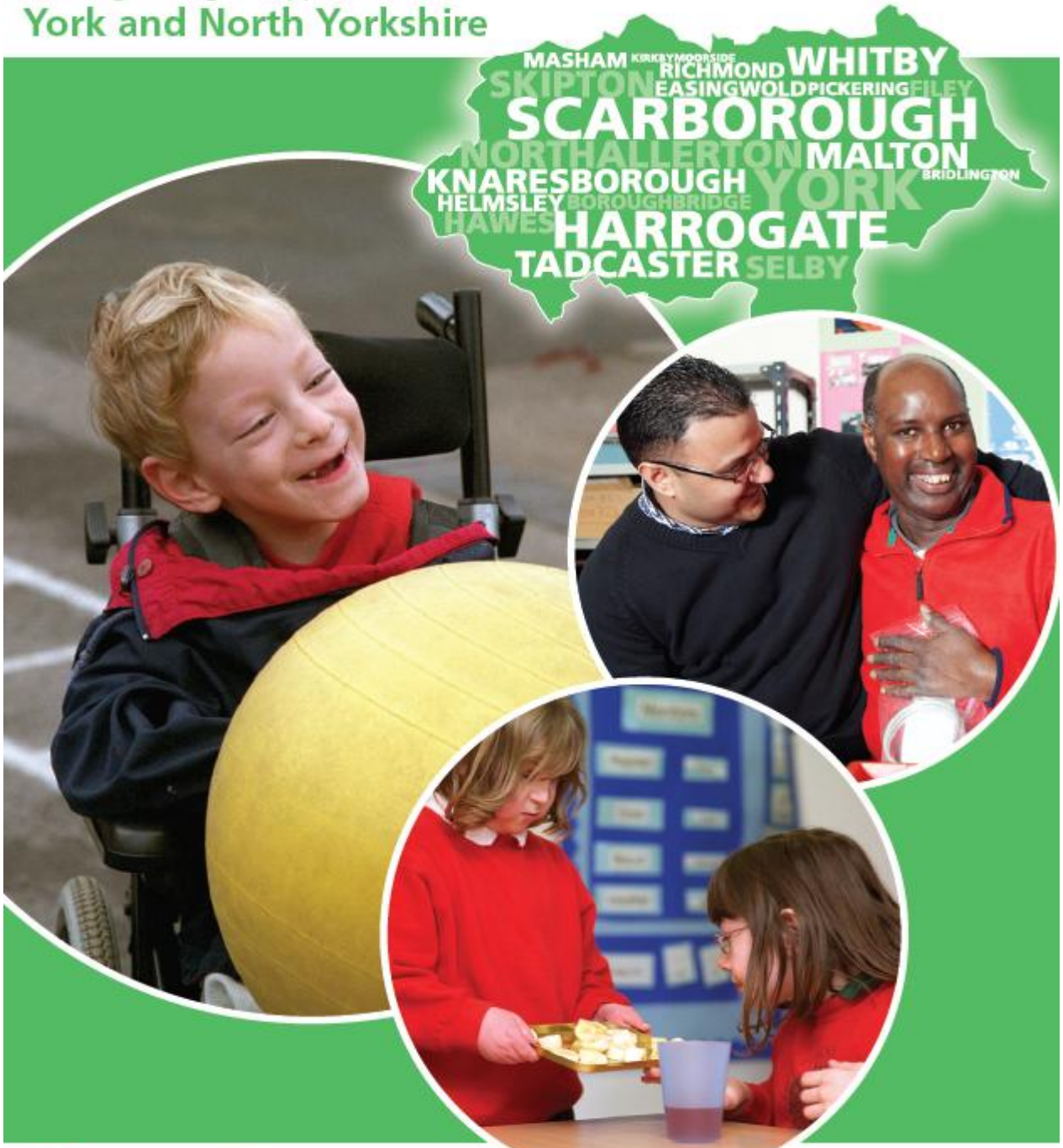
ANNEX 1

Partnership Commissioning Unit
Commissioning services on behalf of:
NHS Hambleton, Richmondshire and Whitby CCG
NHS Harrogate and Rural District CCG
NHS Scarborough and Ryedale CCG
NHS Vale of York CCG

Building the right support across York and North Yorkshire



CITY OF YORK COUNCIL

North Yorkshire County Council

ANNEX 1

Joint transformation planning template

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

Introduction

- **Purpose**

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

- **Aims of the plan**

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

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

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

- **National principles**

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

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

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

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

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

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

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

Summary of the planning template

Planning template

1. Mobilise communities

Describe the health and care economy covered by the plan

The North Yorkshire and York health and social care economy comprises of four main CCGs, who commission services for a total population of 756 thousand :

- Hambleton, Richmondshire and Whitby CCG
- Harrogate and Rural District CCG
- Scarborough and Ryedale CCG

ANNEX 1

- Vale of York CCG

The four CCGs are supported by one Partnership Commissioning Unit for all vulnerable patients: which includes Adults and Children with Learning Disabilities / Autism. The prevalence of Learning Disability is 3700 and Autism is 7500.

There are two main Local Authorities

- City of York Council
- North Yorkshire County Council

Budget 2014/15 – Social Care

In 2014-15, North Yorkshire County Council spent approximately £45.6 million on social care provision for people with a learning disability which represents 30% of the overall Adult Social Care Budget. This figure excludes funding received from the NHS under Continuing Health Care, and expenditure relating to supported employment.

Budget 2014/15 – Health

The total number of vulnerable adults with a learning disability aged 18-64 who are in receipt of healthcare services and are funded by North Yorkshire-based NHS Clinical Commissioning Groups is 38, representing a total cost in the region of £3.3 million (average cost per patient £86,000). Of this amount, approximately £1 million is shared funding with North Yorkshire County Council Adult and Social Care.

There are approximately 400 patients with a learning disability receiving a Continuous Health Care (CHC) package in North Yorkshire, representing a total cost of approximately £22 million (average cost per patient £56,000) – of which £10 million is joint funded.

Within the Transforming Care Partnership (North Yorkshire and York) there is one main statutory health provider of Learning Disability which is Tees Esk and Wear Valley NHS Foundation Trust.

There are no independent commissioned hospital placements in the area however there are out of area independent commissioned placements.

Building the Right Support and The National service model is for all health and social care commissioners – not just learning disability commissioners; in particular, this includes mental health commissioners, Continuing Health Care (CHC) commissioners, public health and children's commissioners. It covers the full range of commissioning – strategic, operational and individual/micro commissioning. The table below provides a broad overview of the health and social care commissioning arrangements; from block contracts to individual commissioned services: there are a number of wider stakeholders/ services which support the health and social care economy such as education /employment support and housing support not identified on the table.

ANNEX 1

Service	Commissioners	Provider Organisation and Service Description
Learning Disability Services		
Inpatient Learning Disability Services	Harrogate and Rural District CCG, Hambleton, Richmondshire and Whitby CCG, Scarborough and Ryedale CCGs via block contract arrangement commissioned by PCU Vale of York CCG	**Tees Esk and Wear Valley NHS Foundation Trust** - Access to 4 inpatient beds at Bankfields Court, Middlesbrough under a block contract, not applicable to Vale of York CCG. HaRD CCG has access to 1 contracted bed at Oak Rise in York **Tees Esk and Wear Valley NHS Foundation Trust** - 7 block contracted beds at Oak Rise York
Community Learning Disability Services	As above	**North Yorkshire Learning Disability service and Vale of York Learning Disability Service – Tees, Esk and Wear Valley NHS Foundation Trust** is a community learning disability service with multi-disciplinary health teams covering Hambleton & Richmondshire, Harrogate and Craven, Scarborough Whitby Ryedale and Vale of York. These teams provide support for adults with learning disabilities who have an identified health need. In Scarborough Whitby and Ryedale there is also a children's LD health team which is predominantly nursing with some psychology input. This is historically commissioned from adult resource and not commissioned in its own right.
Specialist Learning Disability Services	NHS England	**Tees Esk and Wear Valley NHS Trust** - We also have access to 10 forensic inpatient beds under block contract commissioned by Specialist Commissioning Group at Roseberry Park, Middlesbrough. Hambleton & Richmondshire and Scarborough Whitby Ryedale have input into their teams from the Forensic Learning

ANNEX 1

		Disability team within Tees Esk and Wear Valley NHS Foundation Trust for assessment and treatment of clients who meet the forensic criteria. Harrogate and Craven team have a contract commissioned through NHS England for up to 12 forensic assessments p.a. only. These 12 community forensic assessments are commissioned by Partnership Commissioning Unit.
CHC	Joint CCG and LA Commissioning Arrangements	Mixture of Social Care in-house provision and a wide range of independent and 3rd sector organisations providing residential care, supported living, day and respite care. 24 people access health Personal health budgets
Social Care Learning Disability Services (including Independent and voluntary sector)	Adult Health and Social Care and Children and Young People – North Yorkshire County Council* and CYC (*also covers Craven area as part of Airedale Wharfedale and Craven CCG boundaries)	Commissioning arrangements differ with a mixture of in-house provision and a wide range of independent and 3rd sector organisations providing residential care, supported living, day and respite care. In City of York there are 86 adults who have a direct payment or personal health budget. In City of York there are 13 specialist providers (13 including CYC in-house services) who provide supported living and / or day activities. Home care providers also provide support to some individuals. In North Yorkshire there are Supported Living 26 providers and 28 LD Residential/Nursing providers. Additional to social care provision, Advocacy services are commissioned by the local authorities. We have not listed all Independent and voluntary sector as LA have a comprehensive list, such as UBU, Keyring etc.

ANNEX 1

Mainstream Health Services		
Primary Care Services	NHS England	82 GP Practices in North Yorkshire and York (excluding Craven) Pharmacies Dental Practices Optometrists
Community Services Secondary Care Mental Health Services Acute Hospital Services Ambulance Services	Harrogate and Rural District CCG, Hambleton Richmondshire and Whitby CCG, Scarborough and Ryedale CCG, Vale of York CCGs (NB. MH commissioned by PCU under block contract arrangements	***NHS Acute Hospital Services*** Friarage Hospital, Northallerton Harrogate Hospital Scarborough Hospital York Teaching Hospital ***NHS Mental Health Services*** TEWV ***NHS Ambulance Services*** YHA

Relationships and Boundary issues:

There are some small 'boundary' overlaps as Vale of York CCG also covers the Pocklington area which comes under East Riding County Council and North Yorkshire County Council covers the Craven area of the region which comes under the jurisdiction of Airedale, Wharfedale and Craven CCG. For the purposes of the North Yorkshire and York TCP, Pocklington and Craven have been omitted.

Both health and social care providers have good relationships with commissioners and regular events/ meetings ensure consistency in services, and stimulate developments. These arrangements are in place in line with contractual agreements.

Tees Esk and Wear Valley NHS Foundation Trust have recently been commissioned (October 2015) to provide all health Learning Disability services, both inpatient and community for the 4 CCGs. This should assist in the transformation process and reduction of inpatient beds and development of community services. We acknowledge that access to four beds in a neighbouring borough of Middlesbrough is outside of the TCP, and considerations will be made with regard to this in the redesign of services.

Children and young people services are commissioned separately to Learning Disability services; however there are close working relationships between commissioners due to being located in the Partnership Commissioning Unit.

ANNEX 1

Describe governance arrangements for this transformation programme

Governance arrangements are in place with identified leadership and support functions.

The team to oversee the work will be:

- The Senior Responsible Officer for the Transforming Care Partnership is Simon Cox, Chief Officer, Scarborough and Ryedale CCG
- The Deputy Senior Responsible Officer for the Transforming Care Partnership is Kathy Clark, Assistant Director, Health and Adult Service, North Yorkshire County Council.
- Project management from Partnership Commissioning Unit

The North Yorkshire and York Transforming Care Partnership Building the Right Support Governance Framework has been designed to ensure clear communication and governance channels between the local North Yorkshire and York Health & Wellbeing Boards and Partnership Commissioning Unit Management Board (Harrogate and Rural District CCG, Hambleton Richmondshire and Whitby CCG, Scarborough and Ryedale CCG, Vale of York CCG), North Yorkshire County Council and City of York Leadership / Executive Teams. This will give scrutiny and oversight, leadership and advice, supporting development of resolutions.

This will ensure that the North Yorkshire and York Transforming Care Partnership and the North Yorkshire Learning Disability Partnership Board and City of York LD Forum work in partnership, and has linkage/alignment to other programmes:

- The Care Act
- HWBB 20:20 Vision
- Crisis Care Concordat
- Future in Mind
- Local Strategies: Autism, Mental Health and Young & Yorkshire

Whilst also reporting and assuring progress to the NHS England Transforming Care Yorkshire &Humber Regional Group. The North Yorkshire and York Transforming Care Partnership are committed to the following responsibilities:

- To be actively involved in the co-production and commissioning of service redesign and strategic development across North Yorkshire & York to reduce in-patient beds
- To seek wider consultation on challenges and solutions at an organisational level
- To represent organisations, their views and solutions and challenges
- Demonstrate quality assurance to partners and families that services commissioned are meeting the required standards, meeting people's needs, treats people with dignity and respect and allows people and their families to be active partners in their care
- Possess power and authority to act – clinical leads have responsibility to communicate to the group on other internal organisational governance and processes that may act as

a 'barrier to change'

- To ensure co-production is integral in the production and development of the plans/services. "Shifting power to people with learning disabilities / and or autism and their families."

It is acknowledged Experts by Experience are not part of this group, as Transforming Care Partnership Board will be aligned to LD / Autism partnership boards and co –production arrangements.

Please see attached 'Terms of Reference' to understand Transforming Care Partnership membership, objectives and responsibilities. The supporting 'Governance Framework' visual illustrates how the Transforming Care Partnership is integrated within our wider local health and social care system. It also shows how local users of services are represented within this governance framework via the Learning Disability Partnership Board and Forum.


TCP ToR.docx


TCP BTRS Governance Framewc

Please see 'Section 5 – Delivery' to then understand how our various Building The Right Support work-streams feed into this governance structure.

Describe stakeholder engagement arrangements

Governance arrangements:

The governance arrangements/terms of reference (see attached above) for the North Yorkshire and York Transforming Care Partnership provides details of membership and thus some of the local stakeholders that are and will be involved in Building The Right Support planning/implementation. There is a well-established membership of stakeholders who have been involved in delivering the 'Transforming Care' agenda in recent years. Current membership is core as a "development" group however will grow to include wider stakeholders, as part of the development and transformation process. Wider membership has been identified: to include Estates/ Housing, Finances, other organisations: Police, Criminal justice system, voluntary sector/ Advocacy. The North Yorkshire and York Transforming Care Partnership will be aligned to the co-production group/ Partnership groups, with an aim to ensure co –production throughout transformation.

Partnerships:

Stakeholder engagement is strong in many areas; Both within LD health and social care and mainstream services. We will continue to develop our partnerships with acute hospitals, community health teams and primary care to ensure that the physical and mental health needs, of the cohorts we are planning for, can be well met with joined-up / integrated support, to make reasonable adjustments and produce a skilled workforce. This will include workforce development plans being in place to address skills required to develop strategies/interventions for supporting people with behaviours which might be perceived as challenging for these mainstream settings. This has been an active process for several years in line with self-assessment framework and there are two active Self Assessment Framework improvement

plans jointly held by CCG and Local Authority and accountable to the LD Partnership boards.

We are committed to developing stakeholder engagement and good communication across the Transforming Care Partnership, however we recognise that some relationships are more mature, and have been developed over time, whilst others require more development. Good examples include recent Provider Social care events, (three events in the past year) and Learning Disability Partnership Boards participation in consultations.

Our aim will be to build on these and ensure all work streams have strong stakeholder engagement. To achieve this we will expect providers of all types (inpatient and community-based; public, private and voluntary sector) via the Transforming Care Partnership to be involved in the development of one engagement plan across both providers and commissioners. This will be co-produced by people with direct experience of using inpatient services and experts by experience.

Discussions are ongoing with Local Authority specialists in Housing and Education – with the requirement to involve all appropriate partners and explore the 'practical' implication of working through gaps/problems in order to ensure realistic and meaningful participation. We will be extending this to other statutory services, as required, through our engagement plan and work streams.

Finally, in terms of the professional stakeholder landscape, we will also have strong links with our regional NHS England Specialist Commissioning colleagues and the regional Transforming Care team throughout this process.

In line with engaging a wide range of people/stakeholders: The Joint health and social care Learning Disability Strategy for North Yorkshire has recently been out to consultation and will be implemented from May 2016. This strategy is aligned to the principles within Building the Right Support, and has been to LD Partnership Boards for comment and consultation.

With regard to 'non-professional' stakeholder engagement, i.e. those stakeholders with lived experience of services, including their families/carers (Experts by Experience), extensive engagement programmes and relationship building is delivered on an ongoing basis via 'formal' arrangements with the local Learning Disability Partnership Boards and Local Area Groups in North Yorkshire; with specific health-related agenda items being driven by a spin off 'Health Task' Group.

Additionally we need to give consideration to assisting Carers to feel more empowered and skilled, and as such, will ask our NHS Providers to work with us as commissioners to ensure inclusion in skills training. To ensure that we support people well, we recognise that the emotional health and wellbeing of carers requires consideration in respect to the changes we make to planned care pathways. As such, we will work to develop and build on caveats in terms of the need for more frequent short breaks, sitting services holiday spaces to support the often unheard and unrecognised carers' needs.

York's stakeholder engagement comes through the York Mental Health and Learning Disability Partnership Board which has a high level membership and representation from various community groups including a self-advocates group for adults with learning disabilities. The partnership board meets six times a year and in order to be inclusive of people with learning disabilities there is a "LD-focus" meeting twice a year (i.e. two out of the six meetings). The self-advocates group meets monthly and has a broad membership of people with learning

disabilities and representatives from this group are supported to attend the bi-annual "LD-focus" meetings.

Importantly, both frameworks in North Yorkshire and York are supported by self-advocate groups, whom are well networked within the local learning disability community, and are able to both feed into the various 'Boards' and cascade outputs accordingly. As a consequence, our 'reach' within the learning disability community goes beyond those seated around a Board table.

North Yorkshire Learning Disability Partnership Board and York Health Task Group

- Started: North Yorks – 2012 (when four locality boards merged into one Learning Disability Partnership Board) City of York Health Task Group– 2013
- Membership: service users (plus their families and carers), lay members and professionals from social care and health
- Meeting frequency: North Yorkshire Learning Disability Partnership Board - three times annually / York Health Task Group – six times annually
- BTRS Local Plan will be presented/shared for Board and Forum member input, ready for plan re-fresh and re-submission to NHSE by 11 April
- 2016-18 Meeting Programme: 'Building The Right Support planning / implementation / status update' will be added as an ongoing agenda item
- Throughout 2016-18, Building The Right Support Local Plan and Status Updates will also be cascaded via local learning disability and self-advocate networks i.e. Local Area Group (LAG) meetings

Additionally, engagement and co-design activity has been crucial in the development of the North Yorkshire strategies in Autism (published 1 December). Similarly, City of York Council is currently consulting on plans to fully co-produce an All Age Autism strategy and is refreshing their LD Strategy on the basis of recent 'deep dive' activity undertaken with the learning disability community in York.

The North Yorkshire Autism Strategy 2015-2020

The Changing Landscape of Autism in North Yorkshire was launched on 1st December 2015. This is a joint all age strategy between North Yorkshire County Council and 5 Clinical Commissioning Groups, which included the 4 North Yorkshire CCGs. The Partnership Commissioning Unit, on behalf of the 4 North Yorkshire CCGs supported the development of the strategy, the consultation process and final drafting. The plan has been co-produced with children, young people and adults and their families and carers. The strategy was developed with direction from a virtual reference group of people with autism, their families and organisations that work with people with autism. Public consultation was held in the summer of 2015 with five consultation events about the strategy and an online questionnaire survey. The views of people with autism, their families and frontline professionals were reviewed and changes made to the strategy as necessary. A key piece of feedback from the strategy consultation was that the strategy was too long. People said that they wanted a document to sit alongside the strategy that clearly communicated the key ambitions, the vision and what will be different by 2020. Therefore, members of North Yorkshire County Council and the Partnership Commissioning Unit worked with two people with autism to draft a shorter document "The Changing Landscape of Autism in North Yorkshire. The North Yorkshire Autism Strategy 2015-2020 made simple." Both the standard and abridged versions of the strategy contain art work undertaken by the two people with autism who contributed to the "strategy

made simple document."

In addition a "You Said We Did" document has been produced to summarise the changes made to the strategy in response to consultation feedback (currently in design for final formatting) and an Easy Read version of the strategy.

The strategy documents can be found at:

http://www.nypartnerships.org.uk/index.aspx?articleid=22697

The first year strategy implementation plan will ensure the continued progress of the strategy and associated actions required. Moving forwards, implementation plans for years 2-5 will be co-produced with people with autism, their families and carers. The co-production approach will be discussed and agreed moving forward so that expectations are managed and that people with autism are able to be involved and contribute within a framework which meets their needs.

North Yorkshire Learning Disability Strategy – Live Well, Live Longer

A joint local strategy driven by North Yorkshire County Council in partnership with the Partnership Commissioning Unit (working on behalf of the North Yorkshire CCGs) has been in development since May 2015 and is expected to be published in May 2016. The core thinking contained within this draft plan (and the key priorities covered) is based on what local people with a learning disability, their families and carers have told us to date about how their health and wellbeing can be improved and compliments Building The Right Support planning. A supporting Communications and Engagement Plan is currently being implemented in order to facilitate wide distribution of the draft strategy for receiving further comments from local stakeholders (including provider organisations and staff working in LD) and to boost a formal consultation process.

To date, several 'face to face' engagement meetings via roundtable sessions, Local Area Group meetings, self-advocate and carers' forums have either taken place or are being planned with people with learning disabilities, family members and carers. A 'consultation statement' and standard plus easy read versions of the draft strategy and a short survey have also been made available on NYCC and local CCG websites –

http://www.northyorks.gov.uk/ldstrategy

Self-Assessment Framework

One of the areas RAG-rated red for improvement in NY is to increase the numbers of people with a learning disability into paid employment. Development work has commenced to co-produce a North Yorkshire only employment strategy. (NB. This is not applicable to York as Adult Social Care Outcomes Framework ratings highlight that York is ninth in the country with regard to the paid employment measure in learning disabilities).

Tees Esk and Wear Valley NHS Foundation Trust Engagement Arrangements

Tees Esk and Wear Valley Trust, North Yorkshire Learning Disability service has a focus group in Scarborough, Whitby and Ryedale locality which is Chaired by the Service and has links through the Partnership Board and the regional Local Area Group. Tees Esk and Wear Valley NHS Foundation Trust also has a shadow QuAG – a service quality and assurance group

which is a service user forum focussing on patient experience and governance issues.

The Future: achieving a 'shift in power'…

There is a real need to have a service user reference group across North Yorkshire and York that is truly independent and this is something the Transforming Care Partnership will need to consider going forward in line with the other areas involved with Fast Track – e.g. the North East's 'Confirm and Challenge' Group.

Its envisaged that engagement processes and co-production will continue and strengthen, with an aim to shift the power to people with Learning Disabilities and / Autism, by listening and responding to people's needs and views; and the delivery of these 'golden threads'

- Improving Quality of life – people should be treated with dignity and respect. Care and support should be personalised, enabling the person to achieve their hopes, goals and aspirations; it should be about maximising the person's quality of life regardless of the nature of their behaviours that challenge. There should be a focus on supporting people to live in their own homes within the community, supported by local services.

- Keeping people safe – people should be supported to take positive risks whilst ensuring that they are protected from potential harm, remembering that abuse and neglect can take place in a range of different environments and settings. There should be a culture of transparent and open reporting, ensuring lessons are learned and acted upon.

- Choice and control – people should have choice and control over their own health and care services; it is they who should make decisions about every aspect of their life. There is a need to 'shift the balance of power' away from more paternalistic services which are 'doing to' rather than 'working with' people, to a recognition that individuals, their families and carers are experts in their own lives and are able to make informed decisions about the support they receive. Any decisions about care and support should be in line with the Mental Capacity Act. People should be supported to make their own decisions and, for those who lack capacity, any decision must be made in their best interests involving them as much as possible and those who know them well.

- Support and interventions should always be provided in the least restrictive manner. Where an individual needs to be restrained in any way – either for their own protection or the protection of others, restrictive interventions should be for the shortest time possible and using the least restrictive means possible, in line with Positive and Proactive Care.

- Equitable outcomes, comparable with the general population, by addressing the determinants of health inequalities outlined in the Health Equalities Framework. The starting point should be for mainstream services, which are expected to be available to all individuals; to support people with a learning disability and/or autism, making reasonable adjustments where necessary, in line with Equality Act legislation, with

access to specialist multi-disciplinary community based health and social care expertise as appropriate.

How we go about 'realising' this future and achieving a genuine shift in power is outlined in more detail in the section below…

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

Please see above response to 'Stakeholder Engagement Arrangements' which captures top-line details of activity done to date and future opportunities for co-production with people with learning disabilities and/or autism, their families/carers.

The North Yorkshire draft Learning Disability Strategy is very much aligned with Building The Right Support' nine principles and a co-production programme is ongoing in relation to 'Live Well, Live Longer.' We have undertaken 'face to face' consultation with the local Learning Disability Partnership Board to gain their thoughts and input and North Yorkshire Health Task Group. We will ensure people with autism are targeted in line with the vision for autism which is described in the co-produced North Yorkshire Autism Strategy.

We will continue to foster and grow our existing relationships and networks in learning disabilities and autism in order for 'Building The Right Support Planning and Progress' to become an embedded agenda item in all our Learning Disability Partnership Board meetings and other relevant groups' meeting schedules so that it becomes a 'natural' part of our ongoing discussions and relationships within our local learning disability community.

We are clear that when we talk about co-production, we mean how services and local people can work together in a genuine partnership to design and deliver services and support. It is definitely not just asking people what they think.

Our aim will be to ensure that co-production is part of a new Communications and Engagement Plan. This will include

- Agreement of the principles of co-production with the main aim being achieving a 'shift in power'
- Using current and developing new networks.
- Identifying shared roles and partnerships in key /specific pieces of work /work streams
- Ensuring leadership from experts by experience
- Challenging the way we deliver services
- Ensuring co-production arrangements are ongoing and meaningful over the next three years whilst implementing the Building The Right Support Plan
- Targeted work to ensure involvement of children and their Families

We are aware to truly engage people in co-production we will need support from other agencies. Considerations will be required to understand the level of support required for individuals and groups to actively participate. This may be support prior and within a group, learning new skills and /or help with transportation. We have some established partnerships with Inclusion North and Keyring, and York People First. Our aim would be to establish a task

and finish group, to develop an engagement strategy and plan for people within all cohorts including people with communication difficulties/ mental health and behaviours which challenge services.

Recognising and overcoming co-production challenges, and realising the future

The 5 Cohorts – as detailed, in North Yorkshire and York we have well established relationships, mechanisms and community networks in place with the broader population of people with learning disabilities and their carers. This ensures that we have good links and two way communication, which can be built on, and ensure we co-produce from the start of our journey together. Indeed, Building The Right Support planning has already been presented and shared as an agenda item at recent Partnership Board meetings in North Yorkshire and York so we have started the journey of communicating Building The Right Support key messages with the wider community.

However, in order to ensure our Building The Right Support co-production activity is truly meaningful, we plan to examine how we best engage and co-produce specifically with those of all ages from the '5 Cohorts' affected by Building The Right Support planning. Due to the complexity of these cohorts and resulting challenges with respect to communication, their voice will often be represented by their family carers and advocates who have their best interests at heart so it is these groups as well as the service users that we will jointly develop the plan with. Therefore, our co-production activity with Building The Right Support will focus on working with service users, family carers and advocates of the 5 cohorts; whilst continuing to engage with and apprise the wider learning disability community of Building The Right Support developments. If we work only with the latter then we run the risk of not hearing and responding to the 'right' voice. By focusing on the pinnacle of the triangle (p24, Fig 9 – national plan), we can ensure that Building The Right Support messages are highly and accurately targeted and that we have a dialogue and working relationship with the right users of services, their family carers and their advocates. We understand the need for early intervention so we will also be working with families of children and young people who could in the future fall within the 5 cohorts.

System Change – Whilst nobody would dispute that co-production is an absolute and must be intrinsic to all our work, we need to recognise that achieving a genuine 'shift in power' will involve significant system change throughout all levels of health and social care organisations. By April 2019, we want to be able to demonstrate clearly the changes that have been made and implemented as a direct result of working with, hearing and responding to the voices of the 'right' users of our services and their family carers affected by Building The Right Support; with a 'You Said, We Did' approach being applied. System change will be achieved by working in partnership with families and advocates, by their involvement in meaningful working groups and processes to ensure they help lead on and guide all the work – and the next two points will help to kick-start this process…

Best Practice – to reach greater heights on the ladder of co-production and go beyond achieving good engagement, we must learn from co-production experts, NHSE colleagues and Fast Track areas (e.g. Greater Manchester) that are recognised as 'leaders' in co-production and replicate wherever possible their work in North Yorkshire and York.

Resourcing Leaders and Experts in Co-Production – dedicated expert leadership and resource will be needed to ensure co-production is at the heart of our local plans. Inclusion

North is a recognised leader in this area and North Yorkshire County Council is a subscribed member. We are looking at how we consolidate work already undertaken and further develop working relationships with Advocacy groups so that we can co-produce specifically with the 'right' children and adults with a learning disability and/or autism affected by the plan. Additionally, within the Partnership Commissioning Unit links have been established with the Sussex MSK Partnership and their pioneering work which has resulted in having a 'Patient Leader' at Director level. Expanding our work programme with Inclusion North and consideration of having a co-production leader at director level will require additional funding (highlighted within the Finance and Activity template).

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

Any additional information

See finance template attached

Finance and activity 11.4.16.xlsx

ANNEX 1

2.Understanding the status quo

Baseline assessment of needs and services

Provide detail of the population / demographics

CCG population data

CCG area	Total Population with LD	Population with LD 14 -25 years	Population with complex or profound LD	Population with complex or profound LD 14-25 years	Population with LD and Autism	Population with LD and Autism 14-25 years
North Yorkshire	2567	445	171	24	232	99
York	1132	166	119	11	94	30

Total population 18-85 with learning disabilities 2015 (PANSI)	People known to local services age 16-64	In-patient	'At Risk' Register	Total population 18-64 with a learning disability and behaviour that challenges 2015 (PANSI)
11,338 (NY) 3,979 (York)	1,883 (NY) (1,590 currently in receipt of service; does not account for those who fund their own care) 915 (York)	19 (Specialist Commissioned beds) 3 (CHC/VP team)	24 patients on a risk register across North Yorkshire and York.	157 (NY) 59 (York)

There are a total of **2300** people with a learning disability **registered with GP** practices across North Yorkshire and **915** in York. (NB. Reliance on read code searches can result in underestimation of the true number.) There are 7500 people with Autism across North Yorkshire and York

We know from the annual self-assessments we undertake, and the feedback form people with a learning disability and their carers, that we need to improve some areas of health provision e.g. increasing the uptake of annual health checks (and subsequent use of health action plans and where appropriate 'Hospital Passports'), cancer screening and enhanced eye tests. We have

developed a local relationship between the NHS, Public Health, the Learning Disability Partnership Board and North Yorkshire County Council and City of York Council and continue to plan together to improve in these areas.

The self-assessment framework for 2015 for North Yorkshire and York showed:

North Yorkshire

	Red	**Amber**	**Green**
Staying Healthy	4	3	0
Living Well	1	2	5
Keeping Safe	1	3	5

York

	Red	**Amber**	**Green**
Staying Healthy	4	3	0
Living Well	1	1	6
Keeping Safe	1	4	4

The six 'red' areas which require further dedicated work are:

- Improving the accuracy of GP LD registers
- Increasing the uptake of annual health checks and the subsequent generation of health action plans
- Improving the treatment and management of long term conditions (CVD, diabetes, obesity and epilepsy)
- Achieving a 90% annual review rate of all health funded care packages across all life stages (NB. this review rate target is already being achieved by LA partners)
- Supporting people with a learning disability into paid employment
- Systematic collection of data about the number of local people with a learning disability within the CJS

Please note that further work will also be done to quantify how many people are in the various community settings as detailed below, as to date we have incomplete data:

- Residential care (City of York Council figures as of Oct 2015 – 27 in York area, 42 OOA)
- Supported housing (City of York Council figures as of Oct 2015 – 206 tenants)
- Independent living
- Family home with support
- Children in 52 week residential (City of York figures: currently there is only one child with LD in a 52 week residential placement from York. To note this is unusually low, usually there would be an average of 4)

- Understand the population of children under 14 years of age

Our aim in understanding our current population with regard to the cohorts of people with learning disability and /or autism can give a good understanding of care needs and help support the development of current and future services.

The national model describes five cohorts:

- Children, young people or adults with a learning disability and/or autism who have a mental health condition such as severe anxiety, depression, or a psychotic illness, and those with personality disorders, which may result in them displaying behaviour that challenges.

The implementation of this Transforming Care plan will be in parallel with that of the Future in Mind plans. We can show from data collated, the total population for young people with a learning disability aged 14-18 in North Yorkshire is approximately 550. In York, there are 21 known to health services. With this understanding we know we have a group of young people who will require current and future services. The aim will be to identify children and young people who require more complex care, to develop appropriate services around them. On average annually, just over 100 young people will 'move' from Children's Services to Adult Social Care, of whom over a third will have an array of complex needs and will require support with their health needs also. In York there are on average 9 young people who will move from Children's Services to Adult Social Care per annum.

Where appropriate, children and adults with a learning disability and/or autism will receive care and treatment through mental health services for an identified mental health condition. This will need to be factored in to ensure good accessible and responsive services, and joint working for the most complex.

Although low in number, this is an extremely diverse group of people with learning disabilities who often display challenging behaviour and have co-existent mental health problems. They require highly individualised treatment, support and care at an early stage in their life-long care planning to avoid unwanted events and lengthy stays in hospital. In the future, we need to continue identifying those at risk at an earlier stage ensuring their care is proactive, planned and co-ordinated by integrated specialist multidisciplinary teams who work together through a 'Collaborative Care' model. Additionally, to help the shift from a reliance on in-patient care we need to provide more small-scale supported living locally with access to expert and resilient care staff trained and experienced in supporting people with complex needs. With the right preventative services in place in the community, use of inpatient services should be rare and for defined purposes.

- Children, young people or adults with an (often severe) learning disability and/or autism who display self-injurious or aggressive behaviour, not related to severe mental ill health, some of whom will have a specific neuro-developmental syndrome and where there may be an increased likelihood of developing behaviour that challenges.

City of York figures: currently there is only one child with LD in a 52 week residential placement from York. Early intervention targeting these children could reduce high cost placements in the future. Within North Yorkshire there is a steady rise in the numbers of people with a learning disability and autism alongside continued pressure on resources. This means that we need to change what we do and how we do it. We have already started on this journey and have re-shaped some services and decommissioned others (for example day centres and residential care which have been replaced with more personal budgets and more supported living), working

with service users to develop the best solutions for them. This work needs to continue whilst we also encourage the use of universal services by providing support for people with a learning disability to access these services.

The ongoing development of dynamic risk registers across the Transforming Care Partnership will help understand and address care needs more responsively and proactively will be developed. (Approximately 24 are on the at risk registers held by LD teams including inpatients). These individuals, who are generally well-known to services, are in this cohort. They are often in high cost or out of area placements and/or at risk of admission to hospital or an existing inpatient. There are currently 157 (North Yorkshire) 59 (York) adults identified via (PANSI 2015) as having behaviours which challenge.

- Children, young people or adults with a learning disability and/or autism who display risky behaviours which may put themselves or others at risk and which could lead to contact with the criminal justice system (this could include things like fire-setting, abusive or aggressive or sexually inappropriate behaviour).

Once again early detection and intervention is required, identifying the children at a young age and supporting transitions will prove important. Data shows; There are 310 people with learning disabilities who also have autism known to the North Yorkshire local authority. The largest cohort of 162 is age 18 – 34. With reduction in specialist commissioned beds, we will need to ensure this cohort of people are recognised and services are skilled to provide support and accommodation. There are currently 19 people in Specialist Commissioned beds (NHS England Secure Placements)

Again, there are low numbers of local people in secure accommodation with a learning disability or an Autism Spectrum Disorder diagnosis. Based on current experience, around 2-3 people with Learning Disabilities leave secure accommodation each year, and require support to re-integrate into the community. People move out of secure accommodation on the basis of their individual needs, rather than via a stepped approach. For example, people currently in medium secure accommodation maybe ready to move into residential or nursing home placements on discharge. People will have a range of needs in addition to their learning disability, either due to substance misuse, mental health, Autism, ADHD or Personality Disorder.

NHS England is the lead commissioner for this provision and there is no NHS secure forensic accommodation within the North Yorkshire patch. Locally these services are commissioned by the North of England Specialist Commissioning Group, but local commissioners are working with the specialist commissioners to look at more local options for people as part of the Transforming Care programme.

There is a need to work alongside the Police and criminal justice systems, so at an early stage those people with a learning disability who may be at risk of coming into contact with the criminal justice system and support them to stay out of trouble. These individuals should have access to the same services aimed at preventing or reducing anti-social or offending behaviour as the rest of the population. They should also be supported by community 'forensic' services to reduce offending behaviour and the risk they pose to others.

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

which may lead to contact with the criminal justice system.

As stated above a number of these children and Adults will not be known to local authorities, until they come into contact with the criminal justice system. We recognise that during the transitional years /preparing for adulthood some young people may continue in education and training and may move into employment, whilst other young people may need support with housing, transport and developing a social life. This can be a difficult and challenging time for young people and particularly those with a learning disability. We want to ensure that our planning for young people at the point of transition into adulthood is smooth and takes a holistic approach which enables young people to take advantage of wider opportunities that support their aspirations, such as greater independence, employment and accessing social and leisure services in the community.

We know from consultation with young people from the Flying High Group, NYPACT and relevant professionals that our planning often starts too late, is short term and lacks clear outcomes for individuals. Improvements could be made by reducing jargon, being clear on roles and working together. We have responded to this, by establishing a Transition Steering Group of senior officers from Children and Young People Services, Local Authority and Health and Local Transition Groups. These are multi-agency forums in each area of the county, which share information, coordinate assessments and identify suitable pathways into adulthood for young people with complex SEND. We are also continuing to develop a greater range of pathways into adulthood, including local personalised learning for young people post-19 with the most complex needs who would previously have been placed out of county. The next phase is to establish Our Preparing for Adulthood team to build on good practice so that a larger group of young people will not go out of county, can return at an earlier stage and can ensure that the move from transition as a child to becoming an adult is smoother and easier for both the young person and the family. This model will ensure the integration of the work and responsibilities of Children and Young People Services and Local Authorities for young disabled adults. Once staff are in place, and the model is embedded, further work will be undertaken to integrate services from health, housing and leisure, and other relevant agencies. The enhanced support that this model provides will contribute to more efficient planning, reduce costs and improve outcomes for young people with SEND.

- Adults with a learning disability and/or autism who have a mental health condition or display behaviour that challenges who have been in hospital settings for a very long period of time, having not been discharged when NHS campuses or long-stay hospitals were closed.

We are able to monitor admissions and discharges, and with the Care Treatment Review (CTR) process it is easier to support planning, both to prevent admission and support discharge. We aim to reduce inpatient treatment and assessment beds, and provide more robust support in the community. Information gathered in relation to CTRs and risk of admission registers will support better planning and interventions, and reduce out of area placements.

Regular reviews are held for those people who live out of county and everyone who has autism or a learning disability has been reassessed within the last 18 months and where possible and appropriate have returned to North Yorkshire. Our reviews ensure effective safeguarding of people out of county with a learning disability. North Yorkshire County Council regularly reviews any information about safeguarding risks or Care Quality Commission issues, and acts to review

early on anyone where these concerns are identified.

The National Transforming Care agenda provides guidance that there should be 50% of protracted hospital discharges by 31 March 2015. All hospital patients have been reviewed and all patients have discharge and review plans in place. Personal care plans are in place for all patients with the exception of recent admissions.

Current inpatient numbers for those with a learning disability and/or autism in North Yorkshire and York is 16.

Analysis of inpatient usage by people from Transforming Care Partnership

Treatment and assessment beds

The Partnership Commissioning unit on behalf of the 4 North Yorkshire and York CCGs, commission in addition to the contracted in-patient assessment and treatment beds with TEWV, 2 additional in-patient beds from the independent sector for patients originating from North Yorkshire & York. Both patients are from the original Winterbourne cohort reported against in 2014.

For one of these patients a PHB was discussed at the first CTR and again revisited at the second CTR and is being considered by the family. Health commissioners are exploring with both the local authority and the family the most suitable provider pathway for this patient.

The second patient has no carer to support consideration for a PHB and there are provider issues to consider moving forward with a supported discharge plan due to location of the sole family member who supports the individual. This individual will require significant Positive Behavioural Support to prevent future re-admissions and is identified on the risk register.

In respect to exporter business North Yorkshire & York have infrequent and low level activity in comparison to previous years, where we had witnessed significant out of area spot purchasing.

Exporter activity is evident for a proportion of individuals with complex needs within the secure hospital remit and is referenced below. We know that we have 16 patients in secure provision and that seven of these patients have been in hospital for longer than five years. In reducing the in-patient facility at White Horse View we deeply acknowledge we have to build resilience in our community pathways moving forward to be able to provide robust and safe discharge plans.

Importer activity into LD beds again is aligned to the secure population due one. Outside of this remit we do not experience importer activity in to North Yorkshire and York based beds commissioned by the PCU on behalf of the 4 North Yorkshire & York CCGs.

There is a planned closure of an inpatient unit with an aim to develop full integrated, enhanced community teams further.

Further reduction beds will be required in relation to meeting targets:

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

Bed occupancy rates for our inpatient beds in North Yorkshire and York is 70% for 2015/16

(Year to date)

Current bed usage in North Yorkshire and York is 16.

Specialised Commissioning Services

Yorkshire and Humber Specialised Commissioning team lead a specialised commissioning sub-group across six TCPs in the Yorkshire and Humber region to provide support. NHSE commissions general and specialist CAMHS beds in the region; it is expected these will be re-procured together with adult beds as part of a national procurement in 2016/17. Timescales are not known at this stage, though it is felt that a reduction in beds for this cohort of people would be a significant risk and therefore no bed closures are planned in 2016/17 by Yorkshire and Humber Specialised Commissioning Team.

Significant work has been undertaken via care and treatment reviews, Care Programme Approach and case management activity to ensure appropriate access to and egress from adult service secure settings.

Outreach Services - these are provided from two LD adult secure units with one being specific to the LD patient group.

Access Assessments – This process manages the access and egress into and through levels of secure care and the role is undertaken by a range of providers in Yorkshire and Humber who provide access assessments for the North Yorkshire and York population in respect of low secure LD services. The cost of the assessments is priced as part of the bed day price in respective contracts.

Transformation across adult secure services and beyond will involve the development of forensic outreach services that will be able work comprehensively with local community services. The outreach definition within the adult secure specification provides a good basis on which to build this work. In terms of the ASD population who access adult secure care, there is real opportunity to look at the way in which secure and local services can complement each other. Further work on specifications needs to be undertaken locally and nationally to inform this process. What is most important here is to identify resource that can be reinvested from any bed closure through procurement to support these developments. This may involve double running costs to make the pathway work more efficiently.

CAMHS Tier 4

The development of Local Transformation Plans (LTPs) recently enabled a greater understanding of how specialised and locally commissioned services could and would work together to ensure a whole system approach. On this basis it is vitally important that LTPs are aligned to the Transforming Care Plans and this includes the specialised component of both. The purpose of the LTPs is to provide a clear vision for locally delivering 'Future in Mind' and to release the associated funding that the Government has made available for children and young people. As part of the process the LTPs included high level summaries, partnership details and self-assessment checklists to evidence the required information included on baseline investment, activity and staffing data, for example.

As part of the Transforming Care agenda there were a number of elements that the LTPs were expected to reference. This included 'Best Care Now' which includes a new approach to community care and treatment reviews (CTRs) to ensure that those children and young people

identified as 'at risk' of being admitted to a specialist learning disability or mental health inpatient setting are reviewed regularly. It is recognised that prevention and early support is essential to this group of children and young people, in addition to providing robust crisis support to prevent the need for admission or reduce length of stay for those who do need to be admitted. Local transformation and the development of services are still at an early stage; as more intensive treatment services are available, this should impact lengths of stay and access to and egress from inpatient beds. Learning Disability (LD) and/or autism often require professionals to negotiate complex systems across health and social care, as these children and young people often present with multifaceted needs that require robust assessment and interventions.

In terms of inpatient provision, the Specialised Commissioning team have undertaken capacity modelling for all CAMHS Tier 4 requirements for the local population services for this patient cohort. Case management for CAMHS is undertaken on an originating basis so the problems encountered with the adult secure population are not an issue. It is anticipated that the LD and Autism Spectrum Disorders (ASD) beds should be flexible (open and secure) and geographically located centrally in Yorkshire & The Humber with good travel links for ease of access across the whole geography. In addition, the national specification for ASD focusses on consultation and providing assessment services to CAMHS community and inpatient services. Further consideration is required within the capacity modelling work in terms of how this service can support the Transforming Care agenda across the whole pathway. It is anticipated from the work to date that approximately seven beds are required for the population of Yorkshire & The Humber leading up to procurement. This will be kept under review. Based on current trends, the activity and finance information that is submitted with each TCP plan would support this suggestion.

Of course specialised commissioners continue to work collaboratively with local commissioners regarding the implementation and evaluation of all plans and pathways for children and young people.

Extraordinary Packages of Care – Plans to explore a CCG Risk Share Arrangement Across Yorkshire & The Humber

Many of the 23 CCGs in Yorkshire and The Humber are experiencing the need to commission very high cost and complex packages of care specifically in relation to this cohort of patients. The placements required are not those commissioned as specialised (based on the current definitions within the Manual for Prescribed services – January 2014.) They are not only very high cost, but often require specific expertise and intensity from a commissioning and case management perspective.

There is recognition that at times funding for these patients is not available within a defined budget so this becomes a significant cost pressure to local commissioners. Yorkshire and The Humber Specialised Commissioning Oversight Group (SCOG) has made a commitment to explore a collaborative risk share arrangement across CCGs for this patient group. A Task and Finish Group has been established to take forward this work. Whilst this is in the early stages, it is important to include the thinking in these plans as it has the potential to influence how pathways are delivered locally and across the whole of Yorkshire and The Humber for this very complex group of individuals. It is anticipated that the best approach to be explored further would be across the whole of Yorkshire and The Humber as this would give more opportunity in terms of range of provision, provider market and contracting and less risk to individual CCGs.

The patient group initially would be defined as:

- Patients moving on or stepping down from specialised services. For this patient group, this would specifically be adult secure or transition from CAMHS inpatient services to adult services. The Specialist Mental Health team has the relevant data in relation to this patient group.

- Patients with existing packages of care already being commissioned individually by CCGs; many of these patients may never have accessed specialised services but exhibit the same characteristics as the previous patient group and require a similar type of service provision. An understanding is needed of the number of placements already being commissioned by each CCG.

There are a number of opportunities to this model of commissioning, these include:

- A reduction in the financial risk to any single CCG in respect of these very high cost packages of care which are often difficult to plan for or predict
- Pooled resource to enable dedicated expertise in commissioning
- Development of a case management framework that underpins an established access and egress protocol
- Pooled resource of expertise in appropriately skilled clinicians/professionals to work for the CCG collaborative as case managers, across a larger geographical area
- The development of a single contract and standard specification (appreciating the individual requirements of this patient group)
- A single operating model to ensure quality and safety are monitored with the required level of scrutiny
- More opportunity to make better use of the limited provider market and create more confidence and surety amongst existing and new providers

Next Steps

- Financial modelling of various scenarios and governance arrangements
- Tighten up the scope in relation to access and egress to the risk share
- Consider opportunities for financial support to this project via the TCP plans, specifically in relation to any double running costs for specific patients and also project support, commissioning and case management expertise to develop the project further

Involvement and Engagement

From a specialised perspective, adult secure involvement and engagement is facilitated via the Yorkshire and The Humber (and North East) Recovery and Outcomes Group, this group is one of nine groups nationally that include adult secure patients and staff. There is an overarching National Recovery and Outcomes Steering Group which ensures work that takes place across the local groups feeds into and informs the national agenda.

In terms of CAMHS, involvement and engagement is part of the implementation of the LTPs, and specialised commissioners will support the local consultation processes to ensure that the whole system is considered. This will provide stronger plans that are aligned to TCPs, with the acknowledgement that implementation of both plans requires the whole CAMHS system transformation to enable an integrated approach to change.

Specifically, the Yorkshire and The Humber TCP Specialised Commissioning Sub-group will ensure that appropriate representation is on hand to inform the whole process during the planning and implementation stages.

ANNEX 1

Describe the current system

Services and choice in North Yorkshire

Within North Yorkshire, similar to the National picture, we have a good market place of services for people with learning disability. We know however, that there are still areas where we could make further improvements in provision.

Housing and support:

We need to grow our range of housing and accommodation options, and there is a lack of available suitable providers to support people with complex needs in a local residential setting where 24 hour support is required.

This impacts on the ability to discharge people from a hospital setting and may result in people staying in a hospital setting inappropriately and longer than necessary. Our aim is to ensure that, for the majority, residential care is provided as a housing option only as part of a transitional approach to move to a more independent living environment.

We also need to ensure a more equitable provision across the different localities in the County. This will mean reviewing our current services and challenging traditional service models in some places.

We know that people with a learning disability and their carers in North Yorkshire and York rightly expect high quality services, and our younger people have different expectations about the support they require than their older counterparts.

Addressing all of these issues, means that we need to ensure there is a greater range of new support options available which can be tailored to individual need. We are working with the market to develop a full range of care and support services at an individual and local level to assist people with learning disabilities to make choices and decisions.

Moving forward, health and social care will take a joint strategic approach to developing the market where possible to ensure a consistent and a coherent approach across North Yorkshire also encouraging efficiencies. Together, the commissioning teams will review current service provision across the county and develop or modify future commissioning activity.

Out of area placements

Regular reviews are held for those people who live out of county and everyone who has autism or a learning disability has been reassessed within the last 18 months and where possible and appropriate have returned to North Yorkshire and York. Our reviews ensure effective safeguarding of people out of county with a learning disability. North Yorkshire County Council regularly reviews any information about safeguarding risks or Care Quality Commission issues, and acts to review early on anyone where these concerns are identified.

The National Transforming Care agenda provides guidance that there should be 50% of protracted hospital discharges by 31 March 2015. All hospital patients have been reviewed and all patients have discharge and review plans in place. Personal care plans are in place for all patients with the exception of recent admissions.

Employment and Activities

The current government policy is ambitious with its target of 48% of people with learning disabilities to be in paid work by 2025, (Valuing Employment Now 2015)

Department of Health 2009). At present, the national average is 6.1% of people with learning disabilities are in paid employment.

The Joint Health and Social Care Learning Disability Self-Assessment Framework has highlighted the need to develop and publish a local employment strategy and as part of this, it will be important to define clearly what we mean by paid employment. The employment strategy will highlight best practice and ensure that aspiring for paid employment for people with a learning disability becomes customary from a young age and ensure that the expectation starts from childhood throughout school. We intend to challenge local NHS organisations and the council to lead by example and identify recruitment opportunities internally in order for local employers to see the business case.

Encouragingly, a new NHS initiative has been announced whereby NHS England and NHS Employers are developing practical support to make progress in this area, (NHS jobs pledge for people with learning disabilities – NHS England 2015). There is also the 'Valued in Public' guidance issued by the Department of Health in 2009 which offers guidance to Local authorities and other public organisations on actively employing people with a learning disability within their own organisations.

Local Voluntary Sector

North Yorkshire benefits from a widespread and diverse group of voluntary sector organisations that deliver support across the whole county. These groups play an invaluable role in providing extra services that supplement those already provided by the local council and NHS organisations.

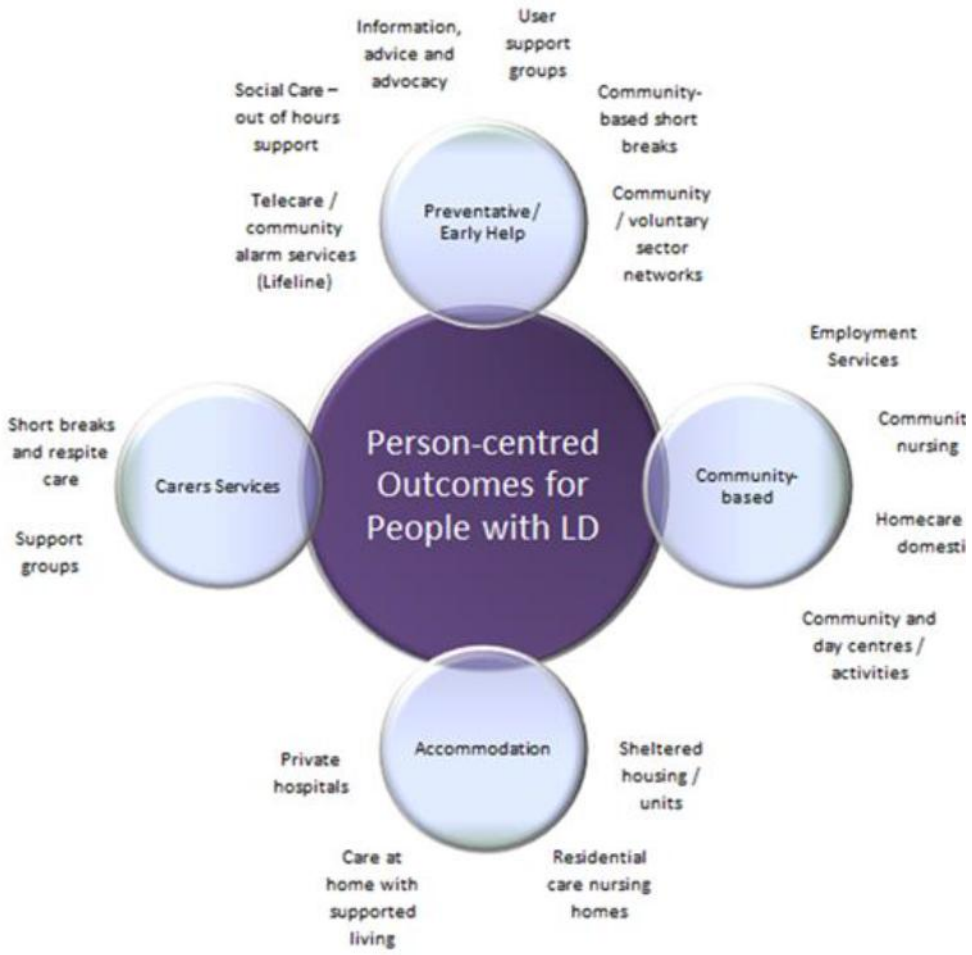
We have established some good solid links contractually and operationally with voluntary organisations. We would want to build on this relationship so that we have a better understanding of the additional support that the voluntary sector can offer people with a learning disability and to enable us to provide clear signposting to service users to enhance provision and choice, activities and support development of friendships to reduce isolation.

Safeguarding

The importance of keeping service-users safe and protected from avoidable harm, outlining clearly what is not acceptable practice, is intrinsic when planning and delivering services for people with a learning disability.

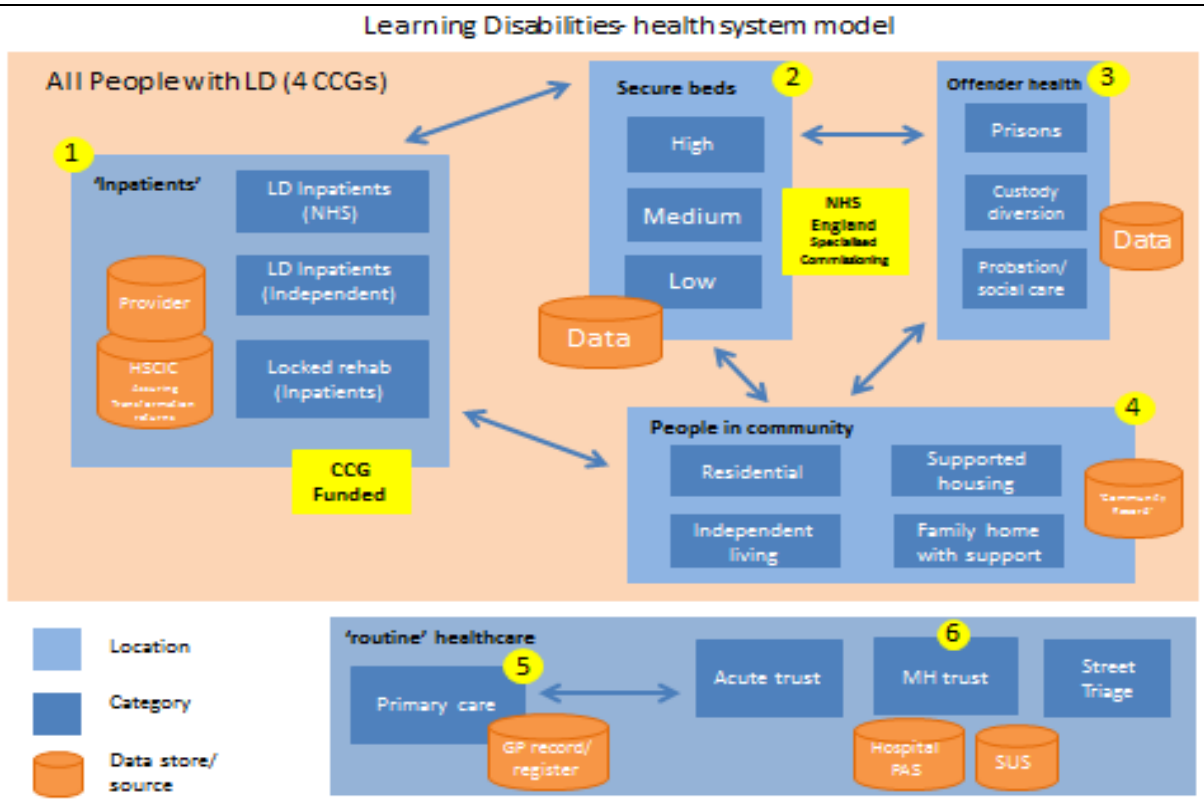
Within North Yorkshire we have established our statutory safeguarding board and a multi-agency approach to safeguarding with the Police, Police and Crime Commissioner, Safer and Stronger Communities, Children and Young People's Services, Community Safer Partnerships, the Fire Service and Health to ensure that our approach to safeguarding is consistent and robust. We know that a particular issue for people with a learning disability is hate crime and have established hate crime reporting centres in libraries and police stations. Over the course of this strategy, we need to continue to build on our practice to date and also to implement our safe

places initiative.



This illustrates the services currently provided within the community for all people with learning disability/ Autism, which are needs based. The 5 cohorts for people with more complex needs should have access to all these services and will most likely be accessing health system described below: the aim will be to increase early intervention and carers support for all these cohorts, and develop proactive planning and contingency plans with positive behavioural support.

ANNEX 1



Please note that the above health system model diagram

Across North Yorkshire, we have a range of services for children and young peoples and adults services from primary and secondary health care services, in which delivery and access can be improved within each CCG. The aim will be to increase consistency of access across the TCP and ensure a lifespan pathway.

In patient services as stated previously require to be reduced, and admissions should be only for individuals when really required and for shorter lengths of stay. More work is required with Police and Criminal justice systems/ Probation, to support people with learning Disabilities for appropriately, however some work has already happened to establish support such as street triage.

Traditional community services are in place which link in and support social care provision, and families in their own homes. However this needs further development. We have successful Personal Health Budgets allocated to a small number of individuals with learning disabilities where we are witnessing positive outcomes for service users. This need to be developed and become part of the local offer, with a focus on developing early interventions and options.

Challenges of Current System

Effective delivery of prevention and early intervention strategies

- Comparative data show that there are higher levels of co-morbidities, higher mortality rates and lower levels of the uptake of cancer screening in those with a learning disability versus the general population. Delivering prevention and early intervention strategies must be at the heart of our future vision for transforming the care of those with a learning disability and

the role of 'Public Health' and 'Primary Care' is therefore vital. However, the robustness of primary care data and the uptake of annual health checks varies greatly across the region. Targeted pilot work is being in done some localities with a view to rolling-out schemes and applying learnings more widely.

- Development of early interventions with children and young people will be a challenge, working across different arms of commissioning and engaging in education health care plans, along with Alignment to futures in Mind.

Systematic and co-ordinated approach

- We recognise that there is a great deal of good work being done locally by the many different agencies, partners and players, including the voluntary and third sectors, that operate within and provide learning disability services across the region. With all areas providing additional support and a number of interfaces for the cohorts described in Building the Right Support. However developing providers and opening up the market, along with positive behavioural support and social care workforce with resilience will be key to community services.
- Effective navigation and signposting represents a challenge with growing demands placed on services. However there is a need to further develop the health and social care navigator role, dynamic risk registers, and improve case management/ contingency planning and timely reactive approaches unified across services to improve integrated services, to improve communication and join up services.
- Development of robust community services including support for people with high risk profiles to support living in the community.

Catching-up with Social Care: Personal Health Budgets

- Recent workshop engagement activity with users of health services and their carers has also highlighted the challenges in getting across the 'Personal Health Budget' message effectively due to its 'newness', unfamiliarity and in some quarters deep-rooted dislike of change. We are progressing personalised options for people with learning disabilities through the development of a robust Personal Health Budget offer.
- The offer will outline joint working arrangements with social care to promote personalisation in managing healthcare, including those children and young people who receive joint-funded packages.
- To enhance the credibility of the scheme, eligible candidates will naturally be entitled to independent advocacy and advice. Independent advocacy and compelling case studies from social care will play a key role from the get-go in helping to deliver successfully the message about the benefits a PHB can bring.

Local Performance versus National Outcome Measures

- Three Categories of Measures:

Need to evidence achievement of improved outcomes in each of the following areas:

1. Quality of Life, as reported by the person using the care and their families

2. Quality of Care, as reported by the person using the care and their families

3. Progress in reducing reliance on inpatient care, in line with plans

We need to develop a baseline of the quality of the services currently provided, so that we can

check what has changed and improved since the start. Bed reductions can be monitored and analysed, however, real stories will need to be followed and feedback systems developed so that they can be used as qualitative measures. Our aim will be for these measures and systems to be co–produced with experts by experience.

ANNEX 1

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

Focusing on Health owned/leased estate across the four York and North Yorkshire CCGs we have the following properties where Learning Disability and Autism services are delivered from. The list contains both clinical and Administrative services and we will validate the list with local authority partners and voluntary sector providers in the next phase of the programme.

Site	Service Description	Condition	Commentary on future use
White Horse View Easingwold	White Horse View is an 8 bedded community based unit for the area of North Yorkshire and York that provides continuing complex rehabilitation for service users who present with longer term and enduring mental health problems. The service is currently a male only provision.	The site has three independent two storey houses. One is the clinical unit and was refurbished and is compliant, one was partially refurbished and is used for admin functions and the third is vacant and has been for a long period of time and would need investment to be bought back into use.	Currently there are 3 clients at White Horse View and the provider is working on transitioning all three clients into alternative placements so that the clinical function on site can cease. This site will then go through the process of assessing if it is surplus to clinical requirements which will allow the property owner, NHSEPS to dispose of this site.
Oak Rise York	An 8 bedded community based inpatient unit for the area of York that provides acute assessment and treatment for service users with a learning disability who present with acute mental health problems. The service has two separate patient areas, one for female service users (4 beds) and the other	The provider of the service is identifying a number of estates issues with the facility, with the owner NHS Property Services. As part of the Vale of York Estates strategy, investment in the property is being assessed and prioritised	Early discussions indicate that the provision of 8 beds will continue.

ANNEX 1

	for male service users (4 beds). There are 7 beds for the York and Selby locality with 1 bed for Harrogate.		
Gibraltar House Northallerton	A leased property for community team administration	Property is in reasonable condition. Recently provider has moved staff into the space from an adjacent office, where the lease ended ensuring better utilisation.	Continued used as an admin base anticipated.
Eastfield Clinic Scarborough	Property owned by NHS Property Services and there are community outpatient clinics here in addition to some administrative support accommodation	Property in need of ongoing maintenance investment and the Strategic Estates Plan for Scarborough and Ryedale CCG will review and assess this.	Continued use of the site for outpatients anticipated.
Systems House York York and Selby Community Learning Disability Team	Property owned by private landlord, leased via NHSPS. Building houses community team, local authority (CYCC) colleagues and community outpatient clinics in addition to administrative support	Property is fit for purpose but has not been redecorated for 10 years and there is no maintenance schedule in place. The fixtures and fittings of the building are in need of replacement / refurbishment.	To continue as community LD hub
Alexander House Knaresborough	A leased property for community team administration	Property is in good condition following recent investment by Tees Esk and Wear Foundation Trust	Continued used as an admin base anticipated.
Skipton Hospital Skipton	Property owned by NHS Property Services and there are some	Older property which has expanded and developed over many years. Needs	Continued used as an admin base anticipated.

	administrative support accommodation.	investment and major reconfiguration	

- The City of York Council has 13 specialist providers (including in-house services) providing supported living and day activities. City of York Council also have care home providers who provide residential support to a number of individuals.

- North Yorkshire County Council has 26 supported living providers and 28 LD nursing and residential providers.

- We have worked with the North PAU lead and have a list of the properties across the four CCGs where a 'health' legal charge is registered. There are around 27 properties identified, all defined as registered care homes provided predominantly by Registered Social landlords or charities. We can provide the list of properties obtained from NHS England but all documentation sits with the Project Appraisal Unit.

To understanding our estates across North Yorkshire and York Transformation Care Partnership. We have considered both our housing and accommodation for people with learning Disability and or Autism, with an aim for people to be in settled accommodation, along with identifying accommodation for our community teams, and estates available for outpatient use etc. This will be extremely important whilst moving on with the transformation programme, with the move to more robust community support, rather than inpatient provision.

Challenges :

- Many people do not want to return to hospital for appointments, and we will aim to provide community appointments in their own homes or a community resource.
- Are current community team bases fit for purpose, to provide resources to see people on site, or is there alternative accommodation in primary care or community resources more suitable?
- Opportunities to share accommodation with other services and share accommodation with local authority.
- Is accommodation size compatible with multidisciplinary/multiagency working, is there rooms for Multi-disciplinary meetings, IT and communication equipment compatible to aid good communication, opportunity for mobile working and hot desking facilities to support effectiveness and efficiency. What accommodation will need to look like to deliver extended hours and weekend access to services?

Wider estates and accommodation:

ANNEX 1

North Yorkshire and York both have challenges around access to affordable housing, which impacts on both the ability to secure accommodation and on the availability of a care and support workforce.

Both Local Authorities are working proactively with Housing partners to develop new housing with support schemes which will hopefully support this programme.

There are however new emerging challenges in respect of Housing Benefit changes which will affect supported housing and may make both current and future schemes unviable, or much more expensive to commission and resource.

We will be aiming to improve how we plan future accommodation needs, with consideration of the needs of the people in the cohorts:

Challenges :

- Ensuring people have control and choice – personal choices to live with families/ with friends or alone.
- Quality of life and care- Need to ensure flexible use of housing, support services and providers, use of personal health budgets
- Accommodation sites availability and their cost
- Needs of complex groups of people described in the cohorts (such as space, additional rooms for support staff, core and cluster type accommodation to support easy access to additional support)
- Deprivation of liberty issues, safety, locked door,
- Safeguarding issues such as locality to other services and community resources
- Step down community resources
- Crisis accommodation, type of accommodation required and locality.
- Respite accommodation, type of accommodation required and locality

ANNEX 1

What is the case for change?

In North Yorkshire and York Transforming care partnership we are committed to:

- Improving Quality of Life
- Keeping people safe
- Choice and control

We would like to do this for all the population of people with learning Disabilities and/or Autism, (all ages) however we understand that if we get it right working with people whose needs are more complex (as identified in the cohorts) we should be on track to deliver transformation of services.

The National Service Model highlights change in service provision so that:

1) People can be supported to have a good and meaningful everyday life - through access to activities and services such as early years' services, education, employment, social and sports/leisure, and support to develop and maintain good relationships.

2) Care and support can be person-centred, planned, proactive and coordinated – with early intervention and preventative support based on sophisticated risk stratification of the local population, person-centred care and support plans, and local care and support navigators/keyworkers to coordinate services set out in the care and support plan.

3) People will have choice and control over how their health and care needs are met – with information about care and support in formats people can understand, the expansion of personal budgets, personal health budgets and integrated personal budgets, and strong independent advocacy.

4) People with a learning disability and/or autism can be supported to live in the community with support from and for their families/carers as well as paid support and care staff – with training made available for families/carers, support and respite for families/ carers, alternative short term accommodation for people to use briefly in a time of crisis, and paid care and support staff trained and experienced in supporting people who display behaviour that challenges.

5) People will have a choice about where and with whom they live – with a choice of housing including small-scale supported living, and the offer of settled accommodation.

6) People can get good care and support from mainstream NHS services, using NICE guidelines and quality standards – with Annual Health Checks for all those over the age of 14, Health Action Plans, Hospital Passports where appropriate, liaison workers in universal services to help them meet the needs of patients with a learning disability and/or autism, and schemes to ensure universal services are meeting the needs of people with a learning disability and/or autism

7) People with a learning disability and/or autism will be able to access specialist health and social care support in the community – via integrated specialist multi-disciplinary

health and social care teams, with that support available on an intensive 24/7 basis when necessary.

8) When necessary, people will be able to get support to stay out of trouble – with reasonable adjustments made to universal services aimed at reducing or preventing anti-social or 'offending' behaviour, liaison and diversion schemes in the criminal justice system, and a community forensic health and care function to support people who may pose a risk to others in the community.

9) When necessary, when their health needs cannot be met in the community, they should be able to access high-quality assessment and treatment in a hospital setting, staying no longer than they need to, with pre-admission checks to ensure hospital care is the right solution and discharge planning starting from the point of admission or before.

However too often the following statement are described:

How can the current model of care be improved?

North Yorkshire and York transforming care partnership have a good understanding of the need to change. Over the last thirty years there has been significant progress which has enabled people with a learning disability to lead fulfilling lives as citizens in the community, with the same rights as anyone else. With the introduction of personalisation and personal budgets, individuals now have greater choice and control over how they are supported to live their lives and be more independent.

ANNEX 1

The Local Authorities and the NHS are proud of the progress made in North Yorkshire and York, particularly over the last 10 years, as individuals have had greater choice and control by having their own tenancies, gaining employment and being part of the wider community.

We want to build upon our success to date and continue to support people to become more independent, lead healthier lives, be part of their communities, have more choice and control, feel ready for adulthood, gain meaningful employment, and also to support carers and families, as this is what people have told us matters most to them and which will enable them to 'live well and longer'.

We recognise that achieving this will mean considerable change, as we are facing some of the most significant challenges in the history of the public sector at the same time. Demand for services is increasing, people are living longer with more complex needs, legislation and service user expectations are changing and this is against a backdrop of reducing public sector budgets. We know that we cannot do what we have always done and that we need to challenge traditional service models, create new solutions, harness community resources and develop services that will provide for people now and for future generations. We recognise that for some people, these changes will be difficult as not everyone will get exactly what they want, however we will support individuals and work together to find local solutions that can meet individual needs.

This plan concentrates on what matters most to people with a learning disability in North Yorkshire. Our strategic approach is centred on what is known as promoting protective factors and maximising people's capabilities and support within their communities. This means promoting people's health and wellbeing, preventing, delaying or reducing the need for services, and protecting people from abuse, thus providing a foundation for continuous improvement in learning disability services and better lives for the people who use them.

The NHS and Local Authority are committed to delivering this strategy and finding creative and innovative new ways of delivering services and solutions that achieve our organisational and individual outcomes including those which are set out in NYCC's 2020 vision and the implementation of the Care Act 2015.

Transformation plans for Children and Young people Emotional and Mental health 2015 highlights changes are required to enable the best start in life though supporting children and families to achieve improved health outcomes. This incorporates safe and effective maternity services for the local area, and support to vulnerable children throughout their childhood and transition to adult life. The major focus of transformation is the move to more personalised packages of care for children with special educational needs and disabilities, the review of child and adolescent mental health services, aligned to Mental Health Transformation, and the reduction of health inequalities for children and families.

Our local joint strategies in learning disabilities and Vision for Autism represents our local response to national policy and legislation that clearly states the case for change :

Winterbourne Review, the Bubb Report, the Transforming Care Agenda and new legislation (changes to Care Act and Children & Families Act) – all of which have now contributed to and evolved into the Building The Right Support national model.

Gaps in provision are being identified from the following:

- Gap analysis from work completed for the Children and Young people Emotional and

mental health Transformation plan

- Our local 'Learning Disability Self-Assessment Framework' return also flagged the key areas that we need to improve – as indicated in a previous sections

- Local intelligence and review of current systems demonstrates our need for development

- Through co-production and consultation of local joint strategies: 'You said, We did' approach adopted

- The available data (through the 'Assuring transformation' process) shows the people with a learning disability who are in in-patient settings. A proportion of these patients require inpatient specialist care, but some can be managed in the community and these individuals are being identified as part of these plans.

Our local strategy is therefore very much aligned with the national Building The Right Support model and focuses on six key priorities with matching strategic themes/platforms and matching outcomes.

Where Do We Want to Be? Our Priorities	**How Will We Get There? Our Strategies**	**What Will We Deliver? Our Outcomes**
1. Improve Choice and Control	Personalisation	Increased self determination
2. Improve health and reduce health inequalities	Prevention, Early Help, Support and Treatment	Reduction in premature death Improved quality of care
3. Reduce out of area placements and long term accommodations (to include in-patient beds)	Right Care in the Right Place • Provide care and support within own home or community, or as close as possible • Develop community-based care and support packages • Reserve and ring fence inpatient and residential care only	Increased opportunities for living within the community and independently Reduced reliance on inpatient services

	for those at times of greatest need and for those with highest needs	
4. Improve Social Inclusion	Empowerment and Enablement	Improved quality of life and wellbeing
5. Provide Support for Families and Carers	Caring for the Carers	Improved quality of life and wellbeing
6. Support Young People into Adulthood	Preparing for Adulthood / Integration	Raised awareness and understanding of the future and increased confidence on entering adult life Improved quality of care

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

Any additional information

Please see below

Finance and activity 11.4.16.xlsx

3.Develop your vision for the future

Vision, strategy and outcomes

The vision and aspirations:

In North Yorkshire and York Transforming care partnership we have a vision :

"People in all communities in North Yorkshire have equal opportunities to live long, healthy lives"

In North Yorkshire, our aspiration is for all people with a learning disability to ***'live well and longer'*.**

This means that people with a learning disability will

- Have the right to choose, and be in control, of their daily life (where possible)
- Be respected and treated with dignity
- Possess positive self-esteem

ANNEX 1

- Enjoy the best health and well-being possible
- Lead a fulfilling and active live
- Feel safe and supported

Both our vision and our aspirations are in line with the "I" statements, and the Service model vision statement below:

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

"Children, young people and adults with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition* have the right to the same opportunities as anyone else to live satisfying and valued lives and, to be treated with the same dignity and respect. They should have a home within their community, be able to develop and maintain relationships and get the support they need to live a healthy, safe and fulfilling life." BRS (NHSE 2015).

Our vision and aspirations is also based on what local people and their carers told us:

They said :

"More choice and control over my life: to have a home of my own and be more independent; safe and secure places where my needs can be met by skilled support staff when needed."

"To have a job and be able to make a valued contribution to the local work force either through paid employment, voluntary work or work experience. I want to occupy my time with meaningful daytime activities."

"Support for my carer: for my carer to feel supported and make sure he/she has a fulfilling life."

"To be Healthy: to be well and healthy and have equal access to health care and health promotion services and to receive reasonable adjustments to achieve this."

"To be socially included: to make friends and have relationships."

ANNEX 1

"To move to adulthood successfully: have the right support to become as independent as possible in my adult life."

Our Priorities

Having listened to people with a learning disability and their carers we have set out six priorities to help us deliver this vision:

- Improving choice and control
- Improving health and reducing health inequalities
- Improving social inclusion
- Providing support for families and carers
- Supporting young people into adulthood
- Reducing the number of out of area and long term accommodation placements

Our Ways of Working will change

To support meeting our priorities, the Local Authority and Clinical Commissioning Groups are committed to: Key objectives

The co-production of any development and change with people with a Learning Disability/Autism

1. Engagement and communication channels will be part of the communication and engagement plan agreed by TCP by April 2016

2. Co-production plan will be developed by experts by experience - This will be achieved by May 2016

3. Co-production groups along with current and additional networks will form part of a confirm and challenge process May 2016

A focus on delivering real measured outcomes for individuals.

1. Outcome measures will be agreed in line with Self-assessment Frameworks, contractual monitoring and quality of life principles "I" statements by June 2016

2. Baseline of current service delivery against each work stream will be completed (if not already done) Analysis will inform a baseline for improving quality by July 2016

Working groups/ task groups and a willingness and commitment to working in partnership.

1. This will include sign up from all the stakeholders within the TCP to achieving a good quality service for the best possible price, with a focus on working in a person centred way

This plan will be published by July 2016.

Commissioning and delivering services differently.

ANNEX 1

1. Delivering support wherever possible through the use of personal budgets. This will be an embedded process and offer by August 2016

2. Continue to ensuring that commissioning decisions are built on an understanding of and an analysis of the information and evidence available in a person centred way (ongoing)

3. Continue to consider ways to improve collaborative commissioning and use of pooled budgets will form part of discussion (ongoing)

Services will look different: People Living and Supported to Live in the Community

- Home Intensive Treatment pathway
- Holistic multi-disciplinary assessments and integrated approaches across health and social care.
- Individual person centred plans that support across the life course and inform Individual Service Designs
- Prevention and early intervention to increase people's quality of life and prevent the need for more intensive support in the future. Core services respond to meet people's needs.
- Specialist services respond quickly as required with the aim of maximising independence and quality of life.
- In reach and integrated approaches across a range of services, Mental Health, CJS, Police etc.
- Care provided in or as close to the individuals home as possible. Home includes residential care, supported living and independent living, Personal health budgets.

Improvements will be made :

Aim : 1. Improve Choice and Control : Personalisation

Where Do We Want to Be and How Will We Get There?

Our Strategies Focus on developing person-centred care, treatment and support plans in close association with individuals and their family carers

Promote the use of direct payments, EHC (Education, Health, Care) plans and personal budgets; providing access to independent advocacy and financial advice services

Increase the availability and choice of services

Stimulate the market to develop personalised and flexible services

Signpost and help people to find out about the services available to them

What Will We Change? Our Outcomes:

1. People will have care planned which includes contingency plans in case of urgent/crisis need.

2. Children and young people will have access to Personal Health Budgets and planning will be part of EHCP. Future needs will be planned for as part of transition into adulthood.

3. A choice of available housing a support options will be available within the locality. Which

is linked by a provider forum, with co-production as part of service development.

4. There will be a number of market providers, statutory, Independent and Voluntary sector providing support as required to increase control and choice. (A local Offer)

5. Positive behaviour Support will be embedded across all health and social care providers

6. Quality of life and care will be measured by "I" statement and outcome measures routinely.

Aim 2: Improve health and reduce health inequalities

Where Do We Want to Be and How Will We Get There?

Prevention, Early Help, Support and Treatment

Identify, offer support and treat as early as possible (from childhood onwards)

Assist people with a learning disability to access universal and mainstream health and wellbeing services; making reasonable adjustments where necessary and having 'liaison' staff in place.

Tailor health promotion programmes to meet individual needs; empowering young people with learning disabilities to make healthy decisions and lead healthy lifestyles

What Will We Change? Our Outcomes:

1. People will have access to mainstream services. Reasonable adjustments and joint working will be a standard offer.

2. There will be an increase in the uptake of an annual health checks. This will be viewed as compulsory activity within primary care together with a dedicated and routine approach to cancer screening and enhanced eye tests.

3. Increase in Annual health checks and screening programmes will be monitored via SAF

4. Use of the Greenlight tool kit – showing good access to services and reasonable adjustments

5. There will be a reduction in premature death

6. Improved quality of care – quality checking of services will be routine

Aim 3 Reduce out of area placements and long term accommodations (to include in-patient beds)

Where Do We Want to Be and How Will We Get There?

Right Care in the Right Place; Maximise Community Support

Provide care and support within own home or community, or as close as possible

Develop community-based care and support packages, including options for supporting people with most complex need

Explore different models of suitable accommodation; including providing small-scale supported living for individuals with more complex needs and short term accommodation

(available for a few weeks) used in times of potential crisis to prevent an avoidable admission into an inpatient setting

Assist individuals to access mainstream services – for example, using the Green Light Toolkit to make improvements for people with a learning disability when accessing mental health services

Put in place clear discharge planning to return individuals to the community or their own home

Review traditional service models of delivery,

Support and train the wider workforce

What Will We Change? Our Outcomes:

1. Enhancement of 'at risk of admission' register and 'Collaborative Care' models for individuals with highly complex needs- creating a Dynamic register to support planning of future services

2. Increased opportunities for living within the community and independently

3. Reduced reliance on inpatient services, CTR process will provide good evidence of early discharge

4. Reduction in admission to hospital, CTR process will provide good evidence of avoiding admission

5. Community teams will be skilled and resourced to work with people and their families, and to work to support people in times of crisis and urgent response, this will include working with a range of services

6. Social care workforce will be skilled and resilient by being able to meet the changing needs of the people they care for (contingency planning will be integral)

Aim 4 Improve Social Inclusion

Where Do We Want to Be and How Will We Get There?

Improve Empowerment and Enablement

Strengthen the voices of people with learning disabilities locally (co-produce in the planning of services)

Strengthen personal skills

Provide access to learning opportunities: take part in education

Encourage the pursuit of every day leisure activities and hobbies - sports, music, the arts, gardening, cooking, DIY

Encourage and support more people with a learning disability into paid employment.

What Will We Change? Our Outcomes:

1. Improved quality of life and wellbeing: good life stories and community opportunities will

be report via the SAF process

2. Increased employment opportunities

Aim 5 Provide Support for Families and Carers

Where Do We Want to Be and How Will We Get There?

Caring for the Carers; Provide support, information and advice which meets the needs of carers and their families.

Offer parenting support/education

Offer opportunities to network and feel part of a larger 'care' community

Review respite provision

What Will We Change? Our Outcomes:

1.Carers will report improved quality of life and wellbeing (carers surveys)

2. Community offers will grow with options in voluntary sector.

3. Short breaks and Respite services will be more available

4. Will be an increase in Direct payments and personal health budgets

Aim 5 Support Young People into Adulthood

Where Do We Want to Be and How Will We Get There?

Implement the Preparing for Adulthood Model

Alignment and joint working with CAMHs

Equip young people with life skills

Ensure clear and consistent planning through into adulthood

What Will We Change? Our Outcomes:

1. Transition pathway will be developed: Raised awareness and understanding of the future and increased confidence on entering adult life (quality of life indicators – "I" statements)

2. Pathways : Improved quality of care, and smooth transitions

3. Improved joint working with CAMHS

How will improvement against each of these domains be measured?

1. CTR process will be embedded for all children young people and adult services. This will be aligned to CPA. This will be measured on a monthly basis based on the numbers of CTRs undertaken within all age groups. Targets will be set on an increasing scale year on year. Measurement will include how many community CTR's have supported avoiding admission to hospital.

2. All people will have timely discharges to appropriate services (lengths of stay will reduce). This will be measured monthly on how many discharges have been undertaken and monitored against length of stay as an inpatient. Investigations will

be undertaken for all service users deemed not to have had a quick a discharge as clinically appropriate.

3. Assessment and Treatment Units' occupancy to match on average the equivalent to 10-15 inpatients per million population. Monitored monthly. Any deviation from these parameters will result in immediate action to return figures to established limits. This will be monitored via CCG vulnerable people's team against trajectories outlined in finance and activity plan and exception reports provided at every to TCP.

4. NHSE Specialised commissioned beds occupancy to match on average the equivalent to 20-25 inpatients per million population. Monitored monthly. Any deviation from these parameters will result in immediate action to return figures to established limits. This will be monitored against trajectories outlined in the finance and activity section and exception reports provided to TCP meetings.

5. Risk register will be in place and will be monitored via planning meetings looking at urgent need with the aim of keeping people at home or in their community. Monitored and reviewed monthly and escalated depending on severity of risks highlighted.

6. Everyone identified on the risk register has a contingency / crisis plan which is reviewed at least six-monthly. This will be monitored for compliance. This will be measured on a monthly basis based on the numbers of CTRs undertaken within all age groups. Milestones will be set on an increasing scale year on year. To ensure appropriate community placements are available for all who require them in a timely way. Discharge plans and transfers will be monitored on a monthly basis.

7. To ensure patient pathway provides availability to stepped up and down care where required. Monitored monthly based on patient journeys. This will be achieved and monitored in line with the 'bid' document outlining the proposed community model.

8. Decrease in hospital admissions. Monitored monthly through performance reporting requirements

9. Decrease in hospital re-admissions. Monitored monthly through performance reporting requirements

10. Collaborative working with all stakeholders involved with the service user to ensure seamless pathway and joint planning. Monitored through governance requirements. This will be measured by the number of service users involved in joint planning.

Quality of Care:

1. Every child/young person in the 5 cohorts going through transition will have a clear pathway and detailed plan as part of their EHCP. Measured monthly through reporting requirements.
2. There is an increase in the number of Personal Budgets (including PHBs) for

children (14+) and adults who have a learning disability and/or autism. A benchmark will be set with an increasing scale year on year.

3. SAF will be used as quality measures example: Measured against SAF action plan on bi-monthly basis and CQUIN process (CQUIN for 16/17 include Annual Health checks promotion)
4. Proportion of people with a learning disability receiving an Annual Health Check
5. Proportion of people with a learning disability with a Health Action Plan and Patient Passport.
6. We will have health and social care adequately skilled with access to Positive behavioural support academy
7. Use of quality measuring tools – Clinical tools and Health Equalities Framework.
8. Ensure friends and family test used.
9. To provide training opportunities/communication for carers personal assistants.
10. Ensure carers/family are involved in decision making process as appropriate. Monitored monthly via reporting mechanisms.
11. Ensure support is provided to family and carers as appropriate. Measure monthly through performance indicator routes.
12. Use of Positive Behavioural Support (PBS) model in managing care. Monitored monthly with benchmark set and increased numbers year on year.
13. Ensure high levels of quality of care by requesting staff training details of Providers to ensure mandatory and development training requirements are up to date. Measured via Provider reports on a quarterly basis.
14. Reduction in scores on agreed validated psychometric scales, such as the Health of the Nation Outcome Scale for people with learning disabilities (HoNOS-LD) Therapy Outcome Measures (TOMS) and Psychiatric Assessment Schedule for Adults who have Developmental Disabilities (PASSAD) and/or Patient Health Questionnaire PHQ9

Quality of life

1. Numbers of people with Personal Health Budget will have increased
2. "I" statement/ principles for monitoring quality of life and care
3. Reported carer and service user stories
4. Numbers of service users screened for cancers increased eg breast, bowel and cervical screening. Monitored through the SAF process.
5. Increased service user choice. Monitored through personalisation requirements.
6. Service user inpatient days reduce. Measured monthly through reporting framework.
7. Family and Carer feedback shows increased satisfaction. Reported quarterly through performance requirements.

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

In describing the principles we need to go back to our vision and aspirations; and "I" statements. As stated in our case for change, North Yorkshire and York Transforming care partnership is continually working to improve current provision. Although this cohort is a

small in number, this is an extremely diverse group of people with learning disabilities who alongside displaying behaviour that challenges may have co-existent mental health problems.

Current pathways can be diverse for people with behaviours that challenge dependant on individual circumstances. For those individuals moving from secure hospital provisions there is a high level of health case management and allocation of local authority care managers, resulting in positive discharge planning. Due to multi agency involvement this can be lengthy in respect to the discharge planning process in terms of professional responsibilities, legalities and availability of future service provision and housing. What is witnessed is the "Getting it Right" for the service user, as time taken ensures a higher success story for the service user.

We will continue to work with NHS England Specialist Commissioning Group to map our secure population and those in the communities with behaviours that challenge through both the risk registers and through continued liaison with NHS England Specialist Case Managers. We know of all the patients in secure pathways and have identified future dates for discharge to allow for early engagement to shape future commissioning needs in line with our view below. Further supported by the CTR process.

For a cohort of services users within the North Yorkshire NHS CCGs, we have limited access to forensic community professionals however, to ensure parity we plan to address this within our future commissioning intentions to ensure:

- People can be supported to have a good and meaningful everyday life
- Care and support can be person-centred, planned, proactive and coordinated
- People will have choice and control over how their health and care needs are met – with information about care and support in formats people can understand,
- People with a learning disability and/or autism can be supported to live in the community with support from and for their families/carers as well as paid support and skilled care staff
- People will have a choice about where and with whom they live – with a choice of housing including small-scale supported living, and the offer of settled accommodation.
- People can get good care and support from mainstream NHS services,
- People with a learning disability and/or autism will be able to access specialist health and social care support in the community

In adopting the principles above we recognise this cohort requires: **highly individualised treatment, support and care at an early stage in their life-long care planning** to avoid unwanted events and lengthy stays in hospital.

We need to continue our work to date in looking at **identifying those at risk at an earlier stage** (via the ongoing development of an 'at risk of admission' register); ensuring their **care is more proactive, planned and co-ordinated by integrated specialist multidisciplinary teams** who work together through a 'Collaborative Care' model.

Additionally, to help the shift from a reliance on in-patient care we need to provide more 24

hour small-scale supported living locally with access to expert and resilient care staff trained and experienced in supporting people with complex needs. With the **right preventative services in place in the community**, use of inpatient services should be rare and therefore ring-fenced for defined purposes. We plan to work alongside national teams to support us in getting this right from the onset. www.pbsacademy.org.uk

We hope to demonstrate that we will develop new models of care based on the principles and effectively provide the additional and more specialist support in the community.

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

Any additional information

Please see attached

Finance and activity 11.4.16.xlsx

4.Implementation planning

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

Overview of your new model of care

Across North Yorkshire and York Transforming care partnership we want people with learning disabilities to live in their own homes, in communities that can support them. We want to build on good existing supported services where there is evidence of robust positive behavioural support in partnership with our providers.

We want to deliver assurance to people with learnings disabilities and their carers that access to support is seamless and can be delivered in a timely and co-ordinated manner.

Through community based treatment and support, our vision is to not repeat history of people going out of area in order to have their care needs met. North Yorkshire & York will lead in achieving positive health and social care outcomes for people with learning disabilities. Collaboratively, partners will embrace and address barriers to inclusion.

Commissioned services will support individuals to use mainstream services and or participate in their local community e.g. employment, education, housing, friendships, relationship, leisure etc. People with learning disabilities who have a mental health need will use mainstream mental health services. We will ensure that we make the most appropriate help available in a timely manner.

Developing new models and improving current models

We are aiming to improve our current services whilst also developing new services. This will

give us a robust integrated model and approach to caring for all people with a learning Disability and /or Autism whilst also focusing on key developments required for the 5 cohorts of people with the most complex needs, as described in Building the Right support. In particular we would like our model to work smoothly and interface with other services across children and young people's services, mental health services and Criminal Justice system. Key to this is:

- Holistic multi-disciplinary assessments and integrated approaches across health and social care.
- Joint working with Children and young people's services, including CAMHS
- Individual person centred plans that support across the life course and inform Individual Service Designs.
- Prevention and early intervention to increase people's quality of life and prevent the need for more intensive support in the future. Core services respond to meet people's needs.
- Specialist services respond quickly as required with the aim of maximising independence and quality of life.
- In reach and integrated approaches across a range of services, Mental Health, CJS, Police etc.
- Care provided in or as close to the individuals home as possible. Home includes residential care, supported living and independent living, Personal health budgets.
- Positive behaviour support integral to all care packages

ANNEX 1

The diagram above identifies key parts of our model

Developing a provider framework

The Partnership Commissioning Unit have begun conversations with supported living and residential providers to develop our market. A primary focus of these conversations is to determine providers' ability to establish positive behaviour support systems, positive experience of managing and preventing crisis, whilst offering personal and tailored packages of support.

Local provider engagement events were held in November 2015 and February 2016 and further events are being scheduled to build on this engagement. We have engaged with procurement leads in terms of identifying our options for developing a robust market of choice. This includes those leaving hospital and for those individuals who have a natural need for changing their living circumstances.

We have knowledge of established health and local authority accommodation pathways and where development opportunities are arising we are consulting on shared care pathways.

Crisis Planning needs to develop in line with the crisis care concordat across North Yorkshire & York. We have committed to developing services that take people away from hospital admissions and to support them their own communities. To date we have asked providers to work with us in developing robust model options across the localities.

Discussions are taking place in specific localities to explore where our voluntary organisational partners can work with us to develop community services that can offer support at the point of crisis that is different to previously accessed support from hospital

providers. Models that are being explored and discussed are, safe places available through the night, twilight hours, weekends where support can be available that keeps people in their communities, with people they know around them. Along with developing schemes to support befriending to reduce isolation, advocacy and carer support.

New "Community" model

The principles will be aligned to the national service model and will be responsive as the service users need changes. People will move through and use different aspects of the community model as required.

Helping people move from secure hospital/out of Area placements and prevent criminal justice processes

People will have access to robust enhanced Community Services offering new community treatment and care packages delivered by a workforce that is confident in community risk assessment and management. We plan to work with our NHS and local authority providers to develop knowledge in respect to the teams being able to provide:

Effective and accurate discharge planning from in-patient services with respective partners and advocacy which will include comprehensive and rapid assessments encompassing

1. Offending and criminogenic need delivering community risk assessments identifying trigger factors to past and future risk behaviours
2. Treatment plans addressing trauma and presenting comorbidity factors.
3. Where required brief hospital in-patient admissions for mental health needs.
4. Effective case management by skilled practitioners including criminal justice partners where applicable
5. Schema focused interventions
6. Effective use of Conditional Treatment Orders
7. Good sign posting when recognised the service user is struggling to manage behaviour that challenges
8. People in Out of Area placements will be supported to come home.
9. Support training in Police, Probation and Criminal Justice systems to help recognise Learning Disabilities/Autism and provide appropriate response

Planned and co-ordinated community care

Improved discharge planning and community living and providing care that is co-produced and person centred:

1. Flexible and intensive supported living interventions from skilled workforce which can be pulled in and withdrawn in a responsive time scale to manage home crisis.
2. Education and awareness training to providers and carers/family through PBS to promote resilience
3. Targeted intervention
4. Access to good advocacy
5. Offer of appropriate age respite giving choice and control to the service user.
6. Provision of Safe Spaces in the community to allow for additional choice at points of crisis or need
7. Vocational and educational access support
8. Choice in accommodation to allow for immediate and further housing choice medium to long term i.e. single supported accommodation, shared accommodation

9. Rigorous and accurate risk register to identify early identification of those at risk of need for admission through the CTR process that are integral day to day business
10. Care coordinators will be assigned to every individual
11. Safeguarding will be the responsibility of all by raising at the earliest point to prevent escalation and jeopardy of interruption to care and support.

Prevention and management crisis

Crisis management for people where traditionally presentations have led to in-patient admissions will present with its own challenges as we prepare for alternatives. Crisis interventions and the planning across North Yorkshire is in its development with providers being central to the success of deliver.

We are clear that with the planned reduction of in-patient services we want to develop services that can be flexible and robust and that can be individual whilst meeting the needs of the North Yorkshire footprint. The challenge is for us to commission services that can work in to a variety of settings that can be personal, safe, manage some high risk behaviours to the individual, their environment, staff and the public.

New model planning across North Yorkshire and York will aspire to develop robust community LD teams that are Positive Behaviour Support (PBS) led and visible in each of the CCG and Local authority footprints. Locally that would consist of 4 PBS support leads across the 4 CCGs, giving 3 across North Yorkshire and 1 in to the City of York. We will aspire to have PBS working across whole community teams, in-reaching where the service user is at any one time. Key to this provision will be to have PBS working with non NHS provider services to develop workforce skill set and avoid care packages from breaking down. Dynamic risk registers and contingency plans will be implemented by all teams.

We have begun dialogue with our provider Tees Esk Wear and Valley NHS Foundation Trust to explore the options around the PBS model with respect to the workforce development needs. This will then be the responsibility for commissioners to develop conversations across the collaborative footprint.

The new model will require to identify training and workforce development needs this includes the needs of carers and families. Development of the skill set within commissioned workforces and with Carers in Positive Behaviour Support (PBS) to allow for emergency response within the community in respect to prevention to admission. In the new model we will have access to a Positive Behavioural Support Academy with an aim to have a skilled and resilient workforce.

ANNEX 1

In patient and specialist commissioning

There will be a reduction of beds in our model.

The formulae provided as part of this plan suggests that the North Yorkshire and York Transforming Partnership will be required to have no more than 9 CCG commissioned beds by 2019 and no more than 15 Specialist Commissioned beds

Care will be concentrated on being provided at Home/within the community. Plans will develop further in line with ways we can use the skills of the clinicians within these services to support the community teams, via Forensic community resources. This includes looking at collaborative commissioning for people with the most high cost packages.

Children and Young People and Transitions

In partnership with the children's PCU case management team and respective local authorities we have begun transitions planning meetings to scope and plan the transition needs for a cohort of three 17 year olds who need to move from residential schools. These pathways need to be in place before the young people reach 19 years of age. Successful move-on plans are focusing on obtaining specialist expert assessments, consultations with the service users and families around choice. We will go out to the provider market for future provision and explore any other creative commissioning options.

Other transitional needs are being addressed for a cohort of young people from the age of 14 years upwards from across North Yorkshire and York by identifying what their individual future educational needs will look like post 18 years. Work is also live in terms of scoping medium and longer term accommodation and care needs including, where applicable, regular respite, social, vocational and recreational needs.

The focus is to deliver successfully for young people and children to avoid all unnecessary admissions developing and delivering:

1. Every child and young person will have a co-produced person centred care Education, Health and Care plan
2. Early transition planning by all agencies, with clear direction to which agency is leading
3. Children and young people will not experience exclusion from access to health and social teams and reasonable adjustments will be made for those 14 years and over.
4. Financial disputes will not interfere with successful planning for the future and joint

panels will be held to determine funding lines
5. Young People and Families will be heard, they will shape and co-design preferred pathways
6. PHBs will be offered at every stage of transition planning

The new proposed community model is highlighted in the below document.

BTRS Bid1 HIT Community Model.doc

What new services will you commission?

Intention	**Actions**
Reduced reliance on inpatient care • Red uced admissions to inpatient learning disability services • Red uced learning disability inpatient beds • Red uction in Length of Stay • Sust ainable and effective crisis support allowing for Early Intervention – enhanced home intensive support teams in the community	Reduce in-patient beds – close eight bed in patient service by May 2016 Develop the skill set within commissioned workforces and with Carers in Positive Behaviour Support (PBS) to allow for emergency response within the community in order to prevent admission Work with providers to create models of community care that meet 7 day services and provide wrap-around 24 hr care

ANNEX 1

	support; personalised, tailored, with a bespoke range of choice

Enhanced Community Provision
• Shift provision to a 'Home' Intensive Treatment model (HIT)
  ○ Complex Care Support 24/7 combined with Supported Living
  ○ MDT review/support
  ○ Medicines Management
• Community Support Unit
  ○ short breaks support
  ○ crisis prevention support
• Intermediate Care Support
  ○ facilitate swifter discharge whilst care packages are being negotiated/approved by funding panels
• Forensic Community Outreach
	Apply learnings from Bootham Hospital in-patient closure and subsequent provision of replacement HIT services
	Explore further forensic community outreach. (step-down support for those discharged from Specialist Commissioning secure in-patient provision, and prevention/early intervention)
	 
	BTRS Bid1 HIT Community Model.doc

Personalisation • Incr eased use of individual budgets • Shift to positive supported living models	We will improve and ensure commissioning of services

• Incr easing up take of Personal health Budgets and developing the provider market	includes Personal health budgets Build on and develop provider framework to meet the needs at times of crisis or planned respite. Develop collaborative commissionin g across CCGs for packages of high cost and to ensure people come back into area from hospital or Out of Area Placements.

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

Health and local authority partners will demonstrate a willingness to co-commission personalised individual pathways to support the personalised agenda. Where appropriate pooled financial envelopes will be explored, the PCU are working on behalf of the North Yorkshire & York CCGs on creating local offers for the Personal Health Budget agenda. Across North Yorkshire we have successful Personal Health Budgets allocated to a small number of individuals with learning disabilities where we are witnessing positive outcomes for service users.

CCG commissioners will look creatively within the constraints of NHS block contracts to seek alternative possibilities for personalised options with the provider. As Tees Esk and Wear Valley NHS Foundation Trust are the provider for many of the services, the aim would be to support them at looking at remodelling, as inpatient beds are reduced, and look to use clinical skills within the community services. Specialist commissioning are developing their own plans with regard to reduction of beds. As the provider Market develops there will be opportunities to review current block purchases and look at more individual commissioned services. Developments in reduction or changes in services will be co-produced with all stakeholders in particularly experts by experience.

Work has commenced within the CCGs and Local Authority colleagues to evaluate existing

third sector contracts to look at the effectiveness of outcomes; to determine where future investment should and could be made. This work is in its infancy and will continue to develop**.**

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

An eight bedded in-patient service (White Horse View) will close by end of April 2016. This service primarily focused on the rehabilitation need of those patients with more persistent behaviours that challenged in a variety of ways, including high risk behaviour, public protection, vulnerability from self-injurious behaviours and non-concordance with treatment. The arrangements for the decommissioning are in place and progressing well.

The current four patients in the service have identified pathways to discharge. The challenge to North Yorkshire & York post closure will be how we provide for this cohort of patients moving forward given our model of integrated community care. The aim will be to increase the capacity and skills within the community teams to meet this need and provide our new model of care, which will include crisis response and contingency planning.

To deliver our new model, we plan to undertake a review of existing capacity with our providers. This will be inclusive of the community teams and the primary focus will be on urgent care provision.

Our NHS contracted provider has demonstrated their interest and commitment in exploring a future extended service model based on extending opening hours from 9am-5pm to 8am-8pm and opening at weekends. Consideration of the financial resources requires further discussion with the CCGs which has already begun. Commissioning leads for adult social care and health continue to review out of area placements and analyse future accommodation provision closer to home. This is now core business to the Transforming Care agenda and will lead to improved care co-ordination pre and post discharge.

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

Service design and packages: There is a massive need for a cultural change to ensure a truly personalised approach to care for people with a learning disability/ and or autism, both within commissioning and providing services.

As described in the Service Model, Choice and Control must be a priority to ensure that a person-centred approach is adopted and meets the needs and wishes of the individual and their family. The use of family member and carers must be considered in review/development of packages and Advocacy services (as required).

We will ensure opportunities for co-production of service design, packages of care, recruitment and selection of staff and carers. Ensuring the training of staff and monitoring the quality of service provision by putting the person central to all decision making will be our focus. The aim will be to have micro commissioning as close as possible to the person (case management) and macro commissioning used to support planning and collaboration of service provision.

With the reduction of in-patient beds and the number of unnecessary hospital admissions being a key focus, delivering the ‘right care in the right place’ and ‘prevention and early intervention’ strategies must take centre stage in our planning. Services will be required to

identify gaps in services, join up resources and work in a more innovative way.

Children and young people: We will need to identify people at risk of poor outcomes from the outset, starting in childhood and continuing through all life stages. We put in place the systems and processes which will help us to do so. Education, Health and Care Plans (EHCPs), transitioning plans, increasing the uptake of primary care based Health Action Plans, 'at risk of admission' registers, and CTRs will all have an enormous part to play. The challenge will be to make sure that this wide range of systems is truly co-ordinated. Pathways and options in the way services are delivered will need to be developed and the idea of health and social care navigators will be explored.

Transitions into Adulthood: We are improving our response to addressing and supporting the needs of young people with a learning disability when moving into adulthood. This may need to include advice and support around decision making and consent, in a format they can understand. Joint working arrangements with health and social care will be required to promote personalisation especially for those receiving joint-funded packages.

Personal health Budgets: We are progressing personalised options for people with learning disabilities through the development of a robust Personal Health Budget offer and direct payments are already well established in the local authorities. LD Children teams within Children and Young people's services and CAMHS services will continue to work jointly on encouraging the take up of Personal health Budgets.

The local Personal Health Budget programme will be managed by focusing on outcomes or "I statements" which will be embedded into project planning. This will inform how CCGs commission in a more personalised way in the future, beyond the Personal Health Budget project.

The "I statements" were developed in 2012, through the NHS Commissioning Board by National Voices, in order to develop a compelling narrative of care based on the experiences of patients, service users, carers and their organisations. These personal "I statements", developed with the help of Think Local Act Personal (TLAP) and through national workshops and consultations, detail how care and support looks from the perspective of the person using the services. These cover:

- Care planning
- Goals and outcomes
- Communication
- Decision making
- Information
- Transitions

A full action plan will be developed which demonstrates how the project is achieving one or more of the "I statements". Overview will be provided by the local Personalisation

Programme Board which will include representatives with a lived experience of living with disability.

Reports will be made on progress via the “Markers of Progress” to NHS England and through the Health and Wellbeing Board metrics for NYCC.

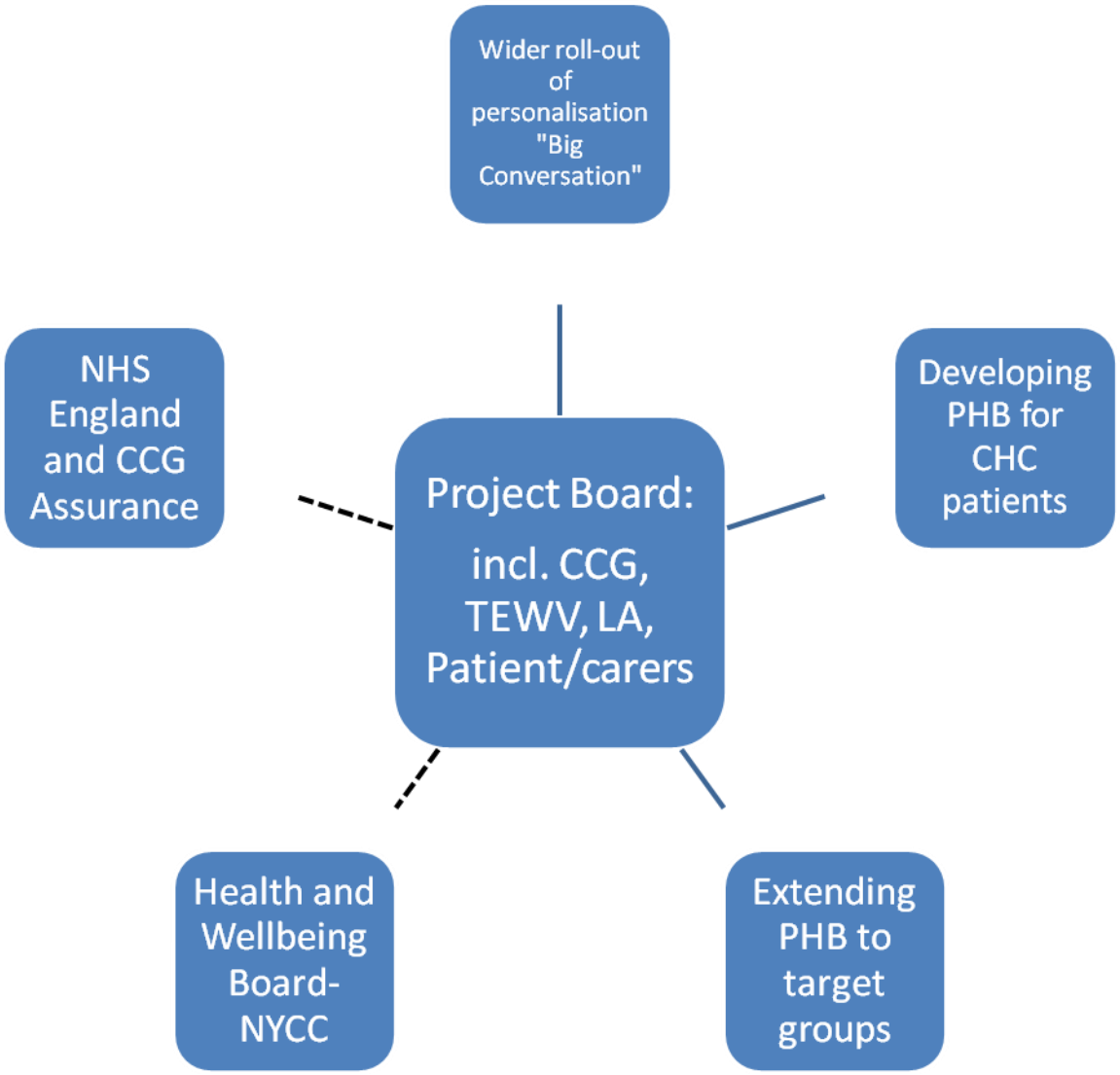


Figure 1Personalisation Programme

Project Overview:

The project will be developed in more detail with stakeholders through individual task and finish groups.

ANNEX 1

Extended local offer

We will also extend the provision of Personal Health Budgets to focus on the client groups outlined below. For each client group we will identify a small cohort of people through engagement and coproduction with local partners:

- People with a learning disability/mental health condition who have had a psychiatric hospital admission and who are eligible for Section 117 Aftercare.

We will do this by

- Including patients and their families or representatives in the way the project is run
- Testing new ways of working with small numbers of patients and their families.
- Working with local NHS providers to develop staff capacity to deliver more personalised services
- Learning from how other parts of the country are developing this agenda

1. Agreeing a roll-out plan

During 2016 we will have a "big conversation" with local stakeholders about how the future should look for the population locally. This will inform how we develop local services, not just to deliver personal health budgets, but to deliver more choice and control for NHS patients in the future. We will consider in this process:

- How we harness the energy and support local communities and families offer
- ICT solutions including an e-market place
- Encouraging people to work as P.A's in the community
- Partnerships we need to foster e.g. joint working with supported housing organisations, domiciliary care providers, extra-care housing, local authority care management teams, as well as local education authorities and schools
- Role of GP's and NHS staff in supporting personalisation of healthcare

Embedding the Care Act will support personalised care: Improvements to current care models will also be achieved through systematic adoption of the Care Act aims and principles. In NYCC, there is team working to implement the Care Act. The changes embodied in the Care Act are designed to make care and support clearer and fairer and to promote the wellbeing of both the people who are cared for and their carers. The aim is to prevent or delay people's care needs becoming more serious and to help carers to continue

their caring role. Changes to provision of and eligibility for care and support was introduced in April 2015 and funding changes were planned to be introduced in April 2016. However, these funding changes have now been delayed until 2020. The local NYCC team are advanced with their preparations for implementing the Care Act and is already doing much that is required. Work will continue to develop and shape local practice in line with the Care Act requirements.

- A new national eligibility threshold based on whether a person's needs are due to a physical or mental impairment or illness; to what extent this affects their abilities and how this affects their wellbeing.
- Unpaid carers will have the same rights as those they care for, so may be able to get more help to carry on caring and look after themselves.
- Continuity of care when people move to another area.
- Deferred payments, which North Yorkshire already offers, will become universal.

Achieving the Care Act: Actions being implemented in North Yorkshire and York

- We are helping people to cope in their own homes through our re-enablement service, which provides intensive short-term support after people leave hospital.
- We are tackling isolation by working with partners and through projects such as the innovation fund, which supports local facilities.
- We have officers who will help people to maximise the benefits available to them

What will care pathways look like?

Future pathways will centre on a model described in our vision, and developed as part of the transformation plan. We will build on current good practice and already developed interfaces/ integrated services. Pathways will be well co-ordinated and easy to navigate for the service user and their carers. The important aspects will be the interfaces and transitions. There will be an emphasis on person centred approaches, and ensuring the care and support meets the needs of all the cohorts. Positive behaviour support principles are essential and multiagency /multidisciplinary approaches will be required within all the pathways.

Key priorities will be:

- Early Intervention - Preventing Admission
- Crisis Response
- Seamless and well defined Children Young People and Transition pathways
- Secure step-down pathway in to appropriate supported services, with support being flexible to opt in and out as and when required by the service user

1. The current in-patient cohort, including those in secure settings/ or at risk of

admission: We will help people move from secure hospital / Out of Area placements back into the locality.

a) A new community model will need to support discharge planning and provide ongoing support to social care providers for those people previously cared for in inpatient settings. This is a well-known cohort whose quality of life and care must be improved. However, this still requires risk management and each individual being in a safe setting with support on hand for all contingencies. This will ensure that, where possible, they can stay in their own home and any future in-patient admissions are minimised. The aim will be to develop this further with our primary NHS provider and social care providers to ensure the complexities of this cohort are met in the least restrictive way. This cohort could also have mental health diagnoses which social care staff may require additional training in.

b) The new pathway will require more robust interfaces with the criminal justice system, police and probation service to provide services based on safety and responsiveness. Education and awareness to prevent a spiral of events taking over resulting in prison/secure ward is paramount. This will include identification of people with Learning Disability and Autism. Most importantly, this must be a life span pathway, and support transitional years into adulthood.

2. Pathway for planned and co-ordinated community care to meet the need of the current 'community' cohort. Those at risk of admission and /or requiring support to remain in their own home/community will have mental health needs and or behaviours which challenge.

2a) Pathways will include early detection and Proactive /prevention measures. Community teams will need to have interventions/ activities accessible before the usual referral route. This is using intelligence to know when people are becoming at risk, or when proactive intervention would prevent any issues occurring. This will need to be developed along with contingency planning.

2b) This pathway will include assessment and interventions/ social and health care that is person centred and will be inclusive of discharge planning and community living that is co-produced and person centred.

2c) The pathway will need to keep people with a learning disability and/or autism living well in communities and prevent deterioration in their wellbeing to reduce the requirement of inpatient services. This pathway will need to meet the needs of people over a seven day week and work in conjunction with other services, as required, over 24/7.

Future Crisis Models will include Emergency response within the community to prevent admission to hospital. This will ensure effective crisis support / Early Intervention and enhanced integrated home intensive support teams in the community. Short term accommodation (available for a few weeks) will be available to be used in times of potential crisis to prevent an avoidable admission into an in-patient setting. Safe places will provide out of hours support alongside an improved interface with Mental Health services to provide integrated community teams

2d) Pathways for people with wider learning disability and autism will include providing support to access services (particularly primary and secondary care). Mainstream services and community networks will need to support people with a learning disability and/or autism

to live well in the community without the need for specialist services where at all possible.

3. Children and Young People and Transitions pathways – This pathway will consider lifespan needs, early intervention, use of personal budgets, and parenting support. This is part of the "Futures in Minds" Vision. The Partnership Commissioning Unit has a 'Transformation plan for Children and Young People's Emotional and Mental Health' to improve services and support developing resilience in schools and families.

The pathway will need to be aligned to EHCP processes and awareness of complications in moving into adulthood. This will usually include interfaces with a range of services, and often requires a facilitation role. In particular, CAMHS will be required to ensure handover is smooth and intervention/support is consistent. We will align plans with Futures in Mind transformation plans, identify gaps and ensure joint working to find resolutions.

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

Our aim is to meet the needs of people with a learning disability and or autism (of all ages) within "life span" services or pathways (including children through to adulthood).

However children's and adults services are currently commissioned and provided separately. Options for changes in commissioning and providing services will be considered as part of the transformation plans, and further development of the transitions pathway.

There is a requirement to ensure smooth pathways/ interfaces between services, whether this is health or social care. There is also a need for services to share practice and develop similar opportunities in pathways and interventions. In particular, it is recommended that positive behaviour support is used. We will ensure that the Transformation plan for Children and Young Peoples Emotional and Mental Health is aligned to this transformation plan.

We will be aiming to use data collected with regard to the needs of children, to provide early detection of the children in the cohorts and provide support /intervention so that services can be developed in a personalised way and proactively prevent admission to hospital, and out of area placement.

We are aware of the differences between child and adult services and therefor there is a need for processes to be used consistently. The Education Health and Care Plans are used to inform the Transition process for young people as they move into adulthood. EHCPs have a planning and review cycle which includes all a young persons' needs in a holistic manner. These are completed for all children with identified special educational needs and Disabilities. This, along with Care and Treatment Reviews, will help planning and support people to move through services. Personal Health Budgets will be offered to support the philosophy of use of mainstream services.

Local developments are happening, such as:

- Implementation of Transformation plan for Children and Young Peoples Emotional and Mental Health.

- A North Yorkshire Preparing for Adulthood Protocol has been developed to support children and young people through the various transition stages. Launch is planned for Spring 2016.

- A new integrated Preparing for Adulthood Model is currently being implemented within NYCC. This will underpin the support available to children and young people who are preparing for adulthood by extending the Disabled Children and Young People's Service from 0 up to 25.

- Young people will move into adult social care services based on need, not just age. They will have access to better information and key worker support, earlier access to Supported Employment Services, with greater emphasis on greater integration into local communities.

Under the Care Act 2014, the Children and Family Act 2014 and the SEND Code of Practice, there is a much stronger focus on preparing for adulthood, including better planning for transition into paid employment and independent living and between children's and adults' services.

How will you commission services differently?

As described above: Health and local authority partners will demonstrate a willingness to co-commission personalised individual pathways to support the personalised agenda and the development of Personal Health Budgets. Whilst recognising the considerable challenges and complexities that will need to be worked-through in detail, where appropriate pooled financial envelopes will be explored; moving towards better integration and future options that break away from traditional service provision.

Joint CCG risk-share arrangements will need to be considered, especially in connection with providing community emergency crisis provision and to allow for more creative and innovative-thinking with service provision. The aim will be to ensure service specifications/ care packages to become more personal and outcome-focused, delivering on the "I" statements and quality measures.

Children and young people commissioning services will work together to support development of services in line with Implementation of Transformation plan for Children and Young Peoples Emotional and Mental Health and this transformation plan. As this develops commissioning of services may change.

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

Future Estate

Our plans include reduction of inpatient beds both treatment and assessment and specialist

commissioning. Initially an eight bedded in-patient service (White Horse View) will close at the latest end of April 2016. In line with this we will be considering what will be the best use of this accommodation as part of a wider picture.

The Vale of York CCG is working with NHS Property Services and Tees Esk and Wear Valley NHS Foundation Trust on a Strategic Estates Plan, as are all the other North Yorkshire CCGs. However, within York there are over 25 individual mental health and learning disability 'health' properties and part of the driver of the estates plan, will be to act as an enabler to the overall service strategy. We anticipate one of the outputs of the plan will be the rationalisation of estate. This was pre-empted by the closure of Bootham Park Hospital by CQC, the acute mental health facility in York. In working through the response to a new mental health unity in York, the Transforming Care Partnership team will be working with specialist commissioners to assess the appropriateness and opportunity to co locate some services in any new development, in addition to reviewing all vacant or potential surplus estate to offer opportunities for Transforming Care Partnership.

More people will be supported to live independently and safely within their own homes and community for as long as possible, having their own tenancies – or have the opportunity to own a home. We will also see a reduction in the number of people cared for 'out of area'; ensuring that those with complex needs are able to live, and be supported, locally.

From considering our current accommodation and the needs of people with a learning disability and /or Autism, including the complex needs of the cohorts living in the community and those currently in hospital or out of the area, the challenge will be to develop new accommodation which will offer choice and meet the needs of the individuals and their support packages and therefore, we will need to extend current stock or redesign new stock of housing /estates.

To achieve this we will engage support from estates and housing professionals to complete a mapping exercise (ongoing). This will link with provider events and opening up the provider Market. Two provider market events have already been held. The aim will be to open up the Provider Market to develop more supportive housing / care packages and provide crisis resources as described in our implementation plans.

Some of our initial thinking to data comprises of looking at a two-tier integration model:

1) 'Interim' intensive 24 hr supported living 'hub and spoke' model

2) Step down accommodation after 26 weeks into more generic supported living model

However we need to plan this fully to understand and identify gaps:

- Current housing provision in the locality and forecasted developments
- Data collected about growing needs, children through to adulthood
- CTR and person centred discharge plans for people move from hospital
- Out of Area person centred plans
- Use of Dynamic registers to understand crisis resource required and future needs of people at risk of admission

- Use of properties which may require to change function

Alongside service redesign (e.g. investing in prevention/early intervention/community services); transformation in some areas will involve 'resettling' people who have been in hospital for many years. What will this look like and how will it be managed?

We are developing processes in place to bring people back to their communities :

- Within North Yorkshire and York Transforming Care Partnership, we have three patients in long term hospital placement, one has a discharge plan mid-2016, the remaining two discharge pathways are being managed through the CTR process and support and transition plans are in place.

- Specialist commissioning and plans for discharge are part of their trajectories and CTR process and work is ongoing with support of discharge coordinators.

- As part of our plan we will also be supporting people back into the locality in Out of Area placements. To do this, we have processes in place to assess and review needs in a person centred way, identify care and support requirements along with housing needs. This is managed and monitored.

Please see – 'analysis of in-patient usage' for further thinking surrounding those people who are currently place in specialist beds.

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

Much of what we intend to do and how we intend to do it is aligned with:

'Live Well, Live Longer' Learning Disabilities: Joint Strategy for North Yorkshire 2015 – 2020 - Our strategic approach is centred around what is known as promoting protective factors and maximising people's capabilities and support within their communities. This means promoting people's health and wellbeing, preventing, delaying or reducing the need for services, and protecting people from abuse, thus providing a foundation for continuous improvement in learning disability services and better lives for the people who use them.

The NHS and Local Authority are committed to delivering this strategy and finding creative and innovative new ways of delivering services and solutions that achieve our organisational and individual outcomes including those which are set out in NYCC's 2020 vision and the implementation of the Care Act 2015.

This plan is aligned with the priorities of the City of York Health and Wellbeing Board and The North Yorkshire Health and Wellbeing Board. There is a shared vision of improving the health of everyone and a focus on prevention and reducing inequalities. Additionally, there is a focus on other areas such as healthy and sustainable communities, improving lives for vulnerable groups, long term conditions, increased emotional wellbeing, reductions in

deprivations, improving mental health for all and support for children and older people.

This plan is mirrored to the work being undertaken with the implementation of the Crisis Care Concordat. The national agreement between multi-services and agencies involved in the care and support of people in crisis is working together to make sure that all people get the help they need when they are having a mental health crisis.

This plan is aligned to The North Yorkshire Mental Health Strategy which sets out a vision of:

"We will work together to ensure the people of North Yorkshire have the resilience to enjoy the best possible mental health, and to live their lives to their full potential, whatever their age and background, supported by effective, integrated and accessible services across all sectors, designed in genuine partnership with the people who need to make use of them and those who care for them."

The Transformation Plan for Children and Young People's Emotional and Mental Health supports this plan. It gives a commitment that by 2020 children and young people:

- Grow up confident and resilient and able to achieve their goals and ambitions,
- Can find help easily when they need it
- Receive help that meets their needs in a timely way
- Are fully involved in deciding on their support and are actively involved in deciding how services are developed and provided.

The North Yorkshire Autism Strategy sets out themes which this plan is aligned to:

- Support for people with autism and their families
- Assessment and diagnosis
- Awareness raising and training
- Information and signposting
- Employment and education
- Supporting people with autism during key life changes
- Working together

The City of York Autism strategy sets out the following themes:

The joint strategy for York aims to put the national guidelines as set out in "Fulfilling and Rewarding Lives" into the local context of York. The five main outcomes within Fulfilling and Rewarding Lives" are:

- increasing awareness and understanding of autism among frontline professionals;
- developing a clear, consistent pathway for diagnosis in every area, which is followed by the offer of a personalised needs assessment;

- improving access to the support that adults with autism need to live independently within the community;
- helping adults with autism into work;
- enabling local partners to plan and develop appropriate services for adults with autism to meet identified needs and priorities.

Our overall aspiration is for all people to live longer, healthier and more independent lives; with greater emphasis on prevention, improvements in health and wellbeing, resilience and active citizenship.

There is a great deal of consistency and complimentary thinking across all our plans and when reviewing the 'essence' of each strategy there are many areas of commonality with shared outcomes. Success in delivering these shared outcomes over the next five years will also contribute greatly to more people having a *positive experience of healthcare and social care services* (one of the key outcomes in the NHS Five Year Forward strategy).

Please also see governance framework diagram in Section 1.

Any additional information

5.Delivery

Plans need to include key milestone dates and a risk register

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

In line with our implementation plan we will have 4 key work streams.

1. Provider Market (Inclusive of Commissioning and contracting , Quality Indicators and developing personalised budgets /packages)
2. New "Community" model- subgroups will be developed - Community model (planned work), Crisis response (Enhanced services and early prevention), health and wellbeing SAF, Specialist commissioning and forensic support, Autism.
3. Children and Young People and Transitions pathways
4. Workforce and Training (Inclusive of Positive Behavioural Support)

And we will have One strategy which will run alongside the work streams. This strategy includes :

- Co-production and engagement with People with a learning disability and or Autism
- Communication and Engagement with Stakeholders

The plan is attached.

ANNEX 1

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Delivery will be co-produced with Experts by Experience.

There will be Experts by Experience in a short term task and finish group to write an engagement and coproduction plan based on the following :

- Experts by experience taking a lead role
- Confirm and Challenge processes
- "You said we did" principles
- Agreeing dates and times for people to meet
- Choosing the right elected person to go to meetings and link with the confirm and challenge group
- Making all information easy to understand
- Work stream leads will make sure that people who will use the service help to design it.

The Partnership Commissioning Unit will provide a project management function and will support each of the work streams. They will provide an overview of all progress made against milestones and support the completion of assurance reporting.

The 4 work streams are as follows:

1. 1. Provider Market (Inclusive of Commissioning and contracting, Quality Indicators and developing personalised budgets /packages): the key programmes of change for this work stream are around all aspects of commissioning services. The aim will be to open up options to give people with Learning Disabilities and Autism more choice and control and improve quality of care and improve quality of life. Firstly, we need to know our population and current spend, and what is currently being provided, before developing new models.

The deliverables will be:

1. Mapping our data 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.

2. Delivery of increased options ie Market development (Provider and Housing options) including Respite and crisis accommodation

3. Draft a paper on a range of commissioning and Procurement options ie: Procurement and performance management (contracts to include the new/changed requirements)

4. Review Block contracts and current contracting arrangements

5. Develop Quality indicators. Staff training, Positive Behaviour support,

6. Increase personalise packages and Personal Health Budgets

7. Increase community resources including advocacy and carer support

8. Develop and increase Respite and alternative accommodation and support options

This will include identifying workforce training issues to the work force work stream.

2. New "Community" model- subgroups will be developed - Community model (planned work), Crisis response (Enhanced services and Early prevention), health and wellbeing SAF, Specialist commissioning and forensic support, Autism. The scope will be: Pathway Developments and New Community Model

This work stream has a wide scope and may be broken down into smaller task and finish groups. The aim will be to build on current good practice and develop more robust community services, which will work across a range of services, over enhanced ours, supporting people to stay in their community.

Key targets:

- Early prevention and keeping people healthy
- Helping people move from Hospital and preventing the criminal justice process
- Planned and coordinated community care
- Prevention and management of crisis
- Flexible and robust services to support people with complex needs (prevention further need for hospital and out of area placements)

The deliverables will be:

1. Pathways of care and agreed care standards
1. Discharges to meet trajectories (evidence of Supported discharge planning)
2. A Pathway regarding the criminal justice system, police and probation service for people with Learning Disabilities and Autism
3. Early detection and Proactive/prevention measures.
4. Dynamic risk register will be in place
5. All people will have a care plan and contingency plan.
6. Assessment and interventions/ social and health care that is person centred
7. Crisis response which prevents admission to hospital
8. Enhanced integrated home intensive support teams in the community.
9. Short term accommodation (available for a few weeks) used in times of potential crisis to prevent an avoidable admission into an in-patient setting.
10. Safe places providing out of hours support.
11. Improved interface with MH services with integrated MH and LD community
12. Access to primary and secondary care for all people with learning Disabilities by

providing Support programmes in place for GPs annual health checks and Screening programmes

Specialist Commission and Forensic support will be part of the wider developing a community model. However we will be to look at the people who have been in hospital long term and or in contact with the criminal justice system to review why and establish how prevention can be increased.

The deliverables will be:

1. Offending and criminogenic teams will deliver community risk assessments identifying trigger factors to past and future risk behaviours
2. Treatment plans will address trauma and presenting comorbidity factors.
3. Hospital admissions lengths of stay will reduce.
4. Effective case management by skilled practitioners including criminal justice partners where applicable will be in place
5. Effective use of Conditional Treatment Orders
6. Good sign posting when recognised the service user is struggling to manage behaviour that challenges
7. People in Out of Area placements will support to come home.
8. Support training in Police, Probation and Criminal Justice systems to help recognise Learning Disabilities/Autism and provide appropriate response

3. Children and Young People and Transitions pathways

This work stream needs to consider lifespan needs, alignment to EHCP processes and awareness of complications of moving into adulthood. This will include interfaces with a range of services in particular CAMHS and ensure alignment of Futures in mind transformation plans.

The deliverables will be:

1. Support programme in place for GPs Health Checks to those with a learning disability from the age of 14
2. ‘At risk of admissions register’ including children and people with autism
3. All young people (14 -25) with an EHC based on learning disability and/or autism and behaviour that challenges will have a Joint Preparing for Adulthood Transition Plan
4. Joint working and pathway development with CAMHS
5. Robust transition pathway
6. Every child and young person will have a co-produced person centred care Education, Health and Care plan
7. Personal Health Budgets will be offered at every stage of transition planning

ANNEX 1

4. Workforce and Training (Inclusive of Positive Behavioural Support)

This work stream will ensure that all staff, carers and people with learning disabilities and autism are considered regarding what training and development they require to be able to deliver the new model. Positive Behavioural Support will be integral to the process. All training needs will need to be identified along with any gaps within the current workforce. It is envisaged this will be:

- Mental health and wellbeing
- Stress management and resilience
- Values and attitudes
- Positive Behaviour support
- Supporting people with a forensic history
- Health promotion and Physical health care
- Parenting
- leadership skills
- self-advocacy

Importantly, as work streams develop, they will add to this list. There will need to be cultural changes to 'shift the power' to people with learning Disabilities and or Autism and their families. There will need to be changes in staff roles and development of new posts, such a PBS nurse role and academy

The deliverables will be :

1. A skilled workforce with resilience shown
2. Values and attitudes across all employers with a consistent approach to person centred care
3. Recruitment of staff with the right skills for the new model of care
4. People with Learning Disabilities and Autism reporting they have choices and control over their life.

The draft workforce plan is attached below.

workforce plan draft 25.02).xlsx

ANNEX 1

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

This needs to be discussed and agreed in detail by the TCP before we can commit to providing further detail, however, the plan will be for the Partnership Commissioning Unit to lead and support the work streams, supporting the CCGs and Local Authorities to take an active role. Please note that the function/remit of each work-stream will be to scope 'Section 4 – Implementation Planning' according to their relevant area and develop individual plans in more detail, and then deliver.

Work-Stream	**Lead**	**Supporting Team / Resources Needed**
New "Community" model - Pathway Development	Maria Pink - Partnership Commissioning unit CCG and Local Authority reps	Representatives from PCU and LA Case Management Team Information Management/Governance
Market Development - provider Framework	Richard Dalby and Maria Pink - Partnership Commissioning Unit CCG and Local Authority reps	Business intelligence Housing and estate Finance and Contracting s
Workforce Development	(TBC)Partnerships Commissioning unit CCG and Local Authority reps	HEE / PBS Training Specialists
Children and Young People and Transitions pathways	Helen Billson - Partnership Commissioning unit CCG and Local Authority reps	Representatives from PCU and LA Case Management Team CAMHS rep
Strategies task finish steering group	Partnership Commissioning Unit	Supporting Team / Resources Needed – Project Management Function
Co-production and engagement	Self- advocates group	Inclusion North York People first, Keyring
Communication and Engagement	CCG Communication teams (TBC)	

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

ANNEX 1

Key milestones

All key milestones have been identified in our Route map.

The route map is embedded below

Copy of North yorkshire and york TC

We expect our key milestones will be:

- TCP board is establish by Feb 2016
- PMO function is in place
- Development of work streams to enable delivery with key milestones identified as part of overarching themes by April 2016
- Full Communication and engagement plan in place by Jul 2016
- Engagement and communication channels will be part of the communication and engagement plan agreed by TCP by April 2016
- Co-production plan will be developed by experts by experience - This will be achieved by May 2016
- Co-production groups along with current and additional networks will form part of a confirm and challenge process May 2016
- Outcome measures will be agreed in line with Self-assessment Frameworks, contractual monitoring and quality of life principles "I" statements by June 2016
- Baseline of current service delivery against each work stream will be completed (if not already done). Analysis will inform a baseline for improving quality by July 2016
- White Horse View (an eight bed in-patient facility) is due to close by end April 2016.

What are the risks, assumptions, issues and dependencies?

All programme risks will be captured, uploaded and monitored on an ongoing basis via the Risk Register process. A Risk Register has been developed along with considering mitigation and key actions to manage risks.

Top-line thinking surrounding the main risks are detailed below and we will build upon this as we continue to hone and develop our local plan and identify any further areas of risk.

Risks highlighted are with regard to : Finance , Quality and safety , Workforce and reputation with regard to children families and carers

ANNEX 1

Key risks issues identified at this stage include:

- Lack of Financial information
- Financial commitments and pressures
- Conflicting demands for many organisations alongside limited capacity

Assumptions:

- Stakeholders are committed to change
- Overview agreed on what needs to change at a high level
- Development over 4 CCGs to meet locality demands against agreed targets

Dependencies:

- 4 CCG
- 2 Local authorities
- Voluntary sector
- Main health provider (Tees Esk and Wear Valley NHS Foundation Trust)
- Overlapping Transformation plans and local strategies

What risk mitigations do you have in place?

See Risk register for evidence of risk mitigation below

Copy of LD Transformation Risk a

Any additional information

Please note that the information populating this template is not a 'definitive' plan at this stage but forms part of a 'work in progress'; highlighting top-line thinking to date and direction of travel. Similarly, the finance template is also a working draft.

6.Finances

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

Finance and activity 11.4.16.xlsx

End of planning template