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Agenda

Coventry Health and Well-being Board

Time and Date
2.00 pm on Monday, 27th June, 2016

Place
Diamond Room 2 - Council House

Public Business

1. **Welcome and Apologies for Absence**

2. **Declarations of Interest**

3. **Minutes of Previous Meeting** (Pages 3 - 10)

   (a) To agree the minutes of the meeting held on 11th April, 2016

   (b) Matters Arising

4. **Appointment of Deputy Chair of the Health and Wellbeing Board**

   To confirm the appointment of Dr Adrian Canale-Parola as Deputy Chair of the Health and Well-being Board for 2016/17

5. **Transforming Care Partnership** (Pages 11 - 88)

   Report of Pete Fahy, Director of Adult Services

6. **Sustainability and Transformation Plan** (Pages 89 - 102)

   (1) Presentation by Andy Hardy, Chief Executive of University Hospitals Coventry and Warwickshire on the Coventry and Warwickshire Sustainability and Transformation Plan Submission

   (2) Harnessing Voluntary Sector Resources in System Transformation – Report of Stephen Banbury, Chief Executive of Voluntary Action Coventry

7. **Coventry and Warwickshire Health and and Wellbeing Alliance Concordat** (Pages 103 - 106)

   Report of Gail Quinton, Executive Director of People

8. **Coventry Health and Wellbeing Strategy 2016 - 2019** (Pages 107 - 110)

   Report of Dr Jane Moore, Director of Public Health

9. **Any other items of public business**

Any other items of public business which the Chair decides to take as matters of urgency because of the special circumstances involved

Private Business

Nil

Chris West, Executive Director, Resources, Council House Coventry

Friday, 17 June 2016

Note: The person to contact about the agenda and documents for this meeting is Liz Knight Tel: 024 7683 3073 Email: liz.knight@coventry.gov.uk

Membership: Cllr F Abbott, S Allen, S Banbury, S Brake, Cllr K Caan (Chair), A Canale-Parola (Deputy Chair), G Daly, B Diamond, Cllr G Duggins, S Gilby, A Hardy, S Kumar, R Light, D Long, J Mason, J Moore, G Quinton, M Reeves, Cllr E Ruane, Cllr K Taylor and D Williams

Please note: a hearing loop is available in the committee rooms

If you require a British Sign Language interpreter for this meeting OR it you would like this information in another format or language please contact us.

Liz Knight
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Coventry City Council
Minutes of the Meeting of Coventry Health and Well-being Board held at 2.00 pm on Monday, 11 April 2016

Present:

Board Members:	Councillor Caan (Chair) Councillor Clifford Councillor Lucas Councillor Taylor Stephen Banbury, Voluntary Action Coventry Simon Brake, Coventry and Rugby GP Federation Dr Adrian Canale-Parola, Coventry and Rugby CCG (Deputy Chair) Professor Guy Daly, Coventry University Ben Diamond, West Midlands Fire Service Juliet Hancox, Coventry and Rugby CCG Professor Sudesh Kumar, Warwick University Ruth Light, Coventry Healthwatch John Mason, Coventry Healthwatch Dr Jane Moore, Director of Public Health Gail Quinton, Executive Director of People Rebecca Southall, University Hospitals Coventry and Warwickshire

Employees (by Directorate):

Resources:	L Knight
People:	S Frossell, L Gaulton, M Greenwood and R Nawaz
Apologies:	Dr Steve Allen, Coventry and Rugby CCG Simon Gilby, Coventry and Warwickshire Partnership Trust Andy Hardy, University Hospitals Coventry and Warwickshire Danny Long, West Midlands Police Martin Reeves, Coventry City Council David Williams, NHS Area Team

Public Business

41. **Welcome**

The Chair, Councillor Caan welcomed Ben Diamond, West Midlands Fire Service who was attending his first formal meeting of the Board. He also welcomed Liz Gaulton, Deputy Director of Public Health and Sue Frossell, consultant in Public Health who had recently commenced employment with the City Council.

42. **Declarations of Interest**

There were no declarations of interest.

43. **Minutes of Previous Meeting**

The minutes of the meeting held on 8th February, 2016 were signed as a true record. There were no matters arising.

44. **Health and Wellbeing Strategy Overview**

Further to Minute 37/15, the Board considered a report of Dr Jane Moore, Director of Public Health which referred to the three priorities previously agreed by the Board and informed of the work that had begun to turn the priorities into a Health and Well Strategy for 2016-19. A copy of draft framework for the Strategy was set out at an appendix attached to the report and a draft strategy document was tabled at the meeting.

The Board also received a presentation on the progress to date with the 100 day plan. The Board reviewed the current and future actions contained in the plan.

Both the draft framework and the draft strategy provided concise information on the three priorities highlighting the case for change; areas to focus; and expected outcomes. A copy of the two page information sheet 'Coventry: A Marmot City' was also circulated as an example of how to present brief informative information on how an issue was being progressed.

The Board raised a number of issues including:

- Who was involved in the review of the governance arrangements
- The importance of having the right people in the right meetings to enable decisions to be taken which could progress the priorities
- The importance of including the word 'prevention' in the strategy
- What were the measures to be used to ensure delivery.

Further detailed information on progress to date with the three priorities was set out in Minutes 45, 46 and 47 below.

RESOLVED that, the direction of travel and the work undertaken on the Health and Wellbeing Strategy be endorsed.

45. **Health and Wellbeing Priority 1 - Health Inequalities Update**

Ben Diamond, West Midlands Fire Service, provided an update on the priority to reduce health and wellbeing inequalities. Further details were set out in the draft Health and Well-being Strategy document, Minute 44 above refers.

The Board were reminded of the statistics from Public Health England that showed that on average men in the most affluent area of Coventry would live 9.4 years longer than men in the most deprived areas and for women the difference was 8.7 years.

The areas of focus were working as a Marmot City in partnership with Public Health England and the Institute of Health Equality to narrow the health inequalities gap by:
(i) Tackling health inequalities disproportionately affecting young people
(ii) Ensuring that all Coventry people including vulnerable residents can benefit from 'good growth' which will bring jobs, housing and other benefits to the city.

Expected outcomes were as follows:

- Better emotional resilience and improved mental health in young people
- Improved levels of education, employment and training in young people
- Vulnerable people helped into work
- Better quality jobs.

Reference was made to progress with the 100 day operational plan and the current work to develop and agree indicators to measure impact. The Board's views were sought as to issues to factor in. Matters discussed included:

- The need to offer valuable apprenticeships and work place experiences to support and inspire young people
- The importance of Board Members networking and using their contacts to encourage other organisations to offer apprenticeships/ work place experiences
- An acknowledgement of the very broad agenda of this priority and how Board Members could contribute to moving the priority forward
- An acknowledgement that some outcomes were very much long term which made it difficult to measure immediate impacts
- The intention to build on existing work and successes and to undertake specific work in a small number of areas where big changes could be made
- The resource implications and whether there was sufficient support for the programme lead
- The importance of the work to review the governance arrangements – the terms of reference and accountability
- The barriers to progress and the need for Board Members to hold one another to account

RESOLVED that the progress to date be noted and an update report be submitted to the next meeting of the Board.

46. **Health and Wellbeing Priority 2 - Multiple/Complex Needs Update**

Dr Jane Moore, Director of Public Health, provided an update on the priority to improve the health and wellbeing of individuals facing multiple complex needs. Further details were set out in the draft Health and Well-being Strategy document, Minute 44 above refers.

Reference was made to how services today were set up to deal with single issues such as drug or alcohol misuse, homelessness or mental health rather than addressing the various needs of the individual meaning that multiple professionals were working with the same person. This priority was about bringing key stakeholders together to be able to make a difference for these individuals.

The areas of focus were to improve the health and wellbeing of those individuals experiencing two or more of the following: mental ill health; substance misuse; violence and sexual abuse; and reducing the risk of people developing complex multiple needs.

Expected outcomes were:

- People facing multiple and complex needs will be enabled to manage their lives better through access to services that are more person-centred and co-ordinated
- Services will be more tailored and better connected and will empower users to take part fully in effective service design, with services taking a whole person approach
- Agencies work together to deliver and commission services for groups of people facing complex needs across the city
- Reduction in offending, anti-social behaviour and frequent users of services.

The Board were informed of the commitment from the police who had already committed resources for the initial scoping work with stakeholders.

Members discussed a number of issues including:

- The importance of including the Probation Service and the Faith Groups in the stakeholder consultation work
- An acknowledgement of the potential contribution from the two local universities
- A suggestion that work could be undertaken to make improvements to end of life care
- The financial implications and linking mental health with the work of the Combined Authority on this issue
- The need for all Members to commit to attending Board meetings to enable decisions to be taken.

RESOLVED that:

(1) The progress to date be noted and an update report be submitted to the next meeting of the Board.

(2) Members to ensure that they attend meetings so that decisions can be made when necessary.

47. **Health and Wellbeing Priority 3 - Accountable Health and Care System**

Rebecca Southall, University Hospitals Coventry and Warwickshire, and Gail Quinton, Executive Director of People, provided an update on the priority to develop an integrated health and care system that meets the needs of the people of Coventry.

The Board were informed that a Sustainability and Transformation Board had been established and was meeting on a fortnightly basis. Four work streams had been agreed with the intention of creating an ambitious proposal which could unlock funding for 2016/17. The final submission was due by the end of June. The Board noted the intention for the development to align with the Health and Wellbeing strategy.

The Board discussed the Sustainability and Transformation Plan which covered both Coventry and Warwickshire and noted the potential for joint working between the two Health and Wellbeing Boards to avoid duplication and conflicts. Further

issues raised included the financial resources in light of the current financial climate and the need to get the maximum benefits for the people of Coventry.

RESOLVED that:

(1) The progress to date be noted and an update report be submitted to the next meeting of the Board.

(2) Andy Hardy, University Hospitals Coventry and Warwickshire, to liaise with the Chairs and Deputy Chairs of the Coventry and Warwickshire Health and Wellbeing Boards regarding the development of the priority.

48. **Coventry City Council Health in All Policies Visit January, 2016**

The Board considered a report of Gail Quinton, Executive Director of People concerning the two day visit by the peer review team held on 5th and 6th January, 2016, to deliver the Health in All Policies peer support pilot programme. The main purpose of this programme was assist the Council to accelerate the good progress made to date on addressing the wider determinants of health and to maximise the impact of all policies and services in keeping people healthy and tackling health inequalities. A copy of the letter sent to Martin Reeves and Councillor Lucas outlining the findings and recommendations of the peer review team was set out at an appendix to the report.

The headline questions used during the visit were:

- Does the Council have a clear vision and ambition for health and Wellbeing?
- How well does the Council enable others to improve health?
- Is the Council making a sustainable impact on health outcomes?
- Is the Council using its resources to best effect to improve health?

Background documents and questionnaire responses were reviewed prior to the visit, with a number of interviews and workshops being held with elected members, employees and representatives of the partner organisations during the two day period.

The recommendations from the Peer Review Team were:

1) Capitalise on the renewed energy in the Health and Wellbeing Board to work with partners to:

a) ensure the revised Health and Wellbeing Strategy is the vehicle that pulls together into one place coherently the outcomes required for Coventry to be a Marmot Exemplar and Top Ten City
b) clarify how the role and purpose of boards and the relationship between them can best achieve the priorities in the strategy
c) to ensure a space is being created for partners to have ongoing and difficult discussions including those relating to their role in investment in upstream prevention

2) Ensure that Council strategies and plans all have a clear link to the ambition for the city with a consistency of language to help mainstream and embed public health considerations throughout all aspects of the Council's work

3) Ensure health needs are taken into account when decisions are being made and that approaches are adopted to reconcile situations where priorities are directly competing

4) Embed the Marmot principles explicitly into service planning processes ensuring there is a focus on prevention and keeping people well, and wherever possible demonstrate where services are offering a positive return on investment in prevention

5) Provide all Councillors with regular data and insight on health outcomes in their area to enhance their leadership role within communities, supporting them to become health champions so they can play their part in reducing health inequalities

6) Maximise the benefit of voluntary sector commissioning by providing mechanisms that enable services to signpost to each other e.g. by hosting networking sessions and facilitating workshops on the services provided.

The report referred to current update of the strategy that was taking on board the Council's ambition to be a Top Ten City and the Marmot agenda and the work to reframe the role of the Board to take forward the strategy. In addition the Council was committed to ensuring that as strategies and plans were developed and refreshed these would be linked to the new Health and Well-being strategy. Also the Insight Team had developed ward profiles for all Councillors to provide information on the health and well-being of constituents.

RESOLVED that, having considered the recommendations arising from the Health in All Policies Peer Review visit, the actions that need to be taken to support their implementation be approved.

49. **Better Care Fund 2016/17**

The Board considered a report of Marc Greenwood, Head of Business Systems, Coventry Council indicating that the Better Care Fund programme required sign-off by the City Council, Coventry and Warwickshire Partnership Trust, University Hospitals Coventry and Warwickshire and Coventry and Rugby CCG. The programme pooled together £53m of funding and the sign off process for 2016/17 required final plans to be submitted by 3rd May, 2016.

The report indicated that the Better Care Fund was to be incorporated into the Sustainability and Transformation Plans (STP) that NHS England were co-ordinating across all local health and care economies. There was an expectation that funds for 2016/17 would not see a reduction in agreed pooled budgets from the previous year and Coventry had agreed the same budget allocation.

Information was provided on the range of improvements that had made to the local health and care system during 2015/16. Priorities for 2016/17 included work to address the on-going challenges faced within the system relating to non-elective admissions and delayed transfers of care. In support of this the System Wide Transformation programme was to report progress on delivery through Better Care and included the following developments:

i) A community support model to prevent people needing to be admitted to hospital
ii) A frailty assessment pathway
iii) A therapeutic model that provides enabling support both in hospital and the community.

The System Wide Transformation programme would continue to be supported by the development and wider rollout of the multi-agency Integrated Neighbourhood Teams. Information sharing also remained a priority for the programme. The work started in the first year to support the return to Coventry of adults with learning disabilities and mental health issues placed out of the city was also to continue. There would also be a work stream on workforce which would identify opportunities for collaborative working and tackle issues relating to skill and capacity shortages. The Board noted that plans on the work stream would be submitted to a future meeting.

The Board discussed a number of issues arising from the report including:

- Further details about the expansion of the integrated neighbourhood teams
- Clarification about the funding ie that it was existing funding to be used to support new ways of working
- Information about targets, indicators and measuring outcomes.

RESOLVED that:

(1) The 2016/17 priorities of the Better Care Fund be approved.

(2) The inclusion of a workforce work stream in the 2016/17 plans be supported. This work stream will be further scoped in line with the Sustainability and Transformation Plan (STP) and plans will be brought back to a future board once further scoped.

(3) Responsibility to approve the final Better Care Fund plan on behalf of the Health and Wellbeing Board before submission on 3rd May, 2016 be delegated to the Chair, Councillor Caan.

50. **Any Other Item of Public Business - LGC Award for Work on Reducing Health Inequalities**

Dr Jane Moore, Director of Public Health informed that the City Council's Public Health Team had been awarded the Public Health Award at the recent LGC Awards for their work on reducing health inequalities. She referred to the submission which centred on Coventry's work with the Marmot City programme since 2013 which had seen improvements in schools readiness for children age five, health outcomes, life satisfaction, employment and reductions in crime in priority locations. Particular reference had been made to the strong partnership work and the commitment from all partners to reducing health inequalities in the city. It was an award for all.

51. **Any Other Item of Public Business - Health Select Committee Visit to Coventry**

Dr Jane Moore, Director of Public Health reported that members had recently been sent a letter informing that, following the Health in All Policies Peer Review in January 2016, the Government's Health Committee was to visit Coventry on 3rd May. The purpose for this visit was for the Committee to learn more about Coventry's Health in All Policies agenda and to meet the services and people that were delivering these plans. The date for the visit had now been put back and it was anticipated that it would be held towards the end of May on a date still to be determined.

(Meeting closed at 3.50 pm)

Briefing note

To
Coventry Health and Well-Being Board

Date
27 June 2016

From
Pete Fahy – Director of Adult Services
Jacqueline Barnes – Coventry and Rugby Clinical Commissioning Group

Subject
Transforming Care Partnership

1. Purpose

The purpose of this briefing note is to seek Health and Well-Being Board support for the programme of work underway across Coventry, Warwickshire and Solihull to deliver the Transforming Care Programme (TCP).

This note summarises the background to the TCP, implementation and achievements to date and the requirement for submission of a delivery plan to NHS England by 1 July 2016. Key risks associated with the programme are also identified. The draft plan for submission to NHS England in included in Appendix One.

2. Recommendations

Coventry Health and Well-Board is recommended to:

- Support the Coventry, Warwickshire and Solihull Transforming Care Partnership Transformation Plan which delivers the values and principles of the TCP programme, recognising that plans cannot have final sign off until greater clarity exists on funding arrangements.

- Receive future briefings on progress to include the management of financial implications and trajectory delivery risks across the health and social care economy associated with the delivery of the Transforming Care Partnership.

3. Background

Transforming Care is an NHS led national programme with cross sector support from the Local Government Association (LGA), Association of Directors of Adult Social Services (ADASS) and the voluntary sector. The programme is aimed at improving care and support for people with learning disabilities and/or autism and mental health problems or behaviour that challenges.

In September 2015 Coventry and Warwickshire with Hereford and Worcestershire submitted a joint fast track plan to NHS England. Following submission of this plan Coventry and Warwickshire received £825k non recurrent transformation funding from NHS England to deliver against the fast track plan.

In December 2015, the transforming care programme was varied by NHS England and introduced a new requirement where all areas of England were to confirm new Transforming Care Partnerships and to develop a new transformation plan including a bid for a share of an additional £30m funding available nationally.

This new partnership includes Coventry, Warwickshire and Solihull. This has required a revised and combined plan to be submitted to NHS England by 1 July 2016.

The way the overall programme is structured means that Coventry is both part of a Fast track programme with Warwickshire, Hereford and Worcestershire and a Transforming Care Partnership with Warwickshire and Solihull.

4. Fast Track Plan Implementation and Achievements

The fast track plan submitted in September 2015 described three phases of implementation. Work has been focussed on delivery of the first phase which required the establishment of an intensive support team to create community resilience in order for the nine bedded assessment and treatment ward at Gosford Ward at the Caludon Centre, Coventry to be de-commissioned. The transformation funding received was used to deliver this change.

Prior to proceeding with any definite plans to decommission the beds admissions were suspended on 31 March 2016 to test to robustness of the intensive support team. Plans will be progressed by health commissioners to achieve closure of the ward by September 2016.

Key achievements to date in delivering the fast track plan are:

- Community facilities have been established at Ashby House in Nuneaton and Gilliver Road in Solihull which provide support for short periods of time and offer treatment and support in a safe environment. To date just 1 person (from Coventry) has needed to use the accommodation at Ashby House to facilitate a discharge from Gosford Ward
- The £1.4m previously invested in Gosford ward has been reinvested in community support through the intensive support team
- Coventry and Warwickshire have collectively achieved a 33% reduction in inpatients comparing March 2015 and March 2016
- Closure of Gosford ward to admissions brought the partnership within the 10-15 beds per million target for CCG commissioned beds
- The average length of stay for discharged patients has reduced from 105 days to 30 days
- Two patients have moved on from low secure environment (commissioned by specialist commissioning) into a less restrictive environment commissioned by local Clinical Commissioning Groups

The fast track plan and progress made is considered a national exemplar.

5. Transformation Care Plan Submission – 1 July 2016

The Coventry, Warwickshire and Solihull partnership was required by NHS England to submit a refreshed and combined plan with a deadline of 11 April 2016. Due to the timescales set by NHS England only a provisional plan was submitted with a further and final iteration required for submission by 1 July 2016. This submission is required to demonstrate how the partnership plans to fully implement the national service model by 31 March 2019.

The national service model describes how people with learning disability and/or autism who display behaviour that challenges, including those with a mental health condition are to be supported in community settings to reduce the requirement for long term in-patient facilities. The development of this plan has been led by Coventry and Rugby Clinical Commissioning Group (CRCCG) and informed through engagement with a broad range of stakeholders including users, carers, families and providers.

The delivery of this model requires a whole system response and partnership working to deliver and as such should be endorsed through the Coventry Health and Well-Being Board.

The refreshed plan focusses on the second and third phases which will extend the model of care to children and young people and people with autism who do not have a learning disability along with people with forensic needs, some of whom will have a learning disability.

The plan is required to contain trajectories associated with delivering the target range 10-15 beds per million population. However, there are a number of risks and issues in relation to inpatient trajectories, not least that predictions and forecasts can be challenging to realise as the individuals concerned have a range of complexities that are subject to change.

Therefore, work on the trajectories is continuing up until submission to ensure these are as accurate as possible. NHS England have also confirmed that final numbers for inpatient transfers will not be known until August 2016. As information is confirmed greater clarity can be achieved as to the financial and organisations implications associated with delivery of the programme.

Despite the levels of uncertainty there has been considerable joint working with all organisations keen to deliver against the principles underpinning the programme. However, there is considerable concern regarding the financial implications that this programme may cause to our already financially challenged economy.

6. Key Issues and Risks

The Transforming Care Programme is an ambitious programme that is required to progress at pace with a lack of clarity existing in some areas. There is a risk management plan in place which is managed through the Transforming Care Oversight Board. There are however two key risks associated with delivery of the plan which will impact of the ability to deliver the aspirations of the programme. These risks are being.

Risk One: Delivering the trajectories

Reducing the beds commissioned in the Coventry, Warwickshire and Solihull locality will require strong collaboration with Birmingham and the Black Country as well as other CCGs and NHS England specialised commissioning as these organisations also place within Coventry, Warwickshire and Solihull. There are a number of clinical issues associated with providing alternative support to complex individuals and the successful management of these issues will be a significant factor in delivering the required trajectories. Actions in place to manage this risk include:

- The Senior Responsible Officer (SRO) is linking with other TCPs and specialised commissioning to confirm their future intentions for commissioning within the area.
- Plans are being developed for alternative provision in the event that people with learning disability and/or autism require a period of assessment and treatment.
- The Partnership is continuing to seek clarity on the issues regarding primary commissioning responsibility with NHS England.

Risk Two: Financial sustainability

Recognising that there is more work to be done, the latest version of activity and finance modelling indicates that an additional £7m could be required to fund the increased cost of packages of care over three years across health and social care. This £7m comprises approximately £3m due to growth and inflation and £4m which is due to additional packages which are likely to be required to support people in the community coming out of specialised services.

One possible mechanism of managing this financial risk is through Dowries payments. NHS England have issued high level guidance regarding Dowries, which will apply for anyone who had been in hospital for 5 years or more as at 1 April 2016. However, there has been no clarity as to how dowry funding is to be calculated.

In addition to the above, additional community health services may also be required, for example specialist forensic services in the community. This could further increase the financial pressure on CCGs of delivering this programme.

Actions in place to manage this risk include:

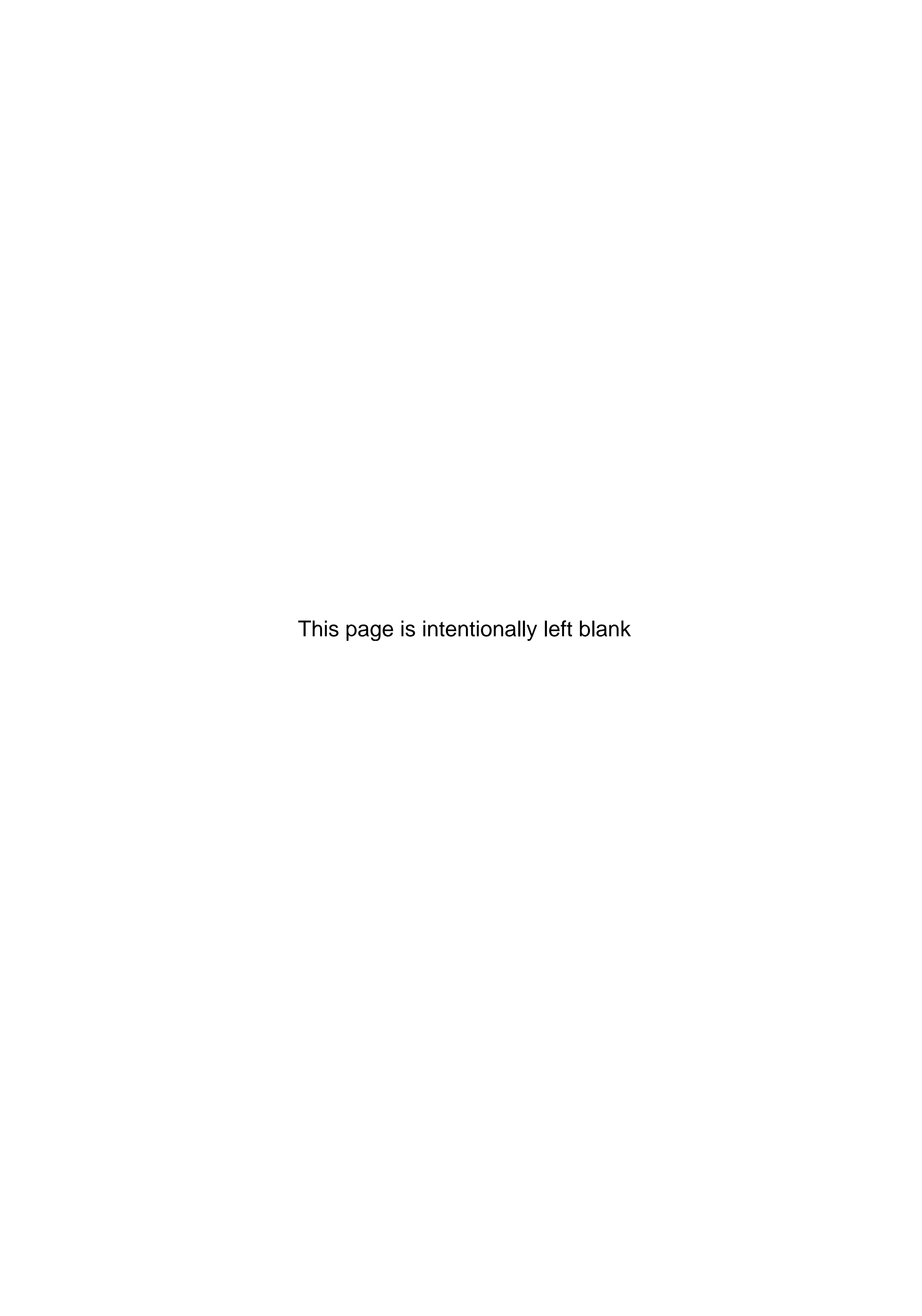
- Further work is being undertaken to understand how, and if, the model of care can be delivered within existing resources, which will require a review of existing spend on learning disability services to understand the extent to which services can be redesigned.
- Continuing to work with NHS England specialised commissioning to better understand how much money will be transferred to local services as people are discharged from specialised services.

The relative impact of these risks will require sign off through the organisations governance structures. The HWBB should note that any individual organisation is unlikely to be able to absorb additional cost, which could, in turn impact on the delivery of the Transforming Care programme.

Appendices

Appendix One: Draft Transforming Care Plan – Coventry, Warwickshire and Solihull

Pete Fahy
Director of Adult Services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Joint transformation planning template

1) Introduction
2) Planning template
   a. Annex A – Developing quality of care indicators

Introduction

- **Purpose**

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

- **Aims of the plan**

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

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

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

- **National principles**

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

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

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

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

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

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

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

Summary of the planning template

Planning template

1. Mobilise communities

Governance and stakeholder arrangements

Describe the health and care economy covered by the plan

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

The Arden and Solihull Transforming Care Partnership comprises four clinical commissioning groups: NHS Coventry and Rugby CCG (lead CCG); NHS South Warwickshire CCG; NHS Warwickshire North CCG; NHS Solihull CCG; and three local authorities: Warwickshire County Council; Coventry City Council; and Solihull Borough Council. 175 member practices make up the clinical commissioning groups in the Partnership.

The combined total population of Coventry, Warwickshire and Solihull is 1,127,715. This comprises 932,480 adults who are registered with a GP across the partnership footprint and 195,235 children and young people under 18 years old.

The Projecting Adult Needs and Service Information (PANSI) and Projecting Older Peoples Population Information (POPPI) databases[2] estimate that in 2015 there were 29,030 adults with a learning disability and/or autism in Coventry, Warwickshire and Solihull. This figure is predicted to rise by 4% by 2020 to 30,070 and by 11% by 2030 to 32,294.

Inpatient Provision

Currently, people with learning disabilities and OR autism, who are experiencing acute mental illnesses or challenging behaviour from Coventry and Warwickshire who are admitted to hospital are usually admitted to tier three or tier four inpatient services at Coventry and Warwickshire Partnership Trust (CWPT). CWPT operates two inpatient facilities in scope for this plan – Gosford Ward and Brooklands Hospital. Geographically, Brooklands is in Solihull and Gosford Ward is at the Caludon Centre in Coventry. There are no independent inpatient provider services located in Coventry, Warwickshire and Solihull.

The Coventry and Warwickshire CCGs have a block contract for Tier 3 (short –term) Assessment and Treatment in-patient beds with CWPT. This caters for up to 8.5 Assessment and Treatment beds in Gosford. Assessment and Treatment beds in Brooklands are purchased on a cost and volume basis. Currently Coventry and Rugby CCG is forecast to contribute 54% of the spend on the contract with CWPT in 2015/16 compared to 21% for Warwickshire North CCG and 25% for South Warwickshire CCG. Non NHS and out of area beds are commissioned by Coventry and Warwickshire CCGs on a case by case basis using spot contracts. Further detail is provided in this plan.

Intentionally, Solihull does not commission an assessment and treatment service, having made the decision to close its local service approximately seven years ago, as part of a local

[2] Projecting Adult Needs and Service Information (PANSI) www.pansi.org.uk and Projecting Older People Population Information System (POPPI) www.poppi.org.uk

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strategy to support people with learning disabilities who have complex and challenging behaviour, in their community. On the occasions that a Solihull resident is so unwell that they need to be detained under the Mental Health Act, they reluctantly admit to local provision (usually at Brooklands Hospital) on a spot purchase basis. However, as this submission details, this is always a last resort and Solihull has striven to create a culture of 'zero tolerance of inappropriate admission to hospital'.

For Coventry, Warwickshire and Solihull, low and medium secure, and CAMHS beds are commissioned through frameworks with Birmingham and the Black Country Specialised Commissioning Unit, or other Specialised Commissioning Units across the country.

There are 93 learning disability/autism inpatient beds in Coventry, Warwickshire and Solihull for Assessment and Treatment and low and medium secure, and another 12 adolescent/young patient unit beds, which are not specifically for those with learning disability/autism. Of the total 105 beds, 96 of these are at the Brooklands Hospital site in Marston Green which is within the Arden and Solihull locality. The remaining nine beds are on the Gosford Ward which is at the Caludon Centre in Coventry.

The table in section 2 of this plan describes how the beds in Coventry, Warwickshire and Solihull are commissioned. Currently, 13 of the non-secure beds accommodate residents from Arden and Solihull CCGs. 12 of the low and medium secure beds and adolescent/young people unit beds in Coventry, Warwickshire and Solihull are populated with residents of Arden and Solihull who have a learning disability and/or autism. This represents just 25 (24%) of the 105 beds in the Partnership area.

The Gosford Ward is being closed to admissions from 31 March 2016 and the intention is to permanently close the ward before 30 September 2016 in line with the Arden fast track transformation plan submitted to NHSE in September 2015. Inpatient beds in the Coventry, Warwickshire and Solihull locality will then total 96, with 19 (20%) of these used by Arden and Solihull residents. 5 of the 19 are commissioned by Arden and Solihull CCGs with the remainder commissioned by NHS England Specialised Commissioning.

Outside of the Arden and Solihull locality, people from Arden and Solihull CCGs with a learning disability and/or autism are placed in a further 5 forensic rehabilitation beds, 2 complex continuing care beds and 7 secure beds. In addition 8 CAMHS beds outside Coventry, Warwickshire and Solihull are populated with people with a learning disability and/or autism from Arden and Solihull CCGs.

Community NHS Provision

Across Coventry, Warwickshire and Solihull, providers of services in the community for people with a learning disability and autism include:

- Coventry and Warwickshire Partnership Trust
- Heart of England Foundation Trust
- Birmingham and Solihull Mental Health Foundation Trust

There are a range of commissioning arrangements for the services provided and these are described in section 2.

Community Local Authority Provision

Coventry City Council have a provider arm and detail about these services is described in

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section 2

Independent Sector Community Provision

Coventry, Warwickshire and Solihull share many, but not all providers of supported living and residential care services. The approach to working with independent sector community providers is described in section 2.

Commissioning Arrangements

In terms of formal commissioning collaborations:

- Solihull, Coventry and Warwickshire are working together to offer a Shared Lives arrangement to the people in our areas;
- Warwickshire and Solihull jointly developed and supported a planning proposal for supported housing for people with complex Autism on the shared boundary of our Boroughs
- Coventry and Warwickshire CCGs jointly contract with CWPT for the provision of community and inpatient services for people with learning disabilities

There are no formal joint or lead commissioning arrangements in place in Warwickshire for our learning disability and autism population as yet. However, this is an agreed strategic intention as outlined in our Joint Statement of Intent for Adults with a Learning Disability and commissioning partners continue to work together to progress an integrated approach. For example, in 2015 the council commissioned community support services for people with high support needs on behalf of social care and the 3 CCG's. A joint service specification and contract was agreed. The council is currently leading the negotiation of residential and nursing care service contracts in Warwickshire on behalf of the 3 CCG's to an agreed outcome based service specification; underpinned by a Section 75 agreement. The Council is also leading the commissioning of a range of Care at Home services with CCG's; this includes domiciliary care services covering Warwickshire and supported living, live in care and complex clinical care services across Warwickshire and Coventry. Again, a joint service specification has been developed.

In relation to services for disabled children and young people the council and CGG's, supported by Arden Gem CSU, continue to undertake a programme of joint service reviews to determine future commissioning intentions while arrangements continue to agree joint packages of care and support as appropriate for individual children and young people with special educational needs and disabilities. The All Age Disability Commissioning Service within the council continues to take action to ensure that contracts for care services, such as domiciliary care and short breaks, can respond to the needs of children and young people, specifically those in transition.

Warwickshire has recently undertaken a significant piece of work to re-design CAMHS locally. This has included agreement to progress joint commissioning arrangements, underpinned by a Section 75.

Solihull has in place Joint Strategic Commissioners:

- Children and families
- People with Learning Disabilities and Autism
- People with Mental ill health – including people with dementia.

These joint commissioning roles are accountable to the Chief Officers of the CCG and SMBC

through a Joint Commissioning Board, which formally links to the Health and Wellbeing Board and the Chief Officer Leadership Teams of the Council and the CCG

As indicated above there is senior level commitment across Coventry City Council, Warwickshire County Council and the three Clinical Commissioning Groups in Coventry and Warwickshire to progress lead commissioning arrangements for people with learning disabilities. These areas have been identified as both national policy and local joint strategic commissioning intentions are clear regarding the need for, and benefits of, integrated commissioning arrangements and pooled budgets for this local population. This plan includes the appointment of a Joint Strategic Commissioning Programme Manager in 2016/17 for a period of 12 months to progress lead commissioning arrangements across health and social care for people with a learning disability and/or autism across Coventry and Warwickshire.

Describe governance arrangements for this transformation programme

Guidance notes; who are the key partners, what is their involvement.

IMPORTANT CAVEAT IN RELATION TO GOVERNANCE

- **This plan is in draft form and has not had full sign off by the Oversight Board, partner organisations nor Health and Wellbeing Boards.**
- **All Board members are aware of the requirement to sign off the plan before July 2016 and have made a commitment to do so once financial implications of the plan are better understood.**

The diagram at Appendix 1 provides a visual representation of the governance structure for the Arden and Solihull Partnership.

The Arden and Solihull Transforming Care Oversight Board, which meets monthly, provides assurance of delivery of the Arden and Solihull Transforming Care Partnership programme and oversees progress across all the agreed workstreams. The Board is chaired by the Senior Responsible Owner (SRO), Jacqueline Barnes, Executive Nurse, Coventry and Rugby CCG. The Deputy Chair is John Dixon, Interim Service Director, People Group, Warwickshire County Council.

Membership includes director and senior level representatives of the following organisations:

- NHS Coventry and Rugby CCG
- NHS South Warwickshire CCG
- NHS Warwickshire North CCG
- NHS Solihull CCG
- Warwickshire County Council
- Coventry City Council
- Solihull Borough Council
- Coventry and Warwickshire Partnership Trust (although discussions are ongoing about the most appropriate place for providers to contribute in the governance structure)

Representatives of the following organisations also attend to inform the discussion and support decision making:

- NHS England Specialised Commissioning Unit

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- NHS England Transforming Care team
- Workstream leads from partner organisations
- Arden and GEM CSU (programme manager)

The primary purpose of the Oversight Board is to:

- Provide an oversight of the delivery of the plan to transform care for people with learning disabilities and/or autism across the Arden and Solihull partnership, recognising the importance of joint working with Birmingham, Herefordshire, Worcestershire partnerships to achieve this.
- Lead and manage the successful implementation of a new model of care which prevents hospital admissions and provides enhanced community support to people at home.
- To oversee the overarching governance for the programme and to provide a route for escalation of issues and risks in relation to the delivery of the programme.
- To report to NHS England and health and wellbeing boards on progress across the Partnership and Fast Track Area.
- In Arden, the Board will be underpinned by a Memorandum of Understanding between all agencies in Coventry and Warwickshire.

In terms of the specific arrangements for Transforming Care, in addition to the Board, the Partnership has :

- a Transforming Care Partnership Group which is made up of people with learning disabilities and autism, family carers, support organisations practitioners, clinicians and managers. This forum now includes Solihull people and links in directly to the Transforming Care Oversight Board. This group's role is to inform, shape and challenge plans, proposals and practice of the three areas; it is organised and managed in a way that ensures people have the opportunity to become partners in policy making and builds on the lessons and knowledge learned through the Partnership Boards for people with learning disabilities.
- Feeding in to the Transforming Care Oversight Board is a Local Delivery Group which comprises Learning Disability and Autism Commissioners from across the three areas as well as key workstream leads and representatives of Coventry and Warwickshire Partnership Trust.

People with a learning disability, people with Autism and their family carers are key stakeholders too and they are involved in the forums described above. More detail about this is reflected in the following sections.

Contractual arrangements

Coventry and Rugby CCG are the lead CCG for the contract with Coventry and Warwickshire Partnership Trust (CWPT) on behalf of the Warwickshire and Solihull CCGs, and commissioning responsibility sits within each individual CCG. This means that all CCGs across the partnership share governance processes such as joint contract review and quality monitoring forums which underpin the relationship with CWPT.

Solihull also has formal contractual arrangements with HoEFT and the BSMHFT so there are already formal arrangements in place to address and progress the governance issues which arise throughout this programme.

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Describe stakeholder engagement arrangements

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

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

Engagement with stakeholders, including people with lived experience

Public engagement in Coventry, Warwickshire and Solihull builds on existing structures that have been in place since at least 2014 around delivering the response to Winterbourne View.

Coventry

The following engagement activities were undertaken in Coventry between May and July 2014 to inform the development of the joint local response to Winterbourne, which clearly articulated the intentions of the local area in relation to Transforming Care and a new model of care.

Over 200 people were engaged in a programme of engagement activity during May 2014 to consider specifically:

- the proposed aims and objectives in the plan
- whether the objectives will achieve the stated aim,
- whether there are identify any gaps in the plan

Feedback from engagement events confirmed support for the intentions and plans outlined in the local response to Winterbourne. Engagement planning and events were led by Coventry City Council as part of wider co-production activity planned relating to the development of the next iteration of the learning disability strategy.

A major engagement event in May was hosted by the co-chairs of the Learning Disability Partnership Board with active participation of people with learning disabilities, their families and our Grapevine advocacy support service. Particular effort was made to ensure that the voices of those with complex needs, their carers and advocates were heard. This event included feedback on progress to date in respect of Winterbourne and broad intentions going forward. Participants were asked to comment on:

- Whether the priorities included in the draft document are the right ones?
- Do the delegates feel we have missed anything?
- Partnership work to achieve goals
- What people would like to see happen and how?

Coventry was represented at the regional TLAP event and used learning from the session to further inform the personalised approach to coproduced solutions for people with complex needs.

A separate engagement exercise was undertaken to ensure that Coventry's autism strategy and planning has been fully informed by service users and other key stakeholders. This included the local joint response to Winterbourne. The City Council has led on a series of market shaping events subsequent to the publication of its Market Position Statement in March 2014. A specific event for providers of service for people with learning disabilities was

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held on 4th June 2014 and incorporated implications of Winterbourne for local market development.

Focused work has continued throughout this period with the Learning Disability Partnership Board to ensure they are able to influence and subsequently endorse plans.

Warwickshire

The following engagement activities were undertaken in Warwickshire between May and July 2014 to inform the development of the joint local response to Winterbourne, which clearly articulated the intentions of the local area in relation to Transforming Care and a new model of care.

Warwickshire's Learning Disability Partnership Board received regular updates on the work being undertaken. In addition, the local peer advocacy group undertook some detailed work with learning disability representatives on the partnership board to ascertain their views to contribute to the development of the joint plan.

The draft plan was developed by April 2014 in line with requirements. However Warwickshire and Coventry agreed to embark on a period of engagement with stakeholders to ensure that the plan appropriately captured local needs. As part of this:

- A programme of engagement activity took place throughout June and July 2014 to meaningfully engage customers, carers and providers to consider the proposed aims and objectives in the plan, whether the objectives will achieve the stated aim and whether there are identify any gaps in the plan. 100 plus people contributed their views during this time.
- An on-line survey and paper survey which was in an accessible format were made available to the public and a workshop was held with over 30 providers to gather their opinions about the plans. The Advocacy and Empowerment Service supported service users with high support needs to take part in the survey. One of the ways they achieved was to support communication through art. We asked people if we had got the plan right 80% agreed and 20% strongly agree that we had got it right. Some questions were asked about how we were going to monitor the plan. We made sure we added this to the plan as it was not clear.

Warwickshire's Learning Disability Partnership Board considered and endorsed the fast track plan submitted to NHS England in September 2015. The Autism Partnership Board operating in Warwickshire has also been updated on the programme with members being invited to join the partnership group.

In addition to the above people with a learning disability and/or autism, and their carers, played a key role in the development of Warwickshire's joint commissioning intentions. Both the Learning Disability Statement of Intent and All Age Autism Strategy were co-produced with customers, carers and professionals and as such are fully endorsed by the local population.

Solihull

Solihull has a nationally recognised programme of Experts by Experience (now operating as a CIC) and Experts are formally part of all strategic and development processes and forums –

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including those projects which are tasked with delivering savings.

- a well established Partnership Board for People with learning disabilities, which is co-Chaired by a person with learning disabilities, and includes stakeholders from all sectors and representing all age groups
- a Borough wide Board of people with learning disabilities called the Changing Lives Board; paid for their expertise, Board members act as a formal source of advice, reference, consultation and challenge to the CCG and Council
- a formal reference group of family carers called the Carer's Leadership Group. They are independently supported by the Solihull Carers Centre.
- a Carers Partnership Board – representing carers across the Borough
- An Autism partnership group which is effectively a sub group of the Health and Wellbeing Board and is now an all age and agency partnership group
- a 'Children and Young People with Special Needs and Disabilities Board'; this group is a partnership and stakeholder Board – including young people, families and independent advocates

Representatives of most of these groups were involved in the development of the Borough's response to Winterbourne View .There was overwhelming support for the work already undertaken to reduce reliance on inpatient provision and extend when possible the Enhanced Support approach.

Pre-dating this, the consultation on the Borough's learning disability strategy, outlined proposals to develop an Enhanced Support approach whilst developing housing and support solutions to enable people with complex needs to live well and safely in the community. The events involved over 200 people who overwhelmingly supported this focus.
.
The Partnership Board for people with learning disabilities has considered and endorsed the proposals which underpin the Partnership Plan and the work undertaken to create this single plan will be formally presented at the forthcoming Partnership Board meeting

The Borough's Autism strategy is an overarching all age plan based on the principles of inclusion and citizenship. Respondents to the consultation supported these principles gathered through survey monkey, specific presentations and events to groups of people with autism, family groups and professionals.

Input from local governance groups

In Coventry and Warwickshire, the joint local response to Winterbourne and the transforming care fast track programme have been presented and endorsed locally on the following occasions:

- Joint local response to Winterbourne – Warwickshire Health and Wellbeing Board November 2014, Coventry Health and Wellbeing Board November 2014
- Warwickshire Learning Disability Statement of Intent (which includes reference to transforming care programme and local response) – Warwickshire Council Cabinet July 2015
- Coventry Learning Disability Strategy (which includes reference to transforming care programme) – cabinet member November 2014
- Transforming Care Fast Track Plan – Warwickshire Adult Health and Social Care Overview and Scrutiny Committee September 2015, briefing to Chair of Coventry Scrutiny Board October 2015
- Transforming Care Launch – held in Warwickshire in December 2015. Both the portfolio holders for adult social care and health from across Coventry and

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Warwickshire were in attendance to support the event.

As Solihull have more recently joined the partnership, and have already been working to a model of care which is aligned with the new national model, the planning process and timescales have been different. However, the overall approach was initially endorsed through the Learning Disability Strategy 'Acknowledgement and Inclusion' (2008), and more recently, through the Health and Wellbeing Board which receives reports about the Borough's progress in this area every 6 months, commencing in July 2013. The Safeguarding Adults Board which requires bi annual reports, commencing December 2013, and Solihull CCG Governing Body, commencing April 2015 and a more recent focus on outcomes for people affected by the programme in February 2016.

Provider Engagement

- Coventry, Warwickshire and Solihull share many of the same NHS and independent community providers, which has supported engagement across the partnership area.
- Clinicians and managers from CWPT have been engaged in the Transforming Care Fast-track programme through the Oversight Board and Delivery Group, and also in the development of the Business Case to develop a community based model of care and to close the Tier 3 assessment and treatment beds in Gosford Ward. This is a collaborative relationship that has been actively working on this programme since the health and care community started work on its Joint Plan in response to Winterbourne View. This relationship will support the reduction in in-patient beds and the testing and development of new community-based care and support services.
- Warwickshire has a provider forum, which has regularly been updated on and engaged in the development of strategies for Transforming Care and this will continue.
- Coventry does not currently have a specific provider forum for learning disability providers, however providers attend generic provider forums and are engaged separately in respect of specific issues including around Transforming Care and Market Position Statement related events.
- A Learning Disability Network has been established in Coventry and Warwickshire since September 2015 to co-produce particular elements of the transforming care programme. This group has included representatives of CWPT, social workers and providers of supported living and residential services. The network has provided input so far to the development of a Quality Assurance Framework and the enhanced support pathway. Further work is planned with wider provider groups to provide input to workforce development planning and implementation.

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

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

As mentioned in the previous section on engagement, a significant amount of engagement has been undertaken to enable strategies, plans, the model of care and associated business cases to be co-produced with all stakeholders.

Transforming Care Partnership Group

- A joint Coventry and Warwickshire co-production group was established in January 2015. This group include representatives of both Coventry and Warwickshire

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Partnership Boards, including service users, carers, providers, clinical and social work professionals, local Partnership Trust and commissioners.

- This group met monthly during the co-production phase of developing the local model of care, creation of the Living My Life DVD and development of the fast track plan submitted in September 2015.
- Representatives of this group have reported back to Partnership Boards on progress with development of the new model of care and fast track plans. Representatives of this group have also engaged with other service users through speaking up groups and other fora.
- Feedback from these groups has supported the development of the model of care and fast track plans.
- The group now meet bi-monthly as the group felt that timeframe was more appropriate. The group has been further strengthened recently with additional service user input from the Autism Partnership Boards and colleagues from Solihull will be joining the next meeting in April.
- There is one carer rep on the Group and we are working to find others who have the time and inclination to join the group.
- In terms of input to the Oversight Board, service user representatives on the Partnership Group have agreed with the SRO that they will attend the beginning of Board meetings at which they will have an opportunity to comment, challenge and endorse the work of the Oversight Board. Service user representatives did not feel that they would like to attend the whole board meeting and instead prefer to maintain the current stakeholder group with close links between the two.

Coventry, Warwickshire and Solihull combined co-production activity

Stakeholders have been engaged with the development of a new local model of care during late 2014 and early 2015, and asked to contribute to the options appraisal of a business case for phase one of the transformation programme, which was completed in August 2015. This new model of care, developed locally with input from clinicians, social workers, independent providers, service users and carers aligns closely with the national model of care which has subsequently been produced. Commissioner and professional input from Solihull supported the development of this programme from an early stage, enabling Coventry and Warwickshire to learn from and build on existing models in Solihull.

A DVD “Living My Life” has been developed across the Partnership, with input from people with lived experience, their carers, providers, clinicians, social workers and commissioners. This DVD tells the stories of four people with learning disabilities and autism who have spent long periods of time in hospital and who now live happy and fulfilled lives in their own homes in the community. The DVD also presents chapters which describe the aims of the transforming care programme and key elements of a new model of care including: values; risk; home; training and celebration.

In December 2015, Coventry and Warwickshire hosted a launch event for the new model of care. This event, which was co-produced with service users, carers, providers and commissioners from across Coventry, Warwickshire and Solihull was hosted by the local council portfolio holders in Coventry and Warwickshire and attended by over 100 people. The event used peoples’ stories as told in the locally developed DVD to promote the new model of care and begin the process of culture change required to make the programme a success.

Planned co-production activity

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The Coventry, Warwickshire and Solihull partnership are committed to continuing the co-production approach to delivering this transformation plan.

Further engagement and consultation is planned in relation to the planned closure of Gosford Ward to ensure that all stakeholders view are incorporated into the model of care and pathways being put in place following closure. Consultation will follow appropriate procedure, with pre engagement being undertaken and formal consultation period to follow.

It is recognised locally that co-production with children and young people beyond the initial strategic planning phase is a gap. As described in the fast track plan submitted in September 2015, activity in Coventry and Warwickshire has been focussed on phase one of the transformation which has been enhancing the support available in the community to adults with learning disabilities and autism to enable the closure of Gosford Ward.

Phases two and three of the programme will extend the model of care to children and young people and people with autism who do not have a learning disability. Accordingly, co-production events are being scoped to understand how the model needs to be developed to meet the needs of all people. Warwickshire has contributed funds to take part in an NDTI study focusing on the transition of children and young people with behaviours that challenge to determine how we can improve the local offer. It is anticipated that this work will assist understanding and steer activity in this area.

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

Any additional information

2.Understanding the status quo

Baseline assessment of needs and services

Provide detail of the population / demographics

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

The combined total population of Coventry, Warwickshire and Solihull is 1,127,715. This comprises 932,480 adults who are registered with a GP across the partnership footprint and 195,235 children and young people under 18 years old.

Adult population with a learning disability and/or autism

The Projecting Adult Needs and Service Information (PANSI) and Projecting Older Peoples Population Information (POPPI) databases[3] estimate that in 2015 there were 29,030 adults

with a learning disability and/or autism in Coventry, Warwickshire and Solihull. This figure is predicted to rise by 4% by 2020 to 30,070 and by 11% by 2030 to 32,294.

Total population aged 18+ predicted to have a learning disability and/or autism for Coventry, Warwickshire and Solihull

Local Authority	2014	2015	2020	2025	2030
Coventry	8,781	8,896	9,375	9,833	10,372
Solihull	5,393	5,424	5,558	5,676	5,842
Warwickshire	14,614	14,710	15,137	15,571	16,078
Total TCP population	**28,788**	**29,030**	**30,070**	**31,080**	**32,292**

Of the 29,030 adults who have a learning disability and/or autism in Coventry, Warwickshire and Solihull there is a cohort that displays behaviour that challenges. Estimates for this vary. Emerson & Einfield [4] estimate that 10-15% of the learning disability/autism population will have behaviour that challenges. For Coventry, Warwickshire and Solihull, this would be between 2903 - 4394 people. The Projecting Adult Needs and Service Information (PANSI) database estimates that 298 people with a learning disability and/or autism have behaviour that challenges in Arden, and Solihull (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, PANSI and POPPI data suggests that 4269 adults or 15% of people in Coventry, Warwickshire and Solihull with a learning disability and/or autism have moderate or severe learning difficulties, 1396 of whom are adults living with parent. Predicted figures indicate that 241 of the people living with a parent are over age 45, which would suggest that their parents may be entering a period of increased support needs themselves, which may present an increased risk of admission to hospital for this cohort.

A study of prevalence[5] of profound multiple learning disabilities suggests that there could be 399 adults (0.035% of the total population) with profound and multiple learning disabilities accessing health and social care services in Coventry, Warwickshire and Solihull. This study suggests that a further 4 adults will join this cohort each year.

21% of people in Coventry, Solihull and Warwickshire with a learning disability and/or autism are aged 65 or over. The profile across the age bands in 2015 is shown in the table below (source PANSI / POPPI data).

Age Band	Estimate of population in 2015 with a learning disability and/or autism	% of total 18+population with a learning disability and/or autism
18-24	3,923	14%
25-34	4,987	17%
35-44	4,707	16%
45-54	5,154	18%
55-64	4,055	14%

[3] Projecting Adult Needs and Service Information (PANSI) www.pansi.org.uk and Projecting Older People Population Information System (POPPI) www.poppi.org.uk

[4] Challenging Behaviour (3rd Edition), Emerson E and Einfeld S (2011)

[5] http://www.debramooreassociates.com/Resources/CeDR%202009-1.pdf

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65-74	3,511	12%
75-84	2,141	7%
85+	553	2%
Total	**29,031**	

However these figures mask an ageing population of those with a learning disability and/or autism. The number of people with a learning disability and/or autism aged 55 or over is estimated to increase by 27% by 2030, with an 84% increase for those aged 85+ and a 52% increase for those aged 75-84. These changes will present challenges across the health care and system as people with learning disabilities are more likely to experience age related health conditions at an earlier stage, including dementia. Meanwhile the number of people with a learning disability and/or autism aged 45-54 is predicted to decline by 9%.

There is estimated to be a 5% increase in the number of people with a learning disability and/or autism with challenging behaviour in Coventry, Warwickshire and Solihull by 2030 based on the estimate of 298 displaying challenging behaviour in 2015.

Children and Young People Population with a learning disability and/or autism

In schools the numbers of pupils with statement of educational need indicating primary need relating to a learning disability or autism as of January 2015 across Coventry, Warwickshire and Solihull were:

Primary type of need	Primary & Secondary Schools	Special Schools	TCP Total
Specific LD	2,804	23	2,827
Moderate LD	6,908	662	7,570
Severe LD	153	821	974
Profound and multiple LD	12	210	222
ASD	2,350	415	2,765
Total	**12,227**	**2,131**	**14,358**

Until more detailed analysis of data can be completed, the number of children attending special school will be used as a proxy measure for the population of children and young people with complex learning disabilities and autism who may be at increased risk of either hospital admission or 52 week residential placement out of the area. However, it is acknowledged that some children and young people may not be school age or may not be attending a special school.

Needs assessment

In Warwickshire, a joint strategic needs assessment for learning disabilities was produced in 2015. The key messages from the joint strategic needs assessment are below and have been used to inform and underpin the transformation plan for this TCP as well as wider learning disability strategies for Warwickshire:

- The total estimated prevalence of all people with a learning disability in

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Warwickshire in 2013 was **11,030** of whom 9,469 are adults aged 18+ and 1,561 are children & young people aged 0-17 years.
- Approximately two-thirds of adults with learning disabilities expected to be in contact with social services are receiving a service from social care in Warwickshire.
- People with learning disabilities have significantly worse health than their non-disabled peers.
- In 2013/14, 57.5% of adults with learning disabilities in Warwickshire received an Annual Health Check.
- The number of people with a learning disability is likely to increase by 1% per year over the next 15 years due to increased life expectancy & increasing numbers of children with complex needs surviving into adulthood.
- The number of adults with learning disabilities with a critical or substantial need using social care services is estimated to increase by 1.7% year on year to 2030.

In terms of understanding the population from the perspective of people with learning disabilities (many of whom also have Autism) commissioners in Coventry, Warwickshire and Solihull know:

- how many people are inpatients,
- who is at risk of being admitted
- who has been in hospital in the past
- Which people from Coventry and Warwickshire have been in hospital for over 5 years (In Solihull there are no ‘long stay’ people)

In Solihull a Transforming Care - compliant model of care is already in place and has been for some years. Coventry and Warwickshire began phase one of their transformation plan to implement the new model of care in December 2015 and have successfully closed a nine bedded assessment and treatment unit to admissions as a result.

However, it is recognised that the full impact of this approach will only be truly realised by extending this approach across:

- services for Children and Young People
- those people with Autism who do not have a learning disability
- those people who have forensic needs.

The national model for ‘Supporting people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition are described in 5 specific cohorts including:

1) Children, young people or adults with a learning disability and/or autism 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) Children, young people or adults with an (often severe) learning disability and/or autism who display self-injurious or aggressive behaviour, not related to severe mental ill health, some of whom will have a specific neuro-developmental syndrome and where there may be an increased likelihood of developing behaviour that challenges.
3) Children, young people or adults with a learning disability and/or autism who display risky behaviours which may put themselves or others at risk and which could lead to contact with the criminal justice system (this could include things like fire-setting, abusive or aggressive or sexually inappropriate behaviour).

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4) Children, young people or adults with a learning disability and/or autism, often with lower level support needs and who may not traditionally be known to health and social care services, from disadvantaged backgrounds (e.g. social disadvantage, substance abuse, troubled family backgrounds) who display behaviour that challenges, including behaviours which may lead to contact with the criminal justice system.
5) Adults with a learning disability and/or autism 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.

The data for the 5 cohorts locally is not currently broken down into the groupings noted however plans are in place to collect this through the local transformation work.

Analysis of inpatient usage by people from Transforming Care Partnership

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

Beds within the TCP footprint

There are 93 learning disability/autism inpatient beds in Coventry, Warwickshire and Solihull for Assessment and Treatment and low and medium secure, and another 12 adolescent/young patient unit beds, which are not specifically for those with learning disability/autism. Of the total 105 beds, 96 of these are at the Brooklands Hospital site in Marston Green which is within the Arden and Solihull locality. The remaining nine beds are on the Gosford Ward which is at the Caludon Centre in Coventry.

The table below describes how the beds in Coventry, Warwickshire and Solihull are commissioned. As at 31 March 2016, 4 of the non-secure beds accommodate residents from Arden and Solihull CCGs. 13 of the low and medium secure beds and none of the adolescent beds in Coventry, Warwickshire and Solihull are populated with residents of Arden and Solihull who have a learning disability and/or autism. This represents just 17 (16%) of the 105 beds in the Partnership area.

TCP inpatient population in beds in footprint (adults)

Unit (NHS)	CCG or NHSE	Type of Bed	No. Beds	No. beds commissioned / contracted by TCP	No. beds in use by TCP
CWPT Gosford Ward*	CCG	ATU	9	9	0
CWPT Brooklands Hospital	CCG	ATU	28	none (spot purchased)	4
CWPT Brooklands Hospital	NHSE	Low Secure	41	Block contract	10
CWPT Brooklands Hospital	NHSE	Medium Secure	15	Bloc contract	3
CWPT Brooklands Hospital	NHSE	Adolescent / YP unit (non LD specific)	12	Spot purchased	0

*The Gosford Ward was closed to admissions on 31 March 2016 and the intention is to permanently close the ward before 30 September 2016 in line with the Arden fast track

transformation plan submitted in September 2015. Specialist learning disability inpatient beds in the Coventry, Warwickshire and Solihull locality will then total 96, with 16 (17%) of these used by Arden and Solihull residents. 4 of the 16 are commissioned by Arden and Solihull CCGs with the remainder commissioned by NHS England Specialised Commissioning.

In addition to the above, there is one adult with a learning disability and/or autism being supported in a mainstream mental health ward, in line with the new model of care. Additionally this person and the staff on the mental health ward are being supported by the new mental health acute liaison service.

Unit (NHS)	CCG or NHSE	Type of Bed	No. Beds	No. beds commissioned / contracted by TCP	No. beds in use by TCP
CWPT Caludon Centre	CCG	General mental health acute	No LD specific beds are commissioned – people with LD & autism will access mainstream MH services which are part of the block contract with CWPT		1

TCP inpatient population in beds in footprint (children)

Unit (NHS)	CCG or NHSE	Type of Bed	No. Beds	No. beds commissioned / contracted by TCP	No. beds in use by TCP
CWPT Brooklands Hospital	NHSE	Adolescent / YP unit (non LD specific)	12	spot purchased	0

Beds outside the TCP footprint

In Arden and Solihull, there are currently no forensic rehabilitation inpatient providers nor inpatient providers specialising in complex continuing care for people with autism who do not have a learning disability. However, it should be noted that of the inpatient providers listed below, three are in Birmingham which is a neighbouring TCP. For example, while Cambian Cedars forensic rehabilitation facility is classified as being outside the TCP footprint, it is only 8 km from Brooklands.

Outside of the Arden and Solihull locality, people from Arden and Solihull CCGs with a learning disability and/or autism are placed in a further 5 forensic rehabilitation beds, 2 complex continuing care beds and 7 secure beds. In addition 11 CAMHS beds outside Coventry, Warwickshire and Solihull are populated with people with a learning disability and/or autism from Arden and Solihull CCGs.

TCP inpatient population in beds outside footprint (out of area) – CCG Commissioned

Unit (NHS)	Unit (non NHS)	CCG or NHSE	Type of Bed	No. beds in use by TCP
	Cambian Sherwood Lodge, Mansfield Nottinghamshire	CCG	forensic rehabilitation	1
	Brookdale Milton Park, Bedford	CCG	Complex continuing care (autism)	1
	Cambian Cedars, Birmingham	CCG	Forensic rehabilitation	1
	Huntercombe	CCG	Forensic rehabilitation	1
	Wast Hills (Danshell), Birmingham	CCG	Complex continuing care (autism)	1
	Cambian Elms, Birmingham	CCG	Forensic rehabilitation	1
	Partnerships in Care	CCG	Forensic rehabilitation	1

TCP inpatient population in beds outside footprint (out of area) – NHSE Commissioned Adults

Unit (NHS)	Unit (non NHS)	CCG or NHSE	Type of Bed	No. beds in use by TCP
Black Country Partnership NHS Trust		NHSE	Low Secure	1
Birmingham and Solihull Mental Health Foundation Trust - Hillis Lodge		NHSE	Low Secure	1
	St Andrew's Healthcare – Birmingham	NHSE	Low Secure	3
	Huntercombe - Ashley House	NHSE	Low Secure	1
	Alpha Hospital, Bury	NHSE	Secure	1
	Priory Hospital Chadwick Lodge	NHSE	secure	1
	The Spinney	NHSE	secure	1

	Calverton Hill	NHSE	Secure	1
Rampton		NHSE	High Secure	1
	All Saints	NHSE	Secure	1
	Stockton Hall (Partnerships in Care)	NHSE	Secure	4
	St Andrews – Nottinghamshire	NHSE	Secure	1

TCP inpatient population in beds outside footprint (out of area) – NHSE Commissioned Children

Unit (NHS)	Unit (Non NHS)	CCG or NHSE	Type of Bed	No of beds currently in use by TCP
Birmingham and Solihull Mental Health Foundation Trust - Ardenleigh		NHSE		1
	Newbridge House	NHSE		2
	St Andrews Healthcare – Northampton	NHSE		2
	Alpha Hospitals Bury	NHSE		2
	Huntercombe Staffordshire	NHSE		3
	Priory - Woodbourne	NHSE		1

Brooklands Inpatient provision

An important patient flow for inpatient provision at Brooklands Hospital is Birmingham and the Black Country. Currently 5 out of the 27 Assessment and Treatment beds and 10 out of the 68 low and medium secure and adolescent/young people's unit beds in Brooklands Hospital are populated with people from Birmingham and the Black Country. This patient flow reflects the lack of NHS inpatient facilities in Birmingham and the Black Country.

In addition Stoke on Trent, Dudley and Walsall have all been high users of the Assessment and Treatment beds during 2015/16 as well as users of low and secure medium secure beds. Wolverhampton is also currently a high user of low and medium secure beds.

Key Issues in relation to the current state

- ***Reducing the beds commissioned in the Coventry, Warwickshire and Solihull locality in total, regardless of whether the patients are from, will require strong collaboration with Birmingham and the Black Country as well as other CCGs and NHS England specialised commissioning around the commissioning of***

inpatient facilities. It should be noted, that the fast track submission (September 2015) included a proposal to close some of the non-secure beds at Brooklands; this aspect of the plan was not supported or funded.

- ***There are a number of actions we will be pursuing in relation to this service:***
    - ***Through Jacqueline Barnes, our SRO, we will link with other TCPs to confirm their future intentions regarding the use of Brooklands hospital***
    - ***We will link regionally and nationally with the Specialised Commissioning team to establish their intentions***
    - ***As a partnership, we will develop our plans for alternative provision in the event that a person with learning disabilities and /or autism legitimately requires a period of assessment and treatment***
    - ***Our plans will reflect our ambitions regarding forensic community provision in order to avoid high usage of locked rehabilitation inpatient facilities***
    - ***We have raised and sought to clarify the issues regarding primary commissioning responsibility with our NHSE Regional lead***

Links with Specialised Commissioning

- In Solihull, commissioners work closely with Spec Comm where a person known to local services has been detained in secure provision and local commissioners have continued involvement. This has been more difficult since the Case Management arrangement were changed by NHSE and it is hoped that the return to 'domestic'/geographical case management responsibilities will assist with this.
- Similarly in Coventry and Warwickshire, it is recognised that closer working practices with specialised commissioning are imperative to the success of this programme. The local clinical review group comprises health and social care professionals and commissioners and meets monthly to review inpatients discharge plans, care and treatment reviews and any unplanned admissions to hospital. Specialised commissioning case managers have been invited to attend this meeting so that the local understanding can be built about the needs of people in secure settings and their trajectories for discharge.
- Across the TCP, Care and Treatment reviews for people in specialised commissioning beds are undertaken jointly with CCGs.

Describe the current system

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

How is the system currently performing against current national outcome measures?

Fast Track Mobilisation

- In September 2015, Arden (Coventry and Warwickshire), along with Herefordshire and Worcestershire submitted a joint fast track plan to NHS England for Transforming Care. Coventry and Warwickshire received £825K transformation funding in response to that plan.
- Implementation of the first phase of the Arden fast track plan as submitted in September 2015 continues at pace, with the enhanced community support team

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mobilised in December 2015 and plans progressing ahead of schedule enabling the 9 bedded assessment and treatment unit (Gosford ward) to close to admissions by 31 March 2016, with full closure of the ward anticipated prior to the original deadline of 30 September 2016.

Inpatient Numbers

- Coventry, Solihull and Warwickshire CCGs have collectively achieved a 33% reduction in inpatients since 31 March 2016.
- Closure of Gosford ward brings the Solihull and Arden partnership within the 10-15 beds per million population target for CCG commissioned beds and as described in the fast track plan ongoing work is planned to further reduce bed usage across the partnership and to support reduction of NHS England specialised commissioning inpatient numbers for the partnership population.

Length of Stay

- The average length of stay for discharged patients in Coventry and Warwickshire has reduced from 105 days to 30 days over that period. In Solihull, the numbers of inpatients are so small that average length of stay is not a meaningful metric.
- The average length of stay has been reducing for people on the assuring transformation data return, however as the local system gets better at preventing admission, a consequence will be that only those people with multiple and complex needs will be admitted to hospital. These will be appropriate admissions for people who are very unwell and who are likely to require longer periods of time in hospital for treatment. Therefore, while average length of stay will be analysed, a more meaningful measure locally will be to look at individual lengths of stay for the very small numbers of people who are in hospital to ensure that the person can be discharged as soon as it is safe to do so.

Building the Right Support – what is the current care model?

Solihull

- Solihull has had an Enhanced Support model in place for the past six years for people with learning disabilities
- This is compliant with the NHSE recommended model and is based entirely on the principles and research of Mansell, Wolfensburger and O'Brian, all of which underpins the accomplishments and characteristics of this programme
- This enabled Solihull to ensure that there are no 'long stay' people in hospital, as significant work has already been undertaken to discharge people into their own homes with their own support
- Solihull has prevented inappropriate admissions entirely for the past four years from this group of people
- Solihull has brought people back to the Borough who were living in out of area 'specialist' provision (i.e. people who had been in hospital or were at high risk of admission
- because of the work undertaken over the past seven years, the two people in Solihull CCG commissioned beds are people who have very complex needs.
- 19 people have been discharged from inpatient services over the past few years with 2 people having a repeat admissions

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- The Enhanced Support Service supports people with very complex needs in the community; the two people referred to above, were successfully maintained in their own homes for considerable periods before their mental health declined to the point where re-admission was necessary
- the partnership plan includes the development of an alternative 'haven ' to admission, however, the two Solihull people in hospital currently required admission and could not have been safely supported in the 'haven' accommodation /safe space.

Coventry and Warwickshire

- Coventry and Warwickshire began planning for the transformation of learning disability services in 2013 and have been working as a strong and committed partnership between health and social care commissioners and with CWPT since then.
- The partnership have scoped, modelled and delivered this transformation in co-production with service users, family carers, community providers and professionals.
- Over this period, health and social care teams have reviewed adults in residential placements living out of the area and have worked with individuals to understand their needs and wishes, bringing people back to Coventry and Warwickshire or supporting ordinary residency arrangements as appropriate.
- A new model of care was developed locally in early 2015 and this is compliant with the national model of care described in building the right support.
- Following receipt of transition funding from NHS England, the enhanced support team were mobilised in December 2015 and are successfully working with adults with very complex needs identified as being at risk of admission to hospital. This team has also supported patients in Gosford ward to be discharged, enabling closure of the ward. A very important role for this team is the work that is undertaken with providers of supported living and residential services to ensure that people receive the right care and support to keep them well. Following the closure of Gosford, the team are starting to now work with people in Brooklands Hospital.
- Two "havens" or emergency admissions avoidance accommodation facilities have been identified in Nuneaton and Solihull and these will be used where required to prevent admission or support discharge for people from across the TCP. One person who was in Gosford ward has spent a week in this facility to enable the enhanced support team to do intensive training and support with the care team from the supported living provider to ensure a smooth transition to the community.
- A Contingency Fund has been piloted. This fund enables clinical judgement to be used to access additional funding where required to increase packages of care and support in the community to prevent admission to hospital. This fund can be access either through a community CTR or blue light meeting and in instances where a CTR cannot be convened in time, this fund can be accessed via trusted assessors in the enhanced support team. This fund has been used to prevent admission to hospital for a number of people and to facilitate discharge for another individual.

Building the Right Support – what are the gaps and challenges?

Solihull Enhanced Team

- In Solihull, the current enhanced team is commissioned to work Monday to Friday 9am to 5pm. This means there is a potential gap in intensive support for people

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overnight and at weekends. The TCP are exploring the possibility of expanding the successful Solihull model in line with the 7 day service commissioned in Coventry and Warwickshire.

Children and Young People

- Both enhanced support teams currently support adults over 18 years, which means there is a gap in intensive support for children and young people. In recognising this gap our Local Transformation Plan for Children and Young People reflects the need to develop pathways between service areas and organisations.
- Further work is required with children and young people and this will include changes in culture and practice to have confidence in the development of bespoke solutions to meet the needs of children and young people.

People with Autism who do not have a Learning Disability

- Those people without a learning disability who have a diagnosis of autism spectrum disorder are typically supported by the mental health teams. It is acknowledged, however that for a very small number of people with autism who have very complex needs, the intensive support required to prevent hospital admission is not currently available. No health services specifically for adults with autism are commissioned across the partnership, although both Solihull and Arden are testing new adult autism diagnostic pathways. Further work is required to understand the best way to support this group of people.

People with forensic needs and those stepping down from secure services

- The current community learning disability teams and enhanced support teams do support people with a forensic history. However, it is recognised across the partnership that more could be done to support individuals coming out of secure settings into local services to ensure a timely and safe transition to the community. There is also scope for improvement in avoiding prison sentences for people who have a learning disability and/or autism who could benefit from a period of hospital treatment. Currently many people come into secure hospital settings via a period of time in prison, where earlier identification of specific health needs could enable more timely access to treatment.

Personal Budgets

- While all partners in the TCP have developed their offer for personal health budgets, it is recognised locally that this cohort of people could particularly benefit from access to personal budgets. Due to the complex nature of their needs, further work is required to understand how to enable people from this cohort to get most benefit from personal budgets.

Workforce Development

- Workforce development is a critical area along with extending family and self-advocate leadership.

Who is providing services and what is the provider base?

NHS Providers

Across Coventry, Warwickshire and Solihull, providers of services in the community for

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people with a learning disability and autism include:

- Coventry and Warwickshire Partnership Trust
- Heart of England Foundation Trust
- Birmingham and Solihull Mental Health Foundation Trust

The following table describes NHS services and providers across the Partnership:

Community Health Services	Commissioner	Provider	Services provided
Community health services for adults with learning disabilities and Autism	Coventry and Warwickshire CCGs commission collaboratively	Coventry and Warwickshire Partnership Trust	Community Learning Disability Team Enhanced Community Support Team* Respite Beds Registered care homes
	Solihull	Coventry and Warwickshire Partnership Trust	CLDT Enhanced Community Support Team Respite
Mental health and wellbeing services for adults	Coventry and Warwickshire CCGs commission collaboratively	Coventry and Warwickshire Partnership Trust	Community Mental Health Services
	Solihull	Birmingham and Solihull Mental Health Foundation Trust	Social work, and Community Mental Health Services
Community health services for children and young people with learning disabilities	Coventry and Warwickshire CCGs commission collaboratively	Coventry and Warwickshire Partnership Trust and SWFT?	Community Learning Disability Team Respite
	Solihull	Heart of England Foundation Trust CWPT	Community learning disability Team Respite
Mental health and wellbeing (CAMHS) services	Coventry and Warwickshire CCGs commission collaboratively	Coventry and Warwickshire Partnership Trust?	Specialist Child and Adolescent Mental Health Service delivered through a multidisciplinary approach
	Solihull	Birmingham and Solihull Mental Health Foundation Trust	Psychiatry, psychology CN Complete scope of SOLAR
Adults with Autism	Coventry and Warwickshire	No discrete provision is commissioned for	
	Solihull		

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		adults with Autism	

*The Enhanced Community Support Team in Coventry and Warwickshire was mobilised in December 2015 using money provided by NHS England as part of the fast track programme. The success of this team to support people in the community following the new model of care has enabled the closure of Gosford ward.

Local Authority Provision

Warwickshire County Council and Solihull Borough Council have no in-house service provision.

Coventry City Council's Maurice Edelman House provides a residential and respite service, promoting independence and community presence for adults with learning disabilities and complex needs, working in partnership with health staff, occupational therapists, physiotherapists, clinical psychology and other professional services. There are 5 respite beds and 11 long stay residential places. There are also a range of supported living units owned and operated by the Council's Promoting Independent Living Service – 13 units in all currently supporting 41 people and ranging from single person accommodation through to a cluster of 11 flats.

Independent and private sector community provision

Solihull

In terms of the independent and private sectors there are a range of productive relationships in place. For example, over the past 5 years, Solihull, in partnership with providers, has developed:

- 93 apartments across 11 schemes. All tenancy based and a number of which were specifically developed to meet the needs of people who had spent part of their lives in hospital
- 13 shared ownership arrangements (again some were targeted at people we were supporting to move out of hospital)
- 6 house shares – mainly for young people leaving school and college 9providing 18 tenancies)
- Numerous individual living arrangements for people labelled as having complex and challenging behaviour to live in their own homes. (in the region of 24 people)

We have worked hard to nurture local person centred organisations and we have found that they are particularly committed to supporting people with complex behavioural needs. The Borough also works with a number of national and regional providers too.

Warwickshire

Warwickshire County Council has no in-house service provision for people with a learning disability and or autism and as such has developed positive relationships, and established a range of contractual arrangements, with a number of independent and private providers to deliver care and support. In the last few years Warwickshire has:

- Commissioned 12 new accommodation with support schemes (1 fully operational, 2-3 coming on stream this year with the following the year after) for adults with disabilities, autism and mental health needs. All the schemes are tenancy based with one specifically designed to meet the needs of people who present behaviours that

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challenge. In addition we have supported over 5 independent provides to develop schemes locally.

- Commenced a pilot of Shared Lives for up to 10 customers in partnership with Coventry City Council.
- Re-commissioned a new framework of 42 supported living services and introduced a new personalised commissioning process to ensure individuals can make a choice about the care and support provider they select to help them achieve positive outcomes and maximise their individual budget.
- Re-commissioned short break services for children and adults with disabilities with a view to widening the offer and encouraging more innovative community overnight and daytime short breaks.
- Outsourced community support services for people with high support needs ensuring the 60 plus customers accessing current services are given greater opportunities to achieve individual outcomes and to access their local community. The contractual arrangement, across health and social care, includes a move to DP, PHB and/or ISF arrangements from year 3 of the contract.
- Re-commissioned the day opportunities framework to offer a wider range of meaningful outcomes based opportunities for individuals with disabilities including access to employment.
- Re-commissioned advocacy services in line with the requirements of the Care Act 2014. The framework includes a range of services accessed by people with disabilities and/or autism including appointee services, independent advocacy, IMCA services and peer advocacy. We also took the opportunity to pilot a new money management service recognising a gap in this area specifically for people with a learning disability.

Coventry

- 18 residential homes are provided by seven providers with approximately 100 residents. Three of these are operated by Coventry and Warwickshire Partnership Trust.
- Eight respite beds are provided through an independent Trust provider.
- 178 people live in a range of supported accommodation which includes flats apartments, bungalows and houses. Some of the above provision caters for people whose behaviour challenges.

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

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

Where the NHS has an existing interest in a property, confirm whether the associated capital grant agreement (CGA) and (where appropriate) legal charge is held by NHS England[6] or the Department of Health / Secretary of State for Health (DH/SoS).

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

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Solihull Housing

Solihull has worked hard to develop housing options for people – see previous section. However, our overwhelming challenge is two-fold:

- cost of land and property (same valuation bracket as the Royal Borough of Kensington and Chelsea)
- Lack of brownfield development sites
- Minimal fit (except for a few areas of the Borough) with the Homes and Communities Agency funding priorities

This makes all developments:

- Extremely costly
- Development sites and opportunities hard to find; we are frequently in competition with private development companies bidding for developments for the affluent self-funding older person's market

Coventry Housing

The local authority runs a care home in Coventry, which although in a desirable location, has limitations in respect of the fabric of the building.

Independent sector provision is variable with a mixture of new build/ refurbished and older properties.

Over the past few years, a number of new schemes have come to fruition, including residential and supported living opportunities and there are additional schemes in the pipeline.

There is one property which is owned by NHS Property Services Limited and rented to Midland Heart, with whom the City Council and CRCCG currently purchase 6 care home places. The property is considered unsatisfactory and plans are in place to engage with service users about stepping down to supported living.

Warwickshire Housing

Within Warwickshire there are now 3 specialised housing with care schemes suitable for younger adults with learning disabilities and one scheme suitable for adults with mental health issues now in operation, which have all been delivered via the current Extra Care Housing Programme. A further scheme is currently under construction, with a further 12 Specialised Housing with Care schemes suitable for Adults with Learning and/or Physical Disabilities, and/or Sensory Impairment and/or Mental Health Issues in the pipeline for delivery by 2017/18, yielding an overall total of approximately 202 housing units.

Capital Charges

Solihull has a number of properties where there is an NHS capital charge arrangement; this is another Solihull work stream and is already the subject of formal discussion with NHSE nationally. Solihull is working on a separate business case to NHSE regarding some of these properties with a view to selling properties which are no longer fit for purpose with a view to reinvesting the resource in further housing – some of which will be required for existing named residents.

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Information about capital charges is held with NHS England and has been requested in relation to Coventry and Warwickshire properties. This information has not yet been received so cannot be included in this iteration of the plan.

Key Challenges in relation to Housing

- ***Across the TCP, the key housing challenge that has been identified is a shortage of local specialised accommodation, both for people with destructive behaviours and for those with forensic needs. Capital bids prepared by all CCGs in the TCP reflect this gap.***
- ***Information about capital charges for Coventry and Warwickshire is not yet available from NHS England property services.***

Inpatient facilities

Coventry and Warwickshire currently commission 8.5 beds of the 9 bedded tier 3 assessment and treatment unit, **Gosford Ward,** which is at the Caludon Centre on the UHCW site in Coventry. This ward was closed to admissions on 31 March 2016 and following public consultation it is intended to close this ward before 30 September 2016. CWPT are planning to use this ward to provide additional inpatient capacity during a period of refurbishment which is urgently required for a number of other inpatient facilities in order to meet new fire regulations.

As described in previous sections, there are 96 specialist inpatient beds at **Brooklands Hospital** in Solihull.

Key Challenges in relation to inpatient estates

- **The implications for this site will only be understood once the intentions of all CCGs and NHS England Specialised Commissioning are understood in relation to this site.**

Estates Issues relating to Respite

The Coventry, Warwickshire and Solihull Transformation Plan includes a review of all respite provision for people with learning disabilities and/or autism in order to more fully understand how current services are being utilised and to establish whether this is meeting the needs of the population. As part of this review, and in line with feedback from service user and carer representatives, the Oversight Board have asked commissioners to consider a range of options for respite, to included bedded facilities and other personalised options. This review which is due to be completed in September 2016, may impact on the following respite facilities currently commissioned across the TCP.

Adult Respite Provision

Shirley House in Solihull is commissioned by Solihull CCG and provides services for people with a learning disability who experience life limiting conditions, complex health care needs and challenging behaviour. The purpose-built facility is divided offers two areas dedicated for planned respite care:

- A newly refurbished unit that has been specifically designed for clients who challenge, and
- A purpose built facility with assistive technology to support client with complex health care

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needs.

A third unit is being refurbished at a cost of £70,000 using transition funding from NHS England to make it fit for purpose for use by people with behaviours that challenge. This unit will provide an option for short term accommodation for people who might otherwise have been admitted to hospital due to a lack of safe and appropriate place to stay.

Ashby House in North Warwickshire is commissioned by Coventry and Warwickshire CCGs. It is a seven bed, purpose built service, which provides respite care for people with a severe learning disability, associated conditions and mental health needs. An eighth bed has been made available as an option for short term accommodation for people who are at risk of admission to hospital, where alternative accommodation options are not available or appropriate.

Children and Young People Respite Provision

Currently in Coventry, Warwickshire and Solihull, respite provision for children and young people across health and social care is commissioned across three sites:

- Warwickshire Disability Service (South Warwickshire, 4 beds, commissioned by WCC)
- **Gramer House** (4 beds for children with additional physical health needs) and **Holly House** (3 beds for children with additional mental health and behavioural needs). Gramer and Holly are on the same site in North Warwickshire and are commissioned by Coventry and Warwickshire CCGs.
- **Bradbury House** (7 beds for children with behavioural needs) and **the Birches** (7 beds for children with additional physical health needs). Bradbury and the Birches are on the same site in Coventry and are commissioned by Coventry and Warwickshire CCGs. Bradbury and the Birches mainly receive referrals from Coventry.
- **Lyndon House** (5 beds for children) is in Solihull and is commissioned by Solihull CCG.

The Warwickshire Disability Service is provided by Action for Children. Following competitive tender, it retained the contract in 2014. The contract runs until March 2016 with the flexibility to extend to March 2019.

Provision at **Gramer House, Holly House, Bradbury House, the Birches** is provided by Coventry and Warwickshire Partnership Trust (CWPT). Provision for forms part of the Learning Disability block contract with the Coventry and Rugby CCG, South Warwickshire CCG and Warwickshire North CCG. The service specifications are reviewed annually. Coventry and Rugby CCG is the lead contractor.

Lyndon House is provided by Coventry and Warwickshire Partnership Trust (CWPT). A review of this facility is already underway as it is recognised that this building is not fit for purpose.

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

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

Across the TCP footprint, Solihull is at a different stage in its transformation journey to that of Coventry and Warwickshire. Solihull began to transition to a model of care more in line with

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building the right support a number of years ago. In Coventry and Warwickshire this work began in 2013 and was accelerated as part of the fast track programme during the second half of 2015. This lends a real strength to the partnership, enabling Coventry and Warwickshire to learn from the work already undertaken within Solihull and for Solihull in turn to build on the changes being made in Coventry and Warwickshire.

In 2008, 19 people from Solihull perceived as having particularly complex and challenging behaviour were living in a variety of settings – in hospital, in 'specialist' placements in Borough and out of Borough.

Of these people, a number of individuals had spent many years of their lives being admitted, discharged and readmitted to hospital. Their needs were diverse – some had severe learning disabilities, some had formally diagnosed mental illnesses others with forensic histories. What characterised most people's stories was anxiety about their ability to live safely in the community; for a number of people it became clear that their historic 'reputation' had come to define them. In order to address this, we set about developing the capacity of the multi-disciplinary team with the principal objectives of:

- Discharging all people inappropriately using assessment and treatment in-patient services
- Doing our utmost to support people in times of great need in their homes, to prevent inappropriate admission to hospital
- To build the capacity of providers to support people locally rather than assuming that the expert resources were out of area

In order to achieve this, the principles of the Mansell reports were applied, formally establishing links with Birmingham's Supported Living Outreach Team by seconding 2 community nurses to their successfully operating service, and bringing in to Solihull's service, 2 highly experienced and confident nurses. This arrangement ended after two years and the Solihull nurses returned to working in the Borough, but with a rich experience and critically, confidence that they would not otherwise have gained.

This approach enabled us to develop what we refer to as *Enhanced Support* – a virtual team made up of Community Nurses, Psychologists, and Speech and Language Therapists at the inner core, but supported by Psychiatry and OT (particularly around areas of sensory processing).

Enhanced Support is effectively the approach we take to 'wrapping support' around an individual, their family and /or support provider to prevent inappropriate admission to hospital or where this has been necessary to facilitate a smooth discharge. This model is entirely consistent with recommendations of the Transforming Care guidance.
Solihull achieved the resettlement of all of the 15 people who were on our original priority list; only 2 of the original people having further periods of time in hospital.

In Coventry and Warwickshire the transforming care programme built on successful initiatives to repatriate people with mental health needs ("coming home") and to review the needs and wishes of all people with learning disabilities living out of the area and where appropriate to find local homes for people. The enhanced support model was mobilised in December 2015, and has already been very successful, enabling the nine bedded Gosford ward to close to admissions on 31 March 2016.

The combined experience across the TCP highlights some key priorities:

- The importance of values and a belief in the rights of people with complex needs to live

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contributing lives in the community. This is critical as it underpins and motivates the whole purpose of Enhance Support
- The importance of person centred planning and working alongside the people supported and their families as equals
- The critical role of providers and the importance of building mutually respectful relationships
- The importance of housing – and a recognition that on occasions specific developments will need to be commissioned
- The importance of clinicians, practitioners and commissioners working together as part of a team
- The importance of achieving a change in practice and perception that has historically assumed it is acceptable to use hospital admissions as part of the portfolio of services to be used with people with learning disabilities who also have challenging behaviour.

The current challenges within this baseline are:

- Widespread recognition that those with a learning disability and/or autism and challenging behaviours are not best served by long term hospitalisation
- The population increases will put pressure on inpatient capacity
- The ageing population of those with a learning disability and/or autism requires more proactive support, integrated around co-morbidities which are more common in later life. This care needs to focus on keeping people healthy and well in the community, and maintain their independence
- As for nationally there is a lack of whole system awareness and working– whether a service is forensic or not is a real dividing line, as it is across the country
- There is no current ability to influence inpatient beds being commissioned in Coventry, Warwickshire and Solihull non-Arden and Solihull residents

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 partnership area with a learning disability and/or autism and challenging behaviours
- Care and support services need to be redesigned to minimise inpatient care to when it is the best place for the person concerned e.g. assessment and treatment as a last resort when community provision is not possible, a mental or physical health needs which necessitates admission (and then admission should be to mainstream services with reasonable adjustments, 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
- Greater collaborative working is needed at a national level to influence the use of beds in Arden and Solihull.
- Significant market development and provider liaison is required to achieve the changes required by building the skills and capacity in the market, and to avoid destabilisation

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We know that this approach works and we want to be able to extend it in order to:

- Extend the hours of operation in Solihull (Coventry and Warwickshire's team operates 7 days a week with telephone support provided out of hours overnight)
- To extend Enhanced Support to children and young people to avoid both hospital admission and 52 week residential school placements
- To be able to work across and with mental health service colleagues (including CAMHS) to support young people and adults who have autism but not a learning disability – as well as building the expertise of professional working in those areas to support this group of people well.
- To support people who are in contact with the criminal justice system, to both prevent admissions and to support those who are being discharged from secure services to resettle within the community.

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

Any additional information

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3.Develop your vision for the future

Vision, strategy and outcomes

Describe your aspirations for 2018/19.

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

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

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

Coventry, Warwickshire and Solihull commissioned a DVD of people's stories to illustrate the new model of care and local aspiration in terms of the lives that we want people with learning disabilities and autism to live. The DVD, entitled "Living My Life" captures the stories of four individuals who have each spent significant periods of time in hospital and who now live fulfilling and happy lives in their own homes near to family and friends. The DVD also captures some of the key tenets of the model of care that is being promoted, namely Values, Risk, Home, Training and Celebration. The DVD chapters and stories will be used across the system as a tool to promote the necessary culture change to embed a more person centred model of care.

A quote from the first chapter of the DVD encapsulates the aspiration for this programme of

work:
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"The future is where people with learning disabilities and autism:

- don't have to go into hospital;
- are not put in a position where they become unwell because of their environment;
- are supported with their needs, emotions and feelings;
- are supported to grow and develop;
- are not taken away from their family and friends and isolated;
- live in their local community;
- go out in their local community;
- work in their local community;
- and are seen as a valued member of society"

Living My Life DVD – Transforming Care Chapter

The purpose of the transforming care programme is to establish a new model of care for people with learning disabilities and/or autism with challenging behaviour, promoting prevention and early intervention and reducing admissions to hospital. This care and support will be:

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

The population that is in scope for the programme are children or adults with a learning disability and/or autism who have/display:

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

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- A mental health condition or whose behaviour challenges who have been in inpatient care for a very long period of time, having not been discharge when NHS campuses or long-stay hospitals were closed

The expected outcomes for services as a result of the transformation, are:

- More people with learning disability and/or autism will be supported to live in the community/at home
- The frequency of people displaying behaviours that challenge will be reduced as will the severity of episodes
- People with a learning disability and/or autism who display challenging behaviours will be kept safe in their communities wherever possible
- Fewer people from Arden and Solihull will be admitted to non-secure and secure hospitals
- Delayed discharges will be minimised
- Any hospital stays will be closer to the individual's home and support networks
- There will be fewer inpatient beds commissioned for the partnership population
- People with a learning disability and/or autism who display challenging behaviours will enjoy an improved quality of care and an improved quality of life

Aspirations in relation to reduction of inpatient population

IMPORTANT CAVEATS IN RELATION TO INPATIENT TRAJECTORIES:

1. **An ongoing challenge in understanding the inpatient population and likely trajectories for inpatient placements has been the difficulty with obtaining information about individuals are in NHS England Specialised Commissioning inpatient placements. Some information has been received by the TCP in early April which has begun the process of understanding the population, trajectories for transfer to local services and financial implications of this. Due to the timeframes for submission of this plan, however, a number of assumptions have been made under advice from clinical colleagues and case managers to enable initial modelling to be undertaken.**
2. **It is acknowledged that the activity and finance modelling requires much further work to enable the TCP to understand the implications for people returning to local services and for financial pressures on commissioning organisations, including the implications of dowries where they apply. Now that information has been received from NHSE, this work is ongoing at pace within the TCP. It is therefore very important to note that the following trajectories may change between now and the lock down date of 1/7/16.**
3. **The below trajectories have been developed with input from clinicians, the local delivery group, some board members and the partnership group. However, due to timeframes there has been NO formal sign off for these trajectories by the Oversight Board or any partnership organisations. Further work to model the impact of trajectories will be complete and local governance processes completed by July 2016.**

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With the above caveats, the following tables summarise the planned trajectories for numbers of inpatients from Arden and Solihull over the life of the programme. These are reflected in the activity and finance template attached to this plan. Appendix 2 describes the assumptions that have been made to develop these trajectories.

Numbers of Arden & Solihull CCG Commissioned Inpatients (target range 10-15 beds per million)

Type of Bed	31/3/16	31/3/17	31/3/18	31/3/19
Assessment and Treatment	4	3	2	2
General Mental Health Acute	1	2	2	2
Locked Rehab	5	7	7	5
Complex Care	2	2	1	1
Other	0	0	0	0
Total	**12**	**14**	**12**	**10**
Beds per million pop.	**12.87**	**15.01**	**12.87**	**10.72**

Number of NHSE Specialised Commissioning Inpatients (target range 20-25 beds per million)

Type of Bed	31/3/16	31/3/17	31/3/18	31/3/19
High Secure	1	1	1	1
Medium Secure	5	5	5	5
Low Secure	23	19	17	12
CAMHS	11	8	5	5
Other	0	0	0	0
Total	**40**	**33**	**28**	**23**
Beds per million	**42.9**	**35.39**	**30.03**	**24.67**

Total number of inpatients (target range 30-40 beds per million)

Commissioner	31/3/16	31/3/17	31/3/18	31/3/19
CCG	12	14	12	10
NHSE	40	33	28	23
Total	**52**	**47**	**40**	**33**
Beds per million	**55.77**	**50.40**	**42.90**	**35.39**

Key Issues in relation to Trajectories

- **Further modelling is required with NHSE Specialised Commissioning to build confidence in the assumptions made about future bed requirements. Current trajectories are based on discharges of current inpatients combined with an estimated need for the size of population.**

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- **It is important to note the impact of people stepping down from secure services into locally commissioned services. In 2016/17, NHS England are forecasting the 11 adults and 8 children will come out from low secure settings into CCG commissioned services (beds or community placements), with a further 12 adults transferring to CCG commissioned services over the next three years. Unless these people can be supported to move to the community, this flow of patients into locally commissioned beds will have a significant impact on inpatient numbers for the TCP.**
- **This flow of complex individuals into local services may also represent a financial risk for CCGs, the detail of which is being modelled and further information will be provided as soon as it is available.**
- **The two people currently in complex care beds require specialised accommodation, for which a capital bid has separately been submitted.**

The following tables represent the proposed future state for inpatient beds used by Coventry, Warwickshire and Solihull CCGs.

IMPORTANT CAVEAT IN RELATION TO FUTURE STATE BED NUMBERS:

- **It is really important to reiterate that the future bed requirements for Brooklands Hospital will depend on the commissioning intentions of other TCPs, including NHS England specialised commissioning. Until there is a clear indication of the bed base required by all commissioners on this site it is not possible to forecast the number of beds required with in the footprint.**
- ***The use by NHSE Specialised Commissioning of secure and CAMHS beds at Brooklands for individuals from the TCP will depend on the suitability of the specialist services at Brooklands to meet the needs of that individual. There may be occasions where independent providers outside of the footprint may be more able to meet the needs of individuals. This will be determined by specialised commissioning working with CCGs on an individual case by case basis. The numbers of secure beds at Brooklands in use by the TCP may therefore be lower than indicated below.**
- **Without more detailed financial modelling it is not possible for partner organisations to commit to these trajectories. Further work is planned and will be completed and signed off by partner organisations by July 2016**

Future State – Inpatients within TCP footprint

TCP inpatient population in beds

Unit (NHS or Non NHS)	CCG or NHSE	Type of Bed	No. Beds	No. beds commissioned / contracted by TCP	No. beds in use by TCP
CWPT Brooklands Hospital (NHS)	CCG	ATU	27	none (spot purchased)	2
CWPT Brooklands	NHSE	Low Secure	41	block contract	12*

Hospital (NHS)					
CWPT Brooklands Hospital (NHS)	NHSE	Medium Secure	15	block contract	5*

In addition, it is anticipated that in line with the new model of care, people with a learning disability and/or autism will be supported within mainstream mental health services, including acute inpatient facilities. In Coventry and Warwickshire this will be either at the Caludon Centre in Coventry or St Michael's Hospital in Warwick.

Unit (NHS or Non NHS)	CCG or NHSE	Type of Bed	No. Beds specifically for LD/Autism	No. beds commissioned / contracted for LD/Autism by TCP	No. beds in use by TCP for people with a learning disability and/or autism
CWPT St Michaels Hospital (Warwick) or Caludon Centre (Coventry) (NHS)	CCG	generic mental health acute	N/A	N/A	2

Future State - Inpatients outside TCP Footprint

Where an individual's needs cannot be met within the TCP footprint, alternative provision will be sought. Currently, people who require locked rehabilitation to step down from secure services and those with autism who do not have a diagnosed learning disability are supported in spot purchased specialist placements outside of the TCP footprint. The placement is chosen on a case by case basis according to the individual needs and wishes of that person as well as the quality of care, location and value for money of the placement.

As outlined above, it is anticipated that five locked rehab and one complex care bed will still be required throughout the programme and potentially beyond 2019. It will remain a last resort for people to be supported in a hospital setting, and alternative community provision will be explored in the first instance.

Unit (NHS or Non NHS)	CCG or NHSE	Type of Bed	No. Beds	No. beds commissioned / contracted by TCP	No. beds in use by TCP
Unit will depend on individual need	CCG	locked rehab		spot purchased	5
Unit will depend on individual need	CCG	complex continuing care		spot purchased	1
Unit will depend on individual need	NHSE	secure		Depends on the unit	Dependent on individual need and how many people for

whom Brooklands is not the most appropriate provision

Key Issues in relation to Future State

- ***It will be important to understand as a partnership what proportion of the forecasted inpatient needs will be able to be met by local services (currently at Brooklands Hospital), in particular in relation to secure services, forensic rehabilitation and support for people with autism who do not have a diagnosed learning disability.***
- ***Commissioners will need to determine the commissioning plan to support the above trajectories. This includes a decision about whether there is appetite to develop the market in-area for inpatient provision for forensic rehabilitation and/or complex continuing care and how to develop links with adjoining TCPs to commission these specialised services together?***
- ***The financial implications of discharges from specialised commissioning need to be modelled. This includes understanding the impact of dowries for each of the partner organisations. This work is in progress and an update will be provided as soon as it is available to inform sign off for this plan by partner organisations.***

How will improvement against each of these domains be measured?

Guidance notes;

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

However, areas should be aware that nationally:

- *To monitor reduced reliance on inpatient services, we will use the Assuring Transformation data set*
- *To monitor quality of life, we are minded to make use of the Health Equality Framework[7]*
- *To monitor quality of care, we are supporting the development of a basket of indicators (see Annex A); exploring how to measure progress in uptake of personal budgets (including direct payments), personal health budgets and, where appropriate, integrated budgets; and strongly support the use by local commissioners of quality checker schemes and Always Events*

One of the workstreams in the TCP is exploring ways to monitor progress and measure the

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

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success of this programme. The combined suite of measures will include those suggested nationally as well as a number of others which it is hoped will give a fuller picture of the quality of life experienced by people in the local community. A draft monitoring framework is attached at appendix 3, although it is acknowledged that more work is required to develop a dashboard of measures which can be reported to the Board.

This transformation of services will be monitored via two streams, firstly service user outcomes and secondly outcomes relating to the transformation and delivery of an enhanced community service. In order to ensure a good range of outcomes are monitored across these two streams, further work will be undertaken across the organisations collaborating to deliver this transformation to develop metrics and share information.

Service User Outcomes

In order to develop a tangible and effective way of really testing the impact of change in people's lives, we are facilitating a piece of work that will be opened up regionally to think carefully about how we do this and how we can be really sure that people are included as citizens in their own communities.

The enhanced support teams in Solihull, Coventry and Warwickshire are already using the Health Equalities framework, but we also need to develop further means of demonstrating the positive impact on people's lives. Training in using the E-HEF is being funded from within transformation funds for relevant professionals to embed this approach across the TCP.

Directly relevant to this workstream is a new joint health and social care Quality Assurance Framework which has been piloted in Warwickshire and which will be implemented across all supported living and residential health and social care packages in Warwickshire from April 2016.

This Quality Assurance Framework will provide an overview of the quality of care and support being received by people in supported living and residential services in Warwickshire. This intelligence, combined with individual information gathered about Health Equalities Framework outcomes will provide good assurance to the Oversight Board about the quality of life and quality of care of people with learning disabilities and autism living in the community. The Quality Assurance Framework is attached at Appendix 4.

The TCP would like to explore the potential to extend this Quality Assurance Framework across Coventry and Solihull in order to share intelligence about provider services and this forms part of the transformation plan.

Although further work is required to develop metrics to monitor these outcomes for individuals, the table on the following page examples of what is planned. Data about whether people are meeting their individual outcomes as per their personalised plan will be collected via regular plan reviews. Providers already submit much of this data via monitoring for other schemes, for example the supported living framework. A Quality survey will be undertaken every six months during the 18 months of this transition phase. The survey will gather views from service users, carers, staff both within health, social care and independent providers about how well the model of care is delivering the desired outcomes for individuals. In Warwickshire, information collected during (announced and unannounced) quality visits by the new Quality Assurance Officer in Warwickshire and by peer reviewers will also be used as part of the monitoring framework.

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During this initial phase, case studies will be collected about people who have been supported by the enhanced support team. Where the individual has been successfully supported to stay at home, the case study will review what contributing factors enabled a positive outcome for that individual, as well as any opportunities for improvement. Themes and lessons from these case studies will be used to develop the model further. Where the individual is admitted to hospital, a root cause analysis will be undertaken to understand the reasons for admission and to examine whether anything could have been done to prevent the admission. This iterative approach to learning and developing the model will produce a rich source of information about how well the model is supporting individuals.

The monitoring workstream have reviewed the suggested national measures and have agreed a local approach as described in the following table.

Suggested national measures	**Local plan**
Proportion of inpatient population that has a person centred care plan	This data will be collected as suggested and Arden GEM CSU business intelligence team should be able to collate this. Locally the view is that it may be just as and perhaps more meaningful to understand which people in the community who are at risk of admission to hospital have a current care plan. We are working with CWPT to understand how this might be captured. This will also be captured through Quality Assurance Visits in Warwickshire.
People receiving direct payments and individual service funds.	Nationally it is suggested to collect this from social care data. Locally the aspiration is to promote the use of personal health budgets for this population which requires the workstream to understand how uptake of PHBs can also be monitored.
Proportion of people readmitted within a specific period	This data is available via the assuring transformation data returns and will be included in the suite of measures used locally.
Proportion of people receiving an annual health check	This data is already monitored via the Self-Assessment Framework (SAF) workstreams which rely on the national annual publication of data. In Coventry, this data is not available as the CCG do not commission primary care so this data would have to be sourced from NHS England. Monitoring the number of annual health checks forms part of the new Quality Assurance model in Warwickshire.
Waiting times for new psychiatric referral	While this can be collected, locally there is a view that this measure as described reinforces a medical model of care. A more meaningful measure locally is the response time of the community and enhanced support teams and this will be monitored as part of the workstream review.
Proportion of people for whom there is a crisis plan	Locally there is a view that a more meaningful measure is the number of people on the “at risk of admission” register who have a crisis plan. This data is already being collected on the at risk of admission register via CTRs and the enhanced support team.

Transformation Programme Delivery Outcomes

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The Oversight Board will monitor the following metrics on a monthly basis:

- Number of inpatients in CCG commissioned beds (per million population)
- Number of inpatients in Specialised commissioning beds (per million population)

Other metrics are also being developed as per the draft monitoring framework.

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

The principles we apply are, at the most succinct, the values of citizenship and inclusion, being able to contribute to society as well as receive from it, to have a life that grows and develops, to be loved and to love.

In more detail this includes the following 'I' statements:

- I am safe
- I am helped to develop friendships and relationships
- I am supported to keep in touch with my family and friends
- I have a choice about living near to my family and friends
- I have regular care reviews check if my supporting is working for me
- I am central to decisions about my life and 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 am supported by people who are respected, respectful and accepting o of me,
- I am supported by a skilled, creative and well trained team

To deliver this requires that we, as the organisations commissioning and providing care and support in Arden and Solihull, will work to a 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

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- 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
- 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 across the Arden and Solihull region will collaborate and share knowledge and experience to achieve the best outcomes for service users, including collaborating regionally across the wider West Midlands 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

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

Any additional information

4.Implementation planning

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

Overview of your new model of care

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

Model of Care Overview

The model of care for Coventry, Warwickshire and Solihull is presented pictorially in Appendix 5. This model was developed as part of the Business Case for the development of an enhanced model of community support and the closure of assessment and treatment beds at Gosford Ward. It has been developed by Arden and Greater East Midlands Commissioning Support Unit on behalf of the CCGs and in collaboration with CWPT and the local authorities. The model fits well for the wider, bigger picture, including the existing model operating in Solihull and involving specialised commissioning.

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Commissioning the new-style services will reduce the demand for hospital placements. 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 Coventry and Warwickshire Partnership Trust (CWPT). CWPT have worked at a regional and national level in the development of a competency framework around Positive Behavioural Support and have staff able to assist other organisations in delivering training in this respect. 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.

Existing community 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. This includes escalating to the intensive support team when they feel additional support is required beyond that which they feel they can provide.

To complement the enhanced model which is being introduced, there will need to be changes to existing services. These are:

Mainstream services, community networks and peer support

People with a learning disability and/or autism will experience similar levels of service provided as the general population. The enhanced support model will facilitate this access by supporting staff 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 will be supported to make these reasonable adjustments will 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 Coventry and Warwickshire
- 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

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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.

We will promote peer networks to be in place across Coventry and Warwickshire 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. The enhanced and crisis support team will help support these peer support networks as and when necessary.

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 in 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 and further information on existing respite services is included in section 2. When people are placed in this accommodation it will be part of a journey of care, seamlessly integrated into community based care by the Intensive Support team. The current short breaks/respite provision will also need to increase in capacity to support the extra volume of people living in the community The support services for these need to be skilled up to be able to take on people with more complex health needs and challenging behaviour, and to be based around a culture of positive behavioural support.

Longer term accommodation options

Longer term accommodation options, including Supported Living, will also need to increase in capacity to support the extra volume 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 already in place to expand accommodation capacity and as part of this bid we are proposing the development of a number of bespoke units to enable individuals currently in hospital to be discharged into the community.

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. The enhanced model uses 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.

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There will also be an improved offender pathway to minimise in-patient admissions. 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. Treatment pathways will range between 2/3 years for low secure and 4/5 maximum for medium secure. This improved offender pathway will include:

- Community forensic support to policy 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

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 a 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.

This will require a greater focus for 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, as well as accommodating this within the contract arrangements with CWPT.

The role of mainstream services and community networks as an important partner in achieving this is also much more of a focus. There is an emphasis on making sure that people with learning disabilities and/or autism can access all the relevant mainstream

services and have the ability to be supported by their peers.

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. Coventry and Warwickshire Partnership Trust have worked nationally and regionally to develop a competency framework for positive behavioural support and are skilled up to support other providers in Coventry and Warwickshire so that this consistent approach is achieved.

Coordinated, integrated care

- *Discharge to Assess*

  The 'Discharge to Assess' approach in mainstream NHS services will be adopted for those in inpatient services with a learning disability and/or autism. This will help ensure that people with a learning disability and/or autism are discharged when it is appropriate for them to be discharged. The Trusted Assessor model will ensure that discharges are not held up due to decisions about whether health or local authorities are to fund the care and support for the person concerned.
- *Care coordinator*

  A local care coordinator will be offered to everyone with a learning disability and/or autism receiving specialist support, not just those on the Care Programme Approach (CPA). This person is likely to be someone from either existing support teams for social care, Section 117 care and continuing healthcare, or from the new enhanced support and crisis support teams. The care coordinator will integrate services and ensure timely delivery of a wide range of services in the plan, working closely with the person and their family. In hospital the care coordinator will work closely with the Discharge to Assess Trusted Assessor around decisions on both H&SC funding.
- *Integration of health and social care*

  There are strong benefits from integrating health and social care through joint and shared plans and assessments. There will be a study as part of the early work of the Transforming Care Fast-track programme to evaluate and agree the most cost-effective approach to integrate health and social care for those with a learning disability and/or autism.
- *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.

What new services will you commission?

New Services commissioned in Phase One (2015 and 2016)

As previously mentioned, the enhanced model has been in place in Solihull for the past seven years. Since December 2015, an enhanced model has been introduced in Coventry and Warwickshire.

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Enhanced and crisis support functions are therefore now in place across the TCP. Match funding from the CCGs in Coventry and Warwickshire has enabled the transitional enhanced support team to be expanded from April 2016 to meet the needs of all adults with learning disabilities who are at risk of admission to hospital. Lessons continue to be captured about what works and what doesn't and these are fed through governance structures to the Oversight Board to enable the model to be tested and refined.

Newly commissioned services in Coventry and Warwickshire in within the enhanced support model in 2016 include:

- **Intensive Support Team**
  A fully staffed intensive support team, which will support people with learning disabilities and autism who are identified as being at risk of admission to hospital. This is a multi-disciplinary team comprising specialist nurses, therapists, support workers and social workers. The service also includes a psychiatrist who will continue to "follow the patients" and support individuals with assessment and treatment in the community in the same way they have previously been supported while in hospital. The inclusion of social workers in this team supports integration of assessments and planning processes.

  This team has supported patients in Gosford ward to be discharged, enabling closure of the ward. A very important role for this team is the work that is undertaken to work with, train and model care practices with providers of supported living and residential services to ensure that people receive the right care and support to keep them well. Following the closure of Gosford, the team are starting to now work with people in Brooklands Hospital.

- **Mental health acute liaison service**
  This service will support individuals to access mainstream mental health services, including community, inpatient and crisis provision. The service will work with individuals and the mental health staff supporting them to ensure that reasonable adjustments are made to enable the needs of people with learning disabilities and autism to be met by mainstream services. This team will also work with other mainstream services, for example primary care services to enhance existing work which is being delivered to upskill mainstream services in relation to the needs of people with learning disabilities and autism.

- **Admissions avoidance or safe "haven" accommodation** (jointly with Solihull)
  Existing respite facilities have been refurbished to provide short term admissions avoidance accommodation for people at risk of admission to hospital
  - One bed at Ashby House in Nuneaton
  - Two beds at Shirley House in Solihull
  - This accommodation will be used for people who need somewhere safe to stay in order to prevent an admission to hospital. A recent successful pilot made use of one of these beds to facilitate earlier discharge from hospital. The individual was supported for a week at Ashby House by the intensive support team and respite teams, working with the care team from the community supported living provider in order to provide training and role modelling of the support required by that individual.

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The above services represent those included in phase one of the fast track plan submitted in September 2015. These services were pump primed using transition funding from NHS England and are now being funded recurrently using match funding of £1.48M from Coventry and Warwickshire CCGs.

New Services Planned for Phases Two and Three

The transformation programme is now moving into phases two and three and the intention is to develop and grow the enhanced support model to:

- **Offer across a 24 hour period where a person's needs require this (in Solihull this is currently not in place)**
- **ensure a robust admissions prevention approach reaching into children's services and preventing both hospital admission and 52 week residential placements**
- **support those with a diagnosis of autism who do not have a learning disability**
- **incorporate the development of community forensic provision.**
- **Develop the market for supported living services for people with complex needs**
- **Offer a range of personalised packages of care and support, particularly in relation to admission avoidance accommodation and/or short term/ emergency respite**

Further detail on these is provided below

24 hour provision in Solihull

- Solihull already have a service which works in the way the Transforming Care programme requires. There is however a resource challenge and in order to effectively address the gaps that have been identified, additional investment is required. This is expected to be achieved through additional investment from the transforming Care monies – which will be match funded by Solihull CCG.
- The requirement for greater integrated working with mental health services has been identified in Solihull as it has in Coventry and Warwickshire. Additional resource is therefore requested for a mental health liaison function to mirror the provision in Coventry and Warwickshire.
- The additional resource required to deliver the above is as follows:

OT specialising in sensory processing	equivalent of 3 days a week, @ Band 6
SaLT specialising in communication strategies	Equivalent of 2 days a week @Band 6
SaLT as above	Equivalent of 2 days a week costed at Band 8a
Health Care Assistants	3 full time posts Band 4
Assitant Psychologists)	3 full time posts Band 4
Social Worker	2.5 days
Psychologist	Equivalent full time post Band 8a
Staff Grade Psychiatrist	
Mental Health Liaison Nurse	Full time Band 6

All Age Intensive Support Team

- It is recognised that transition between children's and adults services is one of the

contributing factors to people being admitted to hospital. Furthermore, it is recognised clinically that a transition point of 18 years is not appropriate for people with a learning disability. It is therefore proposed to extend the existing 7 day intensive support team to support children and young people under 18 years who are at risk of admission to hospital and to provide behaviour support planning for families.

- The provision of in-reach services into residential placements and schools to support behaviour support planning is being considered as it is recognised that school break down is one of the primary reasons for 52 week residential placements.
- Links with local transformation of CAMHS services will be made in order to ensure any new services commissioned align with and build on planned changes to CAMHS provision.
- Services will be developed with service users, carers and families at the heart of planning and delivery. A mapping day for children and adults services is being planned in order to scope this all age approach in more detail.
- Funding is required to develop and test this all age approach across the partnership. Recurrent funding models will depend on the outcome of ongoing discussions with NHS England Specialised Commissioning and providers of inpatient and residential placements to clarify financial implications of proposed changes.
- There are efficiencies to be made by commissioning an all age disability team rather than two separate teams. Further modelling is required to fully understand what this model will look like and the likely costs of that, however initial estimates are that the population of children and young people with a learning disability and/or autism is approximately half the population of adults. It is therefore estimated than an increase in capacity of one third of the existing intensive support teams would meet the needs of children and young people.

Community forensic services

- These may or may not be commissioned separately to the enhanced and crisis support team, dependent on the model that is chosen. Links are already being made with similar community forensic models in Birmingham and these will be used as the basis of co-production design work with service users, carers, community providers and health and social care professionals to more fully understand and scope this service.
- These services will include a criminal justice liaison service, which will work in a similar way to the newly commissioned mental health acute liaison service in order to enhance criminal justice systems and processes in relation to people with learning disabilities
- The concept of court diversion services are particularly relevant to people with a learning disability and/or autism as lengths of stay in hospital are likely to be significantly reduced if the individual goes straight to hospital without a potentially lengthy stay in prison on remand prior to the additional needs being identified.
- Initial modelling of resource requirements are as follows:

Occupational therapist	Band 7	1
Community Nurses	Band 7	1

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	Band 5	1
	Band 3	2
SALT	Band 7	0.5
Clinical Psychologist	Band 8B	1

- Funding is required to develop and test this approach across the partnership. Recurrent funding models will depend on the outcome of ongoing discussions with NHS England Specialised Commissioning and providers of inpatient and residential placements to clarify financial implications of proposed changes.

Supported Living services for people with complex needs

- There are a range of Supported Living providers in Coventry and Warwickshire. With the new model, Supported Living services will need to be commissioned to be able to support people with more complex behaviours, including those who have been in contact with the Criminal Justice system, and also to deliver accommodation options for a greater volume of cases. There will need to be a study to identify how the Supporting Living market needs to develop to support the Transforming Care Fast-track programme. This will be followed by market development activity to create a market of small niche providers in Coventry and Warwickshire to manage very difficult people, since there are few providers of this nature currently operating in Coventry and Warwickshire.

Intensive support for people with autism

- An acknowledged gap in local health services is intensive support for people with autism who do not have a learning disability. Further work is required to scope the extend of the need and to understand how best to provide the support required to prevent admission. Some specialist expertise for working with people with autism exists within the current enhanced team, however feedback from other areas of the country suggests that opening up the existing intensive support team to people with autism and no diagnosed learning disability could result in capacity issues for the team due to the large numbers of people with autism. This remains a challenge for the local model. In order to support the development of appropriate support, it is intended to undertake a pilot phase of extending the intensive support function to people with autism. There is therefore the potential to release resource into the system if these admissions could be avoided.
- The team required to pilot this extension to the model would replicate the existing enhanced support team and would include clinical psychiatrist, nurses and therapists. Recurrent funding models will depend on the outcome of ongoing discussions with NHS England Specialised Commissioning and providers of inpatient and residential placements to clarify financial implications of proposed changes.

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

Some Inpatient Services

- In Coventry and Warwickshire, it is intended following public consultation to re-commission assessment and treatment services in the community rather than at the 9 bedded assessment and treatment Gosford Ward at the Caludon Centre.
- All other inpatient beds are spot purchased. Anticipated future inpatient requirements are described in detail in previous sections.

Block arrangements

- As personal budgets are used more effectively, the TCP would exist to recycle some existing block service arrangements into personal budgets.

Additional services will be identified as phases two and three of the programme are implemented and new models of working are identified.

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

Respite Provision

As part of the community provision following the closure of Gosford, It is recognised that there is a need for short term immediate access accommodation for situations where a person has damaged their home or where carer relationships have broken down. In the short term, one bed at Ashby House and a further two at Shirley House have been identified for this purpose.

At the Transforming Care Oversight Board in February 2016, it was recognised that

1. A more comprehensive understanding of the range of respite provision across the TCP was required in order to determine whether the services currently commissioned meet the needs of the population under the new model of care
2. Bed based respite provision as described above may not suit everyone, so a wider range of options needed to be available to ensure personalised care and support could be provided based on peoples' needs and wishes.

The Board therefore requested a review of respite provision across the TCP to be completed by September 2016. Options to be explored will include:

- Use of existing bedded respite facilities
- Renting a flat in the community to provide short term accommodation with support provided by CWPT
- Tendering for independent support provider to rent a flat in the community to provide short term accommodation with support provided by CWPT.
- Commission a range of existing local providers who support individuals with learning disabilities and/or autism with behaviours that challenge to provide short term accommodation and support.
- Short breaks provision, including funding for family carers

Irrespective of what option is progressed there is recognition that we need to be more

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creative and personalised in our response to individual circumstances making the best use of resources available to us. We also need to be clear that the provision of emergency accommodation would not be covered by any specific legal framework and as such we could not 'force' people to move from their current accommodation to short term accommodation. We would need to clear that this was part of the offer to avoid them going in to hospital but that other approaches could be taken. For example, we should actively be discussing with parents and carers where appropriate them moving out of the family home for a few days to support de-escalation of the situation.

Feedback from the Transforming Care Partnership Group following a discussion on short term accommodation options was as follows:

- The most important thing is that different options will suit different people, so we need a range of options that will suit people with a range of needs.
- Sometimes if there is a breakdown of family carer relationships, we should consider moving the parents to a hotel and keeping the service user where they are in a familiar environment.
- People could travel to emergency accommodation but it would be better to be as close to home as possible being looked after by people that know and love you.
- We should ask people where they would like to go in an emergency when we are talking to them during their CTRs and during their contingency planning when they are well.

Irrespective of which option is selected to provide short term accommodation there is still a recognition locally that there is a gap in short breaks/respite provision to support people with behaviours that challenge, especially in an emergency situation.

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

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

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

It should be noted that children and young people with a learning disability who are eligible for an Education, Health and Care plan should also be considered for a personal health budget, particularly for those in transition and those in 52-week placements.

This process aligns with the 'local offer' areas are developing for personal health budgets and integrated personal commissioning (combining health and social care) in March.

A truly person centred approach drives the options for a personal health budgets, Individual Service Funds and Direct Payments.

Because of the well-established partnership between health and social care in Solihull many people with complex needs (79) receive and arrange their support through a direct payment. More recently, Solihull have developed a contract for Individual Service funds and this has great relevance to this area. Similarly in Coventry and Warwickshire, direct payments and individual service funds are used to deliver person centred packages of care and support.

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Across Coventry and Warwickshire, a formal project team is in place to deliver the local offer for personal health budgets. The local offer for PHBs was launched on 1 April 2016 and commissioners have identified the opportunity to drive PHBs via a number of workstreams under the transforming care programme, including via the Enhanced Support Pathway and through development of more flexible and innovative opportunities for respite provision.

In Solihull, work is already looking at how to build on those people who have complex needs, are jointly funded and receive their support through a Direct Payment. Individual Service Funds have been developed for people who have joint funded packages of support and this is seen as a really powerful base to be able to offer Personal Health Budgets to people whose packages are exclusively funded through the NHS. Solihull CCG is working with **In Control** to support the development of the Personal Health Budgets infrastructure and is a joint approach with Solihull Borough Council.

The use of integrated personal budgets supports the integration agenda which runs throughout this programme and it is understood that with the right support, individuals themselves can often be the best integrators of their care.

There is work to be done to develop the market with providers of care and support for people with complex needs to ensure that personal budgets can be used in the most effective way to deliver truly person centred care.

Funding is requested from NHS England as part of this transformation plan for resource to undertake the work required to:

- understand how to make it easier to access PHBS and remove blockages, risks and streamline systems for people with complex needs
- Support individuals with complex needs and their families to access personal budgets
- Work with providers of care and support for people with complex needs, including NHS, independent and third sector providers to develop the market for person centred packages.

What will care pathways look like?

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

Care pathways are being developed by the intensive support team along with inpatient services. These include care pathways for people admitted to general mental health inpatient settings.

Care pathways will be focussed on early intervention and prevention of crises, with hospital admission included as part of the pathway as a last resort.

Much work has been done to understand how care pathways will be experienced by people and their families

Please see the below links to living my life DVD chapters for details of how this will be different for patients and their families.

- Main film: https://www.youtube.com/watch?v=w_WcdFoJUO0
- Craig: https://www.youtube.com/watch?v=81JDI-VOviM

- Shelia: https://www.youtube.com/watch?v=JK38YpxswDk
- Rachel: https://www.youtube.com/watch?v=EKIObxxNo1U
- John: https://www.youtube.com/watch?v=SJ-KpQ9_K8s

How will this be different for staff and providers?

Becky Hale, Service Manager (All Age Disability Commissioning) Warwickshire County Council

- Introduction of trusted assessments, care coordinators and greater joint working across health and social care. In turn this will ensure a more personalised and bespoke assessment and care management process and release capacity across health and social care as activity is not duplicated.
- Service providers will have access to timely, hands on support to enable them to continue to meet the needs of individuals in the community who may be experiencing a lapse in their mental health or be displaying significant behaviours that challenge where previously admission may be have considered. There will be the ability to share learning across the provider market and potentially develop dedicated support networks for providers supporting individuals with behaviours that challenge in the community.
- Significant cultural change for all professionals working with people with a learning disability that community support can meet the needs of our most complex individuals if additional support is provided in a timely and integrated manner.
- Move to integrated assessment and care management.

From a commissioner perspective a move to integrated commissioning arrangements will support a more consistent, flexible, innovative and outcome based approach to meet the needs of our LD population and achieve best value.

Pete Fahy, Assistant Director Social Care, Coventry City Council
Providers (including the voluntary and community sector) will be required to operate flexibly to support adults with learning disabilities in a personalised way – this will include changing perceptions of levels of risk so that people that would previously have been admitted to a bedded facility are supported effectively in their own home.

Dean Thomas, Workforce Lead, Coventry and Warwickshire Partnership Trust
For staff working with the client group they feel the focus on keeping clients in the community wherever possible resonates with the philosophy of care they wish to provide, the move from providing a community service supported by the Gosford inpatient service to an enhanced community model has been received in a very positive light.

Staff understand that where they may have viewed an inpatient intervention as a safe option they will now be developing their skills and the ways which they assess risk, crisis management and place of safety to understanding how a different model of community provision will meet most client's needs.

Staff will be engaged in a training needs analysis, based on work undertaken by the Local Education and Training Board (LETB), which CWPT has been very closely involved with and a competency framework will be used to evaluate what additional training and educational requirements the staff will need to help transition to a community workstream.

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The existing staff are being given the opportunity to work in the community as part of the transition arrangements and for those who do not feel they wish to work with the community model alternative employment will be found within current service provision.

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

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

This is recognised by the TCP as an area that needs further work to understand the support required by individuals in transition. Warwickshire have funded a research programme with the National Development Team for Inclusion to understand the factors impacting on successful transition and the results of this study will inform future plans for the TCP. TCP planning will also be aligned with existing SEND programmes of work with respect to children and young people in transition.

The following highlights existing and planned services:

- As described above, the TCP are exploring the potential to extend the newly commissioned adult intensive support team to be an all age team. This will mean that the same team of professionals will continue to provide intensive support to people from childhood and through into adulthood. The potential for an all age approach to the commissioning of existing adult and children's community teams is yet to be determined and the design of this model will be undertaken with children, families, adults and professionals.

Warwickshire

- Warwickshire County Council has established a transitions team of social workers who are specifically working to support children approaching transition. This includes those in 52 week placements.

Solihull

- Solihull has a number of NHS and LA bodies and providers supporting its citizens and a series of interlinking pathways are required to ensure that the needs of people across the age range, and at critical stages are supported efficiently, effectively and in person centred ways. A number of events are planned with key partners during April to address this.
- Additionally, some service changes are planned in the coming months which will make a positive contribution to this area, this includes:
    - A number of Local Transformation (Children and Young People) Plan work streams
    - The creation of a 0-25 C&YP SEND service within the local authority by September 2016, with the aspiration to extend this to NHS providers

Coventry

- In Coventry there is a joint health and social care all age disability team which has a specific function for supporting people throughout transition

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How will you commission services differently?

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

The emphasis on community provision over inpatient settings will mean that the size and extent of community provision relative to inpatient provision will continue to develop. This community provision will be focused on three cohorts:

The current in-patient cohort, including those in forensic settings

- 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 remain living in the community and any inpatient admissions are minimised.

The current community cohort

- Community provision will need to keep people with a learning disability and/or autism living well in communities, preventing a 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.
- This will require a greater focus for 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, as well as accommodating this within the contract arrangements with CWPT.

Mainstream Services and community networks

- The role of mainstream services and community networks as an important partner in achieving this is also much more of a focus. There is an emphasis on making sure that people with learning disabilities and/or autism can access all the relevant mainstream services and have the ability to be supported by their peers.
- 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.

Lead Commissioner Arrangements and Pooled or aligned budgets

- There is senior level commitment across Coventry City Council, Warwickshire County

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Council and the three Clinical Commissioning Groups to progress lead commissioning arrangements for people with learning disabilities. These areas have been identified as both national policy and local joint strategic commissioning intentions are clear regarding the need for, and benefits of, integrated commissioning arrangements and pooled budgets for this local population.

- Coventry and Warwickshire's Joint Plan in response to Winterbourne View signed off by respective Health and Wellbeing Boards in November 2014 includes the following specific objectives:
    - Have commissioning arrangements in place which reinforce the model of care
    - Explore the use of pooled budgets to support the provision of joined up care for people.
- In Summer 2015, Warwickshire's Joint Learning Disability Statement of Intent was signed off by Warwickshire County Council Cabinet and CCG's. The Statement of Intent and associated Delivery Plan identified a range of key priorities including partnership working and progressing integration across health and social care particularly in relation to care coordination and funding streams.
- As part of Coventry and Warwickshire's Fast Track submission to NHS England in September 2015 coordinated, integrated care and commissioning was identified as a priority.
- In Coventry or Warwickshire we do not have pooled budgets in place for those with a learning disability/autism. There will be a move to pooled or at least aligned budgets for health and social care spend for the population concerned during the course of the Transforming Care Fast-track programme and work needs to take place to scope how we move to this arrangement for the whole LD population linked to our commitment to progress integrated assessment, carer management and commissioning.
- The Transformation plan includes the recruitment of a Joint Strategic Commissioning Programme Manager for a period of 12 months to progress lead commissioning arrangements for people with a learning disability and/or autism across Coventry and Warwickshire. The post will work across health and social care in Coventry and Warwickshire and will be hosted by Warwickshire County Council on behalf of the two local authorities and three clinical commissioning groups.
- Funding is requested to support the appointment of this post.

Personal Budgets

- While direct payments, independent services funds and personal health budgets are all available and in use to varying extents across the TCP, it is recognised that more could be done to make use of this commissioning tool to deliver person centred packages of care and support.
- The TCP recognise the need to build the capacity of the independent and third sectors to support people with complex needs, including working with the market to provide more
- The local offer for PHBs was launched on 1 April 2016 and commissioners have identified the opportunity to drive PHBs via a number of workstreams under the transforming care programme, including via the Enhanced Support Pathway and through development of more flexible and innovative opportunities for respite provision.

Quality Assurance Framework

In Warwickshire a new joint health and social care Quality Assurance model has been piloted in line with the new model of care. A Quality Assurance Framework has been developed (see Appendix 4) in co-production with services users, carers and providers and this

underpins a new outcome based supported living framework which is being used across health and social care in Warwickshire and for health packages in Coventry. Key to this approach has been the restructuring of traditional contract monitoring approach and the creation of Quality Assurance Officer positions. The Quality Assurance Officer will be likely to be someone with expertise and experience in learning disability services and who will undertake announced and unannounced visits to services to observe the quality of care and support delivered. Quality visits will involve spending a number of hours in a person's home and will provide an opportunity to observe the environment and relationships between carers and people that are being supported as well as review care plans and crisis plans. Quality Assurance Officers will also talk to people about their lives and the care they are receiving.

The Quality Assurance Framework will be used to produce a Quality Assurance Dashboard which will be populated with information gathered through a combination of workbooks completed by providers, CQC information and quality visits by Quality Assurance Officers and targeted visits by peer reviewers, or experts by experience.

Flexible and Responsive Commissioning - Contingency Fund to enable changes to packages of care and support

In the new model of care it is acknowledged that at times delays in approving funding may have got in the way of delivering required changes to packages of care to either prevent admission or facilitate discharge from hospital. An important element of the care model co-produced locally was the development of flexible and responsive commissioning of support.

A contingency fund was piloted in February and March and information gathered about the impact of this. This contingency fund operates as a short term pooled budget which can be accessed in order to support a rapid change in care and support for people at risk of admission to hospital. Similarly the fund has been used to overcome barriers which in the past may have led to a delayed discharge. The fund can be accessed either via a care and treatment review, or via trusted assessors in the intensive support team to enable up to 6 weeks of additional support to be commissioned from supported living providers and other community providers where required.

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

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

There are identified gaps in terms of the housing base in Warwickshire, Coventry and Solihull. This relates to specialised accommodation for people with complex needs, including but not limited to people with destructive behaviours and people with a forensic history.

Commissioners have modelled the capacity required based on:

- numbers of people currently in locally commissioned inpatient settings who require specialised accommodation to facilitate their discharge and support them to live and

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remain in the community.

- Numbers of people currently in secure services who are planned to be discharged to the community over the coming years
- Anticipated growth in the number of people requiring specialised accommodation, including children and young people transitioning back to local services from residential placements

To enable the changes in community provision necessary to allow the transfer of patients from in-patient to community setting, capital funding of £3.5M is required. This will be comprised of two bids submitted for 2016/17 funding:

- £1.2m to develop 6 units of long term specialist housing, three units in North Warwickshire and a 3 unit scheme in South Warwickshire.
- £1.1M to develop 6 units of long term specialist housing in Solihull

A further bid is being developed for submission in 2017/18:

- £1.3M to develop 6 units of long term specialist housing in Coventry with a particular focus on those resettling in the community following discharge from secure settings.

Financial modelling is based on existing estates programmes, with adjustments factored in for particular challenges such as the cost and availability of land in high cost areas such as Solihull.

These capital bids have separately been submitted via CCG financial plans.

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?

Solihull has already undertaken this task and is willing to share their experiences – lessons learned as well as many positive outcomes. As mentioned previously, a DVD has been developed locally which demonstrates the story of one particular person and how he was supported from a hospital placement of over 16 years to his own home. This recently featured as the patient story at the Solihull CCG Governing Body meeting and was shared with stakeholders at the launch event for the model of care in December 2015.

Similarly, in Coventry and Warwickshire, people who have been in hospital for many years have already been resettled. For example an individual discharged in July last year had been in hospital since 1992. Across the TCP, the individuals in hospital now who have the longest stay are those in secure beds, with the longest being an individual admitted in 2004 with a discharge trajectory of March 2018 (14 years).

Workforce development plans include working with community providers to support them to develop the required skills, culture and values to support people who have spent long periods of time in hospital. The DVD mentioned above will be used as part of a training package to share the expertise and experience of local providers who have demonstrated their success at supporting people to heal and develop good and fulfilling lives following a long period of time in hospital.

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

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Guidance notes; How does it fit with:

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

Linkages between this plan and other plans and models is provided by members of the Oversight Board and the Learning Disability and Autism commissioners Group, both of which groups include representatives of all partnership commissioning organisations.

Any additional information

5.Delivery

Plans need to include key milestone dates and a risk register

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

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

The Transforming Care Fast-track programme structure has been in place since October 2015 and has a number of key workstreams. The Solihull workstreams will be amalgamated with existing workstreams for the Coventry and Warwickshire programme, wherein timescales for delivery are clearly articulated. For example, work is already underway to develop a combined communications and engagement plan and stakeholders from Solihull have been invited to join the existing Coventry and Warwickshire partnership group which includes representation from service users, carers and providers of health, social care and supported living services.

A project management approach has been adopted to ensure these areas keep on track and deliver the work required. The programme plan at Appendix 6 is a live document which is updated on a fortnightly basis by workstream leads and is used to inform monthly highlight reports to NHSE.

The key workstreams are as follows:

Clinical Workstream

This workstream relates very closely to the admission prevention workstream and focuses on the needs of specific individuals who are in hospital or at risk of admission to hospital. A monthly meeting of clinical and social work providers and commissioners reviews individual cases to provide confirm and challenge to existing care plans and to enable issues to be addressed, for example any reasons for delayed discharges. In particular the already designed risk register will be implemented, and CTRs, root cause analyses and CPAs will be mainstreamed for all inpatients.

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There will also be a review of safeguarding policies and procedures and how effective they are for people with a learning disability and/or autism particularly around challenging behaviours. This will lead to a series of activities to ensure a consistent approach to safeguarding, and that safeguarding plays the important role that it needs to in terms of prevention admissions.

Deliverables:

- Implemented risk register
- CTRs mainstreamed
- Better understanding of cohort of people in specialised commissioning settings
- Better understanding of children's and autism cohort
- Collation of themes and key learning points from individual case reviews and root cause analysis to inform further iterations of the model of care
- Assuring transformation data returns

Admission prevention

This workstream will create in three phases the enhanced and crisis support team to identify people at risk of admission to hospital and use the model of care to try to prevent admission:

- **Phase 1** implementation to mobilise the enhanced support model for adults and to close Gosford ward - COMPLETED
- **Phase 2** implementation to support the Coventry and Warwickshire inpatients in Brooklands moving out into the community and also the Coventry and Warwickshire residents who are currently inpatients in hospital settings outside the Coventry and Warwickshire area, which includes those people with autism and complex needs - IN PROGRESS
- **Phase 3** implementation to support those people in NHS England Specialised commissioning settings to move out into the community, including children and young people and those in forensic settings CURRENTLY BEING SCOPED

This workstream will recruit and staff the team for the three phases, and provide them with the tools and processes to deliver. The intelligence gathered from the operation of the risk register and the mainstreaming of CTRs and root cause analyses will help inform the design of the enhanced and crisis support team, and how they operate.

The relationship between the enhanced and crisis support team with the Mental Health crisis team will also be designed, so that both teams have the relevant expertise to hand for mental health and learning disabilities. In particular it is anticipated that learning disability knowledge and capabilities will need to be built within the Mental Health Crisis team. However since many of the practitioners in the Enhanced and Crisis Support team are expected to have competencies in both mental health and learning disabilities, then the enhanced and crisis support team is less likely to need additional mental health needs.

Tools and support to help existing teams and providers and also carers prevent unnecessary admissions will also be designed and the enhanced and crisis support team will train teams, providers and carers in using them effectively, as part of the programme plan. Examples of these tools are relapse prevention plans and also checklists for behaviour change triggers.

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The staffed up enhanced and crisis support team will also support an ongoing programme of work with mainstream services to help them make reasonable adjustments so that those with a learning disability and/or autism can access their services. At the same time, the mainstream services will adopt quality assurance schemes to demonstrate they are doing this.

The care coordinator role will be extended beyond the statutory role in the Care Programme Approach, to everyone who is assessed and has a support plan put in place. The care coordinator has an important role in integrating services around the person, working closely with advocates too, to ensure that this happens.

There are a number of integration initiatives that will be developed in parallel through this workstream. Person-centred plans will be developed for each person with a learning disability and/or autism for whom assessment of need and support planning is appropriate. These plans will provide staff and family with the context in which services are set, helping them to integrate them around the person and their family and carers.

An early piece of work will focus on getting better clarity on the autism cohort, and for children with a learning disability and/or autism. Understanding the services these populations use and how risks escalate will allow better prevention and early intervention approaches to be implemented.

Although health checks are in place, more work is required to extend them from 14+ and support GP practices to have the skills to identify appropriate patients for health checks. The Discharge to Assess model is currently implemented in mainstream NHS services in Coventry and Warwickshire. This workstream will explore the potential to extend the principles of the Discharge to Assess model and the Trusted Assessor role, so that those with a learning disability and/or autism in in-patient services are discharged when they are suitable to be discharged, and that their discharge is not held up by funding decisions.

Deliverables:

- An enhanced and crisis support team staffed up and operational for the three phases of implementation, and effectively integrated with the Mental Health Crisis team
- Providers and carers trained in prevention admissions, with the support of tools
- Mainstream services able to provide reasonable access to those with a learning disability and/or autism, and with a quality assurance scheme in place to prove that they are
- More consistency across GP practices for the implementation of health checks from 14+
- More consistency in the use of safeguarding to prevent unnecessary admissions
- Delivery of new crisis accommodation - Shirley House and Ashby House
- Review of respite provision and options for changes to existing provision

Commissioning Infrastructure

This workstream will use the case for change to decide what joint commissioning arrangements need to be in place to deliver the good quality of care and support that is required to be delivered from the new model of care. These joint commissioning arrangements will not just be across local authorities and the CCGs but also look to include specialised commissioning as far as possible, to create a whole system view. The changes that need to be made for greater personalisation through personal budgets and personal

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health budgets will also be considered e.g. the pricing of services. This strategy will inform a set of decisions around pooling budgets, with budgets aligned if they cannot be pooled.

Early in this workstream a strategy will be developed for the integration of health, social care and other services such as housing, to meet the requirements of the Transforming Care Fast-track programme and to facilitate the improved quality of care and quality of life that is the focus of the programme.

This workstream also involves the implementation of changes to commissioned services and the building of capacity in the market as a result of the Transforming Care model of care, as well as the implementation of quality monitoring mechanisms.

There is currently no provider capacity in Coventry or Warwickshire around community forensic services. This workstream will develop the market for supported living services for people with forensic needs by working with providers to build capacity and bring new providers into the local market.

Peer networks are always very highly valued, except for some of those with autism who prefer not to engage with such groups. Whilst recognising their 'organic' nature, the programme will encourage the development of peer networks, so that everyone with a learning disability and/or autism is able to access peer networks.

This workstream also includes the development of a strategy for long term accommodation, including Supported Living, to make sure that a mixed model of accommodation is available to suit different needs. The accommodation and the support provided needs to be able to cope with complex needs and challenging behaviours, and it may be that the existing care and support teams and enhanced and crisis support team play a significant role in the support of people in long term accommodation.

The requirements of the Care Act are already strengthening advocacy services. This workstream will build on this to implement a model for advocacy for those with a learning disability and/or autism which creates a much more long term relationship with advocates, rather than it being issue-based.

As the market develops and adjusts to the new model, commissioning mechanisms to deliver high quality care that improves people's outcomes will be under constant review to see whether the current combination of block and framework contracts providing the health support to those with a learning disability and/or autism is the best way forward.

Commissioning on a capitation basis, and lead provider models may or may not turn out to be appropriate, but outcomes-based commissioning will be incorporated into contracts at the appropriate stage in a way which does not discourage small providers.

Pooled or at least aligned budgets are fundamental to the success of the programme and the financial model to support re-investment of savings in the community. This includes monies for Specialised Commissioning, at least for low secure, though this will need changes at a national level to achieve pooled budgets. The programme will need to prepare budgets to be pooled, or align them if pooling budgets is not possible or appropriate.

Deliverables:

- A joint commissioning strategy for those with learning disabilities and/or autism to support

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the new model of care
- Decisions around pooled budgets to support the commissioning strategy.
- Published Market Position Statements for new commissioning requirements, such as community forensic services and, as well as for decommissioning in-patient services
- Provider capacity built or decommissioned to meet Market Position Statements
- Expanded use of advocacy available for those with a learning disability and/or autism
- Quality assurance and audit schemes in place for mainstream services and mental health services

Workforce development

This workstream delivers the workforce development plans to create a consistent approach across services to dealing with challenging behaviours by using positive behavioural support techniques. In particular, the workforce development programme will make use of the positive behavioural support competency framework developed by Coventry and Warwickshire Partnership Trust amongst others at a West Midlands and a national level. In addition the workforce will need to develop the skills and ability to be able to manage those who have come into contact with the Criminal Justice system, in the community. Training requirements will be identified using a Training Needs Analysis, and the training programme designed and delivered according to this Training Needs Analysis.

A DVD has been developed as a tool for changing culture throughout the health and social care system, as well as mainstream services. The intention is to use the DVD to promote the model of care, starting with the launch event in December 2015 and following up with the workforce development programme. There are five stories, showing how someone with behaviour that challenges can be supported really well. Four are individuals with a learning disability and/or autism with the fifth from a local commissioner and provider perspective. All of the DVD's were put together by a local provider, 'Gettalife', and feature individuals with high support needs that they support in the community who were previously in hospital settings.

A gap locally has been identified for clinicians with a specialist autism skills and experience. This will be explored as part of this workstream, as will the workforce required to deliver community support for people with forensic needs.

Supported living providers will be closely engaged in this work in recognition of the need to develop the local care and support workforce to deliver the new model of care. A network of providers has been established, although more work is required to engage the right providers at the right time with the programmes of work. A train the trainer model is being considered in order to cascade and sustain

Deliverables:

- Workforce whether local authority, CCG, NHS England or supported living providers, has a consistent approach to dealing with challenging behaviours, and also skilled in meeting of those who have a forensic history

Communications and Engagement

This workstream delivers the extensive engagement with the public and also with providers that is crucial to delivering the programme and improved outcomes for people with a learning disability and/or autism. The programme will build on engagement that has already been

delivered around the Gosford Business Case and the wider model beyond this, going back to the engagement exercise that happened in June to July 2014 as part of the cross-Coventry and Warwickshire plan as a response to Winterbourne View.

Effective provider engagement will be crucial to the ability to develop the market around community forensic services and long term accommodation options. Commissioners will signal their commissioning intentions through the use of Market Position Statements, and will engage with providers around the development of these and taking them forward into commissioning plans and the development of provider capability. In addition there will be engagement with Herefordshire and Worcestershire in line with whatever collaboration option is chosen.

Deliverables:

- People with a learning disability and/or autism are engaged and buy-in to the Transforming Care Fast-track programme, and have been able to influence the scope and shape of the programme
- Providers are engaged and buy-in to the Transforming Care Fast-Track programme, and have been able to improve the robustness of Market Position Statements and commissioning plans
- Providers have responded to market development activities, and have developed capabilities and capacity in areas where it has been identified that there is little or no current provision
- Collaboration option agreed between Coventry and Warwickshire, Herefordshire and Worcestershire, and engagement across the geography delivered in line with this decision

Finance and contracting

This workstream will undertake the financial modelling and monitoring required to deliver the programme within available resources. This workstream will also put in place any commissioning and contractual changes required to support the new model of care. The commissioning relationship with Coventry and Warwickshire Partnership Trust will need to change for a number of areas, including:

- Updated contracts to include new/changed requirements
- Decommissioning of inpatient services at Brooklands and Gosford
- Implementation of the enhanced and crisis support team in three phases
- Refurbishment of Shirley House to provide crisis accommodation for those with complex needs and challenging behaviours
- Delivery of training and the competency framework around positive behavioural support that CWPT has been involved in developing, to providers and teams
- Review of bedded respite provision

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

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

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The attached programme plan (Appendix 6) lists workstream leads and teams representing people from all partner organisations as well as providers.
What are the key milestones – including milestones for when particular services will open/close? *Guidance notes; What are the timescales / lead times for each key milestone* *Please either complete a route map – as attached, or some other project management tool to map milestones* Key milestones are outlined in the attached programme plan (Appendix 6)
What are the risks, assumptions, issues and dependencies? *Guidance notes; Are there any dependencies on organisations not signatory to this plan, or external policies/changes?* A live risk and issues register is included in the attached programme plan (Appendix 6)
What risk mitigations do you have in place? *Guidance notes; Consider reputational, legal, safety, financial and delivery, contingency plans* Risk mitigations are included in the attached programme plan (Appendix 6)
Any additional information
6.Finances
Please complete the activity and finance template to set this out (attached as an annex).
End of planning template

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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.[8]

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)

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

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Indicator No.	Indicator	Source	Measurement[9]
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 -	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

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

		Psychiatry of Learning Disabilities or diagnosis of a learning disability or autism.	The consultation took 90 days as the specified period for readmission. We would recommend that this period should be reviewed in light of emerging readmission patterns. Particular attention should be paid to whether a distinct group of rapid readmissions is apparent. 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

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Health & Well-being Board – 27 June 2016

Harnessing voluntary sector resources in system transformation

1. VAC has moved from a bridging to a catalyst role in harnessing resources across the public and voluntary sectors through multi-sector problem-solving workshops:

    - Working with statutory leads to draw up together the desired outcomes, format and target attendance including Council, CCG, UHCW, CWPT, GP Alliance, WM Police & key voluntary sector service providers
    - Formats to spark off new conversations, relationships, opportunities & ideas
    - Quick win action-planning that delegates lead on delivering
    - Golden thread of early help, prevention & building resilience throughout

2. We are working with Janet White and Warwickshire CAVA to ensure that voluntary sector resources are engaged in the right conversations at the right time and within the right geographical footprint as system transformation progresses. This will build on our recent work to harness voluntary sector resources in adult mental health and frailty.

3. At our adult mental health workshop, 15 charities, CCG, Council, UHCW and WM Police engaged in building awareness of preventative services and agreeing quick win actions to promote collaborative working. Three months on, delegates have reported on their actions:

    - development of new services for UHCW
    - better communication and engagement between providers
    - extension of Mental Health Providers Forum to include specialist charities around substance abuse, ex-offenders, etc
    - service mapping as the foundation for better information & awareness of services

4. At our frailty workshop (see appendix for more detail), 8 charities, UHCW, CCG, Council, GP Alliance, Frailty Team, CWPT & WMAS engaged in building awareness of preventative services and agreeing quick win actions which Phil Evans has fed into 4 weekly and quarterly system transformation plans. Three months on, delegates have reported on their actions:

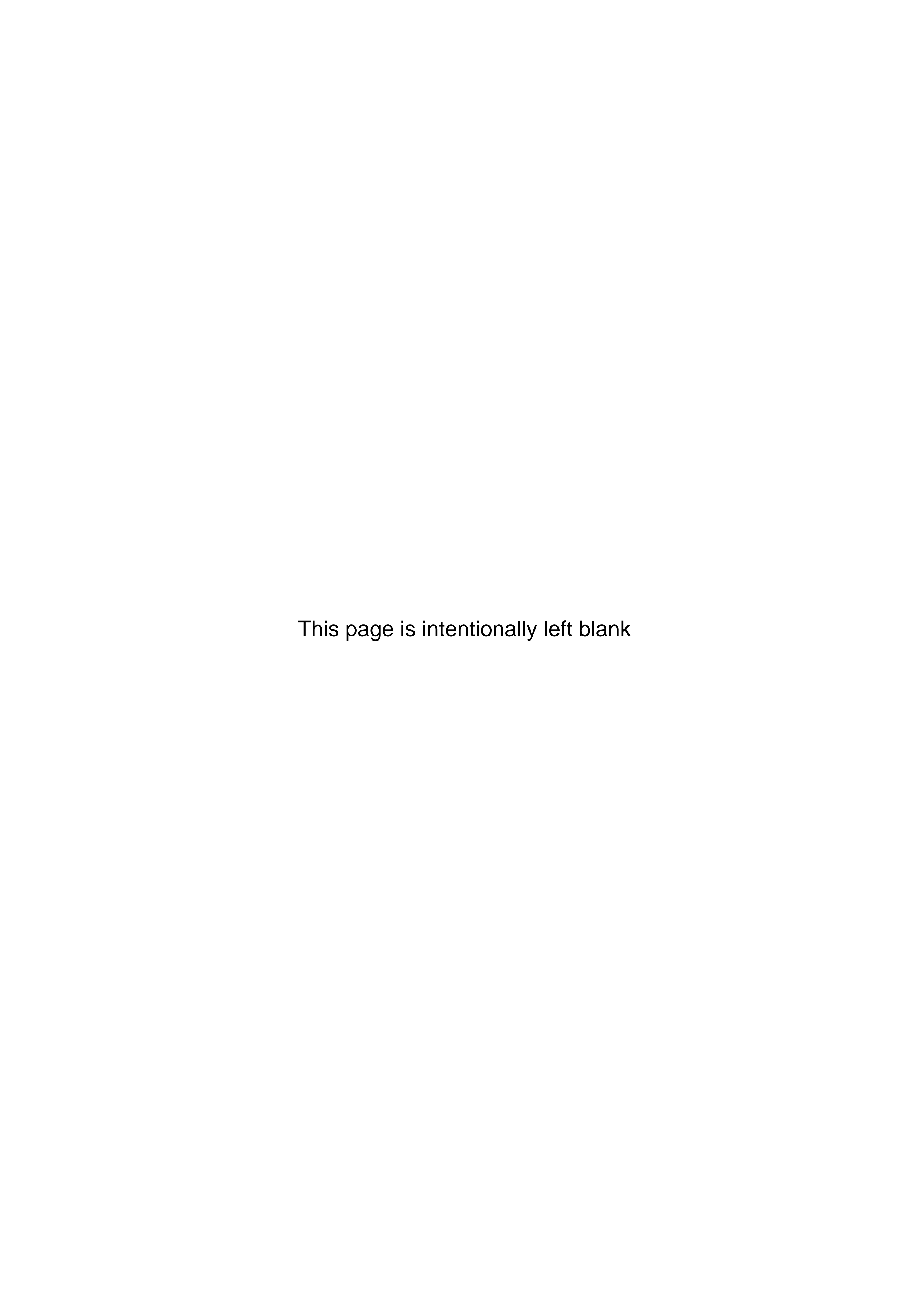
    - work between Integrated Discharge Team and Integrated Neighbourhood Teams to improve referrals including voluntary sector resources
    - inclusion of Community Matron & Age UK Care Navigator details in discharge letters, and closer working between them
    - Integrated Discharge Team, REACT and a proportion of Therapy services have undergone training on the Community Activities Directory (CAD)
    - extension of joint APC/Frailty teaching programme to include voluntary sector presentations, with Age UK Coventry having already done so

5. A larger event on 10 May enabled sectors to consider together the overall direction of travel with system transformation, the Sustainability and Transformation Plan, Connecting Communities and integrated place-based working, with Su Rollason, Jane Moore and Age UK Coventry providing "in a nutshell" introductions followed by table discussions.

6. Next steps:

    - working with Janet White and Warwickshire CAVA on a joint voluntary sector briefing on the STP (probably late September) to continue to prepare voluntary sector providers for more targeted involvement
    - dialogue with the People Directorate & CCG leadership teams in July to:
        - prioritise issues for workshops in the second half of this year
        - identify what conversations we need to be part of to dovetail workshops into partners' conversations

Rob Allison, Voluntary Action Coventry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Early help, prevention & building resilience in frailty services

2.00 – 4.30, 16 March 2016 at UHCW Clinical Sciences Building, Room 10012/14

1. Summary

1.1 A short workshop co-facilitated by Rob Allison (VAC) and Phil Evans (Coventry & Rugby CCG) to develop a better common understanding of the role of early help, prevention and building resilience in frailty services, to identify opportunities and barriers, and to identify actions that delegates can quickly and easily take forward to address these.

1.2 A clear timetabled action plan with leads was developed as a result, including:

- review and/or development of existing services such as Going Home Service and Integrated Neighbourhood Teams
- development of the current Directory of Services and an advice line for the ambulance service
- development of knowledge in the Multi-Disciplinary Team, Integrated Discharge Team and Frailty Team to raise awareness of alternative support and increase referrals to the voluntary sector.

1.3 The following agencies (or teams) took part:

- Age UK Coventry
- Alzheimers Society
- Carers Trust - Heart of England
- Coventry & Rugby Clinical Commissioning Group (CRCCG)
- Coventry & Rugby GP Alliance
- Coventry & Warwickshire Partnership Trust (CWPT)
- Coventry City Council
- Ekta Unity
- Frailty Team
- Moat House Community Trust
- Orbit Care & Repair
- Penderels Trust
- University Hospitals Coventry & Warwickshire (UHCW)
- Voluntary Action Coventry (VAC)
- West Midlands Ambulance Service (WMAS)

1.4 Evaluations (Appendix 3) were very positive – delegates liked the energy & focus of discussion with this format and the excellent mix of people around each table. The session was very action-orientated with an emphasis on actions that delegates could take forward. Progress reports will be taken in three and six months' time.

2. Outcomes achieved

2.1 A better common understanding and awareness of the contribution of the voluntary and statutory sectors to frailty services and their importance to building early help, prevention & resilience and capability to enable people to stay out of hospital and residential care.

2.2 Opportunities for building better services, pathways and collaborative working between voluntary and statutory organisations identified, and the barriers that hinder this.

2.3 Practical actions identified and agreed by delegates to progress opportunities and overcome barriers.

3. Early help, prevention & building resilience within Connecting Communities

3.1 VAC has been promoting recognition of the role of the voluntary sector in ***early help, prevention and building resilience*** which supports Coventry's wider "**Connecting Communities**" narrative to:

- reduce demand and improve services by working with local communities and people to intervene before problems reach a crisis and to find solutions that reflect and build on local people's skills, experience and capability
- encourage resilience in communities and reduce expectations that public services can continue to be demanded and delivered in the same way
- support people to have the capability to do more for themselves (and/or through informal support networks such as their friends, family and neighbours) rather than public services necessarily being the first port of call

4. Methodology

4.1 VAC has re-designed its events to become multi-sector problem-solving workshops to bring together a 'mixed economy' of different partners (statutory, voluntary, community, etc) to use their skills, knowledge and resources to tackle problems in collaboration. This workshop's format was piloted with Adult Mental Health on 10 February and both workshops will feed into VAC's Health & Social Care – Voluntary Sector Network event around system transformation, Connecting Communities and place-based working on 10 May.

4.2 VAC's fast-paced facilitation format quickly raised awareness of existing services, identified opportunities and barriers, and required delegates to identify actions to address these which:

- **lead to better outcomes for frail older people and save money through collaborative working by the voluntary & statutory sectors**
- **are achievable and reported within the next 3-6 months**
- **are clear & specific with a named lead(s) from that table**

4.3 Sue Davies (Coventry & Rugby CCG), Andrea Buckley (Coventry City Council), Carol Speed (Moat House Trust) and Steve Banbury (VAC) were table facilitators, enabling each table to prioritise and record points. A number of delegates took points to the front, giving an engaging and a very participative format, rather than a dull plenary reading from flipcharts.

4.4 Quick wins can improve services through better awareness, communication and co-ordination between providers, but attendees were also encouraged to identify some longer-term actions which could be more transformative on a macro (i.e. systems) level. Phil Evans provided challenge within the broader context of system transformation.

4.5 Phil & Rob worked with UHCW and CCG colleagues to ensure the event included a balanced cross-section of statutory and voluntary sector personnel for frailty. This was key to the workshop's format and success.

5. Examples of early help, prevention & building resilience to enable people to stay out of hospital and residential care

5.1 Specific services such as:

- Age UK outreach, holistic assessment and practical support – working to find solutions to support clients in their own home

- Carers Trust's support for family carers such as Carers Response Emergency Support Service (CRESS) providing up to 72 hours emergency care whilst an emergency situation is being resolved for the carer

- Orbit Care & Repair's home safety and falls prevention checks to prevent / reduce hospital admissions and identify other needs, e.g. safeguarding

- Early engagement of voluntary organisations in multi-disciplinary conversations - e.g. Age UK in the Acute Frailty Unit and Integrated Neighbourhood Teams – and then linking to other voluntary organisations to provide resilience to patients and their families

- Age UK friendship services, bringing people together through community groups, Ageing Better Together campaign

- Carers Trust's carer's assessments - early identification of need and empowering carers to care

- Age UK Contact & Connect service – linking up patients with a range of statutory and voluntary sector services and support through a joined up referral service and plugging the gap for non-medical care and support

5.2 And also collaborative or neighbourhood networks:

- Links between networks of voluntary organisations to provide additional support to frail older people

- Community groups as the eyes and ears in neighbourhoods, looking out for the needs of older people and being a good neighbour

6. Opportunities & barriers

6.1 Opportunities for collaborative working to improve outcomes:

- Short-term: All organisations' details on a single Directory of Service
- Long-term: Efficiency of pathways – redesign a truly integrated pathway
- Trust & respect & value between services and voluntary sector to help build relationships and bridge the gap between home, community & hospital
- Communicating between all sectors (including GPs) on what's out there with updated information
- Overcoming social isolation and loneliness – one system in place with the GP practice as a link point, but also driving away from medicalisation of this problem through the newly started Social Prescribing programme, good neighbours scheme, and use of volunteers
- Workforce roles across health and social care that can be delivered in a community / primary care setting by the voluntary sector

6.2 Barriers that hinder this:

- Lack of awareness of services (services change as funding has run out), policies, training & education
- Funding which is both organisation and Key Performance Indicator specific
- Lack of trust, information-sharing and referrals between organisations and acceptance that we are specialists in our own right with motivation & driving forces
- Risk aversion and lack of trust impacting on taking up of opportunities (including on sharing information due to a lack of understanding on information governance)
- Willingness to commit to what works and switching resources to these

7. Delegates' action plan to address opportunities & barriers – progress after 3 months

Timing	Actions	Lead(s)	Update on progress
Now	Include point of contact (name &tel no) on discharge letter for Age UK Coventry Care Navigator and Community Matron. Measure GP contact. Test from Frailty Team.	Cat Roberts, Frailty Team	We have started adding matron and Age UK navigator details to discharge letters for our turnaround patients whenever possible. Both Age UK Coventry navigators now feel confident contacting matrons and GPs regarding concerns re patients they are following up in the community. We hope that this will continue to become the norm and promote awareness and acceptance of voluntary sector contribution to patient well-being.
0-3 mths	Visiting patients in hospital ("how do you feel about going home, what do you want?") – Going Home service is in place, linking with ward managers and Discharge Team - review capacity, timing and selection of patients	Lynn Thomas, UHCW Jim McCabe, Age UK Coventry	Met to review Going Home from Hospital input- referrals received from ward staff and IDT etc. Daily service over 5 days covering all adult wards- continue with regular liaison/training with IDT REACT as appropriate to improve current service.
0-3 mths	Age UK and Community Development Service (CDS) to provide briefing session for Integrated Discharge Team (IDT) on community activities and specifically Community Activities Directory to raise awareness and encourage use of alternative support	Kerrie Manning, UHCW Jim McCabe, Age UK Coventry Michelle McGinty, City Council	IDT, REACT and a proportion of Therapy services have undergone training on the CAD in May 2016.
3-6 mths	Monitor referrals from UHC to Carers Centre and from Acute Frailty Unit via Age UK Coventry	Pauline Dye, Carers Trust Moira Pendlebury, Age UK Coventry	*Not due to report yet*
3-6 mths	Continue to develop Multi-Disciplinary Team knowledge to ensure robust referral process to voluntary & community sector – carry out assessment on current referral pathways	Richard Coneron & Gary Empsall, Coventry &Rugby GP Alliance	A joint APC/Frailty teaching programme has being developed to cover a variety of educational topics. The teaching runs on alternate Mondays and Wednesdays from 2-3pm. There is an open invitation to all members of the MDT to attend these events. This programme includes sessions ran by Voluntary and Community sector. E.g. 'Age

			UK – A day in the life' & 'REACT—Functional assessment of frail elderly Patients'. This will be further extended to include other voluntary sector attendees from this workshop. Richard Coneron and Ben Atkins (Frailty Clinical Lead) are also part of UHCW's Ambulatory Care Development Group whose aim is to facilitate the delivery and expansion of existing pathways and to support the development of new pathways identified as beneficial to our patient population
3-6 mths	Develop feedback process to understand reasons (social / medical) why patients are presenting at Emergency Department	Richard Coneron & Gary Empsall, Coventry & Rugby GP Alliance	A frailty identification tool (Prisma 7) has now been implemented within ED to identify all frail patients who present at ED based on defined frailty criteria. Working in collaboration with GP Alliance, Coventry University are carrying out an in-depth evaluation of the Primary Care Frailty service, including inviting patients to interview. This detailed interview will seek to identify why patients presented at Emergency Department and what level of care and support they received from the Primary Care Frailty Team. These invites are due to be sent early June.
3-6 mths	Advice line for Ambulance Service (UC Service), e.g. Frailty liaison service	Vicky Williams, UHCW	*Not due to report yet*
3-12 mths	Development of current Directory of Services	Mark Docherty, WMAS	*Not due to report yet*
3-12 mths	Focus on development of Integrated Neighbourhood Team (INT) and monitor impact with a view to expanding the approach at pace	Kerrie Manning, UHCW Jim McCabe, Age UK Coventry Jo Morris, CWPT	Kerrie attended an operational INT meeting to discuss referrals and criteria. An action agreed for Kerrie to attend strategic meetings, identify champions within IDT and INT to review the referral form to reflect the changes and information required. INT scaled up to 3 neighbourhood teams covering all GP practices in Coventry. 3 levels of service aiming to get the patient the right care at the right level at the right time: Level 1 – multi-disciplinary case management of individuals with complex needs.

			Level 2 – Care Navigation for individuals with a specific health or social care need Level 1 – Age UK, the Lead Provider for the social prescribing model to work in partnership with CWPT to sign post patients to appropriate non-statutory services and agencies in their local communities. There has been 130 referrals received into the service between 4 Jan and 3 May 2016 with 75% of those being from GP's, the remainder being UHCW and community services professionals. 'Your Health at Home' has been created as an overall identity to be used across the range of services delivered by the Integrated Neighbourhood Team. This name will be used for all external communications regarding the INT. There is an accompanying graphic element which gives a visual identify to the service.
1-3 years	Agreed standardised pathway which wraps around the citizen with carers' support	Multi-organisation	*Longer term action*

Appendix A - Attendees

Alice Rose	alice.rose@orbit.org.uk	Caseworker & Safeguarding Champion	Orbit Care & Repair
Andrea Buckley	andrea.buckley@coventry.gov.uk	Team Leader, Community Development Service	Coventry City Council
Carol Speed	carol@mhct.co.uk	Community Engagement Officer	Moat House Trust
Cat Roberts	catrobertsuk@yahoo.co.uk	Lead GP for GP in Ed and Frailty	Frailty Team
Cathy Sharman	cathy.sharman@orbit.org.uk	Team Leader	Orbit Care & Repair
Gary Empsall	Gary.Empsall@coventryrugbyccg.nhs.uk	Head of Operations and Delivery	Coventry & Rugby GP Alliance
Jane Moore	jane.moore@coventry.gov.uk	Director of Public Health	Coventry City Council
Jim McCabe	Jim.McCabe@ageukcoventry.org.uk	Services Manager	Age UK Coventry
Jitey Samra	info@ekta-unity.org	Project Co-ordinator	Ekta Unity
Justine Richards	Justine.Richards@covwarkpt.nhs.uk	Interim Director – Strategy & Business Support	CWPT
Kara Dutton	kara-louise.dutton@orbit.org.uk	Tele-health Development Officer	Orbit Care & Repair
Karen Worwood-Foley	kworwood-foley@penderelstrust.org.uk	Independent Living Adviser	Penderels Trust
Kerrie Manning	Kerrie.Manning@uhcw.nhs.uk	Integrated Discharge Team Leader	UHCW
Lynn Thomas	Lynn.Thomas@uhcw.nhs.uk	Group Manager, Support Services	UHCW
Mark Docherty	mark.docherty@wmas.nhs.uk	Director of Nursing, Quality and Clinical Commissioning	WMAS
Michael Vincent	Michael.Vincent@ageukcoventry.org.uk	Chief Executive	Age UK Coventry
Michelle McGinty	Michelle.mcginty@coventry.gov.uk	Head of Involvement & Partnerships	Coventry City Council
Moira Pendlebury	Moira.Pendlebury@ageukcoventry.org.uk	Director of Services	Age UK Coventry
Pauline Dye	paulinedye@coventrycarers.org.uk	Head of Information, Advice and Support Services	Carers Trust – Heart of England
Pete Fahy	peter.fahy@coventry.gov.uk	Director of Adult Services	Coventry City Council
Phil Evans	Phil.Evans@coventryrugbyccg.nhs.uk	Programme Director – Wide System Change	Coventry & Rugby CCG
Pijush Ray	Pijush.Ray@uhcw.nhs.uk	Clinical Lead, Gerontology	UHCW
Richard Coneron	Richard.Coneron@coventryrugbyccg.nhs.uk	Acute Primary Care Project Manager	Coventry & Rugby GP Alliance
Rob Allison	r.allison@vacoventry.org.uk	Director of Policy & Partnership	Voluntary Action Coventry (VAC)
Ruth Nelson	r.nelson@vacoventry.org.uk	Macmillan Community Mobilisation Co-ordinator	Voluntary Action Coventry (VAC)
Salma Jussab	salma@carerstrusthofe.org.uk	Head of Operations	Carers Trust – Heart of England

Sandra Bonniger	Sandra.Bonniger@ageukcoventry.org.uk	Senior Practitioner – AUKC Hospital Care Navigator (Acute Frailty Unit)	Age UK Coventry
Sandra Fulton	sandra.fulton@coventryrugbyccg.nhs.uk	Clinical Care Home Support Nurse - Tissue Viability	Coventry & Rugby CCG
Steve Banbury	s.banbury@vacoventry.org.uk	Chief Executive	Voluntary Action Coventry (VAC)
Sue Davies	sue.davies@coventryrugbyccg.nhs.uk	Director of Integration	Coventry & Rugby CCG
Suraj Bassi	Suraj.Bassi@capita.co.uk	Principal Consultant, Frailty pathway, Capita Health Partners	Frailty Team
Surinder Chaggar	surinder.chaggar@nhs.net	Lead GP for Frailty team	Frailty Team
Tony Refson	Tony.Refson@alzheimers.org.uk	Services Manager	Alzheimers Society
Vicky Hughes	Victoria.Hughes@coventryrugbyccg.nhs.uk	Interim Programme Lead for Information Sharing Programme	Coventry & Rugby CCG
Vicky Williams	Vicky.Williams@uhcw.nhs.uk	Consultant Nurse, Gerontology	UHCW

Appendix B - Format

2.00 Welcome & introductions & context

2.10 Table session 1:

How are voluntary sector services helping to manage the demand for statutory frailty services (and the impact on wider public services) through early help, prevention & building resilience and capability to enable people to stay out of hospital and residential care?

20 minutes for each table, 15 minutes plenary – please briefly feed back 2-3 examples from each table using the coloured cards

2.45 Table session 2:

a) What are the opportunities for pooling our skills and resources through closer collaborative working between the voluntary and statutory sectors - where can we build better services through stronger integrated pathways and/or better use of informal support networks and assets in the community?

b) Are there barriers that hinder this?

30 minutes for each table, 15 minutes plenary – please choose 3 opportunities and 1 barrier to briefly feed back on and use the coloured cards to record each in more detail

3.30 Refreshment break

3.40 Table session 3:

. What actions can we all take forward to progress this?

20 minutes for each table, 15 minutes plenary – please identify 3 actions with a named lead person from your table for each and use the coloured cards to record each one

4.15 Summing up & evaluation

4.30 Close

Appendix C – Event evaluation summary

Voluntary organisation	7	NHS / Council / statutory organisation	10

1. **Did we meet the outcomes?**	Yes	No	?
A better common understanding and awareness of the contribution of the voluntary and statutory sectors to frailty services and their importance to building early help, prevention & resilience and capability to enable people to stay out of hospital and residential care	**15**	**1**	
Opportunities for building better services, pathways and collaborative working between voluntary and statutory organisations are identified, and barriers that hinder this.	**16**		
Practical actions are identified and agreed by delegates to progress opportunities and overcome barriers.	**13**	**1**	**2**

2. What worked well and why?

Voluntary organisations

- Group discussions worked well. Right time for allocated for each topic. Feedback from each table was useful.
- Energy & focus of discussion. Meet new people from across organisations. A willing spirit of collaboration. Preparation & clear process of the meeting.
- The mix of people on each table to make sure all sectors / professions were represented.
- Plenty of time overall (but lots of topics) which is positive. Good mix of people and organisations.
- Sharing thoughts & ideas. Roles & responsibilities. Interesting ideas about navigating.
- Good mix of people on the tables, everyone was receptive and listened to each other, the facilitator was proactive & delegated well & wrote the cards in a manner that can get the point across

NHS / Council / statutory organisations

- Clear instruction on what we were to achieve / outcome of workshop & how it would be achieved. Great to get a wider selection of people together from vol / stat organisations
- Timekeeping & facilitation
- Good length & pace – some lively discussion
- Good facilitation & enough talking and thinking time
- Groups good size – everyone had opportunity to speak. Well-structured, clear direction. Visual presentation. Engaging and motivated people.
- Good mix of organisations across the table
- The format worked well to increase awareness of what services are out there
- Meeting others and understanding their role but also their challenges. Lots of similarities!

3. What didn't work so well or would have benefitted from a different approach?

Voluntary organisations

- Time was limited, fast-paced – could have discussed more.
- Identifying how / when / where capacity issues will be addressed

NHS / Council / statutory organisations

- Perhaps a bit more introduction to what's expected to be achieved through the frail elderly programme
- Big transformational issues highlighted regarding communication but not captured or solutions / plan discussed outside of table
- Not clear what changes would happen coming out of this workshop
- I felt the focus was on persons in their own homes not considering care homes
- All opinions to be taken into account

4. What will you do as a result of today's workshop?

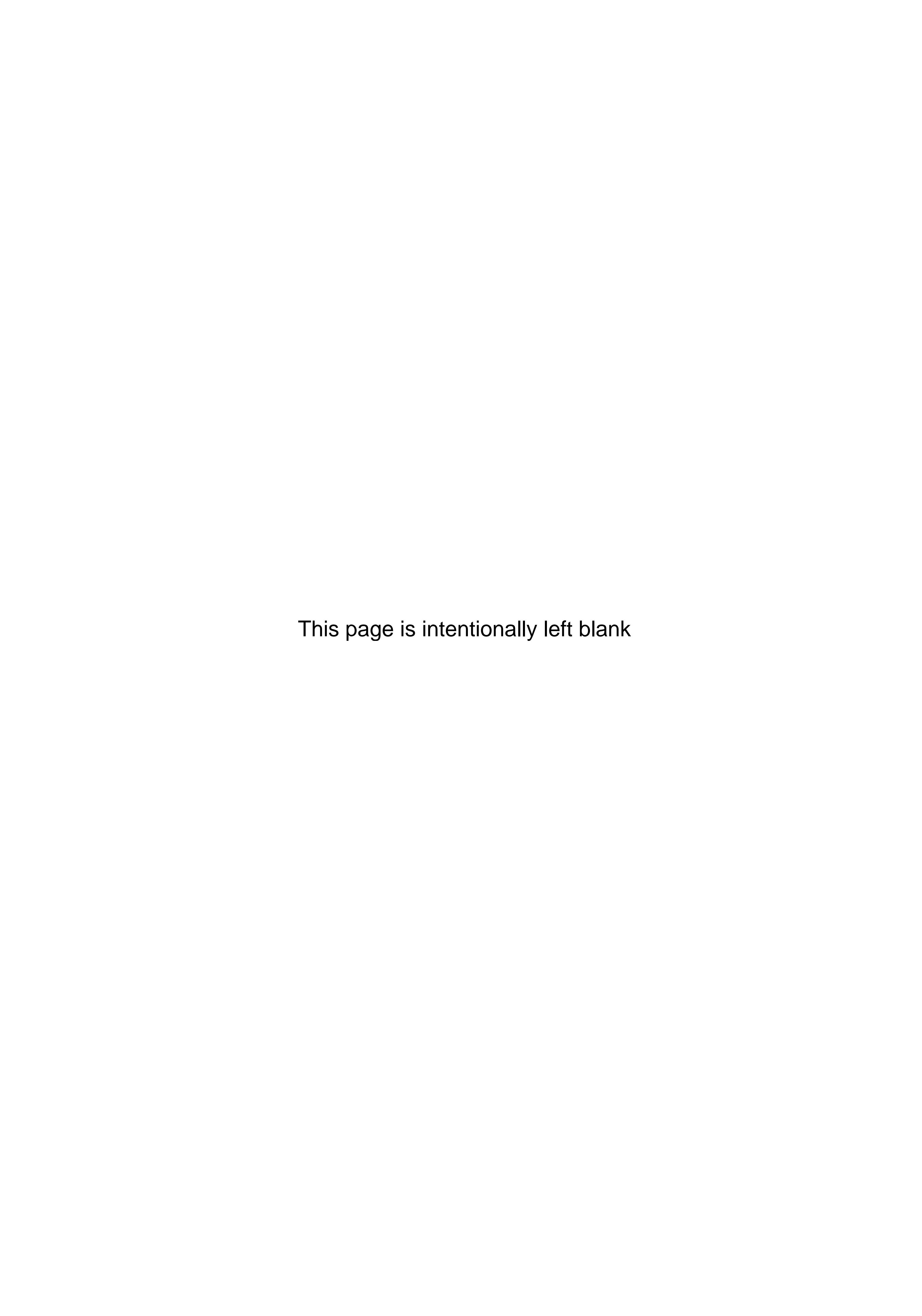
Voluntary organisations

- Proactively be involved in links between medical & voluntary sectors
- Contact organisations. More marketing needed has been identified about our group. Monitoring & outcomes training needed.
- Meet colleagues in IDT & CDS to discuss specific actions. Investigate a number of vol orgs who were present. Consider wider role for social prescribing across vol sector.
- Carry on ensuring we're embedded in whatever pathways we can to ensure a holistic approach for this group.
- Follow up on the identified action
- Feedback to relevant managers on what actions have been agreed and how they will be achieved.

NHS / Council / statutory organisations

- Look at how can improve links with vol sector with projects I am leading on
- I have an action to feedback to my team re: discharge letters
- Complete actions required
- Explore and understand the Community Activity Directory & Directory of Services. Share this information with care homes.
- Communicate with Primary Care and other voluntary organisations
- Get more information from other sectors

5. Your overall rating for today		
Not useful 0	**Useful 9**	**Very useful 8**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Report

To: Coventry Health and Wellbeing Board **Date:** 27 June 2016

Subject: Coventry and Warwickshire Health and Wellbeing Alliance Concordat

1 Purpose of the Note

1.1 The purpose of this paper is to provide Coventry Health and Wellbeing Board with the background and overview of the proposed Coventry and Warwickshire Health and Wellbeing Board Concordat and the opportunities this provides for Coventry to work in alignment with Warwickshire to deliver the Coventry and Warwickshire Sustainability and Transformation Plan.

2 Recommendations

2.1 It is recommended that Coventry Health and Wellbeing Board:

1) Agree to a Coventry and Warwickshire Health and Wellbeing Alliance Concordat
2) Consider the wording and the principles of the concordat and make any suggestions accordingly
3) Agree to work in alliance with Warwickshire Health and Wellbeing Board to implement the principles of the Health and Wellbeing Alliance Concordat
4) Agree to a meeting with Warwickshire Health & Wellbeing Board Partners to formally sign off the Concordat.

3 Information/Background

3.1 The health and care system locally and nationally is operating in an increasingly challenging context. Rising patient expectations, an aging population, the rising prevalence of chronic disease, combined with shrinking resources is putting real pressure on the health and care system. Organisations need to consider how they can take a systems approach to reducing demand and delivering care that is fit for the future in this challenging environment.

3.2 The development of the Sustainability and Transformation Plan in Coventry and Warwickshire provides an opportunity for collaboration to tackle these challenges, through shifting the focus of policies and plans from organisations to places.

3.3 As The West Midlands Combined Authority gathers momentum there are both opportunities and expectation that organisations will become more aligned and increasing work on a systems approach rather than being constrained by organisational and geographical boundaries. The second phase of the WMCA will begin to focus on service for people and seek ways that can both improve services and make significant savings whilst also reducing demand on the public sector and improving outcomes. Given this emerging agenda and the pace of change there are advantages to Coventry and Warwickshire Health and Wellbeing becoming more closely aligned.

3.4 In recent months both Coventry and Warwickshire Health and Wellbeing Boards have separately taken time to look at their own development and the challenges they face going forward. In April 2016, representatives from Warwickshire Health and Wellbeing Board attended an integration summit to consider how organisations can work together to deliver care that is fit for the future across organisational boundaries, and across the Coventry and Warwickshire footprint. Colleagues from Warwickshire and our shared health economy have emphasised the importance of coproducing this agenda across Coventry & Warwickshire.

3.5 Consequently the proposed Coventry and Warwickshire Health and Wellbeing Alliance Concordat has been developed. It sets out principles for joint working with Warwickshire Health and Wellbeing Board, with an emphasis on delivery of the Coventry and Warwickshire Sustainability and Transformation Plan. The concordat has the dual purpose of enabling people across Coventry and Warwickshire to pursue happy, healthy lives, and put people and communities at the heart of everything we do; whilst transforming our services and making significant financial savings.

3.6 The content and principles within the Concordat can be amended to reflect the views of Coventry Health & Wellbeing Board and colleagues in Warwickshire have specifically asked that we consider the wording of principle 4 *'We will only take decisions that impact on other parts of the system after consultation'.* Alternative wording may better reflect the desired aim of inclusivity and agreement between partners.

4 Next Steps

If and when Coventry Health and Wellbeing Board are happy to support and agree the proposed Concordat it is suggested to formally launch and sign the Concordat at a joint event, prior to the local STP meeting with NHE England nationally on the 22nd July. A programme of more aligned working will also be developed, but with both boards operating within their existing governance arrangements.

Report Author(s):

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COVENTRY & WARWICKSHIRE
Health & Wellbeing Alliance Concordat

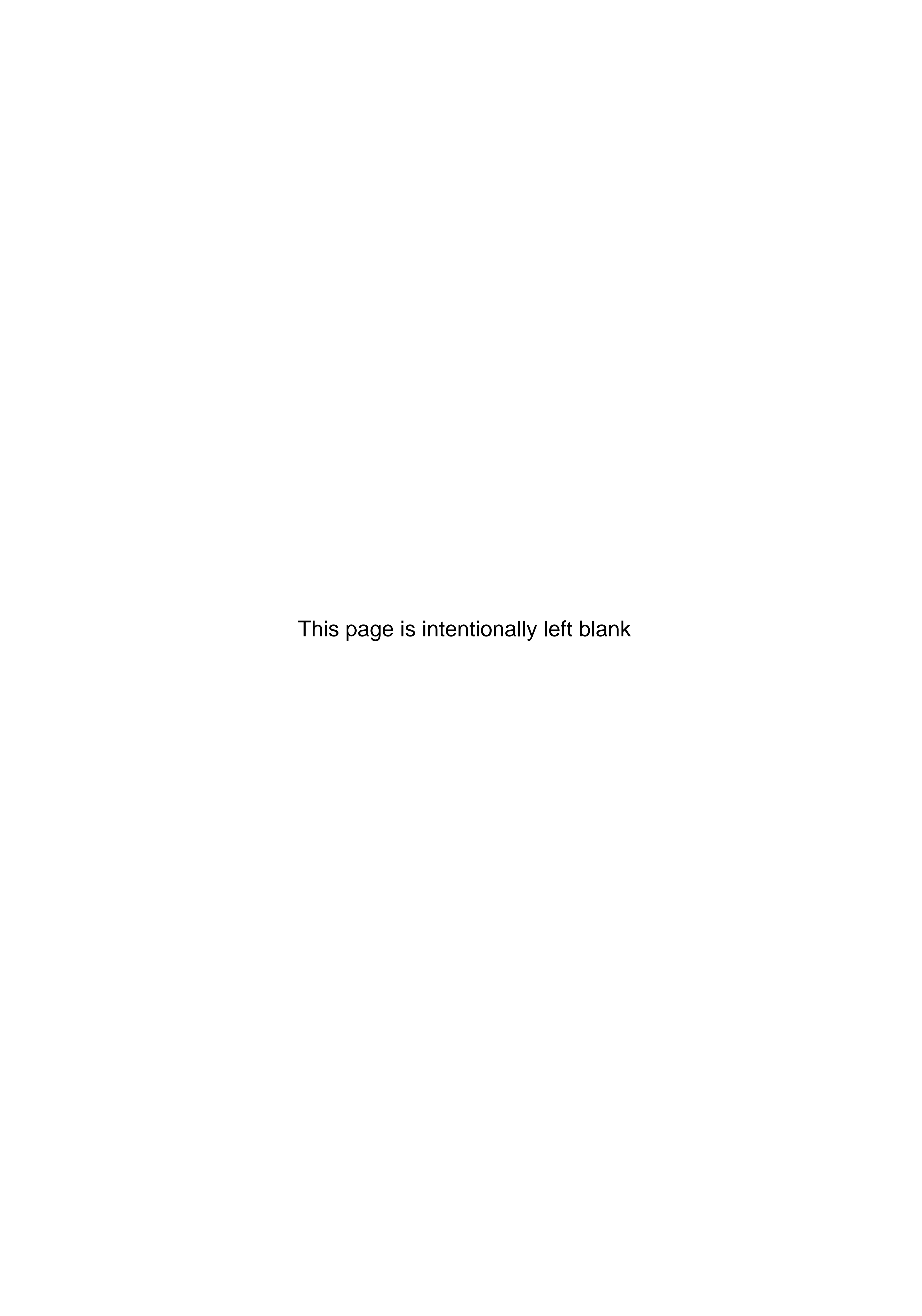
We will do everything in our power to enable people across Coventry and Warwickshire to pursue happy, healthy lives and put people and communities at the heart of everything that we do.

We will share responsibility to transform our services whilst making over £500m savings and efficiencies across Coventry and Warwickshire over the next five years.

PRINCIPLES

- ***We will*** be bold, brave and challenging in the service of the people of Coventry and Warwickshire.
- ***We will*** align, share and pool resources, budgets and accountabilities where it improves outcomes for the public.
- ***We will*** focus on benefits to the public as a whole rather than organisational interests.
- ***We will*** only take decisions that impact on other parts of the system after consultation.
- ***We will*** streamline system governance to enable decisions to be taken at scale and pace.
- ***We will*** design a system that is easy for everyone to understand and use.

To achieve this we will work in alliance with each other operating with mutual respect and mutual accountability.



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Report

To: Coventry Health and Wellbeing Board **Date:** 27 June 2016

Subject: Coventry Health and Wellbeing Strategy 2016-2019

1. Purpose of the Note

The purpose of this paper is to provide Coventry Health and Wellbeing Board with an update on progress on the development of Coventry's Health and Wellbeing Strategy for 2016-2019.

2. Recommendations

The Coventry Health and Wellbeing Board is asked to endorse the direction of travel and the completion of the Health and Wellbeing Strategy.

3. Information/Background

The Health and Wellbeing Strategy from 2016-2019 focuses on a small number of priorities where the Health and Wellbeing Board believes it can make the biggest difference to the lives of Coventry people:

- Reducing health and wellbeing inequalities (the health and wellbeing gap)
- Improving the health and wellbeing of individuals with multiple complex needs
- Creating a place in which the health and wellbeing of our people drives everything that we do, by developing an integrated health and care system that meets the needs of the people of Coventry.

4. Reducing health and wellbeing inequalities

In March 2016, Professor Sir Michael Marmot and his team from University College London (UCL) and Public Health England (PHE) committed to work with Coventry for a further three years. UCL, PHE and Coventry City Council signed a memorandum of understanding which states that UCL and PHE will provide expertise to develop Coventry's capability to reduce health inequalities, provide Coventry with access to learning from other areas, raise the profile of Coventry as an exemplar city for reducing health inequalities and enable Coventry to measure progress against local and national indicators.

On 23 March, Coventry City Council held an event to launch the partnership with UCL and PHE for a further three years, and senior leaders from across Coventry including representatives from Coventry City Council's People, Place and Resources directorates, West Midlands Police, West Midlands Fire Service, Coventry and Rugby CCG, Voluntary Action Coventry and Coventry and Warwickshire Chamber of Commerce committed to work together as part of the Marmot partnership to reduce health inequalities for the next three years. A short film which summarises this event can be accessed via the following link: http://www.coventry.gov.uk/info/176/policy/2457/coventry_a_marmot_city

Over the next three years, partners will continue to work together on projects initiated as part of the first two years of Coventry's Marmot City programme, while working towards the two additional priorities that have been identified for the next three years:

- Tackling health inequalities disproportionately affecting young people
- Ensuring that all Coventry people, including vulnerable residents, can benefit from 'good growth', which will bring jobs, housing and other benefits to the city

Partners will also work together to ensure health, social value and asset based approaches are reflected in policies and decision making, ensure prevention and early intervention are prioritised and ensure resources are targeted based on need. A copy of the Marmot Strategy summary for 2016-2019 can be accessed here:
http://www.coventry.gov.uk/downloads/file/20345/marmot_strategy_summary_2016-2019

The membership of the over-arching Marmot Steering Group which has been accountable for the delivery of the Marmot City programme to date has been widened to reflect the priorities for the next three years. It now includes representation from Coventry and Warwickshire Chamber of Commerce, the Department of Work and Pensions and the Coventry and Warwickshire Local Enterprise Partnership. The group will now have a broader strategic role around overseeing the overall strategy and embedding the Marmot agenda into wider policies, programmes and decision making. The action plans behind the main priorities will be overseen and implemented by existing delivery groups within Coventry, and work is currently underway with the employment, skills and financial inclusion group and children and young people's partnership board to determine where existing governance structures can be responsible for implementing the priorities for the next three years.

Indicators are currently being developed alongside the action plan for the next three years, with support from Public Health England.

5. Improving the health and wellbeing of individuals with multiple complex needs

A Multiple Complex Needs Board (MCNB) has been established in Coventry to provide a re-designed, integrated and co-ordinated service for those experiencing multiple complex needs in Coventry (those experiencing two or more of the following: substance misuse, mental ill health, violence, sexual abuse).

The MCNB is chaired by Commander Danny Long from West Midlands Police and will include representation from Public Health, Insight, Coventry and Rugby CCG, Children's services, probation, education and Whitefriars housing. The analytical component of the

MCNB is being supported by two specialist Public Health registrars from the National Team at Public Health England, to identify best practice, to maximise opportunities for improving outcomes through providing effective management of data, assessment methodology, standardised outcome and valuation tools.

The approach of the MCNB is evidence based and work is being undertaken at present to map local provisions of service (Mental Health Triage, Priority Families, Mentoring West Midlands, Ignite etc) as well as linking in with national initiatives, eg: Troubled Lives, the Mental Health Commission and Pathfinder Programme (headed by Sir Norman Lamb).

The Coventry MCNB aims to ensure that the city will be given the necessary powers, responsibility and accountability to improve the lives of the most excluded through multiple complex needs in order to:

- help individuals who face substantial challenges in relation to multiple complex needs, creating a pathway which is 'person centred' whereby they can live a healthier life free from addiction, substance dependency and fear of harm.
- facilitate and promote interagency collaboration so as to bring together the best levels of expertise, knowledge and resources, creating productive networks, a community of purpose, well defined methodologies and common standards.
- provide the best opportunities for individuals with multiple complex needs to retain a sense of independence, self-worth and self-esteem, taking personal responsibility for their futures.
- encourage individuals with multiple complex needs to share their experiences so that future processes can be designed and delivered on a sustainable basis and learning may be shared amongst service providers
- achieve financial savings to the local authority and public services through cost effective service delivery

A Multiple Complex Needs Network will also be established with a wider membership to collaborate, share best practice and promote and enhance service delivery, while the MCNB will manage the long term strategic priorities to support the convergence of services to support individuals with Multiple Complex Needs.

6. Create a place in which the health and wellbeing of our people drives everything that we do, by developing an integrated health and care system that meets the needs of the people of Coventry

The health and care system locally and nationally is operating in an increasingly challenging context. Rising patient expectations, an aging population, the rising prevalence of chronic disease, combined with shrinking resources is putting real pressure on the health and care system. Organisations need to consider how they can take a systems approach to reducing demand and delivering care that is fit for the future in this challenging environment.

The development of the Sustainability and Transformation Plan in Coventry and Warwickshire provides an opportunity for collaboration to tackle these challenges, through shifting the focus of policies and plans from organisations to places.

Integration of health and care to improve outcomes for local people and manage demand at a time of reducing public sector resource will necessitate working more closely across organisational and geographical boundaries. An outline of the Coventry and Warwickshire Sustainability and Transformational Plan and a proposal to develop a Concordat to align our work more closely with Warwickshire Health and Wellbeing Board, to aid delivery of the Sustainability and Transformation Plan, where it makes sense to do so are both being considered by the Health and Wellbeing Board on the 27th June 2016.

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