Statements (date) New **Transitions panel** and resolutions panel process to be put in place (date) **Step by step guide** to be produced/reviewed	Both areas within the partnership need to consider alternative short term accommodation options.	

Core Principles 5 – I have a choice about where I live and who I live with.				
5a What are the programmes of change/work streams needed to implement this plan?	**5b Who is leading the delivery of each of these programmes, and what is the supporting team.**	**5c What are the key milestones – including milestones for when particular services will open/close?**	**5d What are the risks, assumptions, issues and dependencies?**	**5e What risk mitigations do you have in place?**
Commissioners should co-produce **local housing solutions** leading to security of tenure, that enable people to live as independently as possible, rather than in institutionalised settings. CCGs could consider allowing individuals with a personal health budget to use some of **their budget to contribute to housing costs** if this meets a health need and is agreed as part of the individual's care and support plan. Strategic commissioners need to work with housing strategy colleagues to ensure **strategic housing planning**.	Wiltshire and Swindon - Joint Commissioning Team	Review housing strategies to ensure it covers the 5 cohorts*. (date) Revise housing strategy, if required, after review to meet the needs of the 5 cohorts*. (date) Develop housing options that meet the most needs for the cohorts 5*.(date) Feasibility study and if agreed, policy and procedure agreed to allow individuals with a personal health budget to use some of **their budget to contribute to housing costs** (date) Working on a joint strategy with Housing department to look at the provision of appropriate future accommodation.	**Risks:** Capacity across all areas to deliver **Assumptions**: Assess to match funding for the wider development of early intervention, crisis intervention and housing and support options. **Dependencies**: Change in national PHB guidance to allow them to be spent of housing costs	Public and stakeholder support for the programme.

Core Principles 6 – I get good care and support from mainstream health services.				
5a What are the programmes of change/work streams needed to implement this plan?	**5b Who is leading the delivery of each of these programmes, and what is the supporting team.**	**5c What are the key milestones – including milestones for when particular services will open/close?**	**5d What are the risks, assumptions, issues and dependencies?**	**5e What risk mitigations do you have in place?**
Health commissioners should ensure that people with a learning disability are offered **Annual Health Checks.** Health commissioners should ensure that everyone has the option of a **Health Action Plan**, and are promoting the use of **Hospital Passports**. Mental Health commissioners should ensure that the **Green Light Toolkit** audit is completed annually, and an action plan developed. Commissioners should ensure that practices and care and support pathways within mainstream primary and secondary NHS services are '**reasonably adjusted'** to meet the needs of this group, in line with Equality Act duties, and are routinely monitoring equality of outcomes	Wiltshire and Swindon - Joint Commissioning Team	Review and ensure Annual Health Checks are in place for the 5 cohorts across children and adult services (date) Review and ensure Health **Action Plan** are in place for the 5 cohorts across adult and children's services. (date) Build in the Green Light Toolkit into contracts (Date). Audit reasonable adjustment across mainstream primary and secondary NHS and social care services. (date) Consider the development of the quality checker role (date).	**Risks:** Capacity across all areas to deliver	Public and stakeholder support for the programme.

Core Principles 7 - I can access specialist health and social care support in the community				
5a What are the programmes of change/work streams needed to implement this plan?	**5b Who is leading the delivery of each of these programmes, and what is the supporting team.**	**5c What are the key milestones – including milestones for when particular services will open/close?**	**5d What are the risks, assumptions, issues and dependencies?**	**5e What risk mitigations do you have in place?**
Commissioners should ensure the **availability of specialist integrated multi-disciplinary health and social care support in the community** for people with a learning disability and/or autism. Covering all ages. Commissioners should ensure this specialist health and social care support includes an intensive **24/7 support** function. Commissioners should ensure **inter-agency collaborative working**, including between specialist and mainstream services.	Wiltshire and Swindon - Joint Commissioning Team	Review current care pathways to ensure the availability of specialist integrated multi-disciplinary health and social care support in the community. (date) Put in place a plan, as necessary to enable access a specialist integrated multi-disciplinary health and social care support in the community. (date) Roll out an intensive support service for the 5 cohorts. (date) Roll out of the Care Programme Approach (CPA) for those most at risk within the 5 cohorts. (date)	**Risks:** Capacity across all areas to deliver **Assumptions**: Develop care pathways across children and adults. Roll out of intensive support services for the cohort across children's and adults. CPA will be for people with the most complex needs, others will be offered care management. People with Autism not a learning disability are requesting a different care pathway from those with learning disabilities. **Dependencies**: NHS match funding will be required to ensure that the intensive support service is inclusive.	Public and stakeholder support for the programme.

Core Principles 8 – If I need it, I get support to stay out of trouble.				
5a What are the programmes of change/work streams needed to implement this plan?	**5b Who is leading the delivery of each of these programmes, and what is the supporting team.**	**5c What are the key milestones – including milestones for when particular services will open/close?**	**5d What are the risks, assumptions, issues and dependencies?**	**5e What risk mitigations do you have in place?**
Commissioners should ensure that mainstream services aimed at preventing or reducing anti-social or 'offending' behaviour are making **reasonable adjustments** to meet the needs of people with a learning disability and/or autism, in line with Equality Act duties, and are routinely monitoring equality of outcomes. Commissioners should ensure the availability of **specialist health and social care support** for people with a learning disability and/or autism who may be at risk of or have come into contact with the criminal justice system, offering a community forensic function for this group.	Wiltshire and Swindon - Joint Commissioning Team	Adapt the Green Light Toolkit (or the similar assessment tool) for mainstream services aimed at preventing or reducing anti-social or 'offending' behaviour. (date) Insert into new contracts a duty to use the new toolkit, and contract monitor. To ensure reasonable adjustments are made for the 5 cohorts. (date) Review care pathways for the 5 cohorts looking at availability of **specialist health and social care support** for who may be at risk of or have come into contact with the criminal justice system, offering a community forensic function for this group (date) Put in place an action plan for change to widen availability of **specialist health and social care support** for those within the cohort who may be at risk of or have come into contact with the criminal justice system, offering a community forensic function for this group. (date)	**Risks:** Capacity within the Joint Commissioning team. **Dependencies**: NHSE match funding will be required to ensure the further development of community forensic services.	Public and stakeholder support for the programme.

Core Principles 9 – If I am admitted for and assessment and treatment in a hospital setting because my health needs can't be met in the community, it is high-quality and I don't stay there longer than I need to.				
5a What are the programmes of change/work streams needed to implement this plan?	**5b Who is leading the delivery of each of these programmes, and what is the supporting team.**	**5c What are the key milestones – including milestones for when particular services will open/close?**	**5d What are the risks, assumptions, issues and dependencies?**	**5e What risk mitigations do you have in place?**
Health commissioners should ensure that hospital admissions are supported by a **clear rationale of assessment and treatment**, and desired outcomes, and that services are as **close to home** as possible. Micro-commissioners should be working with individuals, families/carers, clinicians and local community services to ensure that **the discharge planning process starts from the point of admission**, or before.	Wiltshire and Swindon - Joint Commissioning Team	To fully implement the development of the **CPA** process for the 5 Cohort groups. (date) Development of a robust **Crisis Contingency** process for the 5 Cohort groups. (date) Fully implement the **Blue Light Protocol** incorporating the **Pre Care and Treatment Review** process (Pre CTR) for the 5 Cohort groups. (date) Further develop **community assessment and treatment** services which utilise local generic mental health beds, supported by Intensive support services. (Date) Develop appropriate **residential options** that can support the current people in inpatients beds to move back to Wiltshire and prevent readmission. The Daisy	**Risks:** Capacity within the Joint Commissioning team. Registration for new Housing option and service will only happen once the flats are built. **Assumptions**: The first transfer of patients commences in Q4 of 2015/16. This is a worst case situation for the first transfer though as it is anticipated that the discharge of patients will happen in summer 2016. There is an increase in total placements over and above that needed to replace closed in-patient beds based on demographics and other factors. From 2015/16 there will be an average of about 4 new community placements coming on stream each year from 2015/16 to 2019/20. Savings from using fewer medium and low secure, CAMHS (just those for with a learning	Public and stakeholder support for the programme.

Health commissioners should ensure the **appropriate CTR** are taking place and are of a high quality, in line with NHS England policy. Commissioners should ensure that **support for families and carers are part of any commissioning framework**. Consideration will be given to introduce the **Quality checker**		will be a real example of this working well in the community, in practice. (Summer 2016) Develop a regional plan to provide specialist services close to home (e.g. low and medium secure). (date) Care and Treatment review will be imbedded in practice for people in inpatient setting with the 5 cohorts. (date) Review of current practice to ensure that families and carers are at the heart of bespoke commissioning practice. (date). Implement change needed to support for family and carers to ensure that they are part of any commissioning framework for bespoke and whole service commissioning. (date)	disability) and other beds (currently commissioned by specialised commissioning) will be used to fund community services. This will require a national policy decision to implement whole care pathway commissioning for this group of patients and the pooling of specialist and CCG budgets. If this is not possible then the financing of the plan is in jeopardy. Swindon and Wiltshire will not provide, in preference utilising its intensive support teams and local generic inpatient provision. Specialised commissioning beds will commissioned via a regional response to the project. At this stage the potential impact of dowries for 1 person is being consider (on the basis, those who have been an in-patient for five years or more) New Daisy service will come on line in Summer 2016. The will be 5 flats that, in a residential setting that will be able to meet the needs of people currently identified n inpatients settings. Further consultation will be built into the roll out of service model plan. **Issues:** Capacity issue rolling out the wider CTR programme.	

schemes to ensure that mainstream and specialist services serve people with learning disabilities and/or autism well. **Engagement of people with a learning disability and/or autism and their carers and families -** There will be an increased emphasis on close working with people with a learning disability and/or autism and their carers and families in commissioning activities, including the monitoring of contracts. This will help ensure that concerns around services are quickly understood and acted on, and that people's voices are heard and acted on in commissioning the shape and structure of care and support services.			**Dependencies**: NHSE match funding will be required to ensure the further development of Daisy service services. To help engineer the conversation with other CCGs and partnerships to look at a regional response to commissioning specialist services locally National changes to allow budgets for specialised commissioning to be pooled with CCG budgets for non-forensic services for those with a learning disability and/or autism.	

***The 5 Cohorts** – Not just people with learning disabilities. It is for children, young people or adults with a learning disability and/or autism;

6) who have a mental health condition such as severe anxiety, depression, or a psychotic illness, and those with personality disorders, which may result in them displaying behaviour that challenges.
7) who display self-injurious or aggressive behaviour, not related to severe mental ill health, some of whom will have a specific neuro-developmental syndrome.
8) who display risky behaviours which may put themselves or others at risk and which could lead to contact with the criminal justice system
9) often with lower level support needs and who may not traditionally be known to health and social care services, from disadvantaged backgrounds who display behaviour that challenges, including behaviours which may lead to contact with the criminal justice system.
10) who have a mental health condition or display behaviour that challenges who have been in hospital settings for a very long period of time, having not been discharged when NHS campuses or long-stay hospitals were closed.

6.Finances

Due to the short timescales for the bid process, the details contained in this document and appendices have been reviewed but have not undergone a thorough assurance and governance process within each of the represented organisations. Costs are indicative of the work required. Further immediate assurance work is needed to test the financial assumptions and review the finances in more detail. Not all the costs requested are associated with clinical care and therefore it is not expected that match funding the whole amount will be required.

Note - Financial assumption are in Section 5 of this report

Annex A – Developing a basket of quality of care indicators

Over the summer, a review led by the Department of Health was undertaken of existing indicators that areas could use to monitor quality of care and progress in implementing the national service model. These indicators are not mandatory, but have been recommended by a panel of experts drawn from across health and social care. Discussion is ongoing as to how these indicators and others might be used at a national level to monitor quality of care. This Annex gives the technical description of the indicators recommended for local use to monitor quality of care. The indicators cover hospital and community services. The data is not specific to people in the transforming care cohort.[3] The table below refers in several places to people with a learning disability or autism in the Mental Health Services Data Set (MHSDS). This should be taken as an abbreviation for people recorded as having activity in the dataset who meet one or more of the following criteria:

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

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

Indicator No.	Indicator	Source	Measurement[4]
1	Proportion of inpatient population with learning a disability or autism who have a person-centred care plan, updated in the last 12 months, and local care co-ordinator	Mental Health Services Data Set (MHSDS)	Average census calculation applied to: • Denominator: inpatient person-days for patients identified as having a learning disability or autism. • Numerator: person days in denominator where the following two characteristics are met: (1). Face to face contact event with a staff member flagged as the current Care Co-ordinator (MHD_CareCoordinator_Flag) in preceding 28 days; and 2. Care review (Event record with MHD_EventType 'Review') within the preceding 12 months.
2	Proportion of people receiving social care primarily because of a learning disability who receive direct payments (fully or in part) or a personal managed budget (Not possible to include people with autism but not learning disability in this indicator)	Short and Long Term Support statistics	This indicator can only be produced for upper tier local authority geography. Denominator: Sum of clients accessing long term support, community services only funded by full or part direct payments, managed personal budget or commissioned support only. Numerator: all those in the denominator excluding those on commissioned support only. Recommended threshold: This figure should be greater than 60%.
3	Proportion of people with a learning disability or autism readmitted within a specified period of discharge from hospital	Hospital Episodes Statistics (HES) and Assuring Transformation datasets. Readmission following discharge with HES main specialty - Psychiatry of Learning Disabilities or diagnosis of	HES is the longest established and most reliable indicator of the fact of admission and readmission. • Denominator: discharges (not including transfers or deaths) from inpatient care where the person is identified as having a learning disability or autism • Numerator: admissions to psychiatric inpatient care within specified period The consultation took 90 days as the specified period for readmission. We would recommend that this period should be reviewed in light of emerging readmission patterns. Particular attention should be paid to whether a distinct group of rapid readmissions is

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

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