# Transforming Care for People with Learning Disabilities in Nottinghamshire

September 2015

Nottinghamshire County Council

Nottingham City Council

NHS Bassetlaw Clinical Commissioning Group

NHS Mansfield and Ashfield Clinical Commissioning Group

NHS Newark and Sherwood Clinical Commissioning Group

NHS Nottingham City Clinical Commissioning Group

NHS Nottingham North and East Clinical Commissioning Group

NHS Nottingham West Clinical Commissioning Group

NHS Rushcliffe Clinical Commissioning Group

NHS England

Nottinghamshire Healthcare NHS Foundation Trust

## Contents

# 1 Introduction

This document sets out the vision of the Nottinghamshire Fast Track Site for transforming care and services for people with a learning disability and/or autism who also have, or are at risk of developing, a mental health condition or behaviours described as challenging. This includes people of all ages and those with autism (including Asperger's syndrome) who do not also have a learning disability, as well as those people with a learning disability and/or autism whose behaviour can lead to contact with the criminal justice system.

We hope that this plan will be helpful in understanding:

- The Nottinghamshire area
- The services currently commissioned and provided across our area
- Our vision for how future services will be commissioned and provided
- What we need to change to achieve our vision and how we intend to do this

Delivering this plan and our vision will require significant change in the way that services are currently commissioned and provided. This will need the full support of adults with a learning disability, their families, friends and carers. We will work together with them to make these changes happen through the design and provision of effective social and health care services.

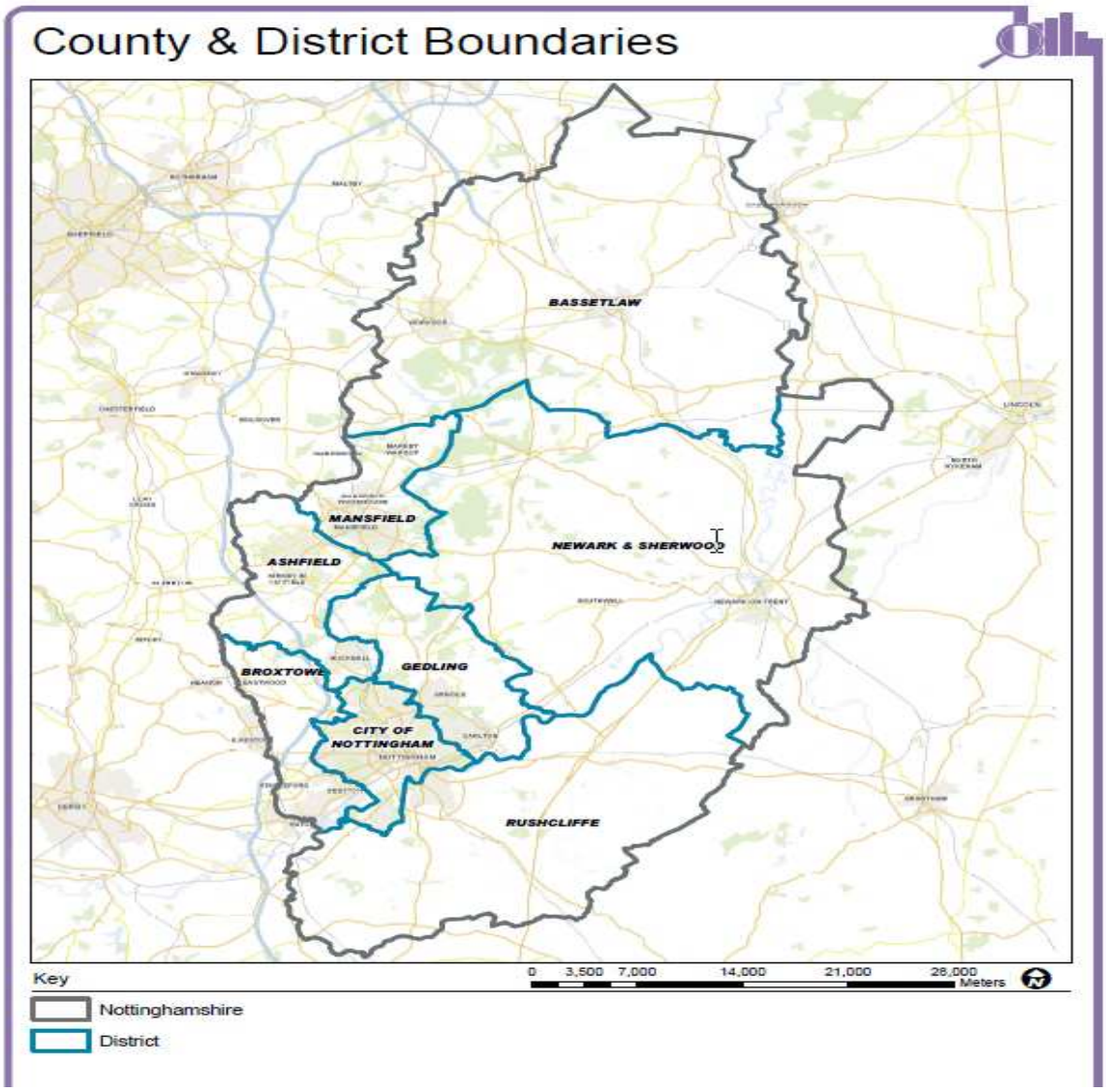
Our plan aims to transform care and support for individuals with a learning disability and/or autism who also have, or are at risk of developing, a mental health condition or behaviours described as challenging so that their care is focused on keeping them healthy, well and supported in the community. Achieving this will minimise the need for inpatient care enabling us to reduce the number of beds we have available over a period of time as the redesign of our services takes effect.

This plan contains a broad overall vision, developed by the Nottinghamshire Fast Track Transformation Board for submission on 7 September 2015. In some areas it contains detailed proposals for how services could look different in the future but there is further work that will be required in a number of areas. In addition, we know that it will take time to turn our vision into a reality and that more detailed planning will be needed. We have included within this document a more detailed plan of the next steps required and how we intend to do this.

## 2 About Us

The Nottinghamshire Fast Track Area covers the populations of the City of Nottingham and Nottinghamshire County including Bassetlaw. There are two Local Authorities, seven Clinical Commissioning Groups (CCGs) and NHS England that are responsible for commissioning care for everyone who lives in the area. Care is delivered by a range of providers from both the NHS and the Independent Sector.

The County and District boundaries within the Nottinghamshire area are shown in the diagram below:




We have involved all the commissioning organisations noted above in the development of this plan as well as other stakeholders, including Nottinghamshire Healthcare NHS Foundation Trust, Health Education East Midlands, Positive Behavioural Support Consultancy, Challenging Behaviour Foundation and the NHS England National Team for Learning Disabilities. They have endorsed the submission of this plan via the Transforming Care

There are other key partners who will also need to be engaged with the work and our plans for the future, for example Nottinghamshire Police and CCGs outside of the area who may place individuals within Nottinghamshire. This is in addition to people with learning disabilities and/or autism, their families and carers as well as wider communities within Nottinghamshire.

# 3 Background and Context

## 3.1 Population

There are no official statistics reporting the number of adults in the UK with a learning disability and/or autism and establishing a precise or accurate figure is not easy due to the social construct of the condition and its wide spectrum.

However, data from the most recent Joint Strategic Needs Assessments for both Nottingham City and Nottinghamshire County shows that Nottinghamshire was home (2011) to approximately 21,000 adults over the age of 18 who have a learning disability and approximately 7,000 adults between 18 and 64 with autistic spectrum disorders (ASD). The National Autistic Society state that as estimates of the proportion of people with ASD who also have a learning disability varies considerably, it is not possible to give an accurate figure. In 2011, there were 346 people with profound and multiple learning disabilities (PMLD) in Nottinghamshire.

There are estimated to be about 4,000 disabled children and young people, aged 0-19, of which almost 900 have severe and lifelong disabilities in the City and between 5,000 and 12,000 in Nottinghamshire County. One of the best sources of information around young people with Special Educational Needs and Disability (SEND) is data from the School Census. This provides pupil level information for all pupils in Nottinghamshire schools detailing their level of need and their primary type of SEN and/or disability. As of January 2015 the numbers of pupils with their primary type of need being a learning disability were across both city and county were: 2,271 (moderate), 90 (severe), 45 (profound and multiple) and 624 (specific).

Where people live makes a difference to the population share across Nottinghamshire with the highest populations in Nottingham City, Mansfield and Ashfield and Nottingham West (which covers the Broxtowe area).

As may be expected, there is also a difference in the people known to be accessing services and the estimated prevalence of learning disabilities and/or autism within the population as can be seen in the table below.

| CCG | Total population | LD/autism population in area* | LD/autism know to services |
|---|---|---|---|
| NHS Nottingham City CCG | 311,000 | 6,000* | 1,594 |
| NHS Newark and Sherwood CCG | 78,292 | 3,372* | 843 |
| NHS Mansfield and Ashfield CCG | 116,686 | 6,176* | 1,544 |
| NHS Rushcliffe CCG | 74,016 | 1,912* | 478 |
| NHS Nottingham North and East CCG | 91,142 | 2,904* | 726 |
| NHS Nottingham West CCG | 57,429 | 6,664* | 1,666 |
| NHS Bassetlaw CCG | 114,000 | 2688 | 672 |
| **TOTAL** | **842,565** | **29,716** | **7,523** |

**Calculated as 4x number of people with a learning disability and/or autism who are known to services based on national information about the proportions of service users known to services/in the area.*

It is estimated that there will be an increase in people with learning disabilities by approximately 14% between 2011 and 2030. However, this overall increase masks an ageing population with large increases in people over 55 years of age and a decrease in those with a learning disability and/or autism below the age of 55. In addition, to the change in the age profile, there will be increases in people with moderate or severe learning disability, challenging behaviours and autistic spectrum disorders.

The reasons for our population increase are likely to be driven by 3 main factors:

- An increase in the proportion of younger adults who belong to South Asian communities (Nottingham City is likely to have the biggest impact from this)
- Increased survival rates among young people with severe and complex disabilities
- Reduced mortality among older adults with learning disabilities

Further detail on the Nottinghamshire population and the trends we expect to see, can be found at Appendix 1.

Please see Appendices 2 and 3 for details of the public health statistics and national outcome measures that relate to this plan.

## 3.2 Commissioning Spend

Health services are expecting to spend £19.73m in 2015/2016 on providing in-patient and community care and services for our population with a learning disability and/or autism whether they are in Nottinghamshire or placed out of area. 70% of this money is spent by CCGs and 30% by Specialised Commissioning. This figure does not include spend on NHS Continuing Healthcare or Section 117 aftercare which is shown separately and totals £10.56m for NHS Nottingham City and NHS Bassetlaw. The actual spend in this area for the 5 CCG's in Nottinghamshire is not available at the time of writing this plan but will be included within the financial data by 14 September 2015.

Meanwhile the Local Authorities are expecting to spend £129.13m on social care for those with a learning disability.

This money is spent in the following way:

| Category (all LD specific) | 2015/16 forecast spend | Contractual arrangements |
|---|---|---|
| **CCG Spend** | | |
| Inpatient Assessment & Treatment beds and community services including CAMHS LD services provided by Nottingham Healthcare NHS Foundation Trust (NHT) | £9.53m | Block NHS Standard contract across all CCGs where spend is by occupied bed day plus 2.5% CQUIN payment |
| Locked Rehabilitation beds provided by the NHS and Independent Sector | £4.08m | East Midlands wide framework – Spot purchase of beds |
| NHS Continuing Health Care for NHS Nottingham City and NHS Bassetlaw CCG's provided by the Independent Sector | £8.98m | NHS Standard contract |
| S117 aftercare for NHS Nottingham City and NHS Bassetlaw CCG's provided by the Independent Sector for both health and social care | £1.86m | NHS and Local Authority contracts |
| **Specialised Commissioning Spend** | | |
| Low and Medium secure inpatient beds are provided by the NHS and Independent Sector | £6.12m | Contracts negotiated on a case by case basis. These are mostly held by Leicestershire and Lincolnshire Specialised Commissioning, though other Specialised Commissioning Units hold the contracts for Leeds & York Partnership Trust, Partnerships in Care and Cygnet. |
| **Local Authority Spend** | | |
| Residential and community care provided by the Independent Sector and some Council run services | £129.13m | Nottingham City Council and Nottinghamshire County Council |

## 3.3 Inpatient Learning Disability Beds

There are 199 learning disability and/or autism inpatient beds in Nottinghamshire. This includes low and medium secure, locked rehabilitation, assessment and treatment beds for adults, and CAMHS tier 4 beds although these are not specifically for individuals with a learning disability.

The table below shows the current data on bed usage within the area shown by NHS and Independent Sector provision.

| Unit (NHS) | Unit (Non - NHS) | Type of bed | No. of beds | No. of beds used by Notts residents | No. admissions and discharges in last quarter (Q1 15/16) | Current occupancy and % |
|---|---|---|---|---|---|---|
| NHT - Orion Unit | | Assessment & Treatment | 18 | 13 | 11 admissions 7 discharges | 14 (77.7%) |
| | Eden Futures - Bestwood Hospital | Locked Rehabilitation | 6 | 1 | 0 admissions 0 discharges | 3 (50%) |
| NHT - Lister Ward | | Low Secure | 16 | 9 | 1 admission 2 discharges | 13 (81%) |
| | Partners in Care – Calverton Hill | Medium Secure | 32 | 3 | 3 admissions 2 discharges | 25 (78%) |
| | Cambian – Sherwood Lodge | Locked Rehabilitation | 26 | 3 | 4 admissions 4 discharges | 26 (100%) |
| NHT - Alexander House | | Locked Rehabilitation | 8 | 7 | 0 admissions 0 discharges | 5 (62.5%) |
| | St Andrews Healthcare - Mansfield | Low and Medium Secure | 64 | 6 | 1 medium secure admission 2 low secure discharges 3 medium secure discharges | 62 (97%) |
| | Danshell – Cedar Vale | Locked Rehabilitation | 16 | 0 | 0 admissions 0 discharges | 0 (0%) |

| | | | | | | |
|---|---|---|---|---|---|---|
| NHT-Thorneywood adolescent inpatient unit | | CAMHS | 13 | 1 | 18 admissions 18 discharges | 12 (92%) |
| | | **TOTAL** | **199** | **43** | | |

In addition, Specialised Commissioning has 3 beds in Nottinghamshire used by Nottinghamshire residents which are non-specific LD/autism beds and therefore not included in the numbers above. Two of these beds are at in the Cambian Ansel clinic for people with a personality disorder, who also present with complex mental health needs and challenging behaviours. The third is a female low secure bed in Thurland Ward in Wells Road provided by NHT (There are no female LD specific low or medium secure needs commissioned in Nottinghamshire).

Nottinghamshire also has 56 high secure Learning Disability male beds at Rampton Secure Hospital which are provided by NHT. Although out of scope for the fast track work, they have been referenced as there are currently 6 patients from Nottinghamshire in these beds who may stay within the Nottinghamshire area if they were to be discharged from high secure services.

In addition, there are 12 out of area non secure beds that are occupied be people from Nottinghamshire CCGs and 10 additional low and medium secure beds occupied by Nottinghamshire residents.

## 3.4 Commissioning Implications

There are variations of provision within the area, with the City having limited inpatient hospital independent sector provision - this is predominantly found in the County. However, the County also has a high number of residential facilities for individuals with learning disabilities and/or autism. This has previously meant that people come into the area and then become the responsibility of Nottinghamshire if they are sectioned under the Mental Health Act although this has now changed with changes to the Code of Practice in April 2015. This together with the high number of inpatient beds (mainly from the independent sector) makes the area an importer of individuals.

Nottinghamshire recognises that those with a learning disability and/or autism and challenging behaviours are not best served by long term hospitalisation. There are some big challenges ahead as the population data shows that will be pressure on all services due to increasing numbers of people requiring support and the changing profile of these individuals, for example an 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.

There is some joint work however it needs to be improved to address some of the issues in terms of commissioning, for example basing this on the type of a service rather than a population as in the current arrangements. We also struggle to influence independent sector bed provision in our area which results in more beds in the Nottinghamshire area being available than are required.

Without changes to the way we commission and provide services the problems will get worse over time. To resolve this Nottinghamshire want to have:

- A systems approach across all commissioners (CCG, NHS England and Local Authorities) for people in Nottinghamshire with a learning disability and/or autism and challenging behaviours.
- Care and support redesigned to ensure that inpatient care is only used when it is the best place for the person concerned e.g. when it is mandated by the courts or for respite or assessment and treatment when community provision not possible
- Person centred care and support planned and delivered to individuals consistently by providers
- A 'whole life' preventative approach needed for care and support with a much greater emphasis on reducing the severity and frequency of challenging or offending behaviours from a young age and beyond into adulthood.
- Greater liaison and influence at a national level about the use of new style inpatient service models and bed numbers in Nottinghamshire
- Significant market development and provider liaison to achieve the changes required by building the skills and capacity in the market whilst not destabilising it unnecessarily

These commissioning principles will link into the recent reforms for children and young people up to the age of 25 with integrated support now being provided with Education Health and Care plans.

# 4 Our Vision for Services

People with learning disabilities have poorer health than the general population, much of which is avoidable. These health inequalities often start early in life and result, to an extent, from barriers they face in accessing timely, appropriate and effective health care. The impact of these health inequalities is serious because as well as having a poorer quality of life, people with learning disabilities die at a younger age than their non-disabled peers.

The 2013 Confidential Inquiry into premature deaths of people with learning disabilities (CIPOLD) found that men with learning disabilities died on average 13 years younger than men in the general population and women 20 years younger. CIPOLD data also showed that people with learning disabilities are three times as likely as people in the general population to have a death classified as potentially avoidable through the provision of good quality healthcare. This suggests that if we can improve the quality of healthcare and support then we can improve their outcomes.

Our vision identifies how we think services will need to be commissioned and provided in the future to ensure that people with learning disabilities and/or autism with behaviours which challenge services who call Nottinghamshire home are supported within their local community and only require in-patient services for clearly defined purposes.

## 4.1 Scope

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 increased likelihood of behaviour that challenges
- 'Risky' behaviour which may put themselves or others at risk (this could include fire-setting, abusive, aggressive or sexually inappropriate behaviour) and which could lead to contact with the criminal justice system
- Lower level health or social care needs and disadvantaged backgrounds (e.g. social disadvantage, substance abuse, troubled family background), who display behaviour that challenges, including behaviours which may lead to contact with the criminal justice system.
- A mental health condition or whose behaviour challenges who have been in inpatient care for a very long period of time, having not been discharged when NHS campuses or long-stay hospitals were closed

## 4.2 Values Underpinning our Vision

- People with learning disabilities and/or autism should have the same rights and choices as everyone else
- People with learning disabilities and/or autism have the right to choice and control and to be treated with dignity and respect
- People with learning disabilities and/or autism should have the same chances and responsibilities as everyone else

- Carers and families of people with learning disabilities have the right to the same hopes and choices as other families

## 4.3 Expected Outcomes

- More people with learning disability 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 will be admitted to secure hospitals and Intensive Community Inpatient Support Services beds
- Delayed discharges will be minimised
- People with a learning disability and/or autism will have a projected length of stay recorded when they are initially admitted to hospital
- Any hospital stays will be closer to the individual's home and support networks
- There will be fewer inpatient beds commissioned for the Nottinghamshire 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

If they were able to put into words, the individual would be able to state in relation to the care and support they receive that:

- My care is planned, proactive, and co-ordinated
- I am involved in deciding how my health and care needs are met
- I live in the community with support from and for my family and paid carers
- I am involved in deciding where I live and who I live with
- I have a fulfilling and purposeful everyday life
- I get good care from mainstream NHS services
- I can access specialist health and social care support in the community
- I am supported to stay out of trouble
- If I need assessment and treatment in a hospital setting because my health needs can't be met in the community, it is high-quality and I don't stay there longer than I need to
- If I need to be in hospital, then I only stay as short a time as is necessary

## 4.4 Principles

We, as the organisations commissioning and providing care and support in Nottinghamshire, have committed to work in partnership in line with all of the overarching principles shown below:

### Access to Mainstream Services

- Encourage the use of mainstream services as the starting point for care and support. These will be available and accessible for those with a learning disability and/or autism
- Where mainstream services are insufficient to meet a person's needs then we will provide access to specialist multi-disciplinary community based housing and support expertise

### Person-Centred Care

- Work with people with a learning disability and/or autism and their families to plan and co-ordinate person centred care and support, providing them with more influence over their care including promoting a culture of positive risk taking
- Ensure a shared commitment to achieving outcomes based on "ordinary life' principles
- People with a learning disability and/or autism, and their carers and families will receive the right information at the right time to enable them to make informed decisions about the person's care and support. The way this information is delivered will take account of the communication needs of the person concerned

### Mental Capacity

- 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
- 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

### Prevention and Early Intervention

- Pro-actively identify needs, including challenging behaviour as early as possible and starting in childhood, and intervene earlier through community solutions wherever possible to prevent needs escalating. This will include:
    - Reducing the exposure to environmental conditions that may lead to behavioural changes
    - Promoting the resilience of those who face such environmental conditions
    - Providing early intervention, support and services that will meet individual needs, including communication needs, for those who are showing early signs of developing behavioural challenges
- Identify those at risk of admission to hospital or of coming into contact with the Criminal Justice system earlier and put strategies in place to manage risk
- Work to ensure that evidence-based interventions are used with people from a young age to minimise 'risky' behaviour which may otherwise put themselves or others at risk
- Protect those with a learning disability and/or autism from abuse and neglect wherever possible, and address safeguarding concerns as soon as they arise

### Challenging Behaviours

- Promote a positive and proactive approach to addressing challenging behaviours
- Provide support in the least restrictive setting possible that is therapeutic and safe for all. If restrictive interventions are required they will be for the shortest time possible

### Community Focus

- Work across health and social care to ensure people's homes are in the community
- Develop cost effective services which promote independence

### Skills, Knowledge and Culture

- Work with everyone involved in providing care and support to ensure expertise is shared, and that there is consistency of practice

- Develop a culture that is fair, accountable and reflective so we can learn from good practice, areas for improvement and mistakes
- Develop an evidence base by tracking the support of individuals, what has worked and not worked. This involves developing an outcomes framework and a costing analysis
- Our workforce will have the relevant skills, knowledge and appropriate values to deliver high quality care and support
- Use data and intelligence to proactively understand and predict people's needs

## 4.5 What Would 'Good' Look Like?

### a) Community and Support Networks

Support given by communities and networks are an important contributor to effective care and support for the individual and their families. Peer networks are encouraged to establish and provide support to other individuals and their families throughout the journey from childhood to adulthood and into older age. Similar to mainstream services, access to community support is facilitated through reasonable adjustments, support staff or through the integrated specialist multidisciplinary health and care support available in the community.

### b) Mainstream Services

Individuals with learning disabilities and/or autism experience the same level of service provided as to the general population. This is facilitated through reasonable adjustments, support staff or through specialist health and care support in the community.

Mainstream services which are particularly important for those learning disabilities and/or autism to access include:

- Activities that enable people to lead a fulfilling and purposeful everyday life
- Education, training and employment services
- Primary care
- Mainstream NHS services and MH services, including those provided by General Practice as people with learning disabilities and/or autism are at increased risk of experiencing mental health physical health difficulties
- Hospitals discharge planning needs to be effective for those with learning disabilities and / or autism as well as the wider population
- 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
- Housing, including small-scale supported living, though this choice may be circumscribed by the Ministry of Justice (MOJ) in some instances if the person is on an offender pathway
- Settled accommodation options including exploring home ownership or ensuring security of tenure
- Local housing strategies have the future needs of this group understood, considered and incorporated
- Substance (drugs and alcohol) misuse services

### c) Specialist Community based Services with Targeted Support

Specialist services centred around integrated specialist multidisciplinary health and care support in the community for people with a learning disability and/or autism. This includes children and young people including during transition to adults, and adults, as well as those who may have come into contact with or be at risk of coming into contact with the criminal justice system, including people with lower level social care and/or health needs. There is a focus on 'whole life' support, providing seamless care and support as children progress into adulthood and into old age.

All care and support staff are trained and experienced in supporting people with behaviours that challenge. Staff are able and confident to deliver proactive and reactive strategies to reduce the risk of behaviour that challenges, such as positive behavioural support (PBS).

Specific specialist services include:

- Support for all parents caring for children of whatever age who have LD and/or autism and who are at risk of developing or are beginning to develop a mental health condition or behaviour that challenges. The support includes:
    - Evidence-based parenting training and practical and emotional support
    - Access to short-breaks
- Alternative short term accommodation which is available as and when needed and for as long as needed in times of crisis or potential crisis as a place where people can go for a short period, preventing an avoidable admission into an inpatient setting. This could also provide a setting for assessment from intensive multi-disciplinary health and social care teams where that assessment cannot be carried out in the individual's home.
- Non-intensive multi-disciplinary health and social care support at home. This provides ongoing care and support for those with a learning disability and/or autism, and their families, helping them to prevent crises and reduce the frequency and severity of challenging behaviour. They work closely with providers as well as family and other support networks.
- Intensive 24/7 multi-disciplinary health and social care support at home to prevent or manage a crisis, and prevent family or support package breakdown. This support is provided by a highly-skilled and experienced multi-disciplinary/agency team with specialist knowledge in managing behaviours that challenge. The 'step up' and 'step down' between specialist multidisciplinary support and this intensive support needs to be seamless and work closely with providers as well as family and other support networks.
- Specialist health and care services that support people who have come into contact with or are at risk of coming into contact with the criminal justice system (i.e. offering a community 'forensic' function) including the expertise to manage risk posed to others in the community. The interventions depend on the need s of the individual and the level of risk they pose.

### d) Hospital-Based Specialist Services

This is integrated into a broader care pathway, working closely with community based mental health and learning disability services. Hospital based specialist services are only be used where community settings cannot provide suitable alternatives and ensures that

individuals are in the least restrictive settings that are therapeutic and safe for all. Hospital staff ensure that people are identified as soon as they become fit for discharge.

Hospital-based support includes both secure and non-secure beds as follows:

- **Non secure**

Where people cannot be supported effectively or safely in mainstream inpatient mental health services, small scale non secure assessment and treatment services integrated into community services are used. Intensive Community Inpatient Support Services will only be used if the person was sectioned under the Mental Health Act.

- **Secure**

Where people with a learning disability and/or autism need assessment and treatment for a mental disorder whilst preventing harm to the public and whose behaviour has often resulted in contact with the criminal justice system.

## 4.6 Enablers

In order for us to be able to deliver our vision, the following system enablers will be required:

### Proactive Care and Support

- An 'at risk of admission register' to provide adults and children most at risk of admission to hospital with proactive, preventative support, supported by risk stratification
- Identification of additional risk factors for:
    - Development and identification of behaviour that challenges, including during adulthood
    - Development of psychiatric disorders since those with learning disabilities
- Everyone with a learning disability over the age of 14 will have an Annual Health Check, resulting in a Health Action Plan which is integrated into the single person-centred care and support plan, including the Education Health and Care Plan for children
- Carer support to help families to lead a full family life and maintain their physical and emotional resilience
- Safeguarding policies and procedures to support whistleblowing and other activities that may prevent or lead to the early detection of abuse or inappropriate treatment

### Choice and Control

- A person centred care and support plan which people and their carers have been involved in drawing up and have a copy of, focused on better meeting an individual's needs and increasing their quality of life in a way that reduces the likelihood of behaviour that challenges occurring in the future
- Information and advice relevant to the individual with the learning disability and/or autism in a format that they can understand
- Any support required to assist people with learning disabilities and/or autism to communicate
- The offer of a personal budget, personal health budget or integrated personal budget with the information, advice and support about how to manage one
- As well as the legal right to statutory advocacy, people with a learning disability and/or autism who have a mental health condition or display behaviour that challenges, would

be offered advocacy support, tailored to meet their needs at key transition points in their lives

### Coordinated and Integrated Care

- A local care coordinator will be offered to everyone to coordinate and ensure timely delivery of a wide range of services in the plan, working closely with the person and their family
- Commissioners in Nottinghamshire will work more collaboratively across boundaries to ensure collaborative commissioning and risk sharing
- There will be pooled or aligned budgets in place for funding associated with the care and support for those with a learning disability and/or autism

### Access to Mainstream Services

- Mainstream services will be available to people with learning disabilities and/or autism can access them with the necessary reasonable adjustments
- Hospital passports will be used to help ensure that staff in mainstream NHS services can make reasonable adjustments for someone with a learning disability and/or autism, including accommodating behaviour that challenges
- Clearly identified and readily accessible liaison staff in universal NHS services, with the specific skills in working with people with a learning disability and/or autism will be available and able to advise on reasonable adjustments
- Reliable methods to check on service quality and ensure that mainstream services serve people with learning disabilities and/or autism appropriately
- Regular audits in mainstream mental health services in relation to how the mainstream services serve people with a learning disability and/or autism and make improvements as a result, using the Green Light Toolkit

### Minimising the Use of Hospital Services

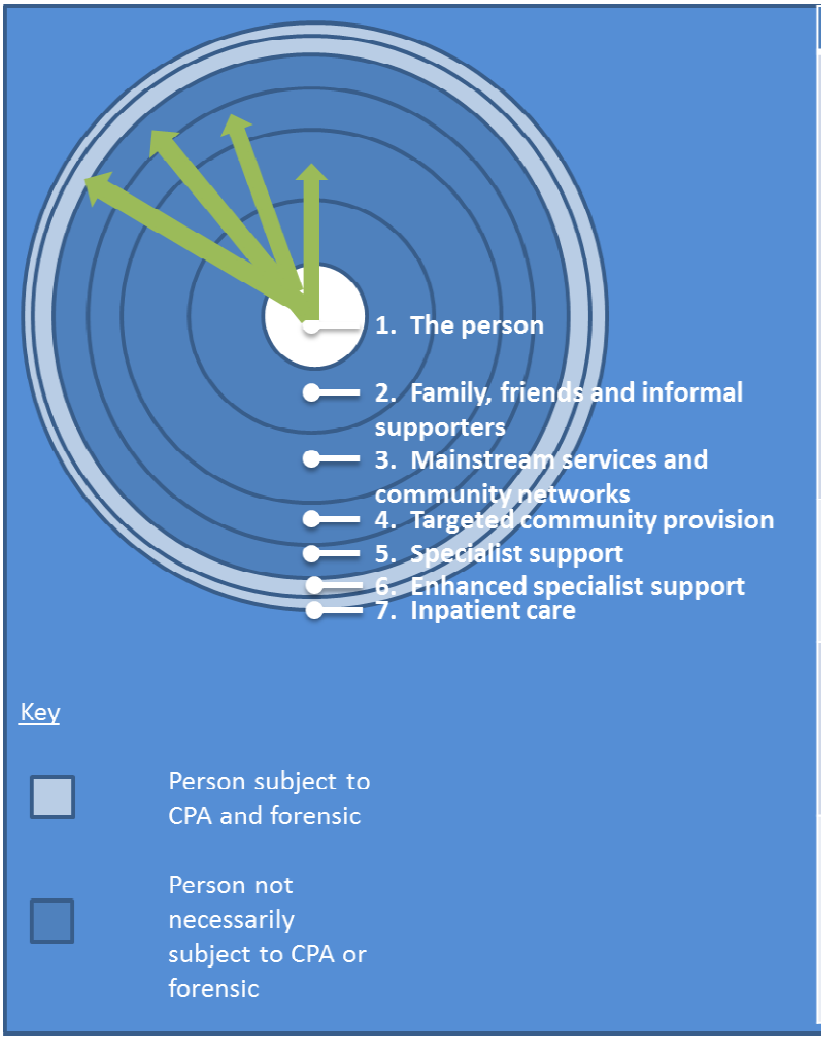
- All planned or unplanned admissions will require a pre admission care and treatment review or blue light review to ensure that hospital based services are the most appropriate setting for individuals

## 5 Delivering our Vision

Our future model of care and support in Nottinghamshire will be focused on enabling access to mainstream universal and community support with enhanced specialist, specialist and targeted community based support only provided when mainstream services cannot provide the support required or people are identified as being at risk of their needs and behaviours escalating and/or deteriorating. Inpatient settings will only be used to complement community services e.g. short breaks, crisis, or where inpatient settings are mandated.

Commissioning these new-style services will reduce the demand on hospital placements which are disempowering and unsettling for individuals and their families. This will allow the amount of in- patient beds to be reduced over time.

Support and care in Nottinghamshire will be orientated around the person and their family, friends and informal support networks. It will have six levels of services around the person as illustrated in the diagram below:




| Level | Example services |
|---|---|
| 4. Targeted community provision | • Special schools and colleges<br>• Leisure groups<br>• Home care<br>• Day opportunities,<br>• Work schemes,<br>• Short breaks (planned)<br>• Services for Looked after children, special education needs, children in need<br>• CAMHS Tier 1&2 |
| 5. Specialist support | • Residential care<br>• Supported living<br>• CLDTs<br>• CAMHS Tier 3 |
| 6. Enhanced specialist support | • ICATT<br>• Crisis Support Breaks (unplanned)<br>• CAMHS Tier 4 & CAMHS Crisis |
| 7. Inpatient care | • Locked rehab<br>• Assessment and treatment units<br>• Low and medium forensic<br>• CAMHS inpatient |

*Figure 1: future model of care in Nottinghamshire*
*Terminology: CAMHS: Child and Adolescent Mental Health Services, ICATT: Intensive Community Assessment and Treatment Team, CPA: Care Programme Approach, CLDT: Community Learning Disability Team.*

In Nottinghamshire we want to ensure that each person's support is coordinated across and between the different levels to provide a seamless pathway focused around the person and their family and carers to enable them to be as independent of public services as possible and maximise their potential. The emphasis will be on supporting the person with a learning disability and/or autism, whether as an adult or child in having as similar a life and access to public services and others as the general population, recognising that in some cases those with autism may choose to play less high profile roles in their communities.

## 5.1 Key Pillars of the New Model of Care

### a) Care Coordination

We feel that one of the keys to our success will be the strengthened co-ordination of care and support for those with a learning disability and/or autism across the different levels of support. In our model, who provides the care coordination will vary according to the complexity of the person's needs. For those with very complex needs and very challenging behaviour, with frequent need for support from the CLDT and/or ICATT teams, or for children from the CAMHS and other children's services teams, it is envisaged that a clinician will coordinate care and support. This is in line with statutory regulations requiring a health or social care practitioner to coordinate if the person is on the Care Programme Approach (CPA). However, if the person is not on CPA, then the person coordinating the care and support need not be a health or social care practitioner, and indeed the role may be best taken by the family or carers of the person concerned, particularly if there is a personal budget or personal health budget involved. For children the design of care co-ordination will be in line with what is designed through our 'Future in Mind' plans.

Whoever the person coordinating the care and support for the individual is, the opinion of the person with the learning disability and/or autism will be listened to and respected in deciding who co-ordinates their care, and changing this person if the complexity of needs change, or if it is felt that their relationship is not as productive as it could be in helping making sure the person's needs and outcomes are met. The person who coordinates the care will be a constant positive force in the person's life, and they need to have an excellent working relationship. Independent advocates have a valuable part to play here in ensuring that the person's wishes are communicated and understood.

It is likely that the person coordinating the care and support, if a practitioner, will need to change as the person progresses from being a child to an adult, because of the different skill sets. However this handover will be done seamlessly and at the right point in time for the person concerned, and will make use of the continuity provided by the family and carers to achieve this.

### b) Training and Education

All staff will be trained and experienced in supporting people with behaviours that challenge, and have an appropriate, evidence-based, range of responses to meeting people's needs and addressing challenging behaviours to ensure seamless care and support. In particular staff will be able to deliver proactive strategies to reduce the severity and frequency of behaviour that challenges, such as positive behavioural support (PBS) including person-centred ethical reactive strategies where behaviour poses a threat to the person or those

around them. This will have a significant and positive impact not only on the individual but also on their care team, developing practical skills and resilience.

### c) Mainstream Services and Community Networks

People with a learning disability and/or autism will experience similar access to services as the general population. The CLDT and ICATT teams will facilitate this access by supporting staff to make reasonable adjustments to cater for those with a learning disability and/or autism, including implementing the principles of positive behavioural support. Particular mainstream services that will be supported to make these reasonable adjustments include:

- Education, training and employment services
- Primary care
- Physical healthcare services and mental health services, including primary care
- 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 home ownership or security of tenure
- Substance (drugs and alcohol) misuse services

In the new model there will be a stronger emphasis on the support available from 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 family carers. There will also be an emphasis on the person making their own contribution to communities. There will be much more of a systematic approach to supporting peer networks, recognising the organic nature in which they evolve and develop. Our feedback from people with a learning disability and/or autism and their families illustrates that where peer networks exist, they are really valued in the most part with the exception of people with autism who might choose to be less involved in social networks. Formal support providers and residential care settings will be commissioned to support these peer support networks as and when possible or necessary.

### d) Targeted Community Provision, Specialist Support and Enhanced Specialist Support

There will be integrated multidisciplinary health and care and support for people with a Learning Disability and/or autism. This includes children, young people particularly at transition, and adults, as well as those who may have come into contact with, or be at risk of coming into contact with the criminal justice system, including people with lower level social care and/or health needs but higher levels of risk of harm to others. There will be a focus on ‘whole life’ support, providing seamless care and support as children progress into adulthood and beyond into old age.

The specialist and targeted community-based support includes:

- Relatively low level community based interventions

- Enhanced support interventions to prevent or divert a crisis, and prevent family or support package breakdown
- Crisis management and stabilisation

Central to the operation of this support will be a register of those at risk of admission to inpatient services, developed to include children, those with autism, and forensic cases as well. This will provide direction as to which adults and children need to be the priority for their services. Where 'unknown' children and adults present to services, this information will be used to refine the register, so that as far as possible all children and adults whose needs remain high risk, are already known through the register. Staff across teams will provide proactive care and support, intervening early to help the person reduce the severity and frequency of their challenging behaviour.

This support will be offered through the following services, with the person coordinating the care and support ensuring that the right input is provided at the right time for the person, integrated seamlessly in a continuum of care for the individual. A multi-organisational steering group will underpin this seamless care and support providing a consistent vision across teams, establishing responsibilities for care and support where there are 'grey' areas, and smoothing the pathway as children transition to be adults.

We want people with forensic needs to be better supported in the community. Although the skills development to provide this will focus primarily on the ICATT and CAMHS teams, all teams will have an understanding of how to manage and address the needs of those who have come into contact with the criminal justice system, as well as identify and mitigate the risk that this presents to the person, their families and carers, and others in the community.

| Team | Description | New/enhanced responsibilities and skills as a result of the model |
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| CLDT teams | • Supporting adults 18+ with a learning disability and/or autism who display challenging behaviour or have a mental illness for long period of time | • Promoting the capabilities of families and providers<br>• Trained and experienced in supporting people with behaviours that challenge<br>• Ability to cater for those who have come into contact with criminal justice system to ensure that they can be maintained in community services rather than being referred for treatment under the offender pathway<br>• More integrated working between health and social care teams |
| ICATT | • For people 18+ who have a learning disability and either show severely challenging behaviour or have an additional mental illness and without ICATT intervention the person would require in-patient admission<br>• Provide the enhanced support interventions - rapid response, short term advice and health interventions to those who are experiencing an increase in emotional and/or behavioural difficulties in community settings | • Better liaison with the County and City CLDTs than currently<br>• 24/7 crisis support with closer liaison with the Mental Health crisis team through joint working to enable the Mental Health crisis team to support those with a learning disability, and the ICATT team to better support those with mental health issues<br>• Community forensic skills integrated within the ICATT teams to support people who have come into contact with or are at risk of coming into contact with the criminal justice system with a mix of early intervention and prevention work, a monitoring and support role, providing advice and support to other services and teams providing specialist and target community based support to those with a learning disability and/or autism<br>• To provide assessment advice and support to police custody areas and magistrates courts about assessing and managing high risk or complex behaviours.<br>• To support the offender pathway service to ensure access and egress from the offender pathway is a key priority<br>• Capacity to maintain a longer term relationship with people with Forensic needs to maintain their safety in the community and continued engagement in therapies and support<br>• Trained and experienced in applied behavioural analysis and the proactive support of people with behaviours that challenge |
| County and City Emergency Duty Team (children and adults). | • Out of hours support and signposting to services for those with eligible needs, including those with a learning disability and/or autism | • High level understanding of the support needs of people with behaviours that challenge<br>• Ability to respond to the needs of those who have come into contact with criminal justice system |

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| Community CAMHS (City and County). | • CAMHS Tier 3 and Tier 4support in the community, including for Learning Disabilities and/or those with autism, providing enhanced support interventions and crisis management | • Linking into the 'Future in Mind' programme<br>• Greater understanding of the growing population of children with autism, and addressing their needs, including aligning eligibility for support<br>• Increased ability to manage the needs of people who have come into contact with the Criminal Justice System, and manage the risk that this presents to their wellbeing, that of their families and carers and the wider community, whilst liaising with justice partners who will manage the risk of offending<br>• Trained and experienced in proactively supporting people with behaviours that challenge<br>• Use the opportunities offered through the Education Health and Care plan (EHCP) to set-up appropriate care and support for those with a learning disability and/or autism as they progress into adulthood |
| County and City Children's teams | • Providing support for Looked After Children, Children in Need, and those with Special Educational Needs | • Support for all parents caring for children of whatever age who have LD and/or autism and who are at risk of developing or are beginning to develop a MH condition or behaviour that challenges, as well as evidence-based parenting training, and practical and emotional support<br>• Greater understanding of the growing population of children with autism, and addressing their needs, including aligning eligibility for support<br>• Increased ability to manage the needs of people who have come into contact with the Criminal Justice System, and manage the risk that this presents to their wellbeing, that of their families and carers and the wider community, whilst liaising with justice partners who will manage the risk of offending<br>• Trained and experienced in supporting children and young people with behaviours that challenge.<br>• Use the opportunities offered through the Education Health and Care plan (EHCP) to set-up appropriate care and support for those with a learning disability and/or autism as they progress into adulthood |

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| County and City Transition Teams. | • Providing transitional support for children into the adult world, and the care and support that they need | • Increased ability to manage the needs of people who have come into contact with the Criminal Justice System, and manage the risk that this presents to their wellbeing, that of their families and carers and the wider community, whilst liaising with justice partners who will manage the risk of offending<br>• Trained and experienced in supporting children and young people with behaviours that challenge<br>• Greater understanding of the growing population of children with autism, and addressing their needs, including aligning eligibility for support<br>• Use the opportunities offered through the Education Health and Care plan (EHCP) to set-up appropriate care and support for those with a learning disability and/or autism as they progress into adulthood |
| Asperger's teams | • Multidisciplinary team for City without social care<br>• Social care team for County | • Increased ability to manage the needs of people who have come into contact with the Criminal Justice System, and manage the risk that this presents to their wellbeing, that of their families and carers and the wider community, whilst liaising with justice partners who will manage the risk of offending<br>• Have a strong link with ICATT to ensure appropriate levels of support for those with forensic needs<br>• Trained and experienced in supporting people with behaviours that challenges |
| Residential care providers, Supported Living providers and Shared Lives carers | • Providing supportive accommodation options for adults with a learning disability and/or autism | • Increased ability to manage the needs of people who have come into contact with the Criminal Justice System, and manage the risk that this presents to their wellbeing, that of their families and carers and the wider community, whilst liaising with local Forensic services and justice partners who will manage the risk of offending<br>• Trained and experienced in the proactive support of people with behaviours that challenge |
| County and City Community Forensic teams | • Providing support to those living with a personality disorder in the community | • Increased ability to manage the needs of people who have come into contact with the Criminal Justice System, and manage the risk that this presents to their wellbeing, that of their families and carers and the wider community, whilst liaising with local Forensic services and justice partners who will manage the risk of offending<br>• Trained and experienced in the proactive support of people with behaviours that challenge<br>• Increased ability to manage the needs of people with Asperger's |

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| Criminal Justice Liaison team | • A liaison and specialist interventions service provided into police stations, the courts and probation services for the treatment of Personality Disorder within the community | • Increased ability to manage the needs of people who have come into contact with the Criminal Justice System, and manage the risk that this presents to their wellbeing, that of their families and carers and the wider community, whilst liaising with local Forensic services and justice partners who will manage the risk of offending<br>• Trained and experienced in the proactive support of people with behaviours that challenge |

### e) Inpatient Settings

Inpatient settings will be integrated into a broader care pathway, working closely with community based mental health and learning disability services. Hospital based specialist services are only used where community settings cannot provide suitable alternatives, and people are held in the least restrictive settings that are therapeutic and safe for all. People accessing inpatient settings will continue to access the community to ensure they do not become reliant on the institutional setting or lose skills they have acquired and so they experience an acceptable quality of life on a daily basis while an inpatient.

The person coordinating a person's care and support and ICATT staff will work with hospital staff from before the day of admission, to ensure an estimated day of discharge is determined with a clear assessment and treatment plan from when the person is admitted with measureable outcomes-based milestones so that discharge planning and preparations for they stay begin before the admission.

With the support of the person coordinating the care and support for an individual and ICATT staff, hospital staff will ensure that people will be constantly monitored for being fit for discharge to ensure they do not remain an inpatient beyond this point.

A clear offender pathway (previously referred to as high, medium or low secure services) will be available for Nottinghamshire residents. Secure Hospital inpatient will be restricted to forensic services and those who present with significant harm to others but are not fit to plead in court and are diverted from the Criminal Justice System. The criteria for admission will follow the following principles: - An admission of a person with a LD 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.

At this stage it is anticipated that there will be no out of area placements required for people in Nottinghamshire but this will need to be confirmed on further analysis of the accommodation options within Nottinghamshire.

Hospital-based support will include both secure and non-secure, as follows:

| Type of accommodation | Sept 2015 No. of beds commissioned for Notts residents | 2020 No. of beds commissioned for Notts residents | Assumed length of stay | New/enhanced provision as a result of the model |
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| Crisis support or beds | Does not exist | To be determined on further planning | Length of intervention or stay to be up to a month. | • A range of options are required from providing assertive support where the person lives or staying with families through to robust accommodation units for people with destructive behaviour<br>• The objective is to learn from Nottingham's Mental Health Crisis House - Haven House<br>• ICATT team supporting staff in units and families and carers in other accommodation options |
| Short break beds | 27 units available | To be determined on further planning | Length of stay to be up to a month. | • Will expand from current 27 units to cater for extra numbers in the community<br>• A range of options required from staying with families to robust accommodation units for people with very challenging behaviour<br>• ICATT and CLDT teams supporting staff in units and families and carers in other accommodation options |
| Low and medium secure | 18 LD/autism beds in area, 3 non-specific beds, and 16 out of area beds | 17 beds | Length of stay – 2-3 years (low) and 4-5 years (medium) | • Fewer beds commissioned for people from Nottinghamshire<br>• Trained and experienced in supporting people with behaviours that challenge |
| Intensive Community Inpatient Support Services (previously Locked Rehabilitation services) | 11 beds in area and 12 out of area | 8 beds | Length of stay to be up to 12 months | • Fewer beds commissioned for people from Nottinghamshire<br>• Trained and experienced in supporting people with behaviours that challenge<br><br>Admission into this part of the pathway will be determined by each individual's level of clinical & treatment needs. The aim of this provision of care is to support people who may require a longer period of support due to the behaviours that they are exhibiting that |

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| | | | | others find challenging. This extended period of support will allow for the further development and testing out of proactive and reactive strategies. |
| Assessment and Treatment | 18 beds (block contract) with 13 currently used | 8 beds | Length of stay to be between 3 to 6 months | • Fewer beds commissioned for people from Nottinghamshire<br>• Trained and experienced in supporting people with behaviours that challenge<br>• All admissions into this part of the pathway will be as a consequence of the person's behaviour changing significantly resulting in the need for their positive behavioural support plan to be reviewed, modified, and adjusted. It is anticipated that all individuals accessing the assessment and treatment service will be detained under Part II of the MHA 1983. L |
| CAMHS Adolescent beds – Learning disability only | 1 bed | 1 bed<br>13 beds* ( Local, regional and national resource – function and funding pathways need further exploration via national procurement work streams for CAMHS) | Length of stay on a case by case basis | • Fewer beds commissioned for people from Nottinghamshire for those with a learning disability and/or autism<br>• Trained and experienced in supporting people with behaviours that challenge |

## 5.2 How is our New Model 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 currently. In particular there will be an enhanced support and crisis team in place – this is currently not provided. The community provision will be focused on three cohorts:

- **The current in-patient cohort, including those in forensic settings**
  The community provision will need to accommodate those previously served by inpatient settings, so people can improve their quality of life, be safe and improve the quality of their care and support so that where possible they can stay in their own home and any in-patient admissions are minimised.
- **The current community cohort**
  The community provision will need to keep people with a learning disability and/or autism living well in communities, preventing deterioration in their wellbeing and crises so that their need for in-patient services is reduced to when they are the best option.
- **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 at all possible.

This will require community provision to be proactive, intervening early to reduce need, including addressing the underlying causes of behaviours so that the frequency and severity of challenging and offending behaviour is reduced. This will be helped by effective risk stratification of the population, with the register of those at risk of admission being the key tool to do this.

The role of mainstream services and community networks are an important partner in achieving this. There will need to be much more of a focus, 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, and to contribute to the support of others in this way as well.

In addition, there will be a consistent approach to challenging behaviours across all teams so that the right interventions are delivered to change behaviours, and therefore reduce the severity and frequency of challenging behaviour and consequently the needs that need to be addressed. The UK Positive Behavioural Support Competence Framework lists the competencies that define best practice, and this framework will be used to create this consistent approach to challenging behaviour across the system. The framework has a number of key themes:

- Creating high quality care and support environments
- Functional, contextual and skills based assessment
- Developing and implementing a Behaviour Support Plan (BSP)

There are also specific enhancements required to key teams delivering community provision, as detailed above e.g. ICATT teams delivering 24/7 care and support, accommodation options to address crises, improved recognition and effectiveness of those co-ordinating care and support for an individual.

## 5.3 How will Care Settings Change?

Care settings will shift from in-patient provision to community settings and will be able to cater for those who have come into contact with the Criminal Justice system. Community settings will be enhanced through improved community services, and expanded capacity as well as the addition of crisis accommodation provision for those with learning disabilities and/or autism. Short term care settings such as crisis accommodation and short breaks, as well as long term care settings through e.g. Shared Lives and Supported Living.

## 5.4 What will be Commissioned that is Different?

### Advocacy Services

Advocacy services are a key enabler for the new model to help those with a learning disability and/or autism exercise choice and control over their care and support over the long term. Currently advocacy services in Nottinghamshire are being re-commissioned. They are currently provided. through a single gateway 'Your Voice Your choice' providing a single point of access for all advocacy services and to provide capacity during the resolution of particular issues as they arise, rather than long term support. Those with a learning disability and/or autism and behaviour described as challenging or with longer term mental health needs are likely to need access to independent advocacy support throughout their lifetimes so the commissioning of advocacy for them needs to reflect this. Consideration should also be given as to how ongoing support can be offered that does not meet the criteria for advocacy.

### CLDT teams

These teams are currently provided and managed by the City and County local authorities with NHT staff co-located within them. They will need to be commissioned to cater for a greater volume of cases and to cater for more people who have come into contact with the Criminal Justice system. As for ICATT teams the commissioning of CLDTs will also need to encourage a culture in the ICATT teams, that promotes a proactive approach to challenging behaviour that seeks to reduce the severity and frequency of challenging behaviour, preventing the escalation of needs and intervening early to reduce their impact.

### Crisis and Short Breaks Support

Learning from the mental health crisis house that has been opened in Nottingham City, Nottinghamshire will look at commissioning a range of options for crisis to support individuals and their families. Short break provision will be expanded to ensure that this is another option for people to prevent hospital admissions.

### Supported Living Services

Nottinghamshire already has a history of developing accommodation options to support the transfer of in-patients into community settings from long stay NHS and private hospital placements. Some of these offer a core and cluster model providing private space as well as shared support and a community, with 6-7 schemes built delivering this model, providing up

to 33 individual flats. With the new model Supported Living services will be commissioned to support people with more complex behaviours including those who have been in contact with the Criminal Justice system, and also for a greater number of people. There will need to be market development activity to create a market of small niche providers in Nottinghamshire to manage people with extremely challenging behaviour, since this support is not consistently readily available across the whole of Nottinghamshire, particularly in the City. Where it does exist there is a need to support our existing core providers to develop greater capability and reliability in meeting the needs of people with challenging behaviour.

### Residential Services

Consideration will need to be given to strengthening the commissioning of residential services in order to ensure that they recruit and train staff to meet the requirements of this cohort.

### ICATT teams

The role of these existing teams, currently commissioned from NHT will expand to provide a 24/7 response, closer liaison with the Mental Health crisis team, closer working with CLDTs, as well as inclusion of community forensic skills and capabilities. The increased capacity of the team will cater for the greater volume of cases. Commissioning will also need to encourage a culture in the ICATT teams that promotes a proactive approach to challenging behaviour that seeks to reduce the severity and frequency of challenging behaviour, preventing the escalation of needs and intervenes early to reduce their impact.

## 5.5 How will it be Commissioned Differently?

Local commissioners have a commitment to work with the independent and third sector to ensure there is a vibrant and high quality market to support the needs of people with complex needs. As the model of care is developed local commissioners will explore the opportunities to develop an integrator model to support alignment and fit of people's needs with a range of providers.

Whilst we have some excellent examples of supported living in Nottinghamshire that is meeting people's needs, it is anticipated that there will need to be significant market development activity to create a sustainable market of providers in Nottinghamshire which can deliver some of the new or enhanced commissioning intentions. This will require close and trusting relationships with providers, listening to their input to create Market Position Statements, and then working closely with them to build capacity in the marketplace.

An example area which will need market development is that of small niche providers who are able to provide accommodation options for those with very challenging behaviours. This need for small niche providers will also require commissioning mechanisms, as well as market development activities, to encourage a much smaller type of provider. Procurement and contracting mechanisms must not to be too time-consuming or to naturally discriminate against small providers e.g. risk in terms of the size of the contract vs. the turnover of the organisation, risk and reward mechanisms, commissioning for outcomes. There may also be a need to encourage social enterprises as a good way to deliver services. This will require additional market development effort to ensure suitable social enterprises are developed that can take on such services.

At the other end of the scale in some cases it will need to be recognised that to achieve cost effective services commissioning may need to happen on a more regional basis than just Nottinghamshire.

Since the approach and culture of providers is critical to delivering effective community services for those with a learning disability and/or autism, commissioners will need to investigate options for commissioning services for outcomes. The outcomes concerned are likely to involve the quality of life of people with a learning disability and/or autism, including the degree of choice and control they have over the care and support options.

As a first stage it is not anticipated that to deliver greater accountability amongst providers to reduce the use of in-patient services that the adoption of lead provider models is required. NHT currently provides both Assessment and Treatment services, as well as the ICATT and the NHS funded components of CLDTs already, so the accountability already exists in one provider to deliver a reduction in the use of in-patient beds. However if commissioning mechanisms are not effective in incentivising the Trust to deliver this reduction in and the use of inpatient beds, then lead provider models across say primary and community care, may need to be considered.

Similarly capitation contracts may provide a better focus on supporting the whole learning disability and autism population on Nottinghamshire, but at this stage it is not clear that they will significantly help deliver improved services.

Decommissioning of in-patient beds needs to be carefully considered and close working relationships between commissioners and providers will be required to deliver this successfully. Nottinghamshire Healthcare NHS Trust currently is commissioned on a block contract to deliver community based services and assessment and treatment in-patient services. The successful prevention of admissions to hospital is likely to impact the numbers in assessment and treatment services most, but realising cost savings from a block contract is unlikely to be as substantial as from a spot or framework contract when volumes reduce.

The resources from this disinvestment will be utilised to fund an enhanced community based support. This will not only include meeting the direct accommodation costs but also through strengthening the services that support this group.

We would want to ensure that there is collaborative commissioning and linked risk-sharing between CCGs and NHS England in commissioning of beds in Nottinghamshire. This will require the support of NHS England in the negotiations to ensure that CCGs and other specialised commissioning teams have a plan to reduce the numbers of beds they commission in Nottinghamshire.

We will link this plan in with existing plans in Nottinghamshire for example our Crisis Concordat action plan, strategic priorities and national outcome measure reporting. We will also ensure that there is alignment to both the Nottingham City and Nottinghamshire County ‘Future in Mind’ plan which is due for submission in October 2015 by having a consistency of personnel involved in the creation of both plans.

## 5.6 What Enablers need to be in Place for our System to Operate?

### Proactive Care and Support

- A register to provide adults and children most at risk of admission to hospital with proactive, preventative support, supported by risk stratification. These risks will include the development and identification of behaviour that challenges, as well as the development of psychiatric disorders. Nottinghamshire already has a register in place, but it will need to be extended to include children, those with autism without having a learning disability and also those with a forensic history.
- Everyone with a learning disability over the age of 14, or those required to do so through having an Education Health and Support Plan, will have an Annual Health Check, resulting in a Health Action Plan which will be integrated into their person-centred care and support plan. Whilst Annual Health Checks are in place across GP practices in Nottinghamshire, practice is variable in a large part due to a lack of skills in helping to diagnose a learning disability. The extension of health checks down to the age of 14 will increase the existing capacity issue in delivering these. Work will be undertaken with primary care which CCG;s are best placed to support with to understand how best they GPs can deliver a consistent approach to Annual Health Checks from the age of 14 for those with a learning disability.
- The impact on families and carers can be especially severe for those with a learning disability and/or autism, particularly if they display challenging behaviour. Support for families to lead a full family life and to maintain their physical and emotional resilience, is particularly important. Information and advice to manage challenging behaviours and to operate personal budgets and personal health budgets, and the availability of peer networks will be particularly important. The recently enhanced duties and responsibilities towards carers provides a clear statutory framework for this, and those working with people with a learning disability and/or autism, will prioritise support to help families and carers improve their quality of life, and to sustain the caring relationship.
- The enhanced responsibilities of health and social care organisations in relation to safeguarding will be particularly important for teams working with people with a learning disability and / or autism, considering what happened at Winterbourne View. There will be stringent policies and procedures in place to support whistleblowing and teams will work quickly to act on any early detection of abuse or inappropriate treatment.

### Choice and Control

- Person centred plan (PCP). 'My plan', will be a person centred care and support plan which people and their carers have been involved in drawing up and have a copy of, focused on better meeting an individual's needs and increasing their quality of life in a way that reduces the likelihood of behaviour that challenges occurring in the future. The use of Person Centred Plans in Nottinghamshire starts from an understanding that people using services, and their carers and communities, are experts in their own lives and are therefore essential partners in the design and development of services. PCPs were initially implemented for a cohort of those with a learning disability and/or autism a couple of years ago, and through the Transforming Care programme they will be extended out to all those with a learning disability and/or autism. The PCP will provide all those involved in working with the person with a learning disability and/or autism, with a sense of the life journey of the person concerned, and what really matters to them in

terms of how they lead their lives. The PCP will be supported by an underlying 'service plan'. 'My plan' will also address physical health, mental health and additional needs such as sleep difficulties, sensory impairments and ADHD need to be identified and addressed in the plan.

- The County and City Councils have new duties in the Care Act in relation to the provision of information and advice both to those receiving Council funded and those receiving self-funded care and support. There will be a particular emphasis on offering information and advice is in a format that the person with a learning disability and/or autism can understand and offering information and advice is in a format that the person with a learning disability and/or autism can or may be able to understand, and also on providing information and support around managing challenging behaviours and how to operation personal budgets and personal health budgets. This will support people with learning disabilities and their families to make choices directly and to be better informed about universal, targeted and specialist services. Teams, particularly the person co-ordinating care and support for an individual will make good use of the enhanced approaches to information and advice to make sure that both the person with a learning disability and/or autism, receives the right information and advice at the right time in their care and support journey, relevant to the individual with the learning disability and/or autism in a format which they may be able to understand, and which helps them influence decisions around their care and support.
- Through the Care Act there is a new duty for the City and County Councils to provide independent advocacy at any point if it is felt a person would have substantial difficulty in being involved in the social care process and have no family or friends who can support their involvement. For those with a learning disability and/or autism, the model will move beyond this to a much more regular use of advocates around key life decisions. As a result the intention is that using an advocate will become the norm for those with a learning disability and/or autism and challenging behaviour or mental health needs. Care and Treatment reviews (CTRs) in Nottinghamshire show that currently only 30-40% of people had accessed advocacy – this needs to change. This will require a refocused approach to commissioning the single point of access to advocacy services, Your Voice Your choice', and we will commission an immediate interim increase in advocacy services for CTRs before the retendered contract starts in September 2016.
- New duties for health and social care organisations around offering and aligning personal budgets and personal health budgets, are particularly important for people with a learning disability and/or autism. By the end of the programme all people who are eligible for services will have the option of a personal budget and/or personal health budget so that people and their families and carers can exert their influence effectively in how care and support is provided. They will also receive the right information and advice at the right time to make informed choices around their personal budget and/or personal health budget. The funding in these personal budgets or personal health budgets will either be managed by the person, their family and carer, a third sector organisation or health and social care provider. In line with the move to pooled or aligned budgets, there will be a move to integrated personal budgets for people with a learning disability and/or autism, combining health and social care funding.

### Co-ordinated and Integrated care

- To help deliver whole system care, there will be a move to pooling budgets across CCGs, Local Authorities and Specialised Commissioning, for low and medium secure to support those with a learning disability and/or autism and those who may/have come in contact with the Criminal Justice System. The ability to move to truly pooled budgets for specialised commissioning will require national changes to NHS funding. Even where pooled budgets prove not to be possible or practical, budgets will be aligned to gain as much of the benefits of pooling funds as possible. The monies released from in-patient services to be re-invested in community services, will need to be pooled, so that replacement care and support commissioned is truly focused on the person and not constrained by the organisation it belongs to.
- It is envisaged that through the Transforming Care programme a single overview plan (both 'My plan' and the underpinning service plan) will be delivered across health and social care, whether the person is on CPA or not. This will require a single ICT system to support these single overview plans, accessible to all those working with a person with a learning disability and/or autism, and potentially to the person and their carers and families. The single overview plan will be supported by more specific plans around specific needs, which are also likely to be shared and available across organisational boundaries.

### Accessing Mainstream Services

- The Hospital Passport will be consistently available within Health Action Plans to help staff in mainstream NHS services make reasonable adjustments for someone with a learning disability and/or autism, including accommodating behaviour that challenges.
- A scheme for quality checking mainstream services will be put in place to ensure that mainstream services serve people with learning disabilities and/or autism appropriately, and that action is taken to address any identified issues.
- There will be regular audits in mainstream mental health services in relation to how the mainstream mental health services serve people with a learning disability and/or autism and make improvements as a result, using the Green Light Toolkit.

### Minimising the Use of Hospital Services

- Care and Treatment Review (CTRs) or 'Blue Light' reviews are already in place in Nottinghamshire prior to any admissions (planned or unplanned) to ensure that hospital based services are the most appropriate setting. They are providing valuable data that is already influencing how services are delivered.
- National Specialised Commissioning Secure Services Access Assessments Guidance is in place across all user groups to access secure hospitals, it is a clinical process to determine that a person meets the criteria for admission into secure hospitals and level of security (medium or low secure) as high secure has a different criteria for admission. This process needs to stand alongside the pre admission CTR and blue light processes to ensure appropriate admissions to secure settings

### Workforce

- The model requires a workforce with the relevant skills, knowledge and values needed to deliver high quality care and support within a culture of fairness, accountability and reflection, learning from experience both within Nottinghamshire and externally.

Recruitment processes need to reflect the skills and values required. There will be a consistent approach to addressing challenging behaviour, using techniques such as positive behavioural support, with a deep and shared understanding of the reasons why each person displays challenging behaviour. A competency framework for positive behavioural support will be chosen which will be implemented to provide this consistency of approach across different health and social care organisations. There will also be much greater skills and awareness in the workforce as to how to manage those who have been in contact with the Criminal Justice system.

- The workforce will also routinely use data and intelligence to challenge and improve how it improves services. Data from CTRs is already starting to inform and shape services, and Nottinghamshire will build on this to shape service based on a better understanding of needs, particularly around children and autism, the experience of people who use the services, and information relating to how services are delivering to meet people's needs and desired outcomes.

## 5.7 How will this be Different for Patients and their Families

***Cases Studies provided by Marcus Callaghan, Supplier Manager Mental Health and Learning Disabilities, Specialised Commissioning***

**Person A**

"This person was placed in a locked rehabilitation hospital. Her mental wellbeing deteriorated and as such she was referred for an adult access assessment with a view that she may require treatment in a low secure hospital. This assessment was undertaken and it indicated that she met the criteria for admission to low secure care. As there are no low secure services within Nottinghamshire for women with a learning disability and or ASD but there was a degree of urgency a discussion took place between the CCG and NHS England to work out a plan to meet her needs.

Due to the crisis this person was in it was agreed that urgent action was required. It was agreed that she would be placed in a PICU (funded by the CCG) for her and others safety. Once assessed and accepted by a low secure provider she would then transfer to that service. A few days later she transferred to the low secure provider (funded by NHS England). As this was out of area the NHS England case manager for that area was involved in the decision making plus it was agreed that this was a "blue light" scenario due to the crisis and that a CTR would be undertaken soon after admission.

This case demonstrates positive integrated commissioning of services to meet a person's needs and risk whilst maintaining their and the public's safety as they were going through a crisis."

**Person B**

"This person has a complicated presentation with a range of diagnoses and has been in hospital both secure and non-secure for several years. An attempt was made to place this person in the community recently but they committed a serious assault that led them to return to hospital. The person's presentation deteriorated earlier this year that led to a request for an access assessment for secure care. This was undertaken and it indicated that he required treatment in a medium secure environment. A provider was sought and a placement offered. However, this transfer did not take place as there were no beds available

at the provider, a situation that continues. NHS England have referred him to all of the medium secure providers, unfortunately none of them have been prepared to accept him for admission. Indeed some providers have indicated that they believe that a low secure environment would be more suitable. This has been heard and a further access assessment to support that has been commissioned. A CTR was held that supports admission to a hospital bed. Low secure providers have also been contacted but no placement has been offered. The CCG involved are also stuck in that no alternative locked rehabilitation provider will consider his case whilst he has been assessed as requiring secure care. Consequently this person continues to be placed in an provider that does not believe that they can meet his current needs.

An integrated approach under the proposed model may have helped this case. A CTR being held prior to the referral for an access assessment would have encouraged discussion and consideration of alternative approaches. That is not to say that this consideration did not take place but the model would have provided a clearer structure for the decision making process".

***Cally Ward, Carer and Challenging Behaviour Foundation***

"Families will be supported and valued as partners and will be engaged on an individual, service and strategic level as part of this plan. Children and adults will receive more timely, responsive, flexible and joined up support and care in the community, across education, health and social care. A focus on early identification of children at risk will target support into early preventative intervention. Families will receive specialist information, advice and a range of practical support in a timely and appropriate way across the lifecycle with a particular emphasis on key transition points and early intervention to prevent crises. Support and care will be co-ordinated across settings to ensure a consistent and holistic approach. Mainstream services will meet their duties under the Equality Act to make reasonable adjustments to the way they work with children and adults with learning disabilities/ autism who have a mental health condition or display behaviour that challenges. Staff will be trained to be competent and confident to include them. Children and adults and their families will be supported by robust specialist services in the family home and community. Intensive, flexible and person-centred support will be available in a crisis to support the child/adult and their families or carers. As for the general population, if admission for inpatient assessment and treatment is necessary the service will be local, short term and outcome orientated."

## 5.8 Staff and Providers

***Dr Richard Welfare, Clinical Director for Specialist Services, LD and CAMHS, NHT***

"In the future we will have greater choice and opportunities for people who challenge services. Most people will be well supported in their communities both within their families or in support services. Carers will have a greater voice in services and will be more able to shape the support their person receives. Much fewer people will be admitted to hospital and in a crisis will be able to call on a much wider set of support services for the individual. The risks and challenges the people in distress can pose will be met with a more comprehensive service response."

***Clare Gilbert, Lead Commissioning Manager, Nottingham City Council***

"The model of care provides a significant opportunity for the CCGs and local authority to work jointly to commission a range of targeted and specialist provision centred around the Care Co-ordinator model. The proposals align strongly with the finding of the City Council's Learning Disability Strategic Commissioning Review which has taken place over the last year. The approach not only focuses on those at highest needs, but enhances provision for all individuals with learning disability by strengthening the utilisation of early intervention.

The reduction of inpatient beds will support significant new investment in the provision of high quality supported living and residential services. This will enhance the range of accommodation provision being provided which should reduce escalation of need and provide effective pathways out of inpatient support. The model emphasises the need for a skilled and well trained workforce to ensure that these outcomes are achieved."

***Jayne Lingard, Commissioning Officer, Nottinghamshire County Council***

"As a social care commissioner for younger adults, this new system model will lead to significant strides in the commissioning landscape. The development of a shared culture of and competence in positive behavioural support across all layers of support (including their families)for people with learning disabilities and or autism has the potential to reduce support costs whilst delivering much improved individual outcomes

- The greater competence and increased flexibility of health and social care services will enable us to commission more robust and more appropriate (home care) support and residential care provision for people with complex needs.
- The pooling of budgets would enable us to spend less time debating who should bear the cost of responding to crises, focussing instead on creative and person-centred solutions between partners and understanding what led to the crises and how to avert them in future.
- The empowerment of families and informal supports has the potential to increase the social inclusion of people with a learning disability and / or autism, greatly increasing my job satisfaction"

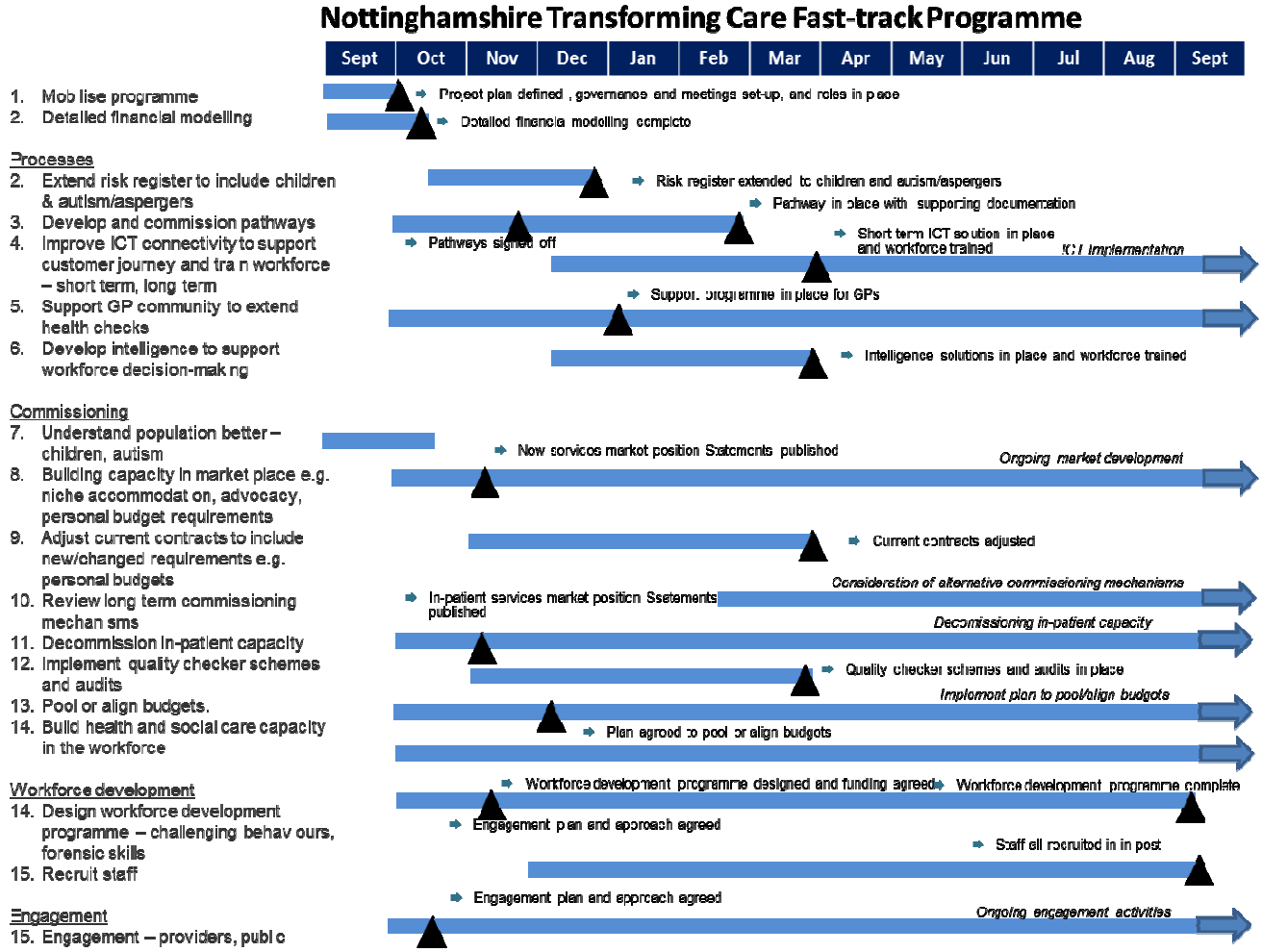
***Gary Watt, LD Nurse Specialist, Bassetlaw CCG***

1. "Staff and providers are able to meet people's needs closer to home, thus having good insight and oversight into local care provision and knowledge of local dedicated pathways in meeting requirements. This will be achieved by the sharing of information within the geographical area the prompting of quality care at the right time and in the right place.
2. The foundation of robust community services will be based upon the building blocks of the care programme approach resulting in an allocated and dedicated care co-ordinator to support an individual well into recovery and beyond. Thereafter care oversight will be delegated to a capable and caring other as more focussed support in adverse behavioural presentations is necessarily lessoned.
3. Care will be delivered within a framework of community services by teams that have clear lines of responsibility within a seamless service."

# 6 Implementation

## 6.1 What are the programmes of change needed to deliver this new model?

The diagram below shows what we intend do next and by when.




To deliver the transformation required the Transforming Care Fast Track programme will have four key workstreams. These, in addition to the ongoing project management function will deliver the evaluation of the programme as the delivery of the model progresses, measuring the intended outcomes, and adjusting the model to deliver this. The four workstreams are as follows:

### 1. Process

This workstream will design and develop the pathways of care and support to deliver joined 2up and integrated care and support around the Person-centred Plan and a supporting single overview plan across health and social care. There will be an emphasis on reducing paperwork, particularly for Care Co-ordinators, and the inclusion of personal budgets and personal health budgets. The detailed design of the pathways of care and support will involve designing the forms and documents required and also defining roles involved in the process. ICT connectivity and integration will be improved to support the improved pathways, initially in the short term using current infrastructure, with a longer term ICT

solution providing a more robust way of creating and sharing the PCP and single overview plan.

Creating intelligence to support operational staff in their day-to-day activities, in particular around the 'at risk of admissions register' will also be delivered as part of this workstream. In parallel to the development and implementation of the improved care and support pathways two current important elements that have already been implemented in Nottinghamshire, will be adjusted to meet the requirements of the programme. This is extending the risk register out to children and to those with autism/aspergers, and also supporting GP networks to consistently deliver health checks, and to extend them out to children aged 14 and over.

***Deliverables:***

- Pathways of care and support implemented, supported by short and long term improved ICT connectivity and integration, intelligence solutions and a trained workforce
- Support programme in place for GPs to consistently provide Health Checks to those with a learning disability from the age of 14
- Existing 'at risk of admissions register' extended out to children and people with autism

### 2. Quality and Commissioning

This workstream will oversee all the actions required at various stages of the commissioning cycle. The first activity that will be undertaken is to improve our data and to better understand our population and their associated needs, including children with a learning disability and / or autism with challenging behaviours, and also the wider population of people with autism. .

Market development to build new and sustainable capacity within the workplace is an important part of this workstream. In addition procurement and performance management activity will be involved in adjusting current contracts to include the new/changed requirements. The block contract with NHT will need to be negotiated to include the new responsibilities of ICATT in particular, for example having a community forensic function, as well as making sure that the planned capacity is appropriate to address the increased number of people whose needs will be met in the community.

As described earlier, there is not consistent provision across Nottinghamshire in terms of community accommodation solutions with particular gaps in the City which will need to be addressed to create a vibrant market for those with very complex needs in the City. Some of this market development activity may be delivered through other projects and programmes.

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 and those who have/may come into contact with the Criminal Justice System is the best way forward. Commissioning on a capitation basis, lead provider models may or may not turn out to be appropriate, but outcomes-based commissioning will definitely be incorporated into contracts at the appropriate stage, in a way which does not discourage small providers.

The programme to decommission in-patient capacity in line with plans will require strong engagement and consultation with providers and the public, and also close financial and contractual management to ensure that the 'savings' planned are released and able to be re-invested in community care and support. The decommissioning plan will need to allow for double running costs of community capacity alongside inpatient services, until the community capacity is established and operating effectively.

Mainstream services and their accessibility by those with a learning disability and/or autism are also within the scope of this workstream. Quality checker schemes will be designed and implemented to provide assurance that they are able to be accessed by those with a learning disability and/or autism and those who have/may come into contact with the Criminal Justice System and an audit mechanism will also be put in place for mainstream mental health services for similar reasons.

There will also be ongoing efforts to improve the capacity of the health and social care workforce to deliver the new models of care in terms of practitioner and clinical skills and capabilities.

Finally 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:***

- Published Market Position Statements for new commissioning requirements, and for the decommissioning of in-patient services
- Updated contracts to include new/changed requirements
- Provider capacity built or decommissioned to meet Market Position Statements
- Quality checker schemes in place for mainstreams services
- Pooled or aligned budgets to support all community and in-patient spend on those with a learning disability and/or autism
- Improved health and social care skills and capabilities in the workforce.

### 3. Workforce Development

This workstream will deliver a workforce development programme to ensure that all staff, regardless of their employer, have the skills and knowledge to work effectively with this client group. An analysis of training needs will be carried out, using a variety of techniques, to identify the skills needed to deliver services, and the gaps within the current workforce. It is likely that these skills will include:

- An ability to build self-resilience and maintain compassion to avoid burnout
- Understanding the narrative surrounding the formulation of challenging behaviour
- Positive behavioural support techniques
- Supporting people with a forensic history

- Physical health care – catheter care, peg-feeding, tracheostomy care, diabetes, substance misuse, and helping people cope with basic health care (such as having an injection)
- Enhanced cross agency working, and an understanding of how different agencies/organisations can work collaboratively to support clients

In addition this workstream will oversee how to ensure successful recruitment and retention of staff into posts to deliver the model of care as providers in Nottinghamshire have already experienced difficulties in recruiting and retaining high calibre staff which is fundamental to a community based model.

***Deliverables***

- A workforce across all employers with a consistent understanding and approach to working with people with challenging behaviour which enables those clients to manage their behaviour in the least restrictive setting
- Recruitment of staff into posts to meet the requirements of the new model of care

### 4. Engagement

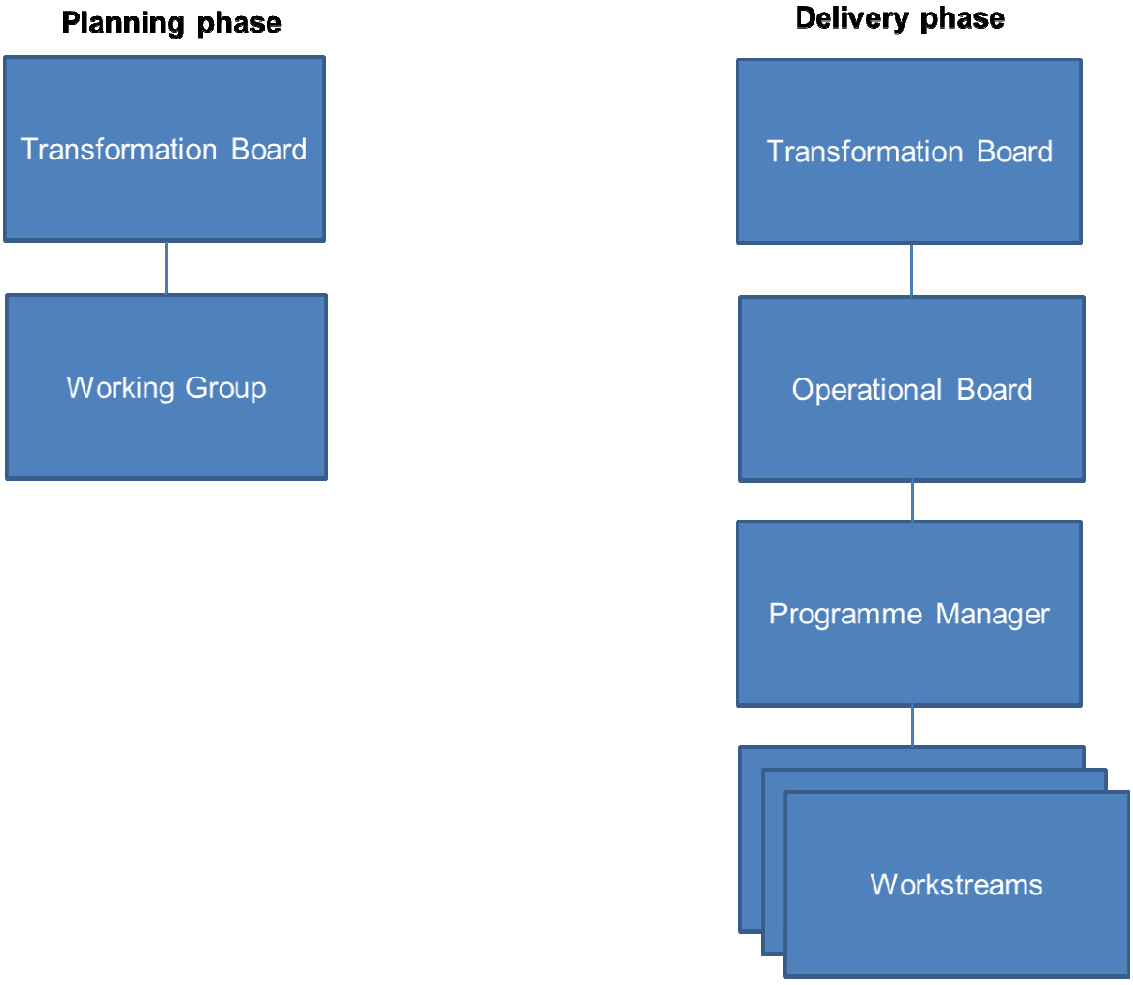
This workstream will deliver the extensive engagement with individuals, families and carers as well as the wider public and providers of care and support. This is crucial to delivering the programme, and improving outcomes for people with a learning disability and/or autism. Co-production will be an important part of our approach, recognising the expertise that the family and carers and providers have, that will be essential to delivering a successful model of care. The programme will use existing provider engagement structures, enhanced as necessary. For engagement with the public a variety of engagement channels will be used, such as Inclusion East and the engagement groups organised by VOX to support the Learning Disabilities Partnership Board. The engagement will be built on the results from the engagement already delivered, such as surveying those involved in CTRs. For more details of the approach to engagement see section below.

***Deliverables:***

- People with a learning disability and/or autism and their carers 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, through co-production, 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

## 6.2 Programme Delivery and Governance

The diagram below shows the intended approach to delivery and governance by phase




The Nottinghamshire Transformation Board will continue and provide assurance of delivery across programme and oversee progress of all the agreed workstreams. The Transformation Board will continue to be chaired by the Senior Responsible Owner (SRO), Sally Seeley of Nottingham City CCG with Caroline Baria of Nottinghamshire County Council as the Deputy SRO.

Membership includes representatives from Nottingham City Council, Nottinghamshire County Council, NHS Nottingham City CCG, NHS Mansfield & Ashfield & Newark & Sherwood CCG (on behalf of all Nottinghamshire County CCG's), NHS Bassetlaw CCG, NHS England, Nottinghamshire Healthcare NHS FT, NHS England Specialised Commissioning and Nottingham CityCare Partnership. The Board will look at how those programme outcomes can be achieved and provide assurance by:

- Developing and agreeing a high level Nottinghamshire programme plan
- Monitoring the delivery of a high level programme plan
- Agreeing/checking the quality of key programme outputs
- Managing programme-level risks
- Managing programme-level issues

- Looking at resources across the programme to make sure that they are used well
- Sign off and agree the Nottinghamshire Learning Disabilities Transformation plan

During the planning phase, a working group, chaired by the SRO has been in place, providing the more intensive input into the design of the plan through a series of four workshops. As the planning phase moves into delivery, the working group will become an Operational Board which the Programme Manager will report into. Chairing arrangements for this group will be agreed but it is likely that it will continue to be chaired by the SRO. The responsibilities of this Operational Board will be to:

- Agree the vision and objectives for the Programme and ensure they are understood within the stakeholder organisations
- Work with their respective organisations to ensure the appropriate resources and organisational support are made available to facilitate successful Programme implementation
- Agree the Programme structure and approach to deliver the transformation
- Monitor progress, issues and risks against the agreed Programme Plans, and take action where progress against plan is insufficient and where issues occur
- Assist in the development of robust processes for embedding the project into business as usual
- Oversee the delivery of key objectives and achievement of outcomes as detailed in the Programme Vision and Plan
- Ensure a clear understanding of the model of care and how this will be implemented in Nottinghamshire amongst stakeholder organisations, providers and the public

## 6.3 Issues, Risks, Assumptions and Dependencies

### Issues

The deadline of 7 September 2015 to create our initial plans has meant that we have not been able to undertake as much engagement with staff and people with a learning disability and/or autism, their family or carers as we would have liked. Whilst we believe our approach of using the Board and the working group to develop ideas has been sufficient to get us to this stage, and we have a plans in place to engage with the public and providers after submission, we recognise that much more work will be needed to ensure buy-in to the plans, which may then change, dependant on the feedback we receive.

### Dependencies

**NHS England**

- To help engineer the conversation with other CCGs so that they don't commission beds in Nottinghamshire.
- National changes to allow budgets for specialised commissioning to be pooled with CCG budgets for non-forensic services for those with a learning disability and/or autism.

### Risks to Successful Delivery

| Risk | Description | Probability (High, Medium, Low) | Impact (High, Medium, Low) | Mitigation |
|---|---|---|---|---|
| Provider response | The market does not develop as envisaged | Medium | High | • Clear Market Position Statements signalling commissioning intentions<br>• Good ongoing provider engagement including listening to providers' issues and concerns |
| Workforce skills | Required workforce skills and capacity do not develop sufficiently | Medium | High | • Clear workforce development plans<br>• Sufficient funding to develop workforce skills, and recruit appropriate staff (note that it can be difficult to recruit mental health nurses and social care support workers as there is a shortage of supply) |
| Mainstream services | Do not make reasonable adjustments to accommodate LD/autism needs | Medium | High | • Senior leadership engaged so mainstream services make adjustments a priority |
| Pooling budgets | Changes not made nationally that would allow specialised commissioning spend to be pooled. This would prevent inpatient funding from being re-spent on community provision, a fundamental principle in the financial model. | High | Medium | • Raise nationally as a key issue<br>• If pooling is not possible, align budgets. |
| Culture change | Lack of single vision and aims across all organisations and teams. | Medium | High | • Create effective stakeholder engagement from the start<br>• Recognise that it takes time to build trusting relationships across organisations |
| Negative publicity | Media coverage of closures prevents decommissioning of beds | High | High | • Create PR campaign led by people with their own stories, and promoting the better outcomes for people |
| GP health checks | GP practices do not step up to providing health checks consistently across | High | Medium | • Support GP networks to build their skills and capacity to be able to provide health checks |

| | | | | |
|---|---|---|---|---|
| | Nottinghamshire | | | consistently |
| Other CCGs | Beds will continue to be filled by service users from outside the area after the transformation plan is in place | High | High | • Need to work with NHS England and other CCGs to prevent other CCGs and Specialised Commissioning from placing patients in Nottinghamshire who are not from Nottinghamshire |

## 6.4 Key Enablers for Success

### Trusting Cross Organisational Relationships

Trusting relationships are required across all organisations in Nottinghamshire involved in commissioning care and support to address the needs of those with learning disability and/or autism and those who have/may come into contact with the Criminal Justice System. The well attended Transformation Board and Working Groups and constructive conversations that have taken place at the Board and Working Groups, have proved that the foundations are in place for these trusting relationships to be established that will support the successful delivery of the programme.

### Single Shared Vision across all Stakeholders

All organisations must have the same aims and vision in relation to the care and support of people with learning disabilities and/or autism and those who have/may come into contact with the Criminal Justice System. This will help them to work effectively together, focused on the same goals. We have already started the process of developing a shared vision and aims and will continue to explore the evidence base and innovative developments of other areas together.

### Public Support for the Programme

Since decommissioning of services is involved, then there needs to be considerable engagement with the local media and a good approach to ensure that the Transforming Care Programme is presented to the public in a positive light.

### Sufficient Funding

Particularly to pump-prime the investment in community services to deliver a reduction in hospital admissions.

## 6.5 Workforce, education and training considerations

### Question A

**1) Does the plan require reconfiguration of existing workforce where provider(s) are remaining the same?**

Yes

**2) Which providers will need to reconfigure the existing workforce – NHS, independent, voluntary, private?**

The ICATT and CDLT teams within the NHS will need to reconfigure their existing workforce to deliver this programme. Private, Voluntary and Independent (PVI) Service providers will also need to develop the skills of their workforce to support people with more complex needs/challenging behaviour. Consequently it would be helpful to hold some cross-agency skills analysis to ensure that PVI providers understand what is being requested of them and to develop a whole systems workforce development plan. We will look to evidence-based reviews such as “Workforce development and people whose behaviour challenges” (IPC/Skills for Care Nov 2012) and the guidance for adult social care employers from NDTi/Skills for Care (Feb 2013) when developing our reconfiguration plans.

**3) Does the implementation plan specify competency frameworks to be deployed in support of workforce reconfiguration?**

There are a number of competency frameworks available which could be useful, which will be decided once the skills analysis has taken place as we want to identify what skills we need and then decide on competency frameworks. It is likely that these will include

- Positive Behavioural Support, developed by the PBS Coalition
- Learning Disability Generic Interventions Pathway Competency Framework, developed by Health Education West Midlands.

**4) Does the implementation plan address Positive Behaviour Support/positive and safe related education and training needs?**

The workforce workstream in the programme will deliver a consistent approach to proactively addressing challenging behaviour across all organisations delivering care and support for those with a learning disability and/or autism.

**5) Does the implementation plan identify how Training Needs Analysis will be undertaken and how results will be employed to support effective education and training commissioning?**

A Training Needs Analysis will be undertaken across organisations to support a shared understanding of what the service model will entail and how the different agencies contribute to the whole pathway. This will be particularly important in developing a consistent approach to positive behavioural support and enabling staff in all agencies to see how their work contributes to the overall goals of the programme and could include

- Mapping the patient pathway to identify skills needed for the whole pathway
- Multi-agency focus groups
- A shared template for training needs analysis

**6) Does the implementation plan identify employment of apprenticeships, assistant practitioners, advanced practitioners and/or physician associates?**

The implementation plan is not yet at a sufficient level of detail where the employment of apprenticeships, assistant practitioners, advanced practitioners and/or physician associates, is addressed. However, the reconfiguration of the workforce may well identify new roles at different levels within organisations. Where these are unregistered staff (Assistant Practitioners and Apprentices) they will be recruited locally to support the economic development of the local area.

**7) Does the implementation plan require the development of any new roles to support the new delivery model?**

The implementation plan is not yet at a sufficient level of detail to definitively say whether new roles will be required other than more senior specialists in PBS, which is a clear gap. However, the reconfiguration of the workforce will probably identify new roles at different levels within organisations, and one of the first priorities for implementation will be to specify the overall tasks to be carried out, the workforce required to do this, and any new roles required to deliver services.

The implementation plan has already recognised that there are areas where there will be a need for more staff in existing services (24/7 ICATT services), and where staff will need to develop new skills, such as working with clients with a forensic history in community settings.

**8) Is there a requirement to develop new education and training to support deployment of new roles? Please specify.**

Yes, it is anticipated that the Analysis of Training Needs will identify new education and training needed to support the deployment of new roles, once they have been identified – see Question 7.

## Question B

**1) Does the plan require development of workforce configuration in services to be newly commissioned?**

Yes, for example the potential development of the market for accommodation options for those with very complex behaviours to accommodate niche providers. Currently these niche providers do not exist in the marketplace in Nottinghamshire and commissioners may determine that they will add to the richness of provision.

**2) Do potential providers of NHS commissioned services (NHS, independent, voluntary, private) have the capacity and capability to identify workforce, education and training needs to the local education and training system?**

We will work closely with providers to support them in developing and implementing their workforce development plans to deliver the capabilities and capacity required for the Transforming Care programme.

**3) Does the implementation plan specify competency frameworks to be deployed in support of workforce development? Please Identify.**

See answer to A3 above.

**4) Does the implementation plan identify how Training Needs will be identified to support effective education and training commissioning?**

A Training Needs Analysis will be undertaken across organisations to support a shared understanding of what the service model will entail and how the different agencies contribute to the whole pathway. This will be particularly important in developing a consistent approach to positive behavioural support and enabling staff in all agencies to see how their work contributes to the overall goals of the programme and could include

- Mapping the patient pathway to identify skills needed for the whole pathway
- Multi-agency focus groups
- A shared template for training needs analysis

**5) Does the implementation plan identify employment of apprenticeships, assistant practitioners, advanced practitioners and/or physician associates?**

See answer to A6.

**6) Does the implementation plan require the development of any new roles to support the new delivery model?**

See answer to A7.

**7) Is there a requirement to develop new education and training to support deployment of new roles? Please specify.**

See answer to A8.

### Question C

**1) What is the estimate of costs for workforce, education and training elements within answers to Question A?**

The total cost estimates at this stage for the workforce development programme is £250k, combining the requirements of both Question B and C. However this figure will need to be verified through more detailed planning. £200k of this will be for education and training, with £50k for backfill/salary support. We will work with Health Education East Midlands on commissioning the education and training element of the workforce development programme. For social care staff we will use our existing commissioning and contract management arrangements to incentivise and to support social care providers to access the specialist training required.

**2) What is the estimate of costs for workforce, education and training elements within answers to Question B?**

This is covered in the answer to A1.

**3) What is the estimate of total costs for workforce, education and training elements within answers to Question A and B?**

The total cost estimates at this stage for the workforce development programme is £250k.See answer for C1 about how we will work with Health Education East Midlands around commissioning the training.

## 6.6 Stakeholder Engagement

The Transforming Care Fast-track programme is committed to embedding consistent, timely and meaningful communications and engagement activity in the transformation of care throughout the implementation of its local plans. This will be achieved through the delivery of a comprehensive communications and engagement strategy and supporting action plan aligned to the local vision and the programme plan.

A communications lead for the programme has been identified and local communications work is already linked to the national agenda and learning from other fast track areas through participation in scheduled national teleconferences and existing regional network meetings. A media handling protocol has been agreed to ensure consistency of messages, clarity of roles within the communications function and management of media / reputational risk for the organisations involved. Engagement activity will be co-ordinated by an identified engagement lead for transformation in collaboration with engagement functions within Nottinghamshire partner organisations.

A mapping exercise to identify existing communications channels and networks within partner organisations, the third sector and patient representation or support groups will also inform the communications and engagement strategy and ensure that we are capitalising on all current opportunities and mechanisms to communicate and engage.

Stakeholder and wider public communications will aim to provide clarity around the need for transformation, the importance of providing improved care in the most appropriate setting for people with learning disabilities and/or autism and mitigate against any potential misconceptions and assumptions through the alignment of local key messages with those being communicated nationally.

Identifying key opinion formers and decision makers across Nottinghamshire and providing them with regular briefings, progress reports and opportunities to comment on transformation plans will aim to achieve buy-in and support for transformation and avoid any delays in implementation. Key individuals and committees such as MPs, councillors, Health and Wellbeing Boards and Health Scrutiny Panels will be engaged on a regular basis as part of our commitment to transparency and accountability to elected officers, lay members and those they represent.

Local key messages, aligned to national communications guidance, are being developed for agreement by all partners and will enable us to articulate our plans with one consistent voice so key communities of interest know what to expect of transformation across Nottinghamshire and the objectives and improvements it aims to achieve.

Based on agreed messages, communications will be tailored to specific target audiences identified within the communications and engagement strategy, ensuring that information is relevant and accessible to those it aims to engage and inform. All communications will include a mechanism for contacting the communications lead or responsible officers within the transforming care team to promote a two-way dialogue that encourages feedback and information requests from stakeholders.

Communications and engagement materials will be produced in a variety of formats and languages as appropriate taking into account the needs of individuals and groups to ensure information is accessible and inclusive.

### 1) Who has a Stake in the Plan?

The key groups are:

#### Individuals with learning disabilities and/or autism, Families, Carers and the Public

In particular those with a learning disability and/or autism and their families and carers. However particularly considering the national profile of Winterbourne View, the wider population in Nottinghamshire also is an important stakeholder and are very important to engage around decommissioning activities.

#### Commissioners of Services for people with a learning disability and/or autism in Nottinghamshire

This includes the Midlands and East Specialised Commissioning Hub, the seven CCGs, and two Local Authorities in Nottinghamshire, providing inpatient and community based health and social care, both forensic and non-forensic. This includes those on Section 117s, those receiving Continuing Healthcare and those receiving social care support, whether Council or self-funded.

### Providers of Services for people with a learning disability and/or autism in Nottinghamshire

A close working relationship is required with health and social care providers to ensure that they are able to respond to changing commissioning intentions, and play a full part in the work to build skills and capabilities in the workforce around positive behavioural support and also the management of complex cases who have been involved with the Criminal Justice System.

### Partner Organisations in Nottinghamshire

This includes those public services involved in public security and justice in particular. In developing improved prevention and early intervention for those with a learning disability and/or autism who display challenging behaviours, effective working with the police and justice services, including with the local street triage services, will be particularly important.

### Commissioners of Services for people with a learning disability and/or autism outside Nottinghamshire

Collaboration is required to help prevent other non-Nottinghamshire commissioning organisations from placing people in beds in Nottinghamshire.

### 2) How have they already been Involved?

A process of stakeholder mapping, analysis and audience segmentation is underway to inform the communications and engagement strategy and ensure that we are communicating and engaging as widely as possible whilst also specifically targeting with those who have a key interest in the transformation of care be it personal, professional, reputational or political.

### Public Engagement

Focused engagement with patients, carers and families has initially been built on the work already in train as part of the Nottinghamshire case-by-case CTR reviews of hospital in-patients and their individual future needs. This work has been predominantly been undertaken through face to face contact with carers, families, many of who have or will be discharged from hospital settings into the community with support, and the Challenging Behaviour Foundation has helped us deliver this work. The experience and learning from these CTRs has helped shape and develop this plan.

We have undertaken a survey of individuals and family carers who have been involved in hospital based CTR's. The findings support our model and confirm our thinking in the following areas:

**Person centred:** The analysis of the information confirms our thinking that support in the community for individuals with Learning Disabilities and Autism needs to be Person Centred, helping individuals create a life that is specific to them.
**Quality of life:** Quality of life should be seen as a goal for individual support but also as a strategy to support individuals to live meaningful and purposeful lives. A Positive Behaviour Support Plan would focus services on this aim.
**Ordinary life:** There is no one model of accommodation that fits all. There needs to be a range of services commissioned but all within "normal" community settings to allow for integration and social inclusion in the wider community, especially to facilitate family life.

**Specialism:** Many individuals recognise their role in achieving discharge and successful community living, however clearly services need to have the right expertise to support a diverse range of people and needs. In particular any shared accommodation needs consideration as to whether the group will live well together. This is especially if there are any shared staff. Many individuals find sharing attention difficult. Many of the individuals surveyed have very complex needs with risky / challenging behaviours. The staff group supporting them will require a different skill set for different individuals according to that need.

**Staff Training and Support:** This should be viewed as the responsibility of all involved and multi-layered, focusing on key skills in each layer. Positive Behaviour Support training would be the model of choice for this client group. The training should include therefore Commissioners (Local authority and Health), voluntary organisations, providers, clinicians, direct care staff and family supports. This should up skill the community staff (knowledge and skills) to provide robust packages of support with additional expertise brought in as required. This may go some way to reduce the staff turnover that many providers face and that the individual's themselves report as a challenge to maintaining positive and productive lives.

In addition we are planning to use the engagement structures that already support the Learning Disability Partnership Boards. Currently we are planning a big consultation day (A 'Listening day') on 30/9/15 for SPLAT (Nottingham City Partnership Board) when we will be speaking to people with a learning disability and/or autism about our plans so far, and getting their thoughts and feedback. SPLAT works on a 3 month cycle so this listening day prepares people on the topics for the 25/11/15 Board agenda. There is also a Working Group on 4/11/15 which is a smaller meeting to pull out key themes and agree how to feed these into the board meeting and who will do this.

### Provider Engagement

NHT and Nottingham CityCare Partnership are represented on the Transformation Board and Working Group currently. We are liaising with NHS England around their engagement with four independent providers around the programme, and will build on this work to engage with independent providers in Nottinghamshire specifically around this programme. This is in addition to ongoing provider forums linked in with social care commissioning activities, and going forwards we will want to use these provider forums to communication with providers around the Transforming Care Fast track programme.

### 3) How will they be Involved in the Future?

An outline schedule of activity is given in the table below which indicates the key initial activities, both planned and underway, to ensure that communications and engagement is embedded effectively within programme planning and implementation.

| Timeframe | Activity | To include |
|---|---|---|
| August / September 2015 | Stakeholder mapping, analysis and audience segmentation | • Boards and executive committees of the nine Fast Track partner organisations across Nottinghamshire<br>• Patient and service-user panels / councils / cabinets attached to the nine Fast Track partner organisations across Nottinghamshire<br>• Nottinghamshire MPs and Councillors<br>• Health and Wellbeing Boards<br>• Health Scrutiny Panels / committees<br>• Healthwatch Nottingham and Nottinghamshire<br>• Voluntary sector communities of interest<br>• Private Sector communities of interest<br>• Provider organisations<br>• NHS England<br>• Professional bodies, staffside and unions<br>• Other CCGs placing out of area patients within Nottinghamshire<br>• Regulators including Care Quality Commission and Monitor<br>• Additional communities of interest |
| September 2015 | Mapping of internal and external communications channels and networks | • Existing internal and external communications channels of the nine partner organisations including newsletters, e-bulletins, workforce communications<br>• Third sector and patient group networks<br>• Social and digital media channels and opportunities<br>• Nottinghamshire print, broadcast and digital media |
| September 2015 | Mapping of stakeholder meetings, committees, reporting mechanisms and opportunities to engage | • Schedule of meetings for Health and Wellbeing Boards, Health Scrutiny Panels, Governing Body meetings<br>• Timeline of agenda planning, reporting mechanisms / deadlines for meeting papers |
| September 2015 | SWOT and PESTLE analysis | • Identify local strengths, weaknesses, opportunities and threats |

| | | |
|---|---|---|
| | | • Better understanding of operating environment and potential barriers to communication and engagement |
| September 2015 | Development of communications key messages | • Raise awareness of Fast Track Partnership and vision<br>• Aligned to national key messages and objectives<br>• Approval from nine partner organisations and national communications |
| September 2015 | Mapping of planned engagement opportunities | • Identification of existing planned engagement activities for 2015/16 hosted by partner organisations / third sector and providing opportunities to engage on local Fast Track plans |
| 14 September 2015 | East Midlands Comms and Engagement Network Meeting | • Update to regional team |
| 16 September 2015 | Fast Track comms and engagement leads teleconference #2 | • Update to national team on local activity and plans |
| 30 September 2015 | Nottinghamshire Fast Track engagement event | • First in a series of stakeholder / citizen engagement events to engage on NHSE assured local plan |
| October 2015 | Draft Communications and Engagement Plan submitted to partnership for approval | • Approval of key messages, media response and communications sign off protocol and planned activity |
| October 2015 | Internal communications briefing | • Briefing to key stakeholders and staff within partner organisations following assurance of local plans |

| | | |
|---|---|---|
| October 2015 | Stakeholder briefing #1 | • Briefing to key stakeholders including MPs and councillors following assurance of local plans |
| October 2015 | Media briefing #1 | • Briefing to local media following assurance of local plans |

## Public Engagement

Effective communication and engagement with patients, carers and families will be crucial to achieving our vision. Giving individuals currently using services and those with potential/future interest in service change the opportunity to share their experiences, co-design new ways of working and service models and be involved throughout the transformation process will ensure that we establish community and support services that are respond to the needs of individuals and are fit for purpose now and for the future.

The public communications and engagement objectives for the programme have been identified as follows:

- Increase awareness of the Transforming Care agenda and local plans to improve care
- Increase awareness with key target audiences and stakeholders of the establishment of the Transforming Care Fast track programme and the joint ambition and vision
- Communicate the need and drivers for change across the health and care system, national and local, for people with a learning disability and/or autism
- Support change in working practice, improved quality of life and patient / carer experience across services for people with a learning disability and/or autism in Nottinghamshire
- Involve patients, carers and families in transformation, using their experiences and feedback to identify and respond to their needs and facilitate an ongoing two-way dialogue to inform local planning and implementation
- Provide effective and meaningful opportunities for public and stakeholder involvement and/or consultation with clearly defined objectives and embedded mechanisms to provide feedback on how engagement has informed plans and implementation
- Promote service change and new community services to support people with a learning disability and/or autism as a safe alternative to inpatient care that improves quality of life and independence
- Reposition inpatient hospital care for those with learning disabilities and autism as a long-term solution only for those whose needs cannot be met in the community
- Support and dovetail with communications for the national Transforming Care agenda to ensure constituency of messaging and narrative to support service change
- Communicate service change to key stakeholders and the wider public across Nottinghamshire through timely, clear and concise messaging and simple, inclusive language, avoiding the use of acronyms, clinical and technical terms

Moving forwards, engagement activity will focus on involving individuals with a learning disability and/or autism who have the potential to develop challenging behaviours, alongside their families and carers, to test the efficacy, equity and validity of new community support services as they are established.

An initial engagement event is planned will be delivered on 30/9/15 using the engagement structures attached to the Nottinghamshire Learning Disability Partnership with a view to scheduling further engagement and consultation activity, as appropriate, in line with key planning and implementation milestones. In order to achieve full involvement the programme

is committed to providing feedback to those who share their experiences and recommendations with us regarding how their input has helped shape future care provision.
Internal communications between commissioning and provider organisations, both NHS and Local Authority, will focus on a consistent flow of information between the partners involved in transforming care, ensuring all those who have a part to play in implementing new models of care are up to date with transformation progress and are sighted on next steps and actions required. Workforce specific communications will aim to explain the national context and drivers, sell and embed the local vision and help staff commissioning or delivering care understand their specific role within transformation.

# 7 Financial Planning

The financial plan for the Nottingham health economy LD service transformation is based on a reduction in the current bed numbers (whether commissioned by specialised services or the CCGs but excluding high secure beds) that releases funds for re-investment into community services. The model is underpinned by an initial investment in community services that permits a consequent reduction in beds that in turn releases funding for further new community investments. This 'funding recycling' is planned to run over a five year period to March 2020 at which point over half of the existing in-patient beds will no longer be used.

Please note that without the savings from using fewer medium and low secure beds (currently commissioned by NHS England) being used to fund community services across health and social care in Nottinghamshire the financing of this plan will not be viable.

## 7.1 Planning Assumptions

There are a number of assumptions that are made in the model which are set out below:

- The plan runs over a five year period to March 2020
- The plan concerns Nottinghamshire patients in beds, whether in Nottinghamshire or outside the area
- There will need to be a build-up of community services before they are able to prevent admissions which the plan assumes commences in Q2 of 2016/17.
- From then on twelve to thirteen new community placements will come on stream from 2016/17 to 2019/20.
- The Assessment and Treatment Unit (ATU) will have 16 beds until the final year of the plan when it will reduce to eight beds. Intensive Community Inpatient Support Services beds will fall to eight from 22 by the end of the planning period
- Savings from using fewer medium and low secure beds (currently commissioned by NHS England) will need to be used to fund community services. This will require a national policy decision to implement whole care pathway commissioning for this group of patients and the pooling of specialist and CCG budgets. If this is not possible then the financing of the plan is in jeopardy
- There is an increase in total placements over and above that needed to replace closed in-patient beds based on demographics and other factors. The plan includes 6 additional such placements between 2015/16 Q1 and 2019/20, across both inpatient and community placements
- It is assumed that £1.68m is made available from the national transition funding of £10m for the Nottinghamshire health economy and that this is matched by recurrent funding from CCGs
- There is a total investment of £9.28m of which £7.6m is recurrent funding for new community placements
- Additional to the plan there will be capital funding required of £5m to develop specialised housing provision and also crisis accommodation
- The average new community placement will need to be kept to £155,159 per annum to include all health, social, residential or other associated costs although this is for new services over and above those currently provided.

- At this stage the potential impact of dowries for those who have been an in-patient for five years or more, have not been included due to the uncertainty as to whether they will be available and to what levels of funding.

## 7.2 Activity Profiles

The following table shows the planned changes in inpatient beds and community placements over the planning period for Nottinghamshire residents. The model tracks changes on a quarterly basis and this is an annual summary of these changes showing the year end numbers.

| | Baseline | End of Year Numbers | | | | |
|---|---|---|---|---|---|---|
| Summary | 15/16 Q1 | 2015/16 | 2016/17 | 2017/18 | 2018/19 | 2019/20 |
| Specialised: | | | | | | |
| Medium | 8 | 8 | 7 | 5 | 4 | 4 |
| Low | 26 | 23 | 21 | 17 | 12 | 12 |
| CAMHS LD | 1 | 1 | 1 | 1 | 1 | 1 |
| | | | | | | |
| CCG: | | | | | | |
| ATU | 18 | 16 | 16 | 16 | 16 | 8 |
| Locked rehab beds | 22 | 22 | 17 | 10 | 7 | 7 |
| | | | | | | |
| Total all in-patient beds | 75 | 70 | 62 | 49 | 40 | 32 |
| | | | | | | |
| Community Placements | 0 | 0 | 13 | 27 | 39 | 49 |
| | | | | | | |
| | | | | | | |
| Grand Total All Placements | 75 | 70 | 75 | 76 | 79 | 81 |

The plan is for an eventual reduction of over 50% into total across all categories of bed listed in this table and for an even reduction of over two-thirds in the Intensive Community Inpatient Support Services that will be commissioned.

## 7.3 Financial Plan

The financial plan that flows from the activity changes that have been described in the previous section is shown in the following table:

| **Summary** | Baseline | Annual Expenditure | | | | |
|---|---|---|---|---|---|---|
| | 15/16 Q1 | 2015/16 | 2016/17 | 2017/18 | 2018/19 | 2019/20 |
| Specialised: | | | | | | |
| Medium | 1,517,566 | 1,517,566 | 1,470,142 | 1,138,174 | 711,359 | 853,631 |
| Low | 4,094,850 | 3,858,609 | 3,425,500 | 2,756,149 | 2,126,172 | 1,889,931 |
| CAMHS LD | 193,316 | 193,316 | 193,316 | 193,316 | 193,316 | 193,316 |
| Total | 5,805,732 | 5,569,491 | 5,088,958 | 4,087,640 | 3,030,847 | 2,936,878 |
| | | | | | | |
| CCG Funded | | | | | | |
| ATU | 2,647,738 | 2,647,738 | 2,647,738 | 2,647,738 | 2,647,738 | 2,647,738 |
| Locked rehab beds | 4,010,688 | 4,010,688 | 3,552,598 | 2,076,533 | 1,211,254 | 956,760 |
| Total CCG Funded In-patient Expenditure | 6,658,426 | 6,658,426 | 6,200,336 | 4,724,271 | 3,858,992 | 3,604,498 |
| | | | | | | |
| Total In-patient spend | 12,464,158 | 12,227,916 | 11,289,294 | 8,811,911 | 6,889,839 | 6,541,376 |
| | | | | | | |
| Total Community Services Recurrent Spend | - | 236,241 | 2,854,864 | 5,332,247 | 7,254,318 | 7,602,782 |
| | | | | | | |
| **Year on Year Investment Profile** | | | | | | |
| Share of £10m National Funding (N/R) | | 1,680,000 | | | | |
| CCG Matching Funding (recurrent) | | | 1,680,000 | | | |
| In-Patient bed reduction savings | | 236,241 | 938,622 | 2,477,383 | 1,922,072 | 348,464 |
| | | | | | | |
| Funding Available for Community re-investment | . | 1,916,241 | 2,618,622 | 2,477,383 | 1,922,072 | 348,464 |

The financial plans shows how £1.68m of pump priming spend in the latter half of 2015/16 is available to support new investments in community services (see below for more details of how the non-recurrent £1.68m in national and local matched recurrent funding will be utilised). This enables £0.24m to be released from inpatient bed closures to be re-invested in community placements in 2015/16 followed by a further £0.94m in 2016/17, £2.48m in 2017/18, £1.92m in 2018/19 and £0.35m in 2019/20. This includes monies released from reductions in medium and low secure beds. This will on average over the life of the plan provide £155,159 per community placement to be invested in the full range of services needed to support these patients. This investment is in addition to the current baseline level of community service provision.

## 7.4 Capital Funding

To enable the changes in community provision necessary to allow the transfer of patients from inpatient to community settings we estimate there will need to be capital funding of £5m. A profile of spend of this £5m is being worked on and it is anticipated that this will need to be available in 2016/17 and 2017/18. An exact split will be determined later this year. The money would be used primarily for recoverable grants to approved specialist housing providers to compensate for the following features of supported living accommodation for people with this profile of need:

- Robust environmental adaptation to provide safe environments for the person, their support staff and other visitors with features such as concealed heating, assistive technology such as overrides on hot taps or other controls, toughened or one-way glass, sound-proofing, non-barricadable doors, bathrooms with no ligature points. These high-cost adaptations are not eligible for Disabled Living Facilities grants and detract significantly from the resale value of properties.
- Low density of housing with more than average-sized gardens, providing private exercise space and greater distance from neighbours. This low-density reduces the development yield.
- Some housing providers have accessed alternative capital funding which has enabled us to proceed with some supported living 'plus' developments. . However, we anticipate that this access to capital could be problematic and there is a need to spread the voids risk by using a range of housing providers, some of whom do not have ready access to capital.
- Increasing difficulty in achieving positive decisions from Housing Benefit Authorities to high rents needed to cover high development costs and the provision of sleep-in rooms and shared areas

Also included within this is capital funding for two locations for crisis accommodation. The development of crisis accommodation will facilitate the reduction in beds in Assessment and Treatment Units. This single-person accommodation would not have a tenancy attached to it to generate rental income so will require a revenue funding stream. It would be developed as a bookable 'hotel' option, staffed by each person's support team when a person needed to move from their own accommodation to reduce risks to themselves or others. The building would be maintained in a ready state as part of a rental agreement, and checked for the need to do any repairs after each stay.

## 7.5 Transition Funding

The plan assumes that £1.68m will be made available to the Nottinghamshire health economy from the £10m national transitional funding. The use of this national funding together with the matched funding in 2016/17 and thereafter is shown on the following table.

**Use of the National Transition Fund in 2015/16 & Match Funding in Future Years**

(This assumes the Nottingham share of the national £10m transition funding is £1.68m)

| | Note | 2015/16 | 2016/17 | Future Years |
|---|---|---|---|---|
| Implementation team | 1 | 105,735 | 211,469 | |
| Workforce Development (staff training, family) | 2 | 250,000 | 250,000 | |
| Improved ICT integration and connectivity | 3 | 350,000 | 350,000 | |
| Advocacy | 4 | 120,000 | 120,000 | 120,000 |
| Community Services expansion and development | 5 | 854,266 | 748,000 | 1,560,000 |
| Total | | 1,680,001 | 1,679,469 | 1,680,000 |

Notes:

1. The implementation team is 1 x band 8b and 3 x band 7 (or local government equivalent) for 18 months commencing in October 2015
2. This includes allowing for backfill for current staff to undertake training, and any increase in commissioning costs to cover provider training
3. To be scoped and progressed with process workstream
4. Covers expansion of advocacy service to employ 3 full time advocates for individuals included within scope
5. Includes the expansion to team roles noted on page 24 of the plan and the investment required to establish crisis facilities, supported living and extending the current step down project which has enabled 8 people to move out of hospital months before they would have otherwise.

## 7.6 Conclusion

The finance and activity plan sets out a trajectory for the closure of in-patient beds and their replacement with community services that will provide more appropriate services for Nottinghamshire residents with a learning disability and/or autism that would currently mean that they are placed in inpatient beds. The key test of the plan is the extent to which the total funding available is adequate to the task of creating high-quality, safe and appropriate services.

# 8 Appendices

## Appendix 1 – Population Data and Trends Expected to 2025

This data has been presented by Nottinghamshire County and Nottingham City as there are differences in populations due to demography between the populations of the two areas.

### Learning Disability – All Types

*Nottingham City*

| Age Band – Predicted Population | 2014 | 2015 | 2020 | 2025 |
|---|---|---|---|---|
| 18-24 | 1,684 | 1,678 | 1,602 | 1,603 |
| 25-34 | 1,223 | 1,223 | 1,252 | 1,245 |
| 35-44 | 920 | 926 | 938 | 983 |
| 45-54 | 841 | 847 | 834 | 793 |
| 55-64 | 606 | 618 | 694 | 750 |
| 65 -74 | 409 | 417 | 466 | 490 |
| 75-84 | 250 | 248 | 254 | 294 |
| Over 85 | 103 | 103 | 114 | 125 |
| **Total population aged 18-64 predicted to have a Learning Disability** | **6,035** | **6,059** | **6,153** | **6,284** |

*Nottinghamshire County*

| Age Band – Predicted Population | 2014 | 2015 | 2020 | 2025 |
|---|---|---|---|---|
| 18-24 | 1,714 | 1,711 | 1,566 | 1,526 |
| 25-34 | 2,306 | 2,331 | 2,465 | 2,445 |
| 35-44 | 2,469 | 2,439 | 2,367 | 2,518 |
| 45-54 | 2,831 | 2,835 | 2,677 | 2,393 |
| 55-64 | 2,266 | 2,290 | 2,546 | 2,704 |
| 65 -74 | 1,884 | 1,934 | 2,048 | 2,037 |
| 75-84 | 1,009 | 1,030 | 1,199 | 1,466 |
| Over 85 | 378 | 391 | 472 | 584 |
| **Total population aged 18-64 predicted to have a Learning Disability** | **14,857** | **14,960** | **15,341** | **15,673** |

### Learning Disability – Moderate or Severe

*Nottingham City*

| Age Band – Predicted % Change from 2014 | 2015 | 2020 | 2025 |
|---|---|---|---|
| 18-24 | 0% | -4% | -3% |
| 25-34 | 0% | 2% | 2% |
| 35-44 | 1% | 2% | 7% |
| 45-54 | 1% | -1% | -5% |
| 55-64 | 2% | 15% | 23% |
| 65 -74 | 2% | 13% | 19% |
| 75-84 | -1% | 1% | 17% |
| Over 85 | 0% | 9% | 19% |

| | | | |
|---|---|---|---|
| **% change in population predicted to have a moderate or severe Learning Disability** | **0%** | **2%** | **4%** |

*Nottinghamshire County*

| Age Band – Predicted % Change from 2014 | 2015 | 2020 | 2025 |
|---|---|---|---|
| 18-24 | 0% | -8% | -9% |
| 25-34 | 1% | 7% | 6% |
| 35-44 | -1% | -4% | 2% |
| 45-54 | 0% | -6% | -15% |
| 55-64 | 1% | 13% | 19% |
| 65 -74 | 2% | 7% | 7% |
| 75-84 | 2% | 18% | 44% |
| Over 85 | 3% | 23% | 51% |
| **% change in population predicted to have a moderate or severe Learning Disability** | **0%** | **2%** | **3%** |

### Autistic Spectrum Disorders

*Nottingham City*

| Age Band – Predicted Population | 2014 | 2015 | 2020 | 2025 |
|---|---|---|---|---|
| 18-24 | 619 | 617 | 587 | 591 |
| 25-34 | 511 | 508 | 521 | 519 |
| 35-44 | 389 | 394 | 399 | 416 |
| 45-54 | 362 | 365 | 359 | 347 |
| 55-64 | 271 | 273 | 307 | 332 |
| 65 -74 | 187 | 192 | 216 | 226 |
| 75 and over | 151 | 151 | 158 | 191 |
| **Total population predicted to have an Autistic Spectrum Disorder** | **2,490** | **2,500** | **2,547** | **2,662** |

*Nottinghamshire County*

| Age Band – Predicted Population | 2014 | 2015 | 2020 | 2025 |
|---|---|---|---|---|
| 18-24 | 648 | 645 | 591 | 577 |
| 25-34 | 921 | 933 | 996 | 993 |
| 35-44 | 993 | 978 | 950 | 1,015 |
| 45-54 | 1,204 | 1,206 | 1,127 | 1,003 |
| 55-64 | 997 | 1,003 | 1,109 | 1,179 |
| 65 -74 | 854 | 876 | 921 | 923 |
| 75 and over | 614 | 630 | 750 | 931 |
| **Total population predicted to have an Autistic Spectrum Disorder** | **6,231** | **6,271** | **6,444** | **6,621** |

### Behaviour that Challenges

*Nottingham City*

| Age Band – Predicted Population | 2014 | 2015 | 2020 | 2025 |
|---|---|---|---|---|
| 18-24 | 28 | 28 | 27 | 27 |
| 25-34 | 22 | 22 | 23 | 23 |
| 35-44 | 17 | 17 | 17 | 18 |
| 45-54 | 16 | 16 | 16 | 15 |
| 55-64 | 12 | 12 | 14 | 15 |
| **Total population aged 18-64 with a learning disability, predicted to display challenging behaviour** | **95** | **96** | **96** | **97** |

*Nottinghamshire County*

| Age Band – Predicted Population | 2014 | 2015 | 2020 | 2025 |
|---|---|---|---|---|
| 18-24 | 28 | 28 | 26 | 26 |
| 25-34 | 42 | 42 | 45 | 44 |
| 35-44 | 45 | 45 | 43 | 46 |
| 45-54 | 55 | 55 | 51 | 46 |
| 55-64 | 45 | 45 | 50 | 54 |
| **Total population aged 18-64 with a learning disability, predicted to display challenging behaviour** | **215** | **215** | **216** | **215** |

*Source: Projecting Adult Needs and Service Information (PANSI) and Projecting Older People Population Information System (POPPI)*

## Appendix 2 – National Outcome Measures which relate to this Plan

| Strategic Objective | Adult Social Care Outcomes Framework 2014/15 | CCG Outcome Indicator Set and NHS Outcomes Framework 2014/15 | Public Health Outcomes Framework 2014/15 |
|---|---|---|---|
| Agree and implement a jointly owned pathway / model of care that reflects best practice and maintains people in their community<br>• Move all service users closer to home<br>• Commission early intervention services to provide 24 hours supported living outreach to people wherever they reside<br>• Improve pre-crisis responsiveness through development of an early warning score and escalation protocol for learning disabilities | 1E Proportion of adults with a learning disability in paid employment<br>1G Proportion of adults with a learning disability who live in their own home or with their family<br>1I Proportion of people who use services and their carers, who reported that they had as much social contact as they would like* | <u>Domain 1</u><br>• Reducing premature deaths in people with learning disabilities (measure in development for future years)<br><br><u>Domain 2</u><br>• Health related quality of life for people with a long term mental health condition<br><br><u>Domain 4</u><br>• Responsiveness to in-patients' personal needs NHSOF4.1<br>• Patient experience of community mental health services NHSOF 4.7<br>• Improving people's experience of integrated care (measure in development for future years)<br><br><u>Domain 5</u><br>• Patient safety incidents reported NHS OF 5a | <u>Improving the wider determination of health</u><br><br>1.6 Adults with a learning disability / in contact with secondary mental health services who live in stable and appropriate accommodation<br><br>1.8 Employment for those with long term health conditions<br><br>1.18 Social isolation |

## Appendix 3 – Public Health England Statistics (2013/14 data)

Compared with benchmark

| Better | Similar | Worse |
|---|---|---|

| Lower | Similar | Higher |
|---|---|---|

| Indicator | England | Nottingham City | Nottinghamshire County |
|---|---|---|---|
| Population | | | |
| Learning Disability QOF Prevalence (18+) | 0.5 | 0.5 | 0.6 |
| Adults (18 to 64) with learning disability known to local authorities | 4.3 | 4.3 | 5.3 |
| Children with Moderate learning difficulties known to schools | 15.6 | 8.2 | 6.3 |
| Children with Severe Learning Difficulties known to schools per 1,000 pupils | 3.73 | 3.66 | 2.38 |
| Children with Profound & Multiple Learning Difficulty known to schools per 1,000 pupils | 1.27 | - | 1.00 |
| Children with autism known to schools per 1,000 pupils | 9.1 | 13.5 | 10.5 |
| Health | | | |
| Proportion (%) of eligible adults with learning disability having a GP health check | 44.2 | 41.2 | 52.0 |
| Accommodation and social care | | | |
| Adults with learning disabilities in settled accommodation | 74.9 | 64.8 | 73.0 |
| Adults with learning disabilities in non-settled accommodation (%) | 21.7 | 34.6 | 24.4 |
| Adults with learning disabilities living in accommodation whose status is unknown to LA (%) | 3.38 | 0.55 | 2.54 |
| Adults with learning disabilities living in severely unsatisfactory accommodation (%) | 0.25 | 0.00 | 0.20 |
| Adults with learning disabilities in employment | 6.7 | 1.6 | 7.2 |
| Adults with learning disabilities receiving direct payments (%) | 30.5 | 28.6 | 38.9 |
| Rates of referral for abuse of vulnerable person per 1,000 | 109.3 | 40.2 | 74.5 |
| Co-ordination and local planning | | | |
| Comparison of LA and QOF prevalence estimates | -0.1 | -0.2 | -0.1 |
| Comparison of pupils with learning difficulties and LA prevalence estimates | 80.2 | - | 46.2 |
| Comparison of pupils with severe and profound and multiple LD and LA prevalence estimates | 13.5 | - | -0.4 |
| Adults using day care services supported by the LA (per 1,000 people) | 323.7 | 329.7 | 380.9 |
| Adults receiving community services supported by local authorities (per 1,000 people with learning disabilities) | 754 | 654 | 652 |
| Children with learning disabilities known to schools per 1,000 pupils | 20.6 | - | 9.6 |
| LA gross current expenditure relating to residential personal and social services for adults | £22,165 | £16,507 | £25,844 |

Source:Public Health England, Learning Disabilities Profiles
http://fingertips.phe.org.uk/profile/learning-disabilities

**Appendix 4 – Survey of Individuals and Family Carers**

# Survey for Individuals and Family Carers

# Nottinghamshire Fast Track Area

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# Nottinghamshire Fast Track Project

## 1. Purpose

The purpose of the project is to identify the needs, current provision and changes that need to be made to ensure individuals in Nottinghamshire with Learning disabilities and / or autism are supported within their local community. Views are needed from family carers of those who use the services to influence and develop the services and shape the future. Alongside this project, we will look at the individuals who use the services with Learning Disability and Autism.

## 2. Scope

Project to undertake the views of family carers' and individuals with Learning disabilities and / or autism who are or have been in inpatient services between April – July 2015 funded by Nottingham City or County CCG's.

## 3. Process

A survey to be developed and information collected by phone from family carers of individuals who have been in inpatient services between April – July 2015 and who have undergone a Care and Treatment Review. Information was taken from individuals directly during the review process.

## 4. Time Scale

Data will be collected and analysed for particular themes and this information sent to the Fast Track Program Board by the 4th September 2015 ready for submission of the bid on the 7th September 2015.

## Project 1: Family Carers

In regard to family carers, key lines of enquiry were followed around the following headings:

- Community support
- Training needs
- Alternatives to admission
- Communication
- Care and Treatment
- Discharge Planning

Community support

1. Prior to admission to hospital do you feel there was adequate support in the community?

   *E.g. ICAT team, Social work input, Support from GP / Psychiatry*

All of those that mentioned the ICAT team said they were a good support but all also felt that the out of hours support was poor, this included residential care. One family carer said, "The social worker only works part-time. The home doesn't have anyone available at weekends and untrained staff have to get on with it. If I could sue the Home/company I would. They said they could take care of my son but they employ carers, a cheaper rate than support workers."
No one highlighted either GP or psychiatry support.

2. Do you feel there is a nominated person that you can always go to should you need help?

   *E.g. Social worker who keeps the case / Community care officer/ Care coordinator*

There was a mixed response, some individuals stating yes others no. Some highlighted their Social Worker as the first port of call, others the Manager of the service. One individual refused to respond.

Training Needs

3. Is training offered to you to meet the needs of the person you care for?

   *E.g. Training in positive behaviour support*

One individual refused to respond. All others stated they had never been offered any training. They were just "left to get on with it."

4. Was there any offer of support groups or similar?

One individual refused to respond. All the others stated they had never been offered any support groups or similar. The majority thought it would be useful to share their experiences with families in similar situations.

Alternatives to admission

5. If there was a service / crisis bed available (not hospital) instead of hospital admission would this have been more appropriate?

   *Was a change of environment needed? Was an increase in the support package required?*

Most of the individuals thought that a crisis / respite bed would have been a better alternative. One refused to answer and two felt there was no option other than hospital.

6. Did you have a quick response when you felt that the situation was changing which led to the admission?

   *Community nurse visit / GP visit*

Though the ICAT team were spoken of in a very positive way the consensus was that the response to the deteriorating situation was poor.

Communication

7. Did you feel that throughout the admission process and when an inpatient that you were communicated with effectively?

   *If there was information that was sought was it given in a timely manner and in a way that you could understand?*

There was a mixed response in regard to communication from very good to very poor. Those that had good communication asked questions and requested necessary information.

8. Do you feel your voice is heard?

   *Would you be interested in being part of a Focus Group?*

There was a mixed response with half the group saying they felt listened to and the other half not. Most carers responded positively to the idea of a support group with the focus on future services. One did not respond and one said they needed to put pen to paper to get their voice heard. One individual stated that their social worker did not listen to them and the only time their voice was heard was at a MDT (Multi-disciplinary meeting) or a CTR (Care and Treatment Review).

9. Would you know where to go and how to raise concerns

*During the hospital stay were they made aware of complaints procedure?*

One individual stated they would not know who to complain to, though everyone else said they did. These did vary though from the Manager, CQC to the Social worker.

One individual stated that they had made a complaint but when she spoke to the manager two weeks later the manager stated she was not aware of the complaint.

<u>Care and Treatment</u>

10. How did you rate the care and treatment while an inpatient

*Any concerns or worries over restrictions placed on the individual?*

One individual stated that they did "not know what was done in these places" and a leaflet would be useful. Two did not comment. One individual commented that she only saw her relative in the visitor room so did not know what the environment was like. Another individual rated the service as 6 out of 10 as there were some poor practices namely wearing other people's clothes and staff did not treat the patients as individuals.
A further carer said, "I would rate the care and treatment between 5-6 out of 10 when the patient was first admitted, they did nothing and she might as well have been at home. The patient wasn't eating and I had to come and feed her"

11 Did you feel that as an inpatient it was a Safe Environment?

*Any problems with other individuals?*

One individual said that her sister was attacked. One said that the doors were locked. All others felt they were safe.

Discharge Planning

11. Were you involved in the whole process?

    *Were your views listened to?*

There was a mixed response, some felt their voices were heard others that decisions were made without taking their views into account. One individual stated "There is one choice, nothing else. That's no choice at all".

12. Did you have opportunity to give your views on what sort of service or support you felt was needed if appropriate?

    *E.g. All male service / in a group setting*

Though a few stated that they did feel listened to one individual stated "Going into hospital was traumatic for the patient and did not help her recovery. There's nothing else and things have not changed much post-Winterbourne and it's a long way off being right".

## Conclusion

**Community support:** An analysis of the information indicated that out of hours seemed to be where most of the problems occur. The staff teams are less skilled and generally weaker with poor support from managers.

**Training needs:** One of the main conclusions that can be drawn from this piece of work is that some families do not feel supported or at times equipped to carry out their role as a carer. They have been offered no training in supporting those they care for and at times struggle with the enormity of it all.

**Alternatives to admission:** There was a positive response to the concept of a crisis / respite bed. It has been recognised that changing the environment can often lead to a change in behaviour and this may allow family carers time to reflect and recharge their batteries, especially after a crisis.

**Communication:** The services which those surveyed have experienced have fallen short of the family carers expectations with communication being one of the biggest issues. It appears that those who ask questions and make themselves heard do well whilst those who rely on the professionals to inform them of changes and decisions being made fall

short. As all the individuals were not sure whom complaints should be addressed to is a concern and that a complaint was not responded to was even more so. The area of discharge planning was also inconsistent.

**Care and Treatment**: Whilst appreciating that many of the inpatient environments may not be suitable for visitors there does need to be more openness in what happens in the service, whether this be information in writing along with staff spending time with relatives. As stated earlier there are differences in experiences, which should be consistent for all.

## Project 2: Individuals

In regard to individuals, they were asked the following questions:

1. What's important to me now?

Family: Those with a family highlighted very firmly that they were important to them and that they liked to have regular contact. This meant living in a place that enabled visiting their family and their family visiting them.
Possessions: The majority of patient's felt that their possessions were important to them. They took into consideration their possessions in regard to where they might live and expressed a wish for them to be also accommodated. Though most patient's had few possessions beyond CD player, TV etc. they specifically enjoyed talking about how important their possessions were.
Activities: The majority of individuals mentioned enjoying music and most activities that were suggested involved their possessions, e.g. CD collection. Few community activities were reported, possibly due to a lack of access in inpatient facilities.

2. What's important to me in the future?

All individuals who had a family said that contact was important and being close by was preferred. Many patient's talked of going to college or finding work. One individual stated they would like "to do voluntary work and help other people". Meaningful activity that gave people a sense of worth seemed very important along with structure and a sense of safety.

3. What staff support would be needed? Type of person, age, sex.

The analysis showed a mixed response. Some individuals wanted staff of the same sex and age and others not specifying any preference. Some individuals reported that they would particularly look for staff with similar interests to themselves. There was a sense that individuals were looking for people to spend their time with who would enjoy the same things, possibly fulfilling the role of a friend/peer in the absence of this network.

There was also comment in regard to the staff being well trained and understanding their needs, as well as being patient and caring. Some individuals reported that they would like regular staff and staff that would stay for the long term. One individual said, "staff must be well trained in supporting me having my angry behaviour."

4. Who would I like to live with?

There was a mixed response, some patient's wanting to live alone and others with groups of people. No one said they would like to live with large groups of people. Of the individuals that stated that they would like to live with others, they all said that they would need their own space and their own staff.

5. My home. What would it look like? What would be important?

The first two questions concerning what is important now and in the future very much shaped the answer to this question in regard to space and vicinity to amenities. No one said that they would like to move away from the area that either their family lived, or an area that they were familiar with. There was a range of answers though, some described a house with a garden, others a flat, others in shared living facilities. There was a strong feeling that a "normal" house in a "normal" community was important.

6. What barriers might there be to stop this happening?

There was some understanding that the individuals themselves could be a barrier preventing discharge, and there was insight to understand that they were working towards goals to make discharge happen. There was some fear around change and individuals were given coping strategies in dealing with these changes. There were a couple of individuals on a section 37/ 41 so the Ministry of Justice needed to be satisfied that the discharge was safe.

**Conclusion**

**Person centred:** The analysis of the information confirms our thinking that support in the community for individuals with Learning Disabilities and Autism needs to be Person Centred, helping individuals create a life that is specific to them.

**Quality of life:** Quality of life should be seen as a goal for individual support but also as a strategy to support individuals to live meaningful and purposeful lives. A Positive Behaviour Support Plan would focus services on this aim.

**Ordinary life:** There is no one model of accommodation that fits all. There needs to be a range of services commissioned but all within

"normal" community settings to allow for integration and social inclusion in the wider community, especially to facilitate family life.

**Specialism:** Many individuals recognise their role in achieving discharge and successful community living, however clearly services need to have the right expertise to support a diverse range of people and needs. In particular any shared accommodation needs consideration as to whether the group will live well together. This is especially if there are any shared staff. Many individuals find sharing attention difficult.

Many of the individuals surveyed have very complex needs with risky / challenging behaviours. The staff group supporting them will require a different skill set for different individuals according to that need.

The training and support of staff should be viewed as the responsibility of all involved and multi-layered, focusing on key skills in each layer. Positive Behaviour Support training would be the model of choice for this client group. The training should include therefore Commissioners (Local authority and Health), voluntary organisations, providers, clinicians, direct care staff and family supports. This should up skill the community staff (knowledge and skills) to provide robust packages of support with additional expertise brought in as required. This may go some way to reduce the staff turnover that many providers face and that the individual's themselves report as a challenge to maintaining positive and productive lives.