Lancashire County Council

Health Scrutiny Committee

Tuesday, 26 January, 2016 at 10.30 am in Cabinet Room 'C' - The Duke of Lancaster Room, County Hall, Preston

Agenda

Part I (Open to Press and Public)

No.	Item	
1.	**Apologies**	
2.	**Disclosure of Pecuniary and Non-Pecuniary Interests** Members are asked to consider any Pecuniary and Non-Pecuniary Interests they may have to disclose to the meeting in relation to matters under consideration on the Agenda.	
3.	**Minutes of the Meeting held on 24 November 2015**	(Pages 1 - 8)
4.	**Transforming Care for people with a Learning Disability and/or Autism**	(Pages 9 - 68)
5.	**Report of the Health Scrutiny Committee Steering Group**	(Pages 69 - 78)
6.	**Work Plan**	(Pages 79 - 84)
7.	**Recent and Forthcoming Decisions**	(Pages 85 - 86)
8.	**Urgent Business** An item of urgent business may only be considered under this heading where, by reason of special circumstances to be recorded in the Minutes, the Chair of the meeting is of the opinion that the item should be considered at the meeting as a matter of urgency. Wherever possible, the Chief Executive should be given advance warning of any Member's intention to raise a matter under this heading.	

Lancashire County Council

9. Date of Next Meeting

The next meeting of the Health Scrutiny Committee will be held on Tuesday 15 March 2016 at 10.30am at County Hall, Preston.

I Young
Director of Governance,
Finance and Public Services

County Hall
Preston

Lancashire County Council

Health Scrutiny Committee

Minutes of the Meeting held on Tuesday, 24 November, 2015 at 10.30 am in Cabinet Room 'C' - The Duke of Lancaster Room, County Hall, Preston.

Present:

County Councillor Steven Holgate (Chair)

County Councillors

M Brindle	A James
Mrs F Craig-Wilson	Y Motala
G Dowding	M Otter
C Henig	D T Smith
N Hennessy	D Stansfield
M Iqbal	

Co-opted members

Councillor Barbara Ashworth, (Rossendale Borough Council)
Councillor R Blow, (South Ribble Borough Council)
Councillor Shirley Green, (Fylde Borough Council)
Councillor Colin Hartley, (Lancaster City Council)
Councillor Bridget Hilton, (Ribble Valley Borough Council)
Councillor Hasina Khan, (Chorley Borough Council)
Councillor Roy Leeming, (Preston City Council)
Councillor Kerry Molineux, (Hyndburn Borough Council)
Councillor Julie Robinson, (Wyre Borough Council)
Councillor E Savage, (West Lancashire Borough Council)

County Councillor Chris Henig attended in place of County Councillor Nikki Penney, and Councillor Renee Blow attended in place of Councillor Mick Titherington (South Ribble Borough Council) for this meeting only.

1. Apologies

Apologies for absence were presented on behalf of County Councillor Bev Murray

Guests

The Chair welcomed:

- CC Jennifer Mein – Chair of the Health & Wellbeing Board and Leader of the County Council
- Sakthi Karunanithi, Director of Public Health
- Richard Cooke, Health Equity, Welfare and Partnership Manager
- Gill Brown, Chief Executive of Healthwatch

2. Disclosure of Pecuniary and Non-Pecuniary Interests

There were no disclosures of interest relating to matters on the agenda.

3. Minutes of the meeting held on 13 October 2015

The Minutes of the Health Scrutiny Committee meeting held on the 13 October 2015 were presented and agreed.

Resolved: That the Minutes of the Health Scrutiny Committee held on the 13 October 2015 be confirmed and signed by the Chair.

4. Health and Wellbeing Board Update

The report was introduced by County Councillor Jennifer Mein, Chair of the Health and Wellbeing Board and Leader of the County Council, and was presented by Dr Sakthi Karunanithi, Director of Public Health. It provided an update on the progress made by the Health and Wellbeing Board (HWBB).

Sakthi used a PowerPoint presentation which briefly explained the role of the HWBB; it referred to a review of the Board which had been undertaken in April 2015, and set out some recent developments and future priorities.

He emphasised that the Board was working in an environment in which resources were diminishing and demand was rising, which could lead to a serious gap in funding.

Members were invited to comment and raise questions and a summary of the main points arising from the discussion is set out below:

- There was concern about proposals related to the transformation of care for people with learning disabilities and in particular transport provision for disabled adults and the consequent effect on carers. It was recognised that the proposals were well-intentioned but it was felt that they were not practical. In response CC Mein explained that some very difficult decisions would have to be taken in light of the financial pressures facing the county council. She assured the Committee that all budget proposals to be considered had an associated equality impact assessment; no decisions would be taken lightly and mitigation would be put in place wherever possible.

- The Chair pointed out that this Committee was to receive a report on services for adults with learning disabilities at its January meeting.
- The Chair noted that services for people with mental health problems were under strain and expressed concern about the cost and appropriateness of moving people to facilities many miles away from their home; he asked that this Committee be involved in any review of these services. Sakthi emphasised that mental health and emotional wellbeing were a priority for the HWBB.
- It was explained that it was the role of the HWBB to ensure that appropriate plans were in place to improve the health and wellbeing of the people of Lancashire and that reports to the HWBB were part of the assurance process. Agenda and minutes could be read on line and members of the public were able to attend meetings to observe. Members were advised that if they required more detail on a particular topic they would be directed to the most appropriate officer/partner.
- In response to a specific question about Occupational Therapy and what service users could expect in the current financial climate, the Chair reported that the Steering Group was hoping to receive a presentation about this service; he added that any member with a particular interest in any matter coming before the Steering Group could ask to attend the relevant meeting.
- It was explained that 'Healthier Lancashire' was a programme currently being scoped and would be considered by the HWBB; significant changes would be needed to meet rising demand and solutions were not yet designed. There would need to be substantial engagement and Scrutiny would be part of that process. The Committee was informed that 'Healthier Lancashire' was undertaking an alignment of some 53 different plans that needed to be brought together to produce a strategy to achieve better spending for the good of the people of Lancashire. It was reported that there was to be a bite size briefing for members about 'Healthier Lancashire' on 2 December.
- It was suggested that the HWBB should raise its profile as a leadership body. In response it was explained that the HWBB had its own website, logo and newsletter, and the Leader of the Council was its Chair which also reflected how important its work is. It was acknowledged that to some extent it was media responses that determined how much publicity the Board received. It was noted that there were some district councillors among the HWBB membership which provided a helpful conduit to the districts.
- Sakthi said that notwithstanding financial pressures going forward there would need to be a different approach to the public health agenda and how services are delivered.

Resolved: That,

i. The content of the report, the areas of progress and the future focus of the Health and Wellbeing Board be noted;
ii. It be agreed that the Health Scrutiny Committee develop better working and links with the Health and Wellbeing Board.

iii. The Committee would consider the areas for future focus of the Health and Wellbeing Board and how this aligns with its future work programme.

5. Healthwatch Lancashire Update

Gill Brown, Chief Executive of Healthwatch Lancashire provided the Committee with a detailed presentation on the evolution of Healthwatch, its responsibilities and strategy, and examples of current and planned work. A copy of her presentation is appended to these minutes.

There was a lengthy discussion about the work of Healthwatch and in particular the pressures facing the care home sector. It was considered important that the sector be offered support and solutions for the difficulties it was facing and to improve services. It was believed that there was potential for the current crisis in the care sector to destabilise the NHS and it was suggested that this might be an important topic to come before this Committee.

Regarding a specific question about whether the conditions for staff were inspected as part of the 'enter and view' project, it was explained that much depended on what staff were prepared to say and that sometimes they were inhibited by the presence of the care home manager. It was explained that Healthwatch did not just look for things going wrong but also at good practice which would be shared with others.

It was recognised that there were many dedicated care staff working in the care sector and it was suggested that sometimes, where homes were falling short of required standards, it was the care home owners, looking to save money, who were responsible for poor standards. It was considered most important not to shy away from robust questioning to understand what was really happening.

There was concern that often CQC (Care Quality Commission) recommendations and follow-up visits did not lead to sufficient positive changes and too many care homes were in need of improvement or, in some cases, inadequate. The point was made that many care home residents suffered from dementia and were not able to express themselves, and there was also sometimes a fear of intimidation in speaking out. It was therefore important to ensure CQC recommendations were carried out robustly.

The Committee was informed that Healthwatch had met with the CQC inspection team and fed back concerns following their visits and they also referred concerns to commissioners to ensure the home was 'on their radar'. It was emphasised that the 'enter and view' team were very well trained and this included dementia training.

There was concern about where residents could go if the home in which they were staying closed down particularly given the pressure on the NHS and the lack of available beds. It was agreed that this was an important question and there was a serious need for action to address this.

It was suggested that the issues around care services needed to be considered in a holistic way not just care homes, for example district councils should be involved because of their role in housing provision, and studies had shown that remote support via technology in people's homes had significantly reduced the number of GP callouts to those people. It was agreed that there was an opportunity for Lancashire to be innovative in how these issues were approached.

It was suggested that it would be interesting to know what all partners were doing with regard the 'Ageing Well' agenda, for example West Lancashire Borough Council was focussing on loneliness, isolation and dementia.

It was reported that the Health Scrutiny Committee Steering Group was to host a meeting with Registered Care Managers Network, originally intended to discuss falls in care homes, but the meeting would provide an opportunity to consider other issues and to develop a relationship which would help to elicit their most serious challenges.

Gill Brown encouraged the members to raise issues of concern with Healthwatch either as a Committee or on an individual basis.

Gill explained that the 'enter and view' team were currently employed on fixed term contracts until the end of March, as part of a pilot scheme, and she was hopeful that the county council would continue to provide its support, though she recognised that there were some difficult budget decisions to be taken.

Resolved: That the report be noted.

6. Report of the Health Scrutiny Committee Steering Group

It was reported that on 14 September the Steering Group had met to consider its current ways of working and discuss ideas and suggestions for the future, and also to consider whether a 'tool kit' for task groups would be useful to members to enable their full participation and involvement in future task group reviews.

In response to concerns raised by CC Holgate about GPs using the Urgent Care Centre (UCC) at Chorley Hospital Ian Crossley, acting Chief Officer and Nicola Walsh, Interim Head of Operations and Delivery from Chorley South Ribble/Greater Preston CCG attended the meeting to provide members with a status update and discuss the plans for the future. A summary of the meeting was at Appendix A to the report now presented.

On 5 October the Steering Group had met with Paul Simic, Chief Executive from the Lancashire Care Association (LCA) to discuss issues around falls in care homes and the challenges faced by the care home sector to address these issues. Following that meeting the Steering Group had agreed to host a meeting of Registered Care Managers which would provide an opportunity to discuss wider issues and the main challenges. Janice Scanlon, from the Trust Development Authority (TDA) also attended the meeting to talk about the

appointment of non-executive directors and the support they can access. A summary of the meeting was at Appendix B to the report now presented.

Resolved: That the report of the Steering Group be received.

7. Work Plan

Appendix A to the report now presented set out a draft work plan for both the Health Scrutiny Committee and its Steering Group, including current Task Group reviews.

It was reported that a report about Services for Adults with Learning Disabilities would now be presented to the January meeting, and the report, originally scheduled for January, about Joint Working in light of the Budget impact would now be presented to the April meeting.

Resolved: That the work plan, as amended, be noted.

8. Recent and Forthcoming Decisions

The Committee's attention was drawn to forthcoming decisions and decisions recently made by the Cabinet and individual Cabinet Members in areas relevant to the remit of the committee, in order that this could inform possible future areas of work.

Recent and forthcoming decisions taken by Cabinet Members or the Cabinet can be accessed here:

http://council.lancashire.gov.uk/mgDelegatedDecisions.aspx?bcr=1

Resolved: That the report be received.

9. Urgent Business

The Chair reported that University Hospitals Morecambe Bay Trust (UHMBT) had arranged a special session for Health Scrutiny Committee members of both Lancashire and Cumbria to take place in Kendal on 11 January 2016, before the next meeting of this Committee. The aim was to enable members of both authorities to learn the Trust's vision for their hospital buildings, their longer term plans and possible changes over the next 12 months. This would assist with future scrutiny of the Trust's performance and activities.

The Chair asked members to approve the session with UHMBT on 11 January as an approved duty.

Resolved: That the session arranged by UHMBT, to take place on 11 January 2016, be treated as an approved duty of the Committee.

10. Date of Next Meeting

It was noted that the next meeting of the Committee would be held on Tuesday 26 January 2016 at 10.30am at County Hall, Preston.

I Young
Director of Governance, Finance and Public Services

County Hall
Preston

Health Scrutiny Committee
Meeting to be held on 26 January 2016

Electoral Division affected:
All

Transforming Care for people with a learning disability and/or Autism
(Appendix A refers)

Contact for further information:
Charlotte Hammond Head of Service Adult Safeguarding, Learning Disability and Mental Health 07771338882
Sally Nightingale Manager Policy, Information and Commissioning (Live Well) 07717301861

Executive Summary
The report provides the committee with a summary and history of the Transforming Care agenda for people with a learning disability or autism and an update of progress. It informs members of Lancashire's inclusion in a National "Fast Track" programme, and its subsequent mainstreaming to form a Transforming Care Partnership, a strategically led Pan Lancashire collaboration of 8 Clinical Commissioning Groups (CCGs), 3 Local Authorities and NHS England specialised commissioners, where the transformation needed can be planned and implemented.

Recommendation
The committee is recommended to:

i. Note the progress made in developing the Transforming Care agenda in Lancashire;
ii. Agree to provide future support and challenge that will enable effective engagement; and
iii. Note the discussions taking place regarding the funding arrangements for this group of people.

Background and Advice
Following the Panorama programme broadcast in May 2011 which exposed the abuse at Winterbourne View, the Department of Health published a report and action plan titled 'Transforming Care'. The report focuses on the care and support experienced by all children, young people and adults with learning disabilities or autism who may also have mental health conditions or behave in ways that are described as challenging.

The review found widespread failings in service design, failure of commissioning, and failure to transform services in line with established good practice.

Winterbourne View – Time for Change
The Bubb report (Winterbourne View – Time for Change, November 2014) reinforced and escalated previous policy drivers and requirements in relation to how

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people with a learning disability are supported. It emphasised a lack of progress and failures to meet the expectations and pace within the National and Local Action Plans on Winterbourne / Transforming Care. The report directed how commissioners needed to respond to the agenda, specifying the need for 'one shared plan', 'one lead commissioner' and ultimately, 'one pooled budget'. These National issues are also reflected locally in Lancashire.

Fast Track - Transforming Care for people with a learning disability
The announcement of Lancashire's (including Blackpool and Blackburn and Darwen) inclusion in a National Fast Track programme in June 2015 provided the impetus and strategic leadership, for the necessary collaboration across the sectors (8 CCGs, 3 local authorities, NHS England specialised commissioners, providers and stakeholders) to plan for and drive the transformation required for the Learning Disability (LD) community. Lancashire partners were required to develop and write the action plan for submission in September 2015.

Governance and support
The programme is led and governed by The Transforming Care Partnership a strategic steering group of representative partners. An existing group, the LD Commissioners Network, has taken responsibility for progress on the identified work streams and associated action plans and report to the Steering group:

- Sharon Martin, Director Performance and Delivery East Lancashire CCG has been identified as Senior Responsible Officer (SRO) to lead the process;
- Tony Pounder, Director of Adult Services, Lancashire County Council has been identified as a Local Authority SRO in support of the lead and also represents Lancashire at the Regional Transforming Care Board;
- There is a governance framework for the LD transformation programme for Lancashire through to the Health & Wellbeing Board;
- An alliance of national organisations support transforming care partnerships to deliver on this ambitious agenda including NHS England, Local Government Association (LGA), Association of Directors of Adult Social Services (ADASS), Health Education England (HEE), Skills for Health, Skills for Care, the Care Quality Commission (CQC), NHS Trust Development Authority (TDA), Monitor, and provider representative organisations;
- A Lancashire Confirm and Challenge group will work closely with people with a learning disability and/or autism as well as their families/carers to ensure the work is co-produced.

The situation in Lancashire
At the time of writing the Lancashire plan there were 47 in- patients in CCG cohorts and 46 in- patients in the NHS specialist commissioning cohort. The Lancashire Plan committed us to:

- Re-home as many of the current in-patients as possible into community care packages
- Appoint Care Co-ordinators to support discharge
- Review Social Work in Lancashire and set up an LD Social Work team – this action has been achieved and the team are operational
- Develop a new service model that will be delivered in communities by key professionals working together; that the new service will provide a uniform

case management process incorporating person centred planning, care and treatment reviews (CTRs)
- Pilot a Positive Behavioural Support Service in 2 areas
- Develop innovative accommodation and care packages

Building the Right Support
The experiences of the 5 Fast Track Local Authorities and their NHS partners chosen to develop and submit, to NHS England, their plans for transforming their LD services over the summer of 2015 were taken and used in the development of Building the Right Support (October 2015) - A national plan and service model to develop community services and close inpatient facilities for people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition (Appendix A).

Key points of the Building the Right Support plan include:
- People with a learning disability have the right to the same opportunities as everyone else - to have a home within their own community not in a hospital
- The need to change services, to build the right community based services to support people at home
- The work needs co-ordinating across organisations

Key points of Building the Right Support that relate to Lancashire include:
- Lancashire has been too reliant on in–patient care
- Calderstones will close by 2019 and peoples care will be re- provided for in the community or where restrictions don't allow in other in patient settings
- If people need hospital their discharge will be planned for as soon as they are admitted
- Clinical Commissioning Groups will be encouraged to pool budgets with Local Authorities
- For people who have been in hospital the longest (over 5 years) the NHS will provide a dowry
- In Lancashire
    - a proposal to develop an integrated community learning disability team
    - improve crisis intervention and support
    - develop staff knowledge and the use of Positive Behavioural Support

Consultations
A stakeholder day for people with a learning disability and/or autism as well as their families/carers and partners was held 18 August at Calderstones NHS Foundation Trust to inform the development of the Lancashire plan. Further consultation will take place with people with a learning disability and/or autism as well as their families/carers through the Confirm and Challenge group.

Implications:
This item has the following implications, as indicated:

Risk management
Financial
A locally defined finance proposal for dowries paid by the NHS to local authorities for people leaving hospital after continuous spells in inpatient care of five years or more years was tabled at the 11 November 2015 meeting of the Transforming Care Steering Group.

Lancashire County Council rejected this proposal and have subsequently taken a decision not to fund patients discharged as part of the transforming care programme, due to the financial implications for the organisation of the costs associated with people discharged from hospital to the community passing from the NHS to Local Authorities.

LCC's Chief Executive has written to the responsible NHS England Director, outlining the pressure this work programme presents and how it compounds the overall financial pressures for the organisation (LCC). This issue is being dealt with at NHS Chief Officer level and a meeting has been set in February aimed at achieving a mutually acceptable resolution.

Legal
Legal advice is being taken in relation to the Transforming Care agenda, there are some people who are going through legal proceedings where further to legal advice Lancashire County Council are continuing to support.

Local Government (Access to Information) Act 1985
List of Background Papers

Paper	Date	Contact/Tel
Scrutiny Committee	18/09/2015	Ian Crabtree Head of Service Policy, Information and Commissioning (Age Well) 07773390254
Lancashire Health and Wellbeing Board	29/10/2015	Ian Crabtree, Head of Policy, Information & Commissioning (Age Well) 07773390254

Local Government Association

directors of adass adult social services

NHS England

Building the right support

A national plan to develop community services and close inpatient facilities for people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition

October 2015

Building the right support

A national plan to develop community services and close inpatient facilities for people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition

Version number: 1

First published: 30 October 2015

Updated:

Prepared by: Anthony Houlden, Commissioning Policy Manager

Classification: OFFICIAL

Gateway reference: 04303

Contents

Foreword

Children, young people and adults with a learning disability and/or autism have the right to the same opportunities as anyone else to live satisfying and valued lives, and to be treated with 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 healthy, safe and rewarding lives.

As a society, we are on a long journey to make that simple vision a reality. We have made enormous strides over several decades. But for a minority of children, young people and adults with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition[1], we remain too reliant on inpatient care - as they and their families have been telling us loud and clear.

It is for that reason that, in February 2015, NHS England publicly committed to a programme of closing inappropriate and outmoded inpatient facilities and establishing stronger support in the community, and promised that further details would follow later in the year. This plan meets that commitment.

We know it comes at a time when many people with a learning disability and/or autism, as well as their families/carers are frustrated - that change has been limited and slow, particularly following the appalling scandal at Winterbourne View. We know too that thousands of frontline carers, clinicians, providers and commissioners want to make progress.

This plan sets out how we will do so: supporting local leadership and making available new investment to kick-start change. It means that we now have an opportunity – to make real the rights of people with a learning disability and/or autism, and to help thousands of people lead happier lives.

We know that this challenge is achievable because many parts of the country are already successfully doing it. There is good practice across the country to replicate, and the skills and expertise of thousands of families and front-line staff to build on. 'Fast track' areas across England are starting to show what kind of transformational change is possible with strong local leadership building a new generation of community-based services.

Now it is time to deliver across the whole country. This plan sets out how we intend to do so – working with people with a learning disability and/or autism, families, staff, clinicians, providers, and commissioners.

Jane Cummings,
Chief Nursing Officer, England

Ray James, President, Association of Directors of Adult Social Services

Sarah Pickup, Deputy Chief Executive, Local Government Association

Dominic Slowie, National Clinical Director for Learning Disability, NHS England

[1] Hereafter people with a learning disability and/or autism.

1. Executive summary

The journey to date

1.1 Over many decades, as a society we have significantly reduced our reliance on institutional care to support people with a learning disability and/or autism, closing asylums, campuses and long-stay hospitals. For a minority of people however, there is still an over reliance on inpatient treatment for people who could, given the right support, be at home and close to their loved ones.

1.2 Over the last few years hundreds of people from hospital have been supported to leave hospital – but others are admitted in their place, often to inappropriate care settings, so the number of inpatients remains steady. We have not made enough progress when it comes to changing some of the fundamentals of care and support.

1.3 To make this permanent we need a change in culture, a shift in power to individuals and a change in services. We need to see people with a learning disability and/or autism as 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. And 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.

1.4 To speed up this process and to help shape a national approach to supporting change, six 'fast track' areas[2] drew up plans over the summer of 2015 and are already making a difference on the ground. Together they envisage shifting money into community services in order to reduce their usage of inpatient provision by approximately 50% over the coming three years. Their plans will result in the development of a range of new community services and the closure of hospital units, including the last standalone learning disability hospital in England.

1.5 This document describes how we intend to build on our experience with fast tracks to implement change across the rest of the country.

The new services we need

1.6 People with a learning disability and/or autism who display behaviour that challenges are a highly heterogeneous group. Some will have a mental health problem which may result in them displaying behaviour that challenges. Some, often with severe learning disabilities, will display self-injurious or aggressive behaviour unrelated to any mental health condition. Some will display behaviour which can lead to contact with the criminal justice system. Some will have been in hospital for many years, not having been discharged when NHS campuses or long-stay hospitals were closed. The new services and support we put in place to support them in the community will need to reflect that diversity.

[2] Greater Manchester; Lancashire; North East and Cumbria; Arden, Herefordshire and Worcestershire; Nottinghamshire; Hertfordshire.

1.7 A national service model, developed with the help of people with lived experience, clinicians, providers and commissioners, outlined in this document and published in full alongside it, sets out the range of support that should be in place no later than March 2019. It should be read in tandem with this plan.

1.8 Implementing this model, and giving people greater power over the services they use, will result in a significantly reduced need for inpatient care. We expect that as a minimum, in three years time, no area will need capacity for more than 10-15 inpatients per million population in clinical commissioning group (CCG) commissioned beds (such as assessment and treatment units), and 20-25 inpatients per million population in NHS England-commissioned beds (such as low-, medium- or high-secure services).

1.9 These planning assumptions will mean that, at a minimum, 45 – 65% of CCG-commissioned inpatient capacity will be closed, and 25 – 40% of NHS England-commissioned capacity will close, with the bulk of change in secure care expected to occur in low-secure provision. Overall, 35% - 50% of inpatient provision will be closing nationally with alternative care provided in the community. The change will be even more significant in those areas of the country currently more reliant on inpatient care. In three years we would expect to need hospital care for only 1,300-1,700 people where now we cater for 2,600. This will free up money which can then be reinvested into community services, following upfront investment.

1.10 These planning assumptions should be seen as the starting point. Commissioners should, working with people with a learning disability and/or autism, be ambitious in thinking about how much further they can go, starting not from the point of what services they have currently but what support people need to live the best possible life.

1.11 Just like the rest of the population, people with a learning disability and/or autism must and will still be able to access inpatient hospital support if they need it. What we expect however is that the need for these services will reduce significantly. The limited number of beds still needed should be of higher quality and closer to people's homes.

1.12 For those that do need this more specialist support in hospital, their length of stay should be as short as possible. We will work with providers, commissioners and clinicians to reduce length of stay overall and ensure areas learn from best practice – for instance one 'fast track' area aims to reduce length of stay in assessment and treatment services to an average of 85 days.

Delivering change

1.13 To achieve this systemic change, 49 transforming care partnerships (commissioning collaborations of CCGs, NHS England's specialised commissioners and local authorities) are mobilising now. They will work with people who have lived experience of these services, their families and carers, as well as key stakeholders to agree robust implementation plans by April 2016 and then deliver on them over three years.

1.14 An alliance of national organisations will support these transforming care partnerships to deliver on this ambitious agenda, including NHS England, Local Government Association (LGA), Association of Directors of Adult Social Services (ADASS), Health Education England (HEE), Skills for Health, Skills for Care, the Care Quality Commission (CQC), NHS Trust Development Authority (TDA), Monitor, and provider representative organisations, working closely with people with a learning disability and/or autism as well as their families/carers.

1.15 In every part of the country there are people with the skills and experience to deliver effective care and support. These people can be found within health and social care services, and amongst the families and carers who support individuals in their own homes. Successful delivery will depend on them. Their insight will be key to designing, developing and launching new services in the community, and their skills and experience will be central to delivering them.

1.16 As part of this alliance for delivery, and working alongside local commissioners, we will work with provider organisations to mobilise innovative housing, care and support solutions in the community. Our collaboration will focus on supporting commissioners to redesign services, scaling up community-based services, developing the workforce, accessing investment to expand community services, and securing the capital to deliver the new housing needed.

1.17 A new financial framework will underpin delivery of the new care model:

- Local transforming care partnerships will be asked to use the total sum of money they spend as a whole system on people with a learning disability and/or autism to deliver care in a different way that achieves better results
- To enable that to happen, NHS England's specialised commissioning budget for learning disability and autism services will be aligned with the new transforming care partnerships
- CCGs will be encouraged to pool their budgets with local authorities whilst recognising their continued responsibility for NHS Continuing Healthcare.
- For people who have been in hospital the longest, the NHS will provide a 'dowry' – money to help with moving people home
- During a phase of transition, commissioners will need to invest in new community support before closing inpatient provision. To support them to do this NHS England will make available up to £30 million of transformation funding, to be matched by CCGs, over and above the £10 million already made available to fast track areas

- In addition to this, £15 million capital funding over three years will be made available and NHS England will explore making further capital funding available following the Spending Review
- From November 2015, *'Who Pays'* guidance will be reformed to reduce financial barriers to swift discharge

1.18 Before the end of 2018, having built up community support and closed hundreds of beds, we will take stock and look at going further.

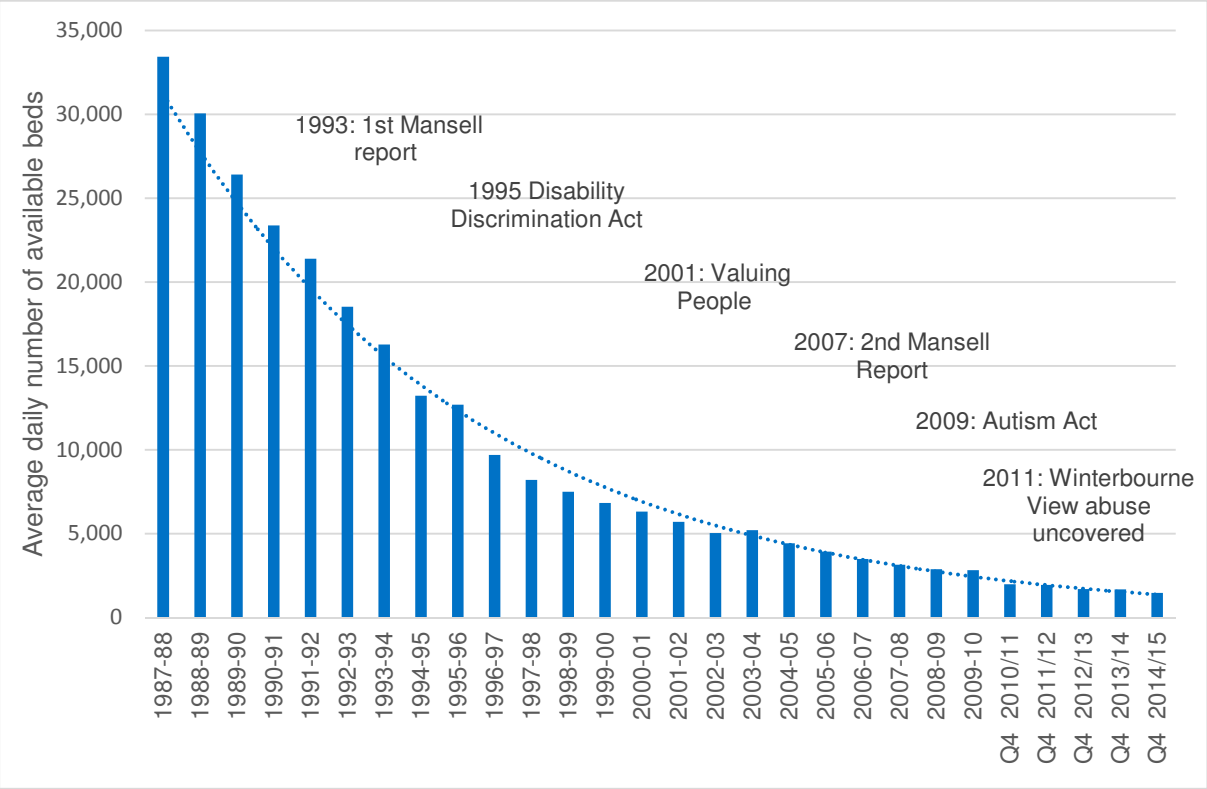
2. The journey to date

Background

2.1 Historically, from the asylum to the long stay hospital, too often people have been routinely placed in institutions away from their homes and communities.

2.2 Rightly, most of these institutions were closed and now the majority of people with a learning disability and/or autism will never come into contact with the types of hospitals – including assessment and treatment services – that are discussed in this document.

Figure 1: NHS learning disability beds since 1987[3]



2.3 The scandal at Winterbourne View, however, was not just an individual episode of appalling abuse. It also highlighted the fact that despite the progress we have made as a society in recent decades, for a small number of people we remain too reliant on hospital care, particularly in some parts of the country (see figure 2 and figure 3).

[3] Data taken from KH03 collection from all NHS organisations that operate consultant-led beds open overnight or day only. Changes to the way data is collected mean only Q4 data is provided from 2010/11. More information: http://www.england.nhs.uk/statistics/statistical-work-areas/bed-availability-and-occupancy/

Figure 2: Geographical variation in reliance on *CCG-commissioned* inpatient services (as at 31 July 2015)[4]

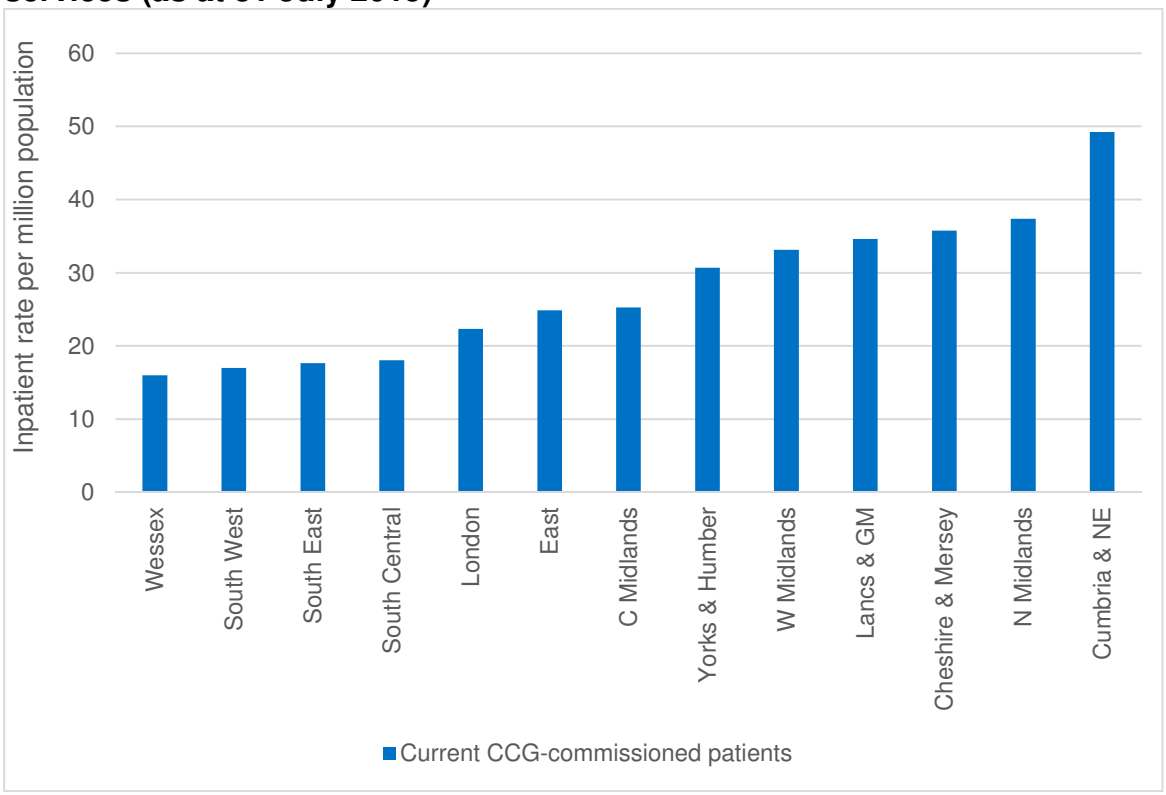
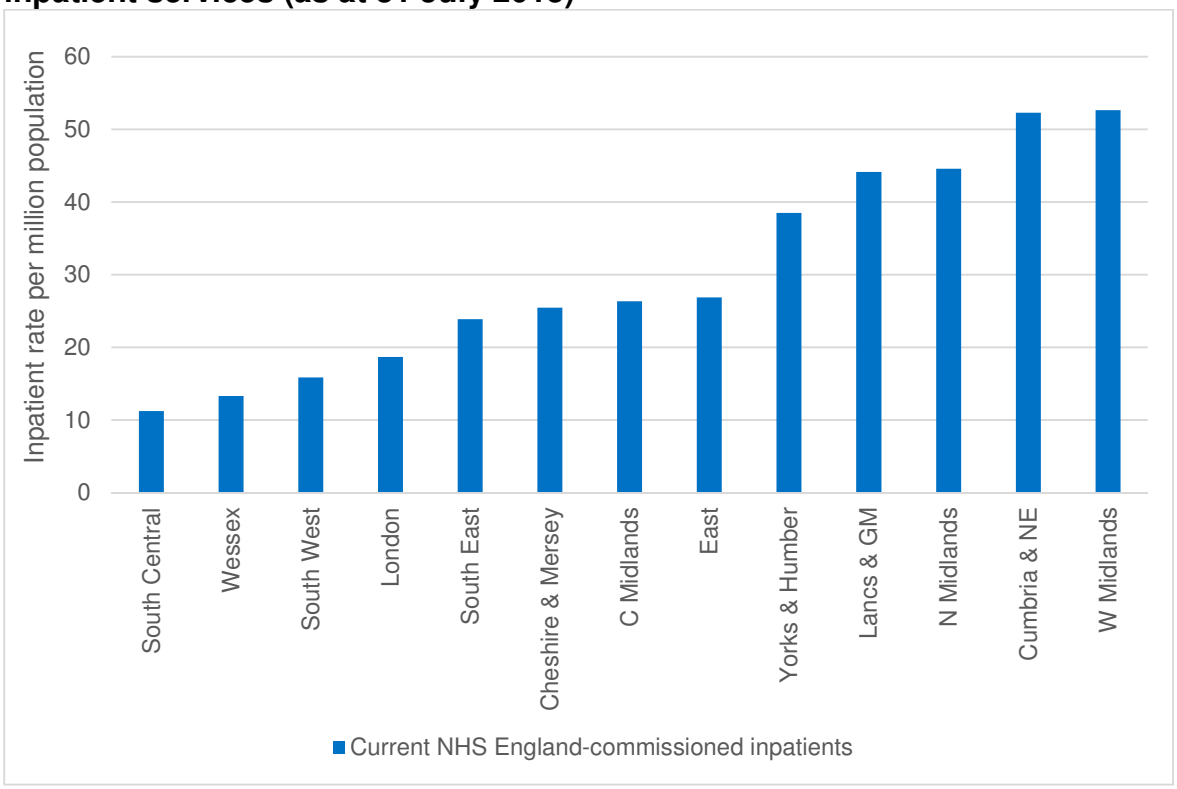


Figure 3: Geographical variation in reliance on *NHS England-commissioned* inpatient services (as at 31 July 2015) [5]



[4] See Annex C for further notes on the data used in these charts.
[5] See Annex C for further notes on the data used in these charts.

2.4 To address this longstanding problem recently there has been a renewed push to address these issues with, for instance:

- The CQC introducing a new approach to inspecting learning disability hospitals and the care of people with a learning disability and/or autism in acute hospitals
- New data systems put in place to track the care people are receiving
- The Department of Health's consultation *No Voice Unheard, No Right Ignored: a consultation for people with learning disabilities, autism and mental health conditions* looked at how to strengthen rights, incentives and duties in the wider system, focusing on how people can be supported to live independently in their communities and make choices in their lives. Views were sought on a range of ideas intended to strengthen or build upon existing policies, including possible changes to legislation. The Government will shortly set out the actions it proposes in response to the consultation

2.5 In addition to this, NHS England has rolled out Care and Treatment Reviews (CTRs) across the patient pathway – reviews of individual patients' care to prevent unnecessary admissions and avoid lengthy stays in hospital. Individuals or families now have a new right to request a CTR. These CTRs bring together:

- People with a learning disability and/or autism and their families/carers
- Independent expert advisors – one clinical and one expert by experience
- The responsible commissioner and others involved in the person's care and treatment

These reviews look to see if someone's care is safe, effective and whether they need to be in hospital as well as whether there is a plan in place for the future. By mid-September 2015 over 2,020 CTRs had been completed since their introduction in October 2014. Between March and August 2015, over 750 people in hospital were discharged or transferred.

2.6 Progress has been made. Hundreds of people previously in hospital are now living in their own homes, and the foundations for future progress have been laid.

2.7 Despite this, we know the most significant changes needed lie ahead. For all the progress made discharging individuals from hospital, the number of people not living at home remains similar to what it was when CTRs were introduced. Admissions remain high, and some people are in hospital when they are ready to be discharged because the right support is not available.

2.8 As Sir Stephen Bubb highlighted in his report for NHS England[7], we need to change the mix of services available on the ground - shifting our investment into better support in the community and closing some inpatient services. To do this "we need both more 'top-down' leadership...and from the 'bottom up'

[7] http://www.england.nhs.uk/wp-content/uploads/2014/11/transforming-commissioning-services.pdf

more empowerment for people with learning disabilities and/or autism and their families."

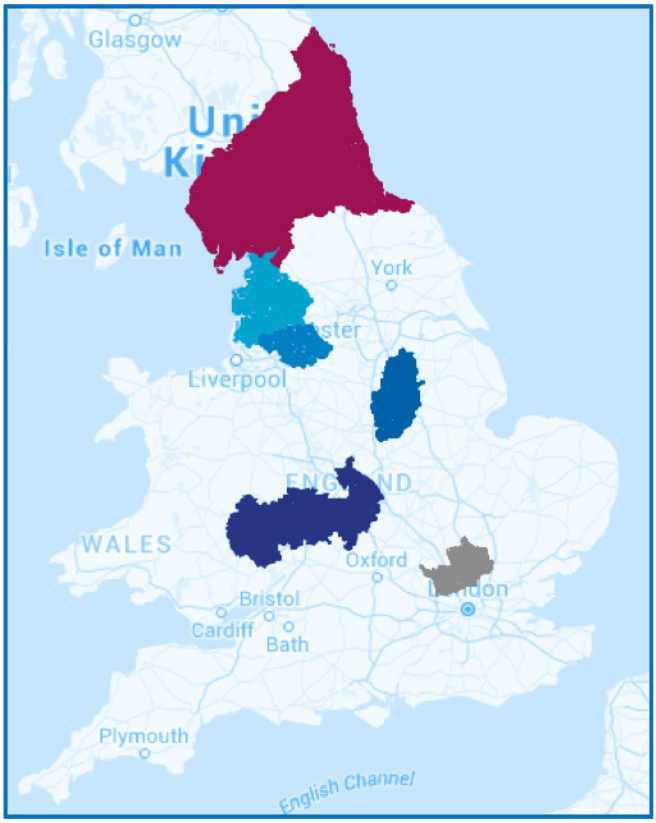
2.9 Six 'fast track' areas have begun that process, and this plan sets out how we will now support the rest of the country to follow suit.

Fast tracks

2.10 Over the summer of 2015, NHS England, LGA and ADASS supported six 'fast track areas'[8] (collaborations of CCGs, local authorities and NHS England specialised commissioners) to draw up plans for service transformation. A £10 million fund was made available to these areas to help fund transitional costs and speed up implementation.[9]

2.11 These areas are highly diverse – in terms of demography, patient flows, provider landscapes, deprivation, urban and rural communities – allowing NHS England, LGA and ADASS to test our approach to a range of different challenges that different communities in England will face as they seek to transform services – from developing the local workforce to designing new community health services to ensuring that funding flows enable change.

Figure 4: Fast track areas



[8] Greater Manchester; Lancashire; Cumbria and the North East; Arden, Herefordshire and Worcestershire; Nottinghamshire; Hertfordshire.
[9] The NHS and local government in these areas spend many millions on care for people with a learning disability and/or autism. The £10 million is not intended to fund all the costs in that new service model.

2.12 Each fast track's plan has been published alongside this document, and fast track areas are now engaging with local communities and providers to help shape delivery.

2.13 Taken together, fast track plans envisage that bed usage across all six areas will reduce by approximately 50% over the coming three years, freeing up tens of millions of pounds which will be invested in community-based support to prevent hospital admissions.

2.14 Below is a summary of some of the actions that each of the fast track areas are implementing.

Greater Manchester

2.15 The devolution deal for Greater Manchester has resulted in new powers and responsibilities for local leaders. In describing their joint ambition for change, they have prioritised the improvement of services for people with a learning disability and/or autism.

2.16 In terms of bed usage, the Greater Manchester Fast Track uses a range of hospital providers but has a significant number of inpatients in Calderstones Partnership Foundation Trust, which is also used to a large degree to provide care to patients from Lancashire. As such their plans are being jointly developed with the Lancashire Fast Track.

2.17 Their ambition is to reduce their use of 130 inpatient beds by 50%: from 77 non-secure beds to 30 (a 60% reduction) and from 53 secure beds to 35 (a 34% reduction) by 2018/19. To re-provide this care they are creating intensive community support services with robust case management and discharge coordination across the area to enable individuals to receive care at home and improve their care experience.

2.18 Recognising that occasionally the needs of individuals can increase, they are also investing, this year, in six local crisis beds and an in-reach/out-reach team providing safe short intensive support when needed.

2.19 Furthermore they are in the process of creating an innovative housing scheme that will ensure round-the-clock care for people with a learning disability and/or autism from early next year.

2.20 A cornerstone of the plan is their intention to retain and build the confidence of the staff, as well as families/carers, to improve quality of care in the community. To do this they intend to deliver a three year family and staff development programme.

2.21 In addition, to monitor the impact of the plan by March 2017 - as part of the wider Greater Manchester Public Sector Reform Programme - there will be a formal evaluation assessing its impact over an 18 month period.

Lancashire

2.22 Similarly to Greater Manchester Fast Track, Lancashire uses a range of hospital providers but has a significant number of inpatients in Calderstones Partnership Foundation Trust.

2.23 Lancashire intends to reduce their reliance on non-secure beds by 70% and substantially reduce the numbers of people who come into contact with secure services. This high ambition will be achieved by focussing on putting in place high-quality individual packages of care and creating a hub and spoke community support model (expected to be fully operational by March 2018). They will develop:

- An integrated community learning disability team across the whole of Lancashire
- Crisis intervention and support services across the area
- A small number of community-based assessment and treatment services to prevent unnecessary out of area placements

2.24 To help with developing these services, Lancashire is rolling out a local engagement plan to ensure people impacted by these changes are fully involved in the building up of community capacity and shaping the services they use.

2.25 Their intention to retain staff to work in new models of care is a vital part of the plan. A comprehensive development programme will be rolled out this year, with two CCGs implementing Positive Behavioural Support (PBS) training and a scheme designed to offer rights-based training to improve access to mainstream health and social care services for people with a learning disability and/or autism.

2.26 Finally, in line with the national service model, they expect from April 2017 to reshape advocacy services across the region and develop a more robust model for delivering short break services.

- **Calderstones Partnership NHS Foundation Trust**

2.27 A key plank of the plans being developed in Lancashire and Greater Manchester will be to close and re-provide services offered by Calderstones Partnership NHS Foundation Trust.

2.28 Calderstones Partnership NHS Foundation Trust is the only remaining standalone learning disability hospital trust in England with 223 beds. They have initiated a collaboration with Mersey Care NHS Trust driven by an ambition to develop person-centred care, and sustainable services that stand the test of time, underpinned by a strong quality, clinical and financial case for fundamental changes in local secure mental health and learning disabilities care.

2.29 The plan is for Mersey Care NHS Trust to take over Calderstones Partnership NHS Foundation Trust, which from July 2016 will cease to exist.

2.30 The plans developed by Greater Manchester and Lancashire Fast Tracks with NHS England Specialised Commissioners, subject to consultation, will implement a new service model resulting in a substantial reduction of beds (>60% fewer than currently).

2.31 NHS England will also cease commissioning secure services on the Calderstones site.

2.32 All hospital beds on the current Calderstones site will therefore, subject to consultation, close and be re-provided over the next three years on a case by case basis for each patient, in the community or in new state of the art units elsewhere in the North West, and the Calderstones site will close.

2.33 Ongoing consultation and engagement with people with learning disabilities, their families and carers will be central to the process of change and the commissioners and providers involved are committed to ensuring that patients and families are always involved in decisions about their care and support.

2.34 Calderstones Partnership NHS Foundation Trust and Mersey Care NHS Trust have appointed a joint Medical Director to provide clinical leadership in the process of bringing these two organisations together. The post holder will help sustain and build world class leaders and staff, enabling them to be part of the future.

2.35 The trusts are already focussing on a range of joint quality initiatives with staff to improve quality and increase efficiency - for instance, they have initiated an international collaboration with Stanford Risk Authority (Stanford University) to manage risk and learn lessons in a way that has never been undertaken in the NHS.

Cumbria and the North East

2.36 Compared to the rest of the country, Cumbria and the North East have more individuals with a learning disability registered on GP registers and a higher usage of inpatient services (255 inpatient beds) mainly making use of two key hospital trusts – Northumberland, Tyne and Wear Foundation Trust and Tees Esk and Wear Valleys Foundation Trust.

2.37 These beds are a collection of secure and non-secure beds and are occupied not only by people from the area, but from across the country. Cumbria and North East aim to deliver a 52% reduction (76 beds) in non-secure beds and a 43% reduction (47 beds) in low secure beds. Commissioning action is already underway to facilitate this reduction, with 40 beds being empty at time of publication.

2.38 Building on service improvements in physical health, Cumbria and the North East are creating a single set of standards to incorporate into contracts used locally. Each local authority and CCG is developing and building community capacity, including in 2015/16 new investment in:

- Services to support people with attention deficit hyperactivity disorder and autism across Northumberland, and Tyne and Wear
- Advocacy services
- Carers' support

2.39 Localities are also testing new approaches to improving quality. For example, in Newcastle an innovative housing initiative, developed through collaboration between social care providers and an NHS provider, is providing preventative care and treatment to improve the quality of support people with a learning disability and/or autism experience and to avoid unnecessary admissions.

2.40 A central plank to the plan is to retain staff to work in new models of care, and develop and up-skill the workforce. For instance, working with Northumbria University and local clinicians they intend to implement a National Vocational Qualification (NVQ) based on PBS training for staff.

Hertfordshire

2.41 For several years Hertfordshire CCGs have been working with Hertfordshire Partnership Trust, Hertfordshire County Council and others to modernise services for people with a learning disability and/or autism, and they have already successfully closed many assessment and treatment beds across the area. But they believe they should go further.

2.42 Their ambition is now to bring adult and children's services together into a dedicated integrated service. This will include a single point of access that will empower service users of all ages to access help, support and appropriate treatment in the community. This model will be consulted on before the end of the year.

2.43 By 2018/19 they expect to reduce their usage of low-secure beds by over 30%, and to reduce length of stay in assessment and treatment beds to an average of 85 days.

2.44 Furthermore, they are establishing an evaluation partnership with Hertfordshire University to test a number of prevention and early discharge services for individuals who have been in contact with the criminal justice system. This includes a strengthened community forensic team to enable faster supported discharge and greater use of community restriction orders, and a Circles Project to deliver community support to people with a learning disability and/or autism who are deemed to be at high risk of sexual offending.

2.45 Recognising that individuals' needs can increase, a number of innovative crisis intervention pilots will be commissioned and evaluated from 2015/16, namely:

- A hosted family crisis support pilot which will provide intensive home support during crisis periods
- A 'crash pad' pilot providing short term accommodation for people who need crisis intervention in situations where there has been a placement breakdown or termination of tenancy

2.46 Finally, Hertfordshire has already begun work to pilot the implementation of integrated personal health budgets, which will start to be introduced from April 2016.

Nottinghamshire

2.47 Nottinghamshire intends to reduce its reliance on non-secure services from 40 occupied beds to 15 (a 63% reduction) and almost halve its usage of low and medium secure beds from 34 to 16 (a 56% reduction). Nottinghamshire now has 65 people in inpatient care in NHS trusts and the independent sector.

2.48 Nottinghamshire's plan has individual rights at its centre and an immediate priority is to commission an increase in advocacy for people during care and treatment reviews. Early plans also include strengthening their existing community learning disability and intensive care and treatment teams, as well as risk registers, so they can confidently support individuals who are at risk of coming into contact with the criminal justice system and subsequent admission to hospital.

2.49 Recognising that confidence of staff and families is paramount to helping individuals stay at home, families will be offered evidence-based parenting training as well as practical and emotional support locally. In addition, to retain and up-skill staff to deliver the new care model workforce training will be undertaken to ensure staff have a consistent understanding and approach to working with people who display behaviour that challenges which enables individuals to remain in the least restrictive setting.

2.50 Next year, they will expand their personal health budget offer and tackle gaps in the accessibility of mainstream services. As the needs of individuals can increase, new crisis accommodation will be established as well as new pioneering housing options for people with complex behaviours and those in contact with the criminal justice system as they are discharged from hospital.

2.51 Nottinghamshire will start to pool budgets for crisis care from April 2016 and work towards further alignment and pooling arrangements from April 2017.

2.52 Finally, across Nottinghamshire there are a high number of local inpatient beds (199), many of which are not used by local commissioners. The Fast Track has recognised that the longer term plan of this economy will require strong partnerships with other commissioners across the country.

Arden, Herefordshire and Worcestershire

2.53 Commissioners in Arden, Herefordshire and Worcestershire have been driving forward improvements in learning disabilities for several years and have agreed strategies for improving both physical and mental health and been steadily reducing reliance on hospital beds. They now have 47 people in inpatient care, mainly in Coventry and Warwickshire NHS Trust.

2.54 It is expected that across the area they will reduce the number of beds used by inpatients to 14. This means reducing their usage of non-secure beds from 19 to 3 (an 85% reduction), and of secure beds from 21 to 11 (a 48% reduction). They also intend to reduce their usage of child and adolescent mental health service (CAMHS) beds by children with a learning disability and/or autism by seven.

2.55 These closures are expected to start this year, with a nine-bed assessment and treatment ward shutting (subject to appropriate local consultation).

2.56 Their intention is to redeploy staff working in that unit to new community services, and having learnt from the experience and undertaken appropriate consultation, to apply the learning to other sites.

2.57 In addition, the area plans to develop by November 2015:

- An admission avoidance scheme in Coventry and Warwickshire NHS Trust
- A short-term accommodation for people who need support when a placement breaks down or, for example, if a tenancy breaks down

2.58 Throughout the rest of the year, across Arden, Herefordshire and Worcestershire the aim is to create intensive community support teams which will work with existing mental health crisis teams to provide comprehensive crisis care 24/7. To facilitate this they plan to have a liaison nurse who will work to improve support and the interface between learning disability and wider mental health services.

2.59 From April 2016 a community forensic service will be commissioned to support people to be discharged who are currently out of area and enhance the support locally to avoid future admissions. The aim is to then review the coverage and plan for further closures in 2017/18.

2.60 Finally, Coventry and Warwick Partnership Trust are commissioned by other West Midlands commissioners. The Arden, Hereford and Worcestershire Fast Track is exploring strategic alliances with them to spread learning and support change.

Figure 5: Projected bed usage rates across fast track sites (inpatients per million population)[10]

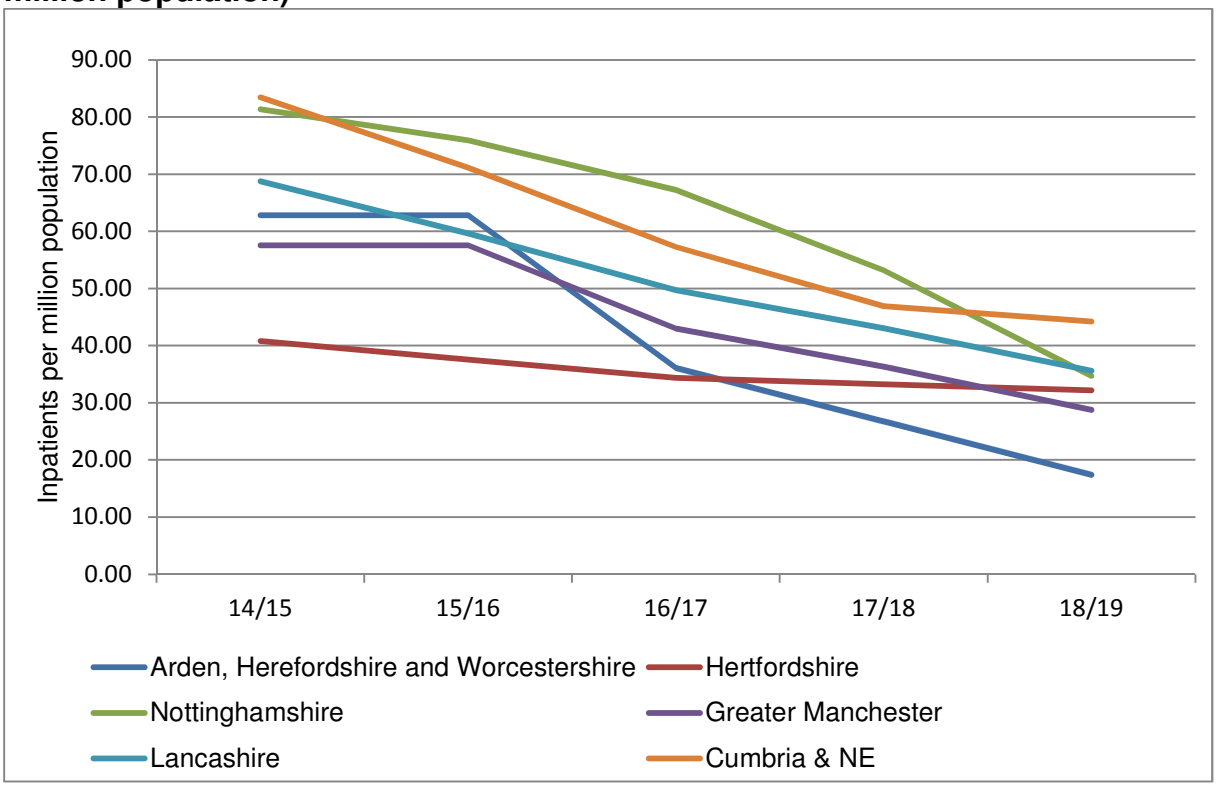
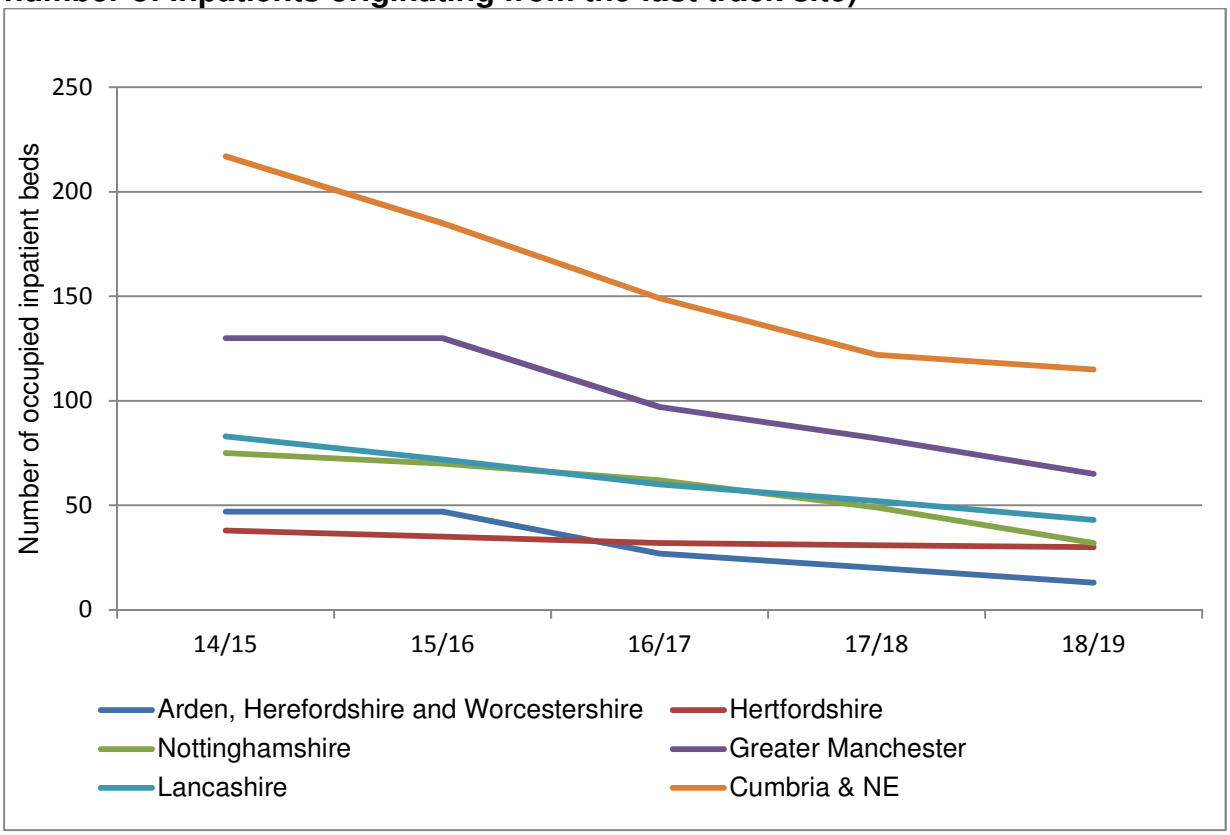


Figure 6: Projected *total* bed usage across fast tracks (chart shows projected number of inpatients originating from the fast track site)[11]



[10] See Annex C for further notes on the data used in these charts.
[11] See Annex C for further notes on the data used in these charts.

Figure 7: Projected usage of *NHS England*-commissioned beds across fast tracks (chart shows projected number of inpatients originating from the fast track site)[12]

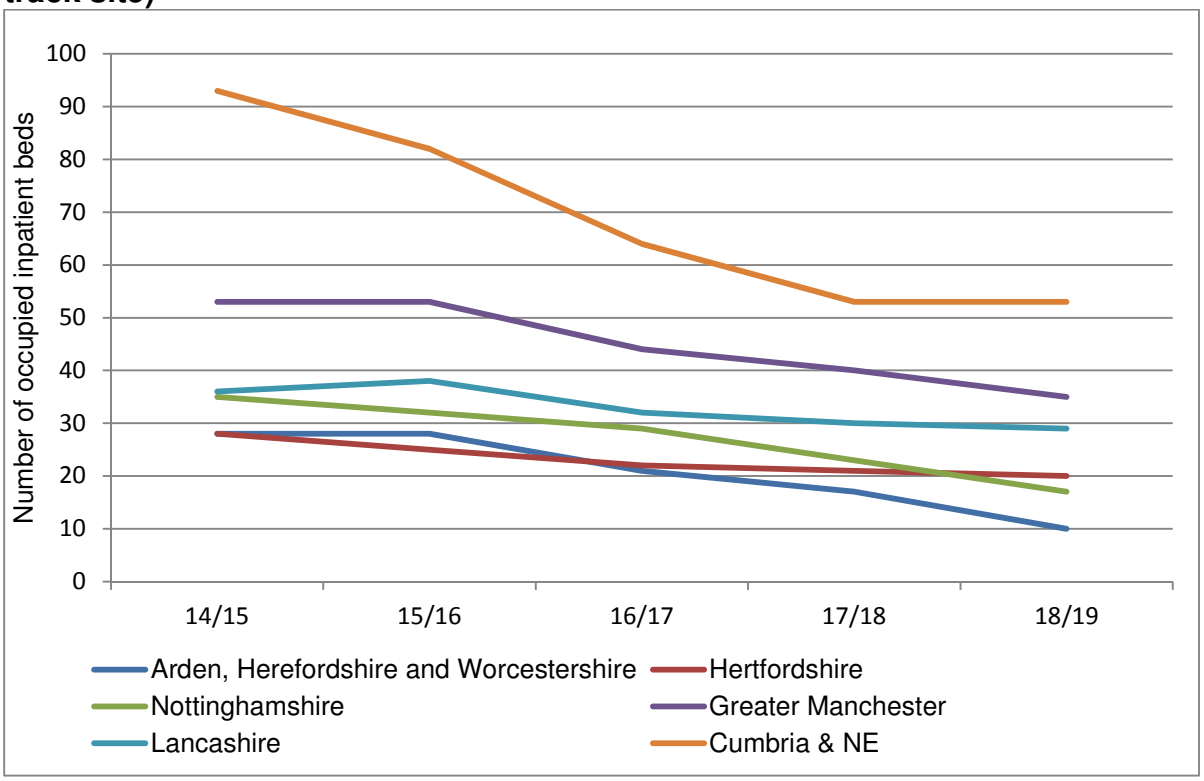
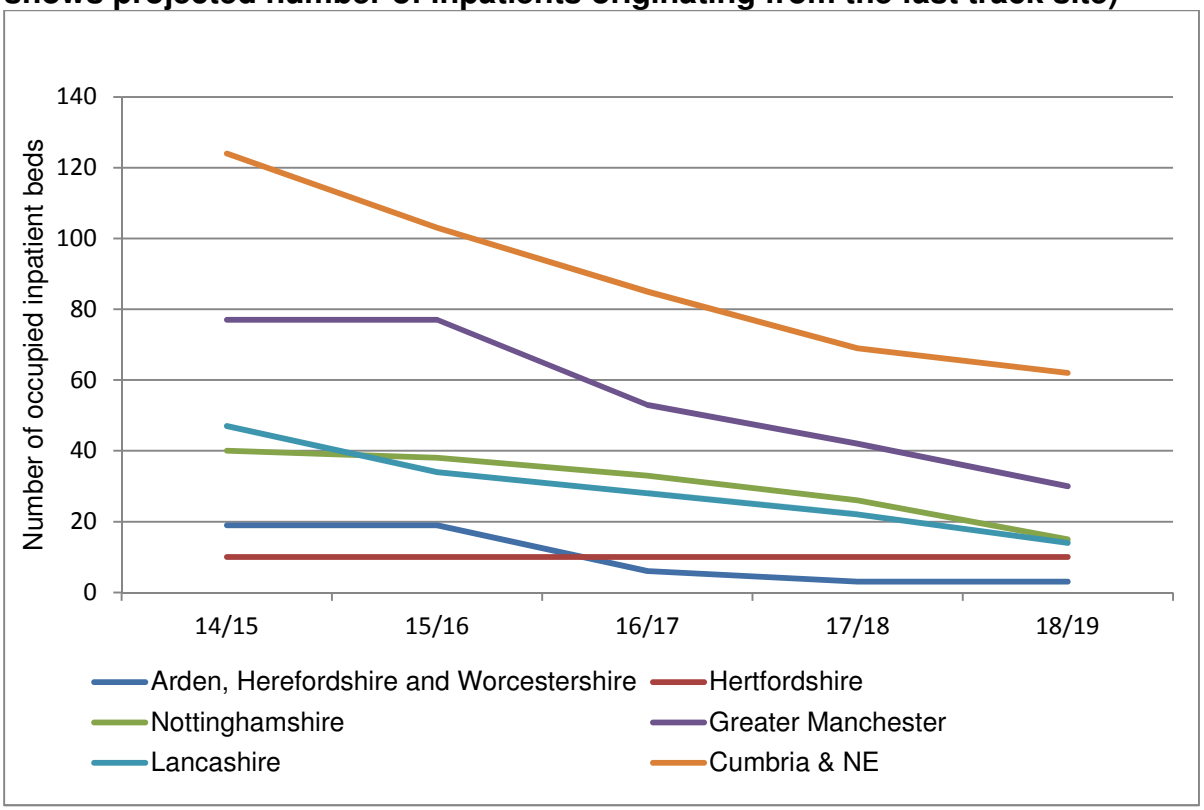


Figure 8: Projected usage of *CCG-commissioned* beds across fast tracks (chart shows projected number of inpatients originating from the fast track site)[13]



[12] See Annex C for further notes on the data used in these charts
[13] See Annex C for further notes on the data used in these charts

2.61 The actions outlined above represent just the start of what the fast tracks will do, and as their plans develop and community services mature we expect the bed reduction trajectories set out in their plans to translate into further closure of individual wards and units. As the fast track areas start to implement their ambitious plans for change, NHS England, LGA and ADASS will draw on our experience of working with them to support the rest of the country to build new community services and close inpatient provision that is no longer needed. The rest of this plan sets out how these new services should look, and how we plan to work together to deliver them.

3. The new services we need

3.1 People with a learning disability and/or autism have the right to the same opportunities as anyone else to live satisfying and valued lives and to be treated with dignity and respect. They should expect, as people without a learning disability or autism expect, to live in their own homes, to develop and maintain positive relationships and to get the support they need to be healthy, safe and an active part of society.

3.2 As Professor Jim Mansell highlighted in 1993 and in 2007, however, too rarely do people receive this type of personalised support across their whole life. In turn, many of the behaviours services label as challenging could be prevented from developing if the right support were made available to people and their families or carers when they needed it.

3.3 The changes to services we plan to make are intended to put that right.

Improving services for a heterogeneous group

3.4 People with a learning disability and/or autism who display behaviour that challenges are a highly heterogeneous group. The task of reshaping services will reflect that diversity.

3.5 For people who have been in inpatient settings for a very long period of time, the task facing commissioners will be to resettle those individuals into the community and close the hospital beds behind them. This will include a number of people who will have been in hospital for many years, in some cases having not been discharged when NHS campuses or long-stay hospitals were closed. It is the group of people for whom hospital has effectively become a permanent home, and for whom the task now is to find them a more appropriate home in the community, with the right package of health and care support around them. This is the group who will likely be eligible for NHS-funded dowries when they are ready to be discharged, to help fund their new package of care in the community (see chapter 4 for more detail on how these dowries will work).

3.6 Approximately a third of the people currently in hospital have been in inpatient settings for five years or longer. Whilst hospital may be the right place for some of this group (for clinical reasons often combined with Ministry of Justice restrictions), Care and Treatment Reviews have already identified transfer/discharge dates over the coming three years for just under 40% of the individuals concerned, and we would expect that number to rise as we build the right set of services in the community.

3.7 In the main, however, the challenge facing commissioners is as much about preventing new admissions and reducing the time people spend in inpatient care by providing alternative care and support, as it is about discharging those individuals currently in hospital. The task requires: advocacy, early intervention, prevention and ensuring the right set of services are available in the community.

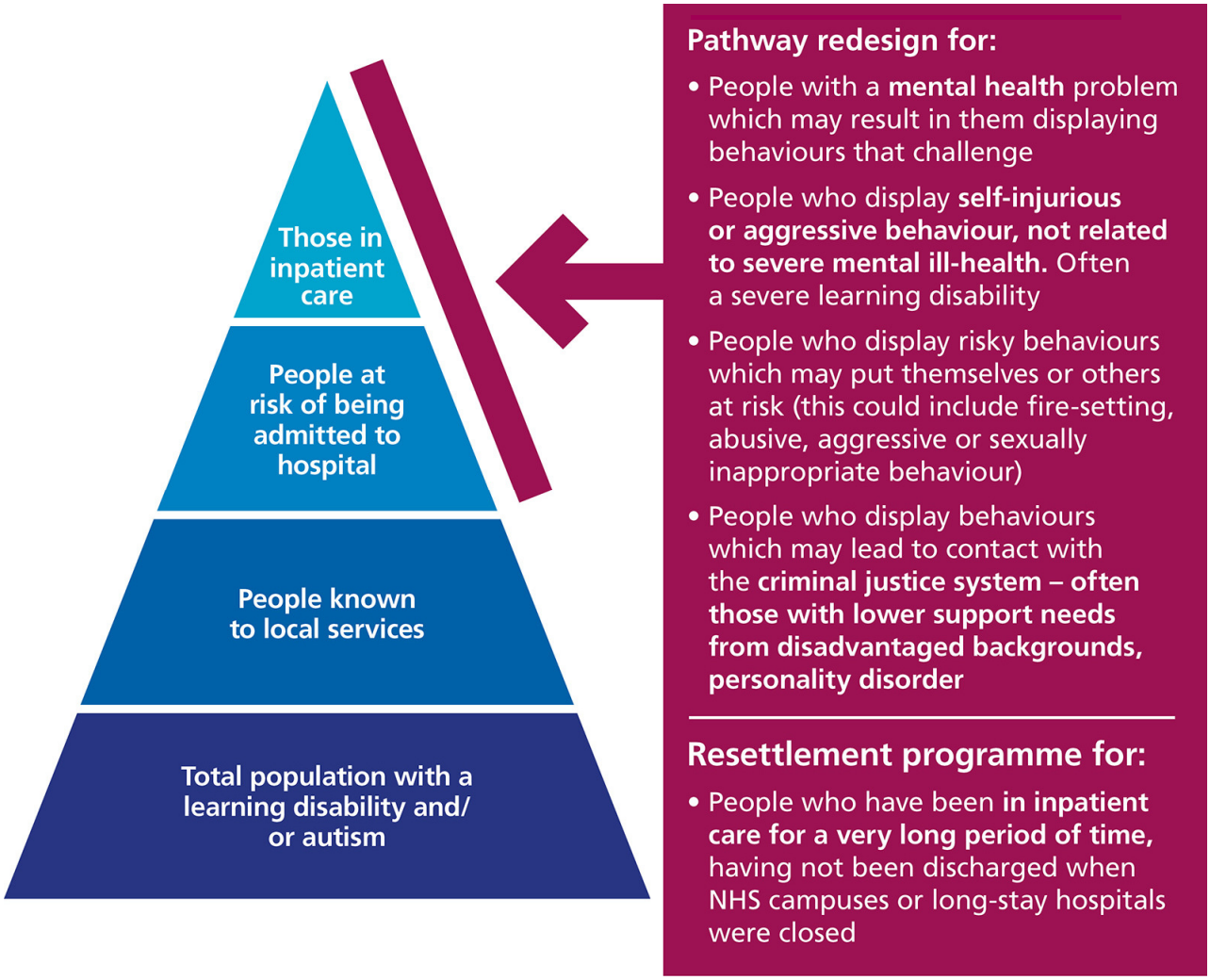
3.8 In many cases, it will involve close collaboration not just between the NHS and social care, but also with parts of the criminal justice system, building on recent joint work between NHS England and the Ministry of Justice to facilitate the discharge of patients subject to restriction orders - currently more than one in five of the people in hospital settings have been detained on part III of the Mental Health Act with a Ministry of Justice restriction.

3.9 Transformation will mean redesigning services to better meet a range of common sets of needs. For instance, it will mean better serving 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 people with personality disorders, which may result in them displaying behaviour that challenges
- Display self-injurious or aggressive behaviour (not related to severe mental ill health), some of whom will have a specific neuro-developmental syndrome where there may be an increased likelihood of developing behaviour that challenges
- 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, aggressive or sexually inappropriate behaviour)
- Often have 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

3.10 The different kinds of shift in service response required to better meet these heterogeneous needs are set out in more detail in a national service model for commissioners of health and social care services, developed with the support of a group of independent experts, including people with lived experience of services, and published alongside this document.

Figure 9: People for whom we need new services



The service model

3.11 Each local area is different. Local populations have different needs, and their range of providers have different strengths and weaknesses. The mix of services they put in place will need to reflect that diversity. However, there does need to be some national consistency in what services look like across local areas, based on established best practice.

3.12 The national service model, developed with the support of people with learning disability and/or autism, as well as families/carers, and a group of independent experts and published alongside this document, sets out how services should support people with a learning disability and/or autism who display behaviour that challenges.

The National Service Model

1. People should 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 should 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 should 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 should 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.

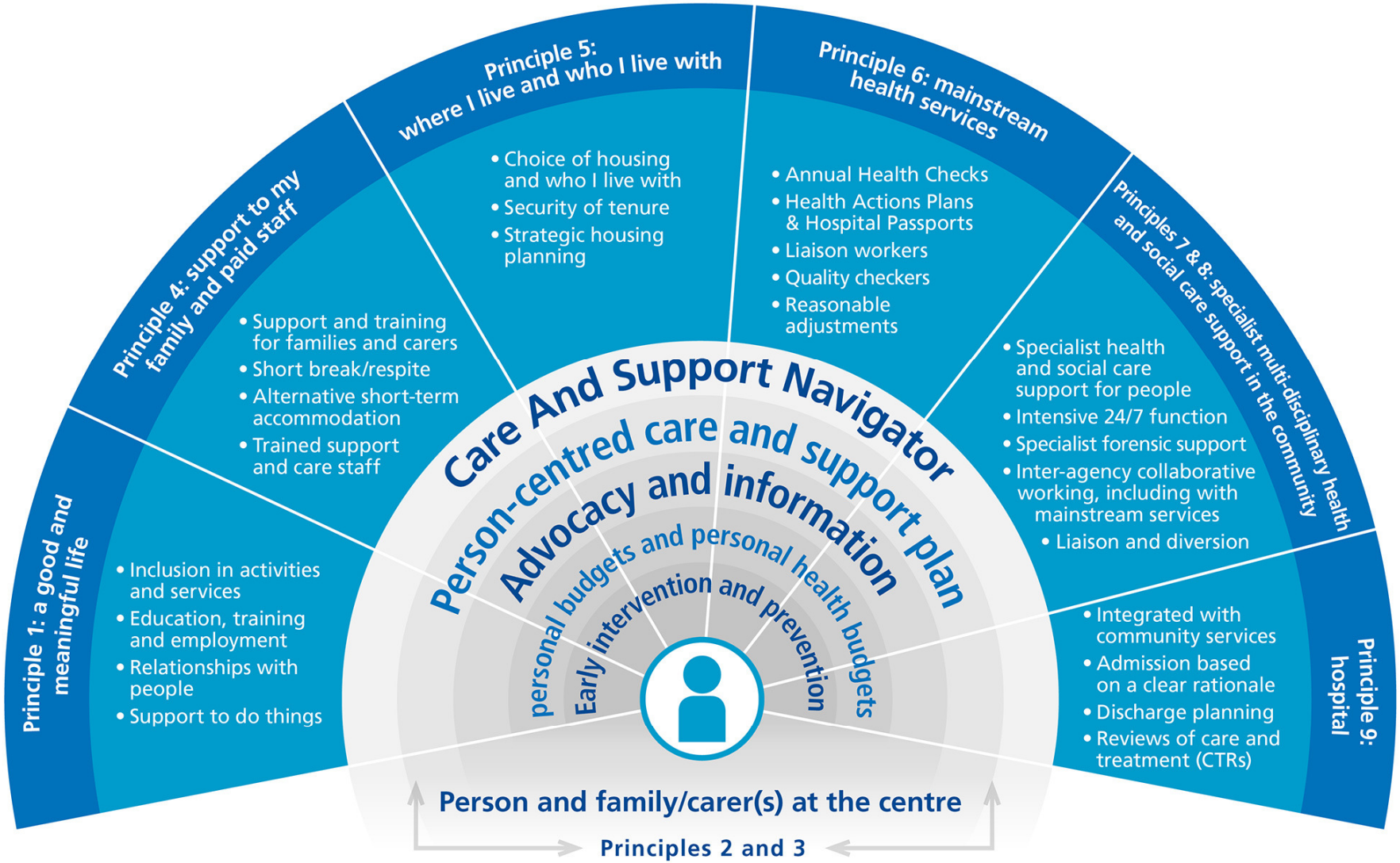
5. People should have a choice about where and with whom they live – with a choice of **housing** including small-scale supported living, and the offer of settled accommodation.

6. People should 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 (such as quality checker schemes and use of the Green Light Toolkit).

7. People with a learning disability and/or autism should 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 should 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.



Service Model

Commissioners understand their local population now and in the future

Reduced need for inpatient services

3.13 With the right set of services in place in the community, the need for inpatient care will significantly reduce, and commissioners will need to have in place far less hospital capacity.

3.14 We will support local commissioners to plan exactly what inpatient capacity they do need, starting with a set of national planning assumptions. Those planning assumptions are that by March 2019, no area should need more inpatient capacity than is necessary at any one time to cater to:

- 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

3.15 In some local areas, use of beds will be lower than these planning assumptions, and we will encourage those local areas to see if they can go further still in supporting people out of hospital settings above and beyond the these initial planning assumptions.

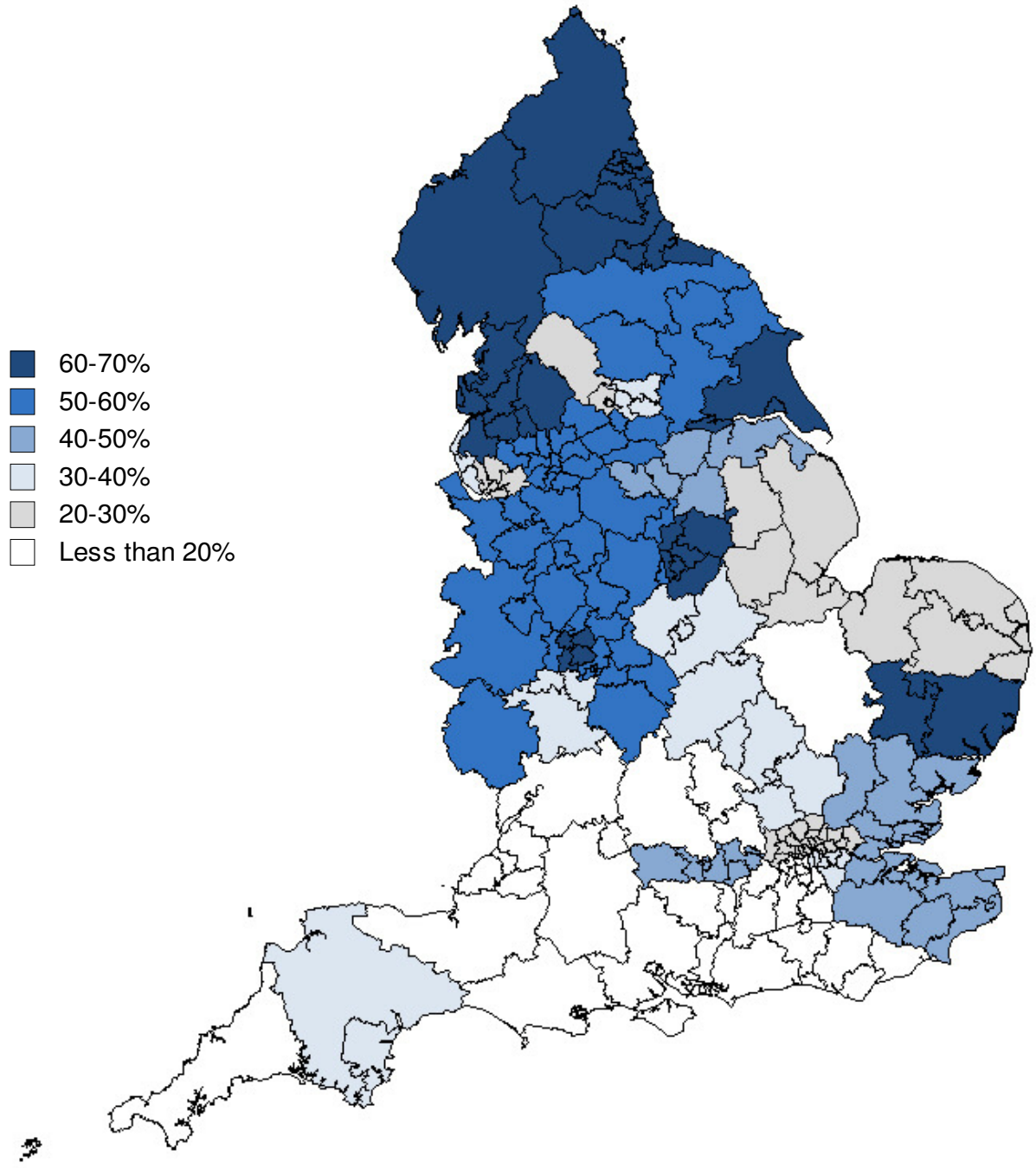
3.16 These planning assumptions are based on what fast track areas have told us they believe is possible, 'sense-checked' against current geographical variation in usage of inpatient services (see figures 2 and 3 below).

3.17 These planning assumptions (10-15 inpatients in CCG-commissioned beds per million population; 20-25 inpatients in NHS England-commissioned beds per million population) would translate to closing, at a minimum:

- 45-65% of CCG-commissioned inpatient capacity (such as assessment and treatment units)
- 25-40% of NHS-England- commissioned inpatient capacity (such as secure services, where we expect the bulk of change to occur in low-secure provision)

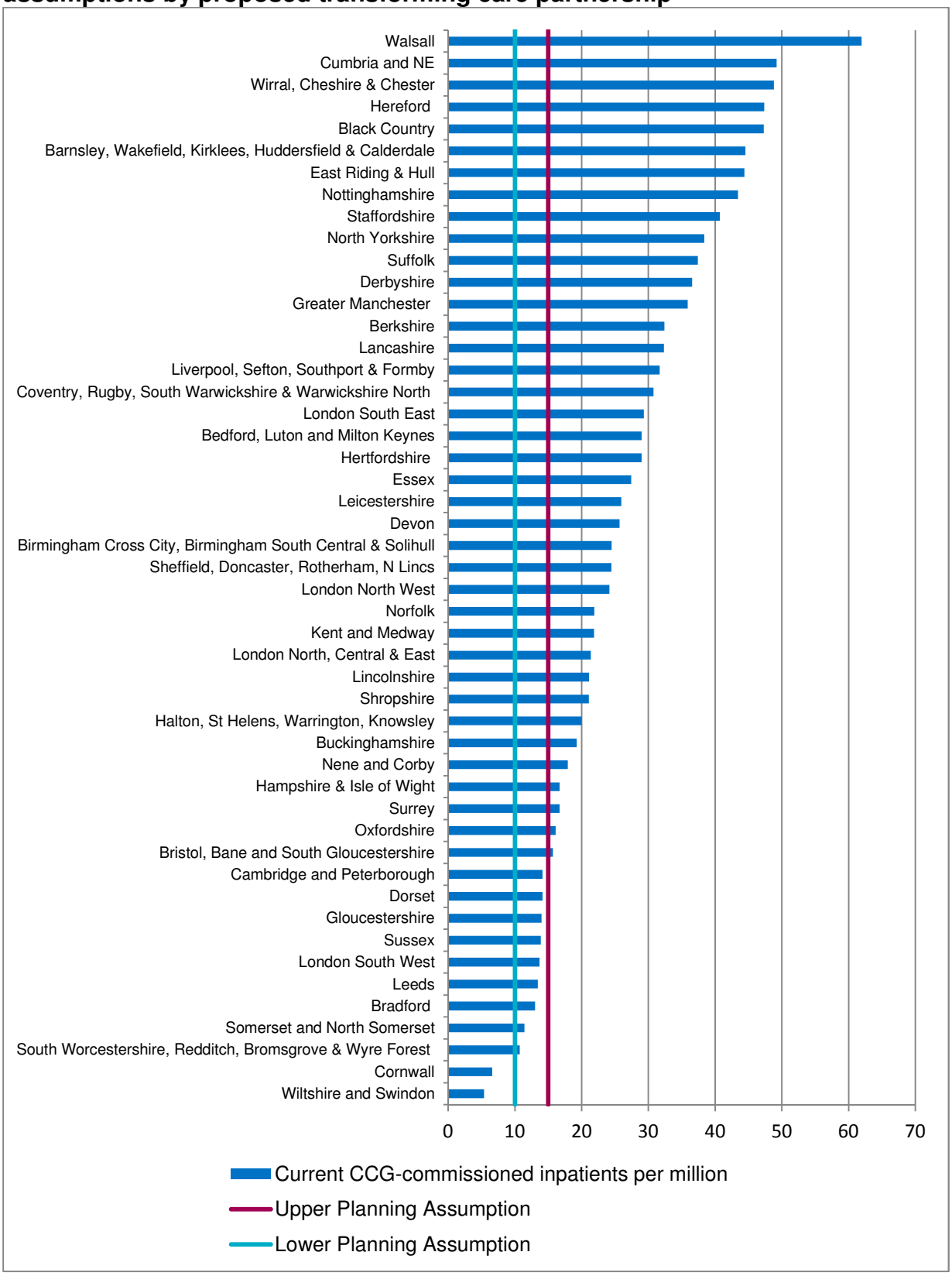
3.18 Taken together, that means closing, at a minimum, between 35% - 50% of inpatient provision nationally. In some areas more reliant on hospital care the change will be even more significant, as the following map and charts illustrate.

Figure 10: Reduction in bed usage (%) implied by national planning assumptions, by proposed transforming care partnerships[14]



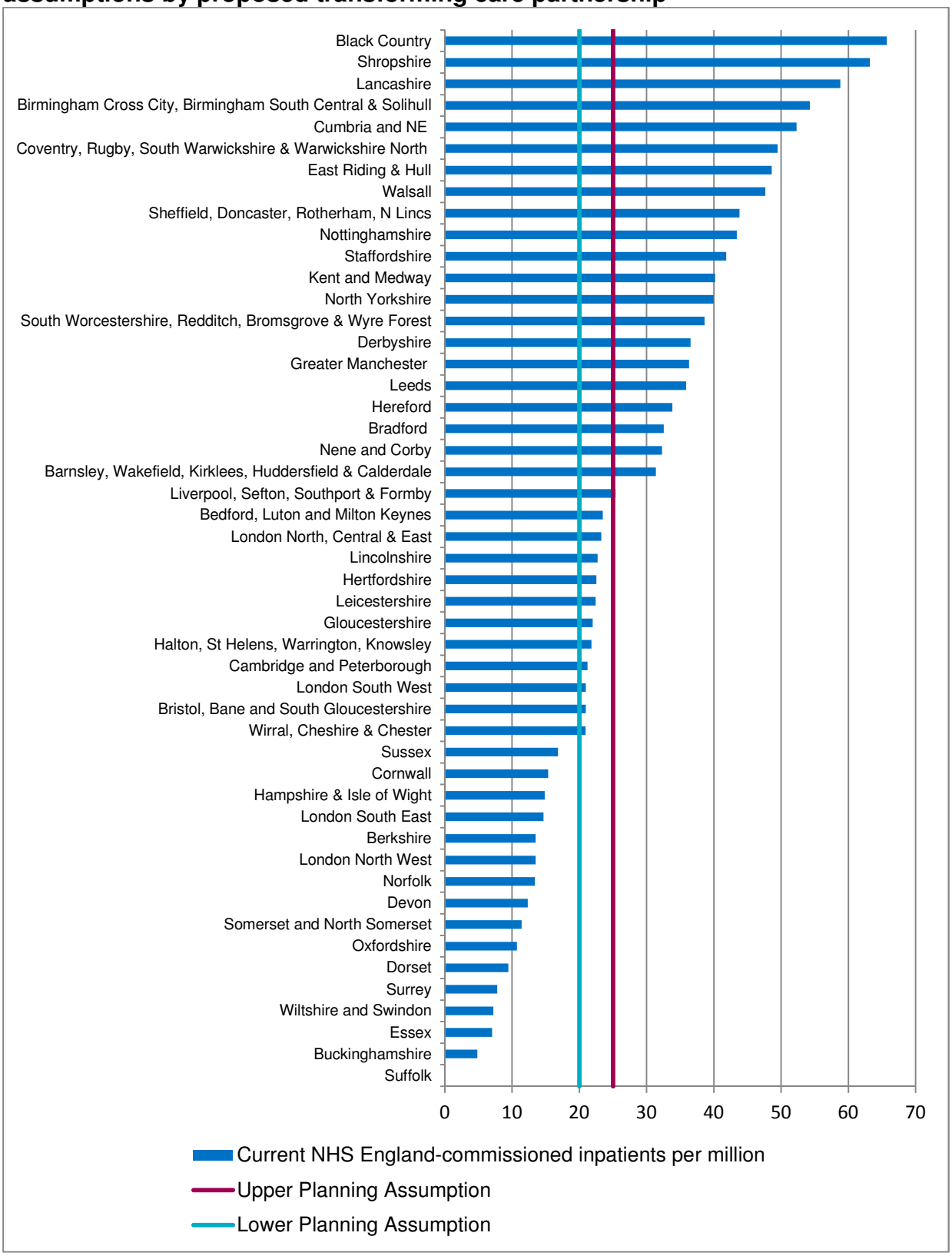
[14] Upper and lower planning assumptions have been applied to current inpatient rates at a transforming care partnership level. The map shows the % reduction in inpatient numbers represented by the midpoint between the projected upper and lower rates for each partnership. See Annex C for further notes on the data used in these charts.

Figure 11: Geographical variation in reliance on *CCG-commissioned* inpatient services (as at 31 July 2015), shown against new national planning assumptions by proposed transforming care partnership[15]



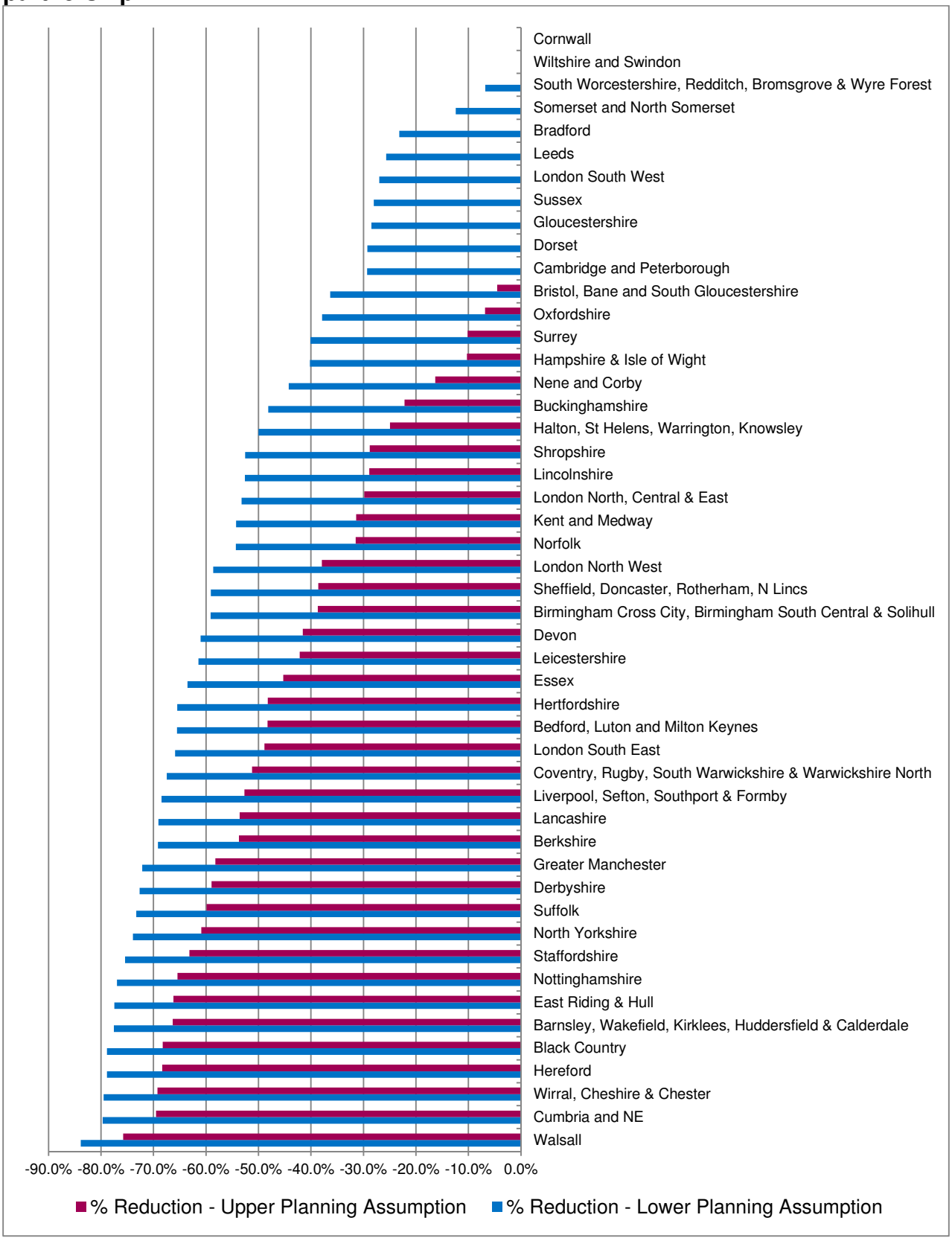
[15] See Annex C for further notes on the data used in these charts.

Figure 12: Geographical variation in reliance on *NHS England-commissioned* inpatient services (as at 31 July 2015), shown against new national planning assumptions by proposed transforming care partnership[16]



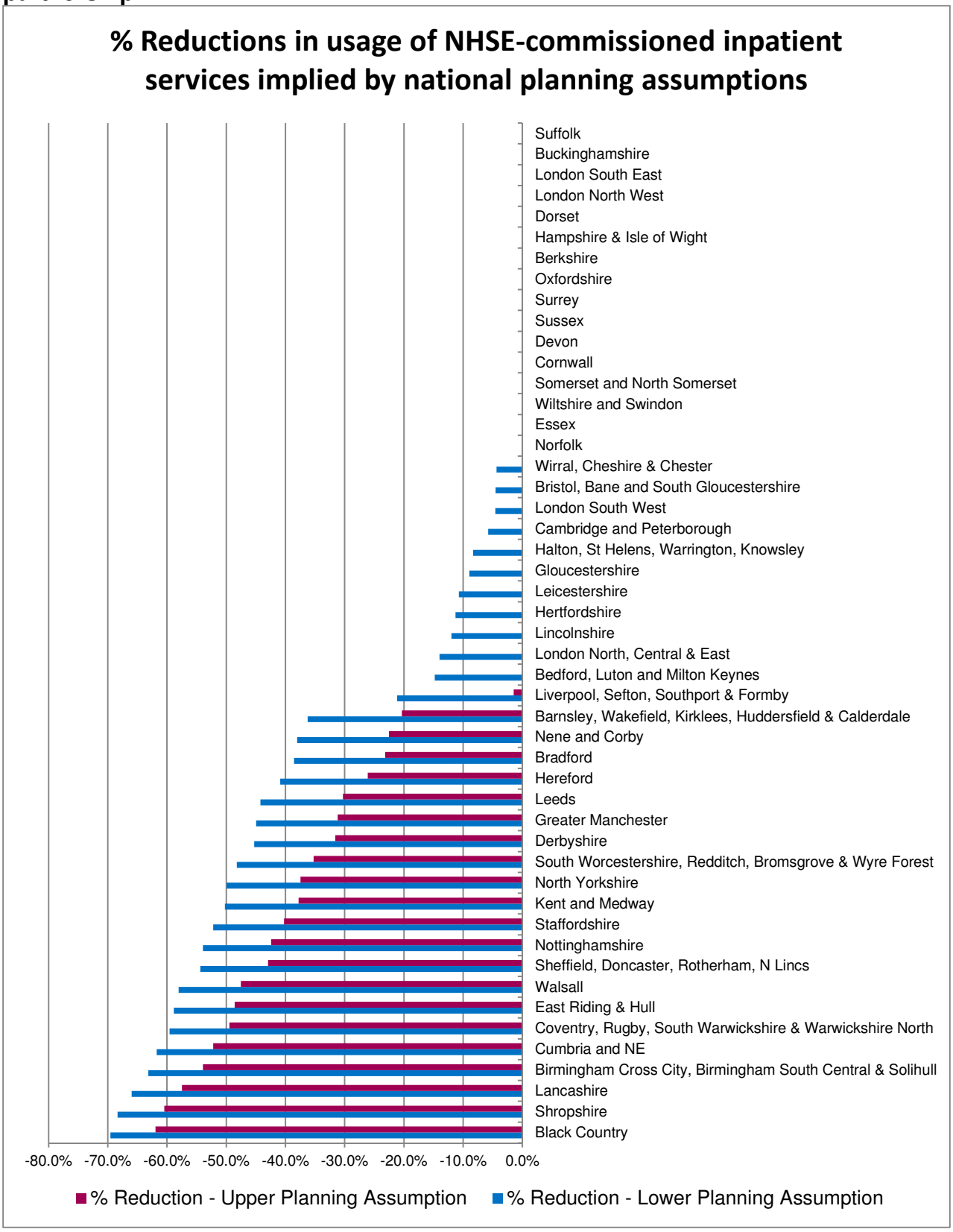
[16] See Annex C for further notes on the data used in these charts.

Figure 13: Reductions in usage (%) of *CCG-commissioned* inpatient services implied by national planning assumptions by proposed transforming care partnership[17]



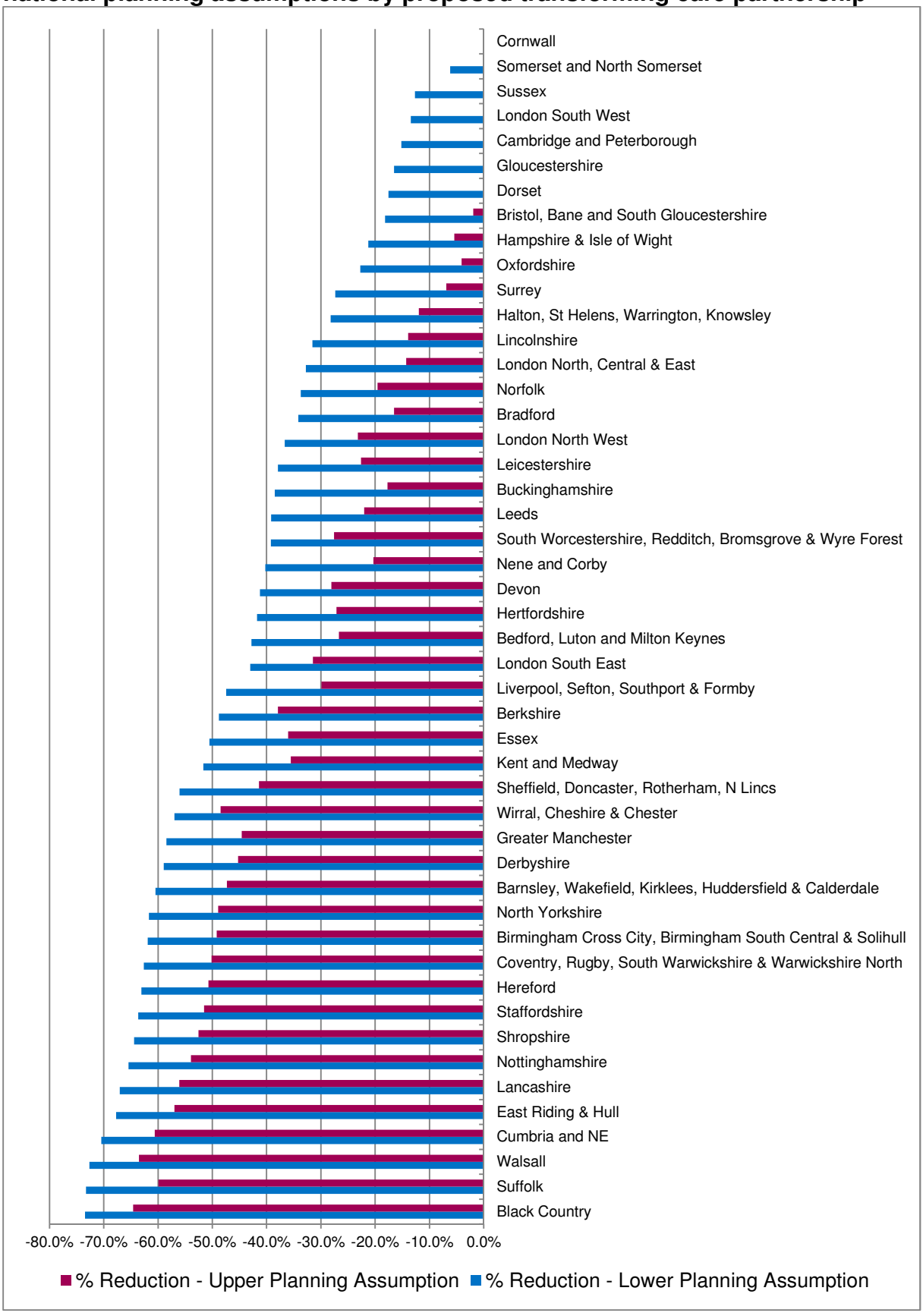
[17] See Annex C for further notes on the data used in these charts.

Figure 14: Reductions in usage (%) of *NHS England-commissioned* inpatient services implied by national planning assumptions by transforming care partnership[18]



[18] See Annex C for further notes on the data used in these charts.

Figure 15: Reductions in *total* usage (%) of inpatient services implied by national planning assumptions by proposed transforming care partnership[19]



[19] See Annex C for further notes on the data used in these charts.

3.19 These national planning assumptions should be seen as articulating a minimum ambition for the coming three years - not a target that, once met, renders the task complete.

3.20 These 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. The starting point for service planning should be to think creatively about what support would help people to live the best possible life, as opposed to making marginal change to the set of services we have currently – and we will support people with lived experience, clinicians, providers and other experts to work with commissioners and help them think ambitiously and creatively in that way.

3.21 In parallel to these planning assumptions, for the inpatient provision that remains we will work with clinicians, providers and commissioners to reduce the period of time that people spend in hospital, building on and spreading best practice – for instance, Hertfordshire's fast track plan aims to help reduce length of stay in assessment and treatment services to an average of 85 days. We will also use Care and Treatment Reviews (CTRs) to this end: if someone is still in hospital after a year a mandatory CTR will take place, and people in hospital will also have a right to request a CTR.

3.22 The planning assumptions articulated here should not be seen as describing an 'end state' after which services can be set in aspic. We will always want to improve the services and support we make available to people with a learning disability and/or autism. So before the end of 2018, having built up community support and closed hundreds of beds, we will take stock and look at going further with the development of community support and the closure of inpatient services.

3.23 The immediate task now, however, is to start delivering the ambitious changes set out above. What follows is our plan for doing that.

4. Working together to provide new services

Transforming care partnerships

4.1 To deliver the change outlined in the previous chapter, and following what we have learned from the fast tracks, NHS commissioners, in discussion with local government, are mobilising transforming care partnerships – collaborations of CCGs, local authorities and NHS England specialised commissioners.

4.2 Currently the approach to commissioning services for people with a learning disability and/or autism is fractured, with responsibility split between local authorities, CCGs and NHS England. It can be difficult to move funding from one agency to another, to enable the commissioning of less inpatient care and more preventative, community-based services and support. Furthermore, many CCGs will be commissioning for a small number of people with a learning disability and/or autism, making it difficult to take a strategic approach to changing services across the system. Hospitals caring for this group of patients will often be commissioned by a large number of CCGs and NHS England, so that it is difficult for one commissioner to work with those providers to change the services they offer.

4.3 The new transforming care partnerships, currently mobilising, are intended to help address these weaknesses in commissioning arrangements. They will bring together the commissioners responsible for funding health and social care for people with a learning disability and/or autism (CCGs, local authorities with their responsibilities for care and housing, NHS England specialised commissioning), with their budgets aligned or pooled as appropriate. Figure 16 below and Annex A set out further details on how CCGs propose to cluster together in order to work with local authorities and NHS England specialised commissioning hubs in these new partnerships. We expect all CCGs in England to have finalised these arrangements by December 2015.

4.4 Transforming care partnerships will be supported to work alongside people who have experience using these services, as well as their families/carers, clinicians, providers and other stakeholders to formulate and implement **joint transformation plans** – closing some inpatient provision and shifting investment into support in the community.

4.5 They will bring commissioners together at a scale larger than most CCGs and many local authorities, with their geographical footprint based on:

- Building where possible on existing collaborative commissioning arrangements (e.g. joint purchasing arrangements amongst CCGs, joint commissioning arrangements between CCGs and local authorities)
- Local health economies of services for people with a learning disability and/or autism (e.g. patient flows, the provider landscape, and relationships between commissioners and providers). Where, for instance, a number of CCGs tend to use the same hospital provider for inpatient services for

people with a learning disability and/or autism, it makes sense for those CCGs to implement change collaboratively
- Commissioning at sufficient scale to manage risk, develop commissioning expertise and commission strategically for a relatively small number of individuals whose packages of care can be very expensive

The challenge

4.6 Each Transforming Care Partnership will be supported to improve outcomes for people with a learning disability and/or autism – both those currently in inpatient services (of whom there are approximately 2,600 nationally) and those in the community at risk of being admitted to hospital without the right support (of whom there are an estimated 24,000 nationally[20]).

4.7 We will support local transforming care partnerships to make progress on three outcomes:

- Reduced reliance on inpatient services (closing hospital services and strengthening support in the community)
- Improved quality of life for people in inpatient and community settings
- Improved quality of care for people in inpatient and community settings

4.8 People with a learning disability and/or autism as well as their families/carers should be supported to co-produce these plans. The change we need to see is as much about a shift in power as it is about service reconfiguration, and that should be reflected not just in the new services and support put in place (where for instance the national service model calls for the expansion of personal health budgets and high-quality independent advocacy), but in the way service changes are planned and delivered.

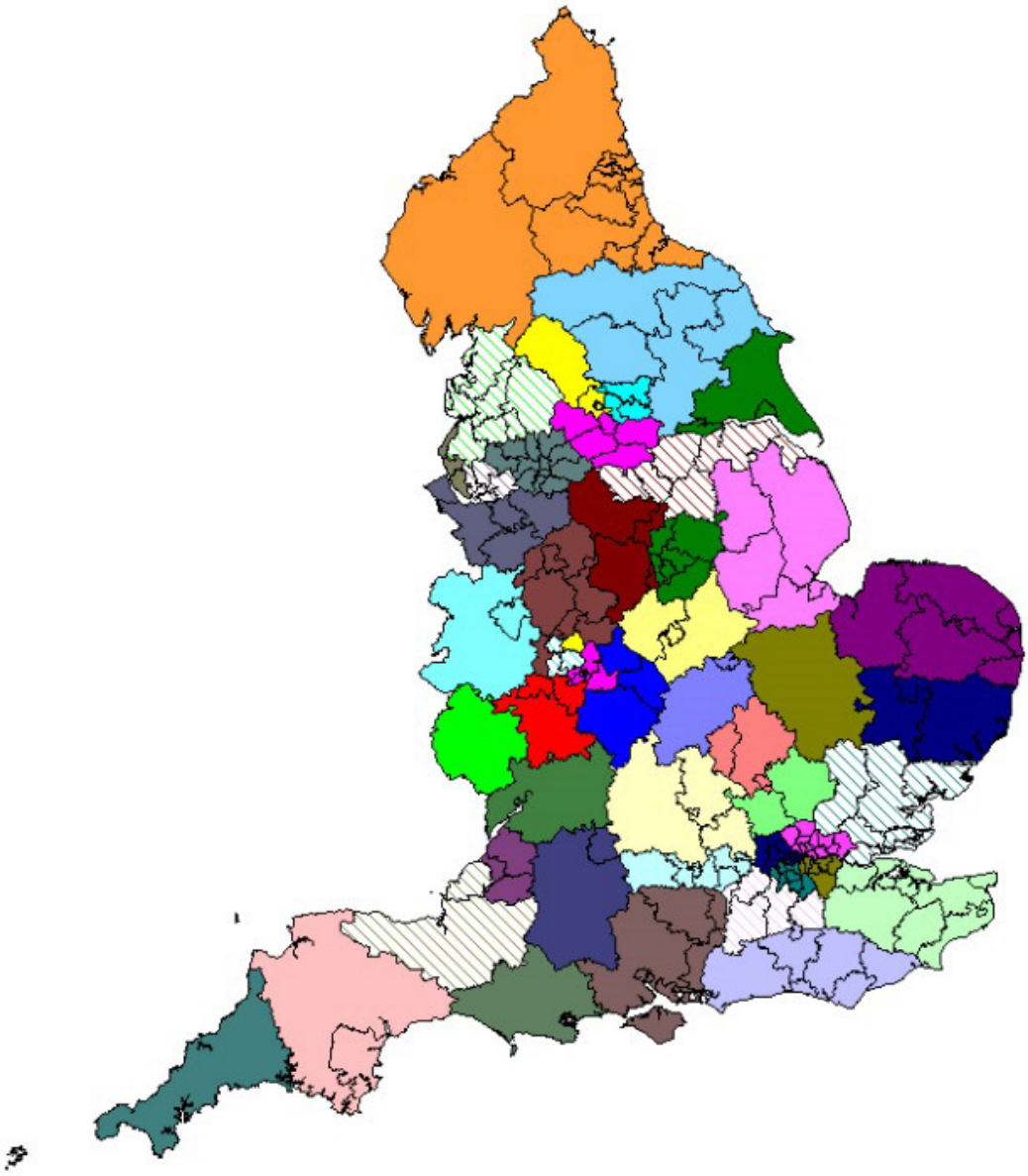
4.9 We will expect transforming care partnerships to tailor their approach based on local context, but in a way that is consistent with national parameters - in particular, the national service model and minimum planning assumptions on inpatient capacity outlined in chapter 3.

4.10 This work will also need to align with a number of other national priorities, such as:

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

[20] K. Lowe et al, Challenging Behaviours: prevalence and topographies. Journal of Intellectual Disability Research, 51, 625–636 (2007).

Figure 16 – Proposed transforming care partnerships



Transforming Care Partnerships

- South Worcestershire, Redditch, Bromsgrove & Wyre Forest (Fast Track)
- Hereford (Fast Track)
- Coventry, Rugby, South Warwickshire & Warwickshire North (Fast Track)
- Birmingham Cross City, Birmingham South Central & Solihull
- Walsall
- Black Country
- Derbyshire
- Nottinghamshire (Fast Track)
- Suffolk
- Norfolk
- Cambridge and Peterborough
- Essex
- Bedford, Luton and Milton Keynes
- Hertfordshire (Fast Track)
- Nene and Corby
- Lincolnshire
- Leicestershire
- Shropshire
- Staffordshire
- Gloucestershire
- Wiltshire and Swindon
- Bristol, Bane and South Gloucestershire
- Somerset and North Somerset
- Cornwall
- Devon
- Kent and Medway
- Sussex
- Surrey
- Oxford and Buckinghamshire
- Berkshire
- Hampshire & Isle of Wight
- Dorset
- Wirral, Cheshire & Chester
- Halton, St Helens, Warrington, Knowsley
- Liverpool, Sefton, Southport & Formby
- Greater Manchester (Fast Track)
- Lancashire (Fast Track)
- Cumbria and NE (Fast Track)
- North Yorkshire
- Barnsley, Wakefield, Kirklees, Huddersfield & Calderdale
- Bradford
- Leeds
- Sheffield, Doncaster, Rotherham, Lincs
- East Riding & Hull
- London North West
- London North, Central & East
- London South East
- London South West

Supporting local areas

4.11 NHS England, LGA and ADASS will support transforming care partnerships through the different stages of their journey in planning for and implementing change.

Mobilisation

4.12 Local areas will need to have a solid foundation upon which to base transformation, including strong leadership and sound governance, engagement, and commitment to joint working amongst a complex range of stakeholders.

4.13 As with the fast track areas, we envisage all transforming care partnerships having a single Senior Responsible Officer (SRO) responsible for the development and delivery of this work.

4.14 Transforming care partnerships will need to engage with and involve a broad range of people, including: all the CCGs; NHS England specialised commissioners; local authorities, including those commissioners responsible for adult and children's social care, education, housing and safeguarding; people with a learning disability and/or autism, their families/carers; clinicians; third-sector organisations; the police and those responsible for the criminal justice system; and relevant Local Education and Training Boards.

4.15 We will support local commissioners in this phase to mobilise the necessary project management resource, governance arrangements and partnership working across the range of organisations who need to be involved.

Understanding the starting point

4.16 Transforming care partnerships will need to base their plans on a strong understanding of: the population they are seeking to achieve better outcomes for (both current inpatients and those in the community at risk of admission without the right support); how much money CCGs, local authorities and NHS England specialised commissioners are currently spending on health and care for that population; which providers are delivering what services for that spend; and how the system is currently performing, its strengths and weaknesses.

4.17 In addition to the above areas will need to understand the estate and housing requirements to implement their plans, and establish whether there are

available capital receipts which could be recycled as part of this programme – including those relating to the estimated 2,000 properties used by councils or social landlords to provide housing or care to people with a learning disability but under an NHS charge.

4.18 NHS England, LGA and ADASS will provide data and access to subject matter experts to support local commissioners to understand the strengths and weaknesses of existing local services.

Developing a vision for the future and designing a future model of care

4.19 We will support local commissioners to develop a shared vision of how services will change, in line with the national service model.

4.20 NHS England, LGA and ADASS will support local areas with independent facilitation to bring local stakeholders together to design a jointly-owned future model of care. We will also support commissioners to access a range of experts, such as people with a learning disability and/or autism and their family carers who are 'experts by experience', clinicians, people with experience of person-centred planning - and integrated personal budgets - and providers of innovative community care and support.

Implementation planning

4.21 Local commissioners will need to draw up a road map for implementation, covering issues such as finance, workforce development, market development, or changes to estates.

4.22 NHS England, LGA and ADASS will provide technical expertise to support local areas with implementation planning. Building on the review process developed for assuring fast track plans and in alignment with the process for assuring CCGs' annual plans, local implementation plans will be reviewed and challenged by a range of stakeholders including people with a learning disability and/or autism, their families/carers, clinicians and commissioners from other areas.

Delivery

4.23 We expect local transforming care partnerships to have drawn up robust implementation plans and be delivering against them from 1 April 2016.

4.24 A cross-sector alliance of organisations will support these transforming care partnerships to deliver on this ambitious agenda.

4.25 Working alongside local commissioners, NHS England, LGA and ADASS will work with providers and their representative bodies to rapidly mobilise new housing and care services in the community. This work will focus on supporting providers to:

- Support commissioners to redesign services, including through advice on commissioning plans and market development, expertise on legal frameworks (such as the Mental Capacity Act and Deprivation of Liberty

Safeguards [DoLS]), and supporting individuals and families to design person-centred packages of support
- Deliver appropriate community-based services at scale, including through joint work between social care providers and providers of clinical services, and developing local responses to emergencies
- Train the local workforce within and beyond their organisations (e.g. through PBS training)
- Access the investment needed to expand and improve their offer at pace, including potentially through social investors
- Secure the capital required to deliver high-quality housing in community settings, including through potential social investment solutions such as charity bond issues (see case study below)

Case study – Retail Charity Bonds

In 2014, the first charity bond to be listed on the London Stock Exchange's Order Book for Retail Bonds was launched.

The bond, which raised £11 million to fund accommodation for people with a learning disability, was so oversubscribed it closed its offer period two and half weeks early.

The bond was launched by Retail Charity Bond plc and the funds have been used by Golden Lane Housing, the national charity which provides housing for people with a learning disability, to invest in buying and adapting much-needed community based housing across the country for over 100 people with a learning disability.

4.26 Alongside this work with providers to mobilise new services and housing in the community, we will explore the establishment of a national collaborative improvement programme (co-ordinating peer-learning and shared problem-solving between local areas), and a national accelerated support team able to work intensively with local areas with the biggest challenges and/or struggling to make progress.

4.27 HEE, Skills for Health and Skills for Care will collaborate to support the development of an appropriately skilled workforce to build the capacity to support people in the community. As far as possible, this will include working to support current inpatient staff to develop skills to work in the community. Every transforming care partnership will have a lead HEE contact to support them with planning and delivering workforce change. That lead contact will help them access relevant tools (such as competency frameworks), funding streams and training (for example leadership development or training to support staff in mainstream services to understand the needs of people with a learning disability and/or autism). Annex B sets out some of these resources in more detail.

4.28 NHS England, Monitor and the TDA will work together to support hospitals proactively in order to shift their business models, increasingly offering NHS assessment and treatment services in the community.

4.29 We will work with the CQC, Monitor, the TDA and local commissioners to ensure that inpatient units are only closed when people living in those units are supported to move in an appropriate and timely way to high quality services that can meet their needs. The CQC is also undertaking work to review their fundamental standards against the service model. When regulating active services (or those seeking registration) these fundamental standards will be used and robust action taken if services are not compatible with these and therefore the new service model.

4.30 We will review governance arrangements for the Transforming Care programme at a national level to ensure it reflects this alliance of organisations supporting local areas to deliver.

Monitoring progress

4.31 Nationally, we will monitor progress on delivery against the overarching outcomes we expect transformation to achieve, namely:

- Reduced reliance on inpatient services (closing hospital services and strengthening support in the community)
- Improved quality of life for people in inpatient and community settings
- Improved quality of care for people in inpatient and community settings

4.32 Reduced reliance on inpatient services will be monitored using Assuring Transformation data,[21] and from January 2016 the Mental Health Services Single Data Set[22] (MHSDS), incorporating data from the Learning Disabilities Census and Assuring Transformation dataset.

4.33 We will explore with transforming care partnerships an appropriate way to monitor improvements in quality of life, but are minded to support areas to roll out use of the Health Equality Framework tool[23] to monitor quality of life. In particular, we are considering how to support the use of this tool to understand changes to quality of life as people are supported to move out of inpatient services.

4.34 We will support the development of a basket of indicators to monitor improvements in quality of care, aligned with the newly developed service model. This basket of indicators will, as far as possible, be based on existing data sources currently collected in the NHS and social care.

4.35 Furthermore, as part of the roll out of the CTRs across the NHS, NHS England will work with system partners on introducing a metric for measuring the outcomes of this process. This may involve introducing a Patient Reported Outcome Measure (PROM) and/or a Patient Reported Experience Measure

[21] http://www.hscic.gov.uk/article/6328/Reports-from-Assuring-Transformation-Collection
[22] This is replacing the Mental Health and Learning Disabilities dataset.
[23] http://www.ndti.org.uk/publications/other-publications/the-health-equality-framework-and-commissioning-guide1/

(PREM). Development of this CTR outcome measure will have to involve people with a learning disability and/or autism, as well as their families/carers, clinicians, providers and commissioners to ensure it is robust and can be used at a national level to assess progress.

4.36 We will also revise the Learning Disability Self-Assessment Framework (SAF) and the Autism Self-Assessment Framework so that they reflect how well local areas are doing in building up support in the community and closing inpatient services.

4.37 With all the measures outlined above, it is important that people are supported to understand who will see their information, how their information will be used and make decisions about sharing their information. People should be given help to do this. For those people who lack capacity, they should still be involved as much as possible in any decisions made in their best interests.

4.38 NHS England will also support people with a learning disability to check the quality of services themselves, through a programme of work to establish a centralised system for NHS Quality Checking by people with a learning disability. Quality checker services train and support experts by experience to audit service quality. Quality checkers use their own experiences to make assessment on the quality of care and support, and to give a view that can be often missing from other forms of quality review. This entails using indicators of quality which people with a learning disability themselves consider to be relevant and important and which may therefore differ from those which have historically been used. Quality checkers with a learning disability will themselves carry out the evaluation, part of which will involve talking to service users about their experiences and views of the service in question. Evaluation of quality checking programmes show them to be an effective and efficient use of resources and to be associated with increases in quality and improved outcomes.

4.39 In addition, pilot work supported by NHS England has also demonstrated the potential of ‘Always Events’ to strengthen the voices of people with a learning disability and/or autism in the quality assurance of services.

4.40 Lancashire Care NHS Foundation Trust - in partnership with the Institute for Healthcare Improvement (IHI), the Picker Institute Europe and NHS England - has co-produced with people with a learning disability a set of ‘Always Events’ to improve the quality and consistency of transitions within and between services. NHS England will expand its work on ‘Always Events’, share the case study from Lancashire and produce a toolkit with IHI to support the further use of this tool in order to improve the responsiveness and accountability of services.

Financial underpinnings

4.41 A new financial framework will underpin and enable transformation.

4.42 Local transforming care partnerships (CCGs, local authorities and NHS England specialised commissioning) will be asked to use the total sum of money they spend as a whole system on people with a learning disability and/or autism to deliver care in a different way to achieve better results. This includes shifting money from some services (such as inpatient care) into others (such as community health services or packages of support). The costs of the future model of care will therefore be met from the total current envelope of spend on health and social care services for people with a learning disability and/or autism. We estimate that the closure of inpatient services of the scale set out in chapter 3 will release hundreds of millions of pounds for investment in better support in the community.

4.43 To enable that to happen, NHS England's specialised commissioning budget for secure learning disability and autism services will be aligned with the new transforming care partnerships, and CCGs will be encouraged to pool their budgets with local authorities whilst recognising their continued responsibility for NHS Continuing Healthcare. CCGs, NHS England specialised commissioning and local authorities will be supported to, where appropriate, put in place governance and financial mechanisms to align or pool resources and manage financial risk. The degree of change and financial risk will inevitably vary across localities, and we will support local commissioners to base decisions on transparent, open-book discussions, focussed on achieving the best outcomes for the people they serve.

4.44 For people who have been an inpatient for five years or more (approximately one third of the total inpatient population) and who are ready for discharge, we expect the transformational change required to be one of 'resettlement' out of hospital and into a more suitable home, as opposed to redesigning services to reduce the 'revolving door' of admissions and discharges. For this group, money will 'follow the individual' through dowries.

4.45 Dowries will be paid by the NHS to local authorities for people leaving hospital after continuous spells in inpatient care of five years or more at the point of discharge. We expect that NHS England will pay for dowries when the inpatient is being discharged from NHS England-commissioned care, and that CCGs will pay for dowries when the individual is being discharged from CCG-commissioned care. Dowries will be recurrent, will be linked to individual patients, and will cease on the death of the individual. An annual confirmation of dowry-qualifying individuals should be undertaken by local authorities and CCGs. Dowries are to be prospective only, and so should not be applied to any patients that have already been discharged. They should apply to those patients discharged on or after 1 April 2016, and only to those patients who have been in inpatient care for five years or more on 1 April 2016 (not any patient who reaches five years in hospital subsequent to that date). They should apply pro rata in the start and finish year. To ensure that the costs of the future model of care fit within the existing funding envelope, it is important

that dowries are set at a level which is consistent with this principle. The absolute level of the dowry is not expected to be set nationally, but is to be left to local discussions which should be subject to the principles set out here. In addition to paying for these dowries, the NHS will continue to fund continuing healthcare (CHC) and relevant Section 117 aftercare.

4.46 In addition, from November 2015 *Who Pays* guidance - determining responsibility for payment to providers - will be revised to facilitate swifter discharge from hospital of patients originating from one CCG but being discharged into a different local area. This will ensure continuity of care with responsibility remaining with one CCG rather than being passed from commissioner to commissioner.

4.47 Transformation of this scale will entail significant transition costs, including the temporary double running of services as inpatient facilities continue to be funded whilst new community services are established. The extent of the transition costs will depend on the efficiency of the bed closure programme, and the timing and extent of required new community investment. We will work with commissioners and providers to support the closure of inpatient capacity and development of new community services as efficiently as possible, but we recognise that non-recurrent investment will still be necessary. To support local areas with these transitional costs, building on the approach tested with fast track areas, NHS England will make available up to £30 million of transformation funding over three years, with national funding conditional on match-funding from local commissioners.

4.48 In addition to this, £15 million capital funding over three years will be made available, and NHS England will explore making further capital funding available following the Spending Review.

4.49 As set out in the national service model, alongside these new financial underpinnings to enable transformation, we expect to see a significant growth in personalised funding approaches (personal budgets, personal health budgets, and integrated personal budgets as well as education, health and care plans). Local transformation should, for instance, be aligned with existing requirements for CCGs to set out a ‘local offer’ on personal health budgets.

4.50 In some parts of the country, local transformation plans will also need to align with Integrated Personal Commissioning (IPC) pilots. IPC sites are currently testing approaches to enable people to purchase their care (including clinical services currently commissioned using NHS standard contracts) through personal budgets, combining resources from health, social care and other funding sources where applicable. The work these sites are undertaking includes linking cost and activity data across services and trialling new contracting and payment approaches that enable the money to be used differently. As IPC sites progress their work, we will support local transforming care partnerships to learn from them and apply the lessons to their own local areas.

Conclusion

This document started with a simple vision that people with learning disability and/or autism have the right to the same opportunities as anyone else to live satisfying valued lives and to be treated with dignity and respect. They should have a home, be able to develop and maintain relationships, and get the support they need to live healthy, safe and fulfilling lives in the community.

For all the frustration of recent years, it is a vision that we can make real. Thousands of people with a learning disability and/or autism are today supported in the community who would years ago have lived in hospitals. There is good practice across the country. There are thousands of people with the expertise and commitment to make this shift happen, from people with a learning disability and/or autism themselves, their families/carers as well as frontline clinicians and staff. We have local leaders across social care, the NHS and criminal justice system ready and willing to take up the challenge. At a national level there is an alliance of organisations committed to breaking down the barriers to change, supporting local leaders to make a difference.

Together we have an opportunity to transform thousands of lives. Together we must seize the day and deliver.

Annex A – Proposed CCG clusters for transforming care partnerships

This table shows how CCGs currently propose to cluster together to work with local authorities and NHS England specialised commissioning to build up community services and close inpatient provision that is no longer needed.

Transforming Care Partnership	Clinical Commissioning Group (CCG)
South Worcestershire, Redditch, Bromsgrove & Wyre Forest	NHS South Worcestershire CCG
	NHS Wyre Forest CCG
	NHS Redditch and Bromsgrove CCG
Hereford	NHS Herefordshire CCG
Coventry, Rugby, South Warwickshire & Warwickshire North	NHS Coventry and Rugby CCG
	NHS South Warwickshire CCG
	NHS Warwickshire North CCG
Birmingham CrossCity, Birmingham South Central & Solihull	NHS Birmingham CrossCity CCG
	NHS Birmingham South and Central CCG
	NHS Solihull CCG
Walsall	NHS Walsall CCG
Black Country	NHS Dudley CCG
	NHS Sandwell and West Birmingham CCG
	NHS Wolverhampton CCG
Derbyshire	NHS Erewash CCG
	NHS Southern Derbyshire CCG
	NHS Hardwick CCG
	NHS North Derbyshire CCG
Nottinghamshire	NHS Mansfield and Ashfield CCG
	NHS Bassetlaw CCG
	NHS Newark and Sherwood CCG
	NHS Nottingham City CCG
	NHS Nottingham North and East CCG
	NHS Nottingham West CCG
	NHS Rushcliffe CCG
Suffolk	NHS Ipswich and East Suffolk CCG
	NHS West Suffolk CCG
Norfolk	NHS North Norfolk CCG
	NHS Norwich CCG

	NHS South Norfolk CCG
	NHS West Norfolk CCG
	NHS Great Yarmouth and Waveney CCG
Cambridge and Peterborough	NHS Cambridgeshire and Peterborough CCG
Essex	NHS Basildon and Brentwood CCG
	NHS Castle Point and Rochford CCG
	NHS Mid Essex CCG
	NHS North East Essex CCG
	NHS Southend CCG
	NHS Thurrock CCG
	NHS West Essex CCG
Bedford, Luton and Milton Keynes	NHS Bedfordshire CCG
	NHS Luton CCG
	NHS Milton Keynes CCG
Hertfordshire	NHS East and North Hertfordshire CCG
	NHS Herts Valleys CCG
Nene and Corby	NHS Nene CCG
	NHS Corby CCG
Lincolnshire	NHS Lincolnshire East CCG
	NHS Lincolnshire West CCG
	NHS South Lincolnshire CCG
	NHS South West Lincolnshire CCG
Leicestershire	NHS East Leicestershire and Rutland CCG
	NHS Leicester City CCG
	NHS West Leicestershire CCG
Shropshire	NHS Shropshire CCG
	NHS Telford and Wrekin CCG
Staffordshire	NHS East Staffordshire CCG
	NHS North Staffordshire CCG
	NHS South East Staffordshire and Seisdon Peninsular CCG
	NHS Stafford and Surrounds CCG
	NHS Cannock Chase CCG
	NHS Stoke-on-Trent CCG
Gloucestershire	NHS Gloucestershire CCG
Wiltshire and Swindon	NHS Swindon CCG
	NHS Wiltshire CCG
Bristol, Bane and South	NHS Bristol CCG

Gloucestershire	NHS South Gloucestershire CCG
	NHS Bath and North East Somerset CCG
Somerset and North Somerset	NHS North Somerset CCG
	NHS Somerset CCG
Cornwall	NHS Kernow CCG
Devon	NHS North, East, West Devon CCG
	NHS South Devon and Torbay CCG
Kent and Medway	NHS Ashford CCG
	NHS Canterbury and Coastal CCG
	NHS Dartford, Gravesham and Swanley CCG
	NHS Medway CCG
	NHS South Kent Coast CCG
	NHS Swale CCG
	NHS Thanet CCG
	NHS West Kent CCG
Sussex	NHS Brighton and Hove CCG
	NHS High Weald Lewes Havens CCG
	NHS Eastbourne, Hailsham and Seaford CCG
	NHS Hastings and Rother CCG
	NHS Coastal West Sussex CCG
	NHS Crawley CCG
	NHS Horsham and Mid Sussex CCG
Surrey	NHS Guildford and Waverley CCG
	NHS North West Surrey CCG
	NHS Surrey Downs CCG
	NHS East Surrey CCG
	NHS Surrey Heath CCG
Buckinghamshire	NHS Aylesbury Vale CCG
	NHS Chiltern CCG
Berkshire	NHS Bracknell and Ascot CCG
	NHS Slough CCG
	NHS Windsor Ascot and Maidenhead CCG
	NHS Newbury and District CCG
	NHS North and West Reading CCG
	NHS South Reading CCG
	NHS Wokingham CCG
Hampshire & Isle of Wight	NHS North East Hampshire and Farnham CCG
	NHS North Hampshire CCG

	NHS Portsmouth CCG
	NHS South Eastern Hampshire CCG
	NHS Southampton CCG
	NHS West Hampshire CCG
	NHS Fareham and Gosport CCG
	NHS Isle of Wight CCG
Dorset	NHS Dorset CCG
Wirral, Cheshire & Chester	NHS Wirral CCG
	NHS West Cheshire CCG
	NHS Eastern Cheshire CCG
	NHS South Cheshire CCG
	NHS Vale Royal CCG
Halton, St Helens, Warrington, Knowsley	NHS Halton CCG
	NHS St Helens CCG
	NHS Warrington CCG
	NHS Knowsley CCG
Liverpool, Sefton, Southport & Formby	NHS South Sefton CCG
	NHS Southport and Formby CCG
	NHS Liverpool CCG
Greater Manchester	NHS Bolton CCG
	NHS Bury CCG
	NHS Central Manchester CCG
	NHS Heywood, Middleton and Rochdale CCG
	NHS North Manchester CCG
	NHS Oldham CCG
	NHS Salford CCG
	NHS South Manchester CCG
	NHS Stockport CCG
	NHS Tameside and Glossop CCG
	NHS Trafford CCG
	NHS Wigan Borough CCG
Lancashire	NHS Blackburn with Darwen CCG
	NHS Blackpool CCG
	NHS Chorley and South Ribble CCG
	NHS East Lancashire CCG
	NHS Fylde and Wyre CCG
	NHS Greater Preston CCG
	NHS Lancashire North CCG

	NHS West Lancashire CCG
Cumbria and NE	NHS Cumbria CCG
	NHS Newcastle Gateshead CCG
	NHS North Tyneside CCG
	NHS Northumberland CCG
	NHS South Tyneside CCG
	NHS Sunderland CCG
	NHS Darlington CCG
	NHS Durham Dales, Easington and Sedgefield CCG
	NHS Hartlepool and Stockton-on-Tees CCG
	NHS North Durham CCG
	NHS South Tees CCG
North Yorkshire	NHS Hambleton, Richmondshire and Whitby CCG
	NHS Harrogate and Rural District CCG
	NHS Scarborough and Ryedale CCG
	NHS Vale of York CCG
Barnsley, Wakefield, Kirklees, Huddersfield & Calderdale	NHS Barnsley CCG
	NHS Wakefield CCG
	NHS North Kirklees CCG
	NHS Greater Huddersfield CCG
	NHS Calderdale CCG
Bradford	NHS Bradford Districts CCG
	NHS Bradford City CCG
	NHS Airedale, Wharfdale and Craven CCG
Leeds	NHS Leeds North CCG
	NHS Leeds South and East CCG
	NHS Leeds West CCG
Sheffield, Doncaster, Rotherham, North Lincolnshire	NHS Doncaster CCG
	NHS Rotherham CCG
	NHS North East Lincolnshire CCG
	NHS North Lincolnshire CCG
	NHS Sheffield CCG
East Riding & Hull	NHS East Riding of Yorkshire CCG
	NHS Hull CCG
London North West	NHS Brent CCG
	NHS Central London CCG

	NHS Ealing CCG
	NHS Hammersmith and Fulham CCG
	NHS Harrow CCG
	NHS Hillingdon CCG
	NHS Hounslow CCG
	NHS West London CCG
London North, Central & East	NHS Barking and Dagenham CCG
	NHS Barnet CCG
	NHS Camden CCG
	NHS City and Hackney CCG
	NHS Enfield CCG
	NHS Haringey CCG
	NHS Havering CCG
	NHS Islington CCG
	NHS Newham CCG
	NHS Redbridge CCG
	NHS Tower Hamlets CCG
	NHS Waltham Forest CCG
London South East	NHS Bexley CCG
	NHS Bromley CCG
	NHS Greenwich CCG
	NHS Lambeth CCG
	NHS Lewisham CCG
	NHS Southwark CCG
London South West	NHS Croydon CCG
	NHS Kingston CCG
	NHS Merton CCG
	NHS Richmond CCG
	NHS Sutton CCG
	NHS Wandsworth CCG
Oxfordshire	NHS Oxfordshire CCG

Annex B – Workforce development

i. In every part of the country there are people with the skills and experience to deliver effective care to people with a learning disability and/or autism. These people can be found within health and social care and amongst the people with a learning disability and/or autism themselves, as well as families/carers that support individuals in their own home.

ii. As such, an essential part of delivering each joint transformation plan relies on how areas can harness these skills.

iii. Areas need to develop, focus and refine the skills needed to enable them to work in a different way. They need to manage risk efficiently and have robust and effective ways of intervening in crisis situations that lead to the best possible solutions in the least restrictive environment.

iv. Each area needs to establish mechanisms to understand the skills and competencies that are required to support the specific needs of every individual. Only then will they be able to commission a service that is flexible enough to care for each person and their own specific circumstances. The development of new and innovative approaches to supporting people will be reliant upon the development of a flexible and skilled workforce equipped to adapt and adopt new practices. This may involve commissioning new roles from those traditionally employed within the current provision.[24] Those commissioned to provide such services will need to define competencies and skills required, assess the capability currently available within their workforce, and access appropriate training and development. This will include developing skills to deliver services across all ages in the areas of mental health, autism, managing behavioural problems and offending behaviour.

v. HEE alongside partner organisations Skills for Care and Skills for Health will offer practical support with the aim to:

- **Equip commissioners with the tools and confidence to commission for workforce skills and competencies.** Commissioners are an essential part of the workforce that needs development and support to deliver the new service model. This includes enhancing existing service provision, creating new service models and commissioning beyond the traditional service boundaries, for example placing learning disability nurses in primary and secondary care in order to support health and care professionals to make better decisions. Skills for Care have developed a workforce commissioning model that provides a systematic way of linking service commissioning with workforce commissioning and financial strategy. This can be found here

vi. There are several models for testing workforce assumptions and undertaking Strategic Workforce planning, including Integrated Workforce Planning

[24] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/309153/Strengthening_the_commitment_one_year_on_published.pdf

Solutions from Skills for Health, and Skills for Care's Workforce Capacity Planning guidance.

- **Work with existing service providers to review the skills and competencies within their existing workforce to identify education and training needs, and facilitate transition to a new way of working.** HEE in partnership with Skills for Health have developed a skills and competency framework which can be utilised to undertake a training needs analysis of the existing workforce, and to build a competency based team model against which new and existing roles can be mapped. The framework, alongside an illustrative animated video, can be found here: HEE Skills & Competency Framework

vii. We are in the process of developing an interactive tool to support the implementation and use of the competence framework.

viii. The Positive Behavioural Support (PBS) Coalition have published a PBS Competency Framework. For ease of use, the PBS competencies have been mapped into the HEE Skills and Competency Framework.

ix. Whilst this framework has been developed primarily for the health care workforce it can be utilised in a range of services. Skills for care have developed a strategy for the social care sector to support functional and employability skills (Core Skills), which impact directly on the quality of care and support services.

- **Ensure that education and training to enable the wider workforce is able to meet the needs of people with a learning disability in all care settings**. Recognising that most people with a learning disability have their health and care needs met by mainstream health care services, HEE commissioned the development of education and training resources 'Learning Disability Made Clear' that can be used by staff in a range of health and care settings to increase their knowledge and support how services can make adjustments to meet specific needs

x. A suite of existing resources developed to raise awareness of the needs of people with autism, have been reviewed and located in one place to enable individuals and organisations to select the most appropriate resource for their needs. A marketing and promotion strategy is underway to ensure these resources are widely accessed by employers, employees, volunteers and carers across the country. These can be found here.

xi. In addition to the above, work is being undertaken to develop specific learning disability and autism skills in the mainstream mental health workforce on whom we will become increasingly reliant as specialist services become more integrated.

- **Developing leadership capability across the system including commissioners, service providers and carers to promote innovation and change services to focus on people's needs.** HEE, Skills for Health and Skills for Care will coordinate access to the various provision and funding streams available across agencies to ensure that creative and innovative leadership activities are supported as part of the national transformation plan

Annex C – Notes on data used in this document

All modelling to produce planning assumptions and charts was based on calculating inpatient rates per million population. The following notes apply to all charts used in this document which describe projected reductions in fast track bed usage and current geographical variation in reliance on inpatient care across England.

- All inpatient rates are based on GP registered population aged 18 and over as at 2013/14
- Inpatient numbers include children under the age of 18 but these patients represent less than 5% of the total inpatient population
- High secure services have been excluded (65 patients[25])

Data on the current position and projections for fast track areas is taken from the fast track plans, but projections exclude Worcestershire (part of Arden, Herefordshire and Worcestershire Fast Track).

The data set used to calculate the current geographical variation as at 31 July 2015 combines information on CCG-commissioned patients from the Assuring Transformation collection and data on NHS England-commissioned patients from NHS England's Local Trackers (this includes information on the home CCG of NHS England-commissioned patients). This means that the presentation of inpatient data is based on where patients originally come from, not where their hospital is located.

Assuring Transformation data is collected and published by The Health and Social Care Information Centre (HSCIC). Assuring Transformation data is presented in accordance with HSCIC rules on suppressed data for collections involving small numbers of records.

Not all NHS England-commissioned patients in the Local Tracker data could be matched to a CCG of origin, and these patients are therefore omitted from the analysis of geographical variance on a Transforming Care Partnership level. The geographical analysis presented in Figures 2 and 3 assigns these patients to the locality of their commissioner.

[25] Number of inpatients in high secure settings suppressed in accordance with HSCIC rules on suppressed data for collections involving small numbers of records. Figure correct as at 31st July 2015.

Building the right support

A national plan to develop community services and close inpatient facilities for people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition

October 2015

Local Government Association (LGA)
Association of Directors of Adult Social Services (ADASS)
NHS England

Health Scrutiny Committee
Meeting to be held on 26 January 2016

Electoral Divisions affected:
All

Report of the Health Scrutiny Committee Steering Group
(Appendices A & B refer)

Contact for further information:
Wendy Broadley, 07825 584684, Democratic Services,
wendy.broadley@lancashire.gov.uk

Executive Summary

On 26 October the Steering Group met with Sam Nicol to provide an update on Healthier Lancashire and Gill Brown, Chief Executive of Healthwatch Lancashire A summary of the meeting can be found at Appendix A.

On 16 November the Steering Group met with Cllr Barbara Ashworth and Pat Couch from Rossendale Borough Council to present their draft task group report on ambulance services and also Erin Portsmouth and Dr Kumar from Chorley South Ribble and Greater Preston CCGs to discuss workforce planning. A summary of the meeting can be found at Appendix B.

Recommendation:

The Health Scrutiny Committee is asked to receive the report of the Steering Group.

Background and Advice

The Scrutiny Committee approved the appointment of a Health Scrutiny Steering Group on 11 June 2010 following the restructure of Overview and Scrutiny approved by Full Council on 20 May 2010. The Steering Group is made up of the Chair and Deputy Chair of the Health Scrutiny Committee plus two additional members, one each nominated by the Conservative and Liberal Democrat Groups.

The main purpose of the Steering Group is to manage the workload of the Committee more effectively in the light of the increasing number of changes to health services which are considered to be substantial. The main functions of the Steering Group are listed below:

- To act as the first point of contact between Scrutiny and the Health Service Trusts;

Lancashire County Council

- To make proposals to the main Committee on whether they consider NHS service changes to be ‘substantial’ thereby instigating further consultation with scrutiny;
- To liaise, on behalf of the Committee, with Health Service Trusts;
- To develop a work programme for the Committee to consider.

It is important to note that the Steering Group is not a formal decision making body and that it will report its activities and any aspect of its work to the full Committee for consideration and agreement.

Consultations

N/A.

Implications:

This item has the following implications, as indicated:

Risk management

This report has no significant risk implications.

Local Government (Access to Information) Act 1985
List of Background Papers

Paper	Date	Contact/Directorate/Tel

N/A.

Reason for inclusion in Part II, if appropriate

N/A.

Appendix A

Lancashire County Council

Health Scrutiny Committee - Steering Group

Minutes of the Meeting held on Monday, 26 October, 2015 at 2.00 pm in Room B18b, County Hall - County Hall, Preston

Present:

County Councillor Steven Holgate (Chair)

County Councillors

M Brindle
Mrs F Craig-Wilson
Y Motala

1. Apologies

None to note

2. Notes of the last meeting

The notes of the Steering Group meeting help on 5 October were agreed as correct.

3. Healthwatch

Gill Brown, Chief Executive from Healthwatch attended the meeting to talk to members about the role of Healthwatch, its current activities and discuss the content of the presentation that Healthwatch (HW) will deliver to Committee on 24 November.

Gill set out the functions and responsibilities of HW

A discussion took place and the main points were:

- The challenges that Lancashire faces such as geography, demographics etc.
- History on the formation and development of the Board and the organisation.
- Current position is that Gill is CEO and Mike Wedgeworth is Interim Chair.
- Looking to become independent from the County Council from 2016. However as LCC are the commissioners and the funding comes through them they still will have the opportunity to exercise an element of control.
- Future work of HW includes: community & on-line activity, development of engagement database, Roadshows (not supported by LCC), scrutiny of residential care. She talked to members about a number of specific pieces of work that have been undertaken across the county.
- CC Holgate gave some positive feedback he'd heard about one of the projects that HW did at UHMBT. This project has been shortlisted for an award.

- NHS Trusts and CCGs are contacting HW to engage with the public because of the success of their engagement database.
- Enter and View – 3 project officers on a temporary contract until March. The Mum's Test (would I leave them here?) is applied to all visits.
- Members talked about the CQC inspections of care homes and how they are perceived and carried out.
- CC Brindle mentioned her concerns about CQC inspections of care homes, particularly one in Burnley that she had raised issues with previously
- Members were reminded that HW England is a sub-committee of the CQC.
- Plea that LCC continue to support HW to enable them to continue their current and future projects.

Members thanked Gill for her time and looked forward to her attending Committee in November.

4. Healthier Lancashire

Sam Nicol from Healthier Lancashire attended the meeting to provide an update on the work of the Healthier Lancashire Programme. The main points of the discussion were:

- Potential for scrutiny to play a bigger role over the next 12 to 18 months.
- Purpose document produced at the end of 2014.
- 5 year forward view – National picture that is represented in Lancashire.
    - The future will see a lot more care delivered locally but also the rise of specialist centres.
    - 2 Vanguards (Fylde – community model), North Lancs (accountable care organisation)
    - Emergency care services should be redesigned
    - New roles for midwives
    - More support to frail/elderly in care homes
    - GPs to have more support
    - More money for Primary Care and GPs to have more control of the budgets
    - New uses of health technology
    - New ways of using the money
    - Action will be needed on demand, delivery and funding
- Alignment of Plans – testing of individual local plans to see if met the 5-year forward view, how far do they go, what's the gap, what needs doing
- Independent review – Ernst Young were appointed to carry out the alignment (funded by all providers and commissioners on the patch)
- Key findings:
    - Compared to national average have greater areas of deprivation
    - A number of areas are worse than national, life expectancy, unhealthy behaviours, co-morbidities etc.

    - Invest quite a lot in some services that don't produce results (mental health services)
    - Work force issues – getting older, average pay
    - Need to reduce the demand
    - Geography of the area presents challenges
    - Estates under utilised
    - 53 different strategies - No single unifying vision to improve health & social care.
- The definition of deprivation needs to be considered – i.e. not having access to chances to improve life, key factors include education, employment and housing.
- Healthier Lancashire Forward View was provided by Sam for members but was at the present time a confidential document.
- HSC to be involved in the development of a 'Vision for Lancashire' – to liaise with Sam about how we can progress this.
- CC Holgate suggested that HL look at 0-5 health care services as a system wide change.
- Leadership needs to be sorted, mandate to move forward on next steps and a more co-ordinated process to deliver.
- No engagement at grass roots at the moment but that is the ultimate aim. Mandate that will be achieved on 19 Nov (meeting of Lancashire organisational Chief Execs), only then can staff and the general public can be involved.
- Launch – end Jan/early Feb central location.

BSB in November.

5. Work plan/Actions from Committee

The work plan of the Committee was noted

6. Date of next meeting

16 November – Rossendale to present their final report following the conclusion of their task group review of NWAS and CSR CCG will attend to discuss the workforce planning project.

I Young
Director of Governance, Finance and Public Services

County Hall
Preston

Appendix B

Lancashire County Council

Health Scrutiny Committee - Steering Group

Minutes of the Meeting held on Monday, 16 November, 2015 at 2.00 pm in Room B18b, County Hall - County Hall, Preston

Present:

County Councillors

M Brindle Y Motala
Mrs F Craig-Wilson

1. Apologies

Apologies were received from CC Holgate.

2. Notes of the last meeting

The notes of the meeting held on 26 October were agreed as correct.

3. Rossendale Task Group Report - NWAS

CC Motala welcomed Cllr Barbara Ashworth and Pat Couch, Scrutiny Officer, who attended the meeting to talk members through their scrutiny task group review of the North West Ambulance Service for Rossendale.

Barbara went through the background to the report, methodology, visits etc, and the recommendations. A discussion took place and the main points were:

- Raised wider issues of areas of concern re NWAS – hub & spoke model, availability of ambulances in rural areas.
- Need to find out views of other Districts.
- Report will be reported to Rossendale Scrutiny Committee 1 Feb – it will be published then. Will also have the responses to the recommendations.
- It was agreed that the HSC could pick up any outstanding issues their behalf. – the report can be added to March Committee agenda for information.
- The report had identified a number of Highways issues re signage – it was suggested that CC Oakes write to CC Fillis as Cabinet Member.
- Concerns still outstanding about falls and also emergency planning.
- Can NWAS identify best practice across their patch in terms of handing over patients from ambulances to EDs?

It was agreed that at the next Steering Group meeting members would provide a formal response to the recommendations of the report.

4. Workforce for the Future

Erin Portsmouth, Head of Communications and Engagement and Dr Kumar from Chorley South Ribble CCG attended to talk to members about the work force planning project they are undertaking.

A copy of the report produced can be found at the following link
Workforce for the Future

A discussion took place and the main points were:

- This project is aimed at central Lancashire but it fits in with the wider county and regional context.
- Not just GPs, includes social care, nurses.
- Work force challenges – map and measure the numbers – not just looking at the numbers but what the skills that are needed. Perception that the big cities soak up the working population. New ways of working require new skills and practices.
- Challenge of viewing general practice as a specialism – even though it's very difficult as have a large breadth of conditions.
- Asked stakeholders to state what they felt the gaps were.
- Lot of workforce leave the area.
- Number of vacancies impact on the remaining workforce.
- Number of GPs in Lancashire that are approaching retirement? – Can provide more up to date data on this – Wendy to liaise with Erin – this issue is part of the CCGs forward strategy.
- The role of the 'family doctor' is a thing of the past.
- Need to change the face of primary care practice – not just have more GPs
- The project is long term as it's aimed at getting in to schools, colleges etc. to interest people in the profession in the first place.
- Training for primary care staff – particularly working with receptionists to make sure they make sure patients get to see the best person at the best time.
- Other GPs can often promote negative images to trainees - Need to make the career attractive.
- Some GPs are very good at the art of conversation to get to the bottom of the problem – knowing your patient and also over a period of time.
- The term 'general practitioner' can be seen as derogatory and not as exciting as a specialist.
- They need to get to the bottom of issues not just be satisfied with carrying out lots of tests and telling them it's clear.
- Many doctors have inconsistent career advice – some consultants look down on GPs.
- Not much support to branch out into other things for periods of time – portfolio boundaries – Lancashire needs to offer these opportunities.

- Maybe work on the perception that nurses are female – maybe target men for the profession.
- A teaching scenario model is being developed in Lancashire (with LTHT) for schools to visit and see what the NHS has to offer.
- Need to remember that GPs are independent businesses – need to attract entrepreneurs.
- Many GPs signpost a lot as they've received criticism for over referring.
- Many large practices can provide peer to peer instant support but often you don't get to see the same doctor twice.
- The model that is emerging is a mixture of the best bits of single practice and large practices by bringing together single GPs to share back office functions – needs organisation.
- Need variable access - a mixture of quick appointments with any GP and the continuity of a dedicated GP.
- Need to future proof – need to do something in the immediate future whilst determining what the long term strategy is.
- Many existing contract issues are very rigid and therefore potentially unattractive.
- CCG are looking at 'beacon' training.
- Working with care homes to improve access to GPs, other nursing to enable to connect better with peers in the NHS. Improving access to continual training.
- Another challenge is the negative perceptions of the nursing home sector.
- Need to get the public behind the initiative.
- The amount of money spent on agency should force the conversation to address issues such as 'rural waiting' not just London waiting'.

CC Motala summed up by stating the positive moves in place and acknowledgement of what still needs to be done and the importance of collaboration.

It was agreed that officers be invited back to a future Steering Group meeting to update members.

5. Work plan

Members noted the work plan

6. Date of next meeting

The date of the next Steering Group meeting is Monday 7 December.

I Young
Director of Governance, Finance
and Public Services

County Hall
Preston

Health Scrutiny Committee
Meeting to be held on 26 January 2016

Electoral Divisions affected:
All

Health Scrutiny Committee Work Plan 2015/16
(Appendix A refers)

Contact for further information:
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wendy.broadley@lancashire.gov.uk

Executive Summary

The Plan at Appendix A is the work plan for both the Health Scrutiny Committee and its Steering Group, including current Task Group reviews.

The topics included were identified at the work planning workshop that members took part in during April 2015 and also additions and amendments agreed by the Steering Group.

Recommendation

The Health Scrutiny Committee is asked to note and comment on the report.

Background and Advice

A statement of the current status of work being undertaken and considered by the Committee is presented to each meeting for information.

Consultations
N/A.

Implications:
This item has the following implications, as indicated:

Risk management
This report has no significant risk implications.

Lancashire County Council

Local Government (Access to Information) Act 1985
List of Background Papers

Paper	Date	Contact/Directorate/Tel

N/A.

Reason for inclusion in Part II, if appropriate

N/A.

Appendix A

Health Scrutiny Committee – 2015/2016 Work Plan

Updated – 26 January 2016

Health Scrutiny Committee	
Date	**Topic**
2 June	• North West Ambulance Service
15 July	• Prevention – to focus on falls, care homes 'no lift' policies and the role of CQC regarding those policies. What LCC and partners can do to address the issues
1 September	• Joint Working – fragmented commissioning amongst partners. To use mental health commissioning as the example. To include how partners share information and intelligence.
13 October	• Access to Services – using services for deaf people as an example and a comparison between rural and urban areas
24 November	• Health & Wellbeing Board update • Healthwatch update
26 January	• Transforming care for adults with learning disabilities

15 March	• Director of Public Health – Annual report
26 April	• Update on Joint Working in light of budget implications – follow on from September Committee • Update on year's topics

Steering Group		Progress
CQC/Monitor inspections – ongoing review	• A review of the inspection process undertaken by CQC and Monitor in relation to Acute Trusts	22.6.15 – met with CQC Inspection Manager to determine the process/management of an actual inspection
Non-Executive Directors – ongoing review	• An investigation into the role, responsibilities and effectiveness on Non-Executive Directors on Acute Trust Boards	• 22.6.15 – agreed dates to attend individual Trust Board meetings • ELHT Board attended by CC Brindle • Meeting to be arranged with TDA officers – 5 October • SOHT Board attended by CC Holgate – 7 October • LTHT Board attended by CC Holgate – 11 November
End of year HSC report	• An annual report highlighting the work and outcomes of the Committee	
Healthwatch – joint working	• Consideration of how the Committee and Healthwatch can work in partnership to achieve shared outcomes	Healthwatch Chief Executive invited to SG 26 October. Follow up with attendance at Committee (24 Nov)

Additional topics	• Inclusion and Disability Service – at the request of the Budget Scrutiny Working Group	tba
	Occupational Therapy - capacity and collaborative working	Meeting to be arranged with OT service managers for both adults and children's services
	• Commissioning of Health Visitors from October 2015	Meeting to be arranged with Mike Leaf
	• Maintaining oversight of Healthier Lancashire	Met with Sam Nicol 26 October. BSB 2 December.
	• Lancashire Teaching Hospitals Trust o Your Hospital, Your Health – review of clinical strategies and hospital estate o Financial situation following investigation by Monitor	Attended SG on 13 July. BSB delivered 17 November
	• Southport & Ormskirk Hospital Trust – action plan following CQC inspection	Attended SG on 3 August. CC Hennessey and Cllr Liz Savage also in attendance.
	• CAMHS review for Health & Wellbeing Board	Officers to be invited to a SG meeting in the Autumn to provide an update - tba
	• Falls Prevention – role of care homes	Meeting with Paul Simic, Chief Executive of the Lancashire Care Association arranged for 5 October
	• GP recruitment/vacancies	CSR/GP CCG undertaking a 'Workforce for the Future' project. Meeting to discuss to be arranged for 16 Nov
	• SOHT – retendering of Community Services	Officers from WLCCG to be invited to meet with Steering Group. (7 December)

	• Commissioning Support Unit	Meeting with Lynda and Maureen Harrison from CSU to discuss delivery of support in Lancashire – 18 January
	• Rossendale Task Group report on NWAS	Cllr Barbara Ashworth at Pat Couch to present final report 16 November

Task Groups:

- Shortage of Nurses – request presented to Scrutiny Committee 13 November

Health Scrutiny Committee
Meeting to be held on 26 January 2016

Electoral Division affected: None

Recent and Forthcoming Decisions

Contact for further information:
Wendy Broadley, Democratic Services, 07825 584684
wendy.broadley@lancashire.gov.uk

Executive Summary

To advise the committee about recent and forthcoming decisions relevant to the work of the committee.

Recommendation

Members are asked to review the recent or forthcoming decisions and agree whether any should be the subject of further consideration by scrutiny.

Background and Advice

It is considered useful for scrutiny to receive information about forthcoming decisions and decisions recently made by the Cabinet and individual Cabinet Members in areas relevant to the remit of the committee, in order that this can inform possible future areas of work.

Recent and forthcoming decisions taken by Cabinet Members or the Cabinet can be accessed here:

http://council.lancashire.gov.uk/mgDelegatedDecisions.aspx?bcr=1

The County Council is required to publish details of a Key Decision at least 28 clear days before the decision is due to be taken. Forthcoming Key Decisions can be identified by setting the 'Date range' field on the above link.

For information, a key decision is an executive decision which is likely:

(a)to result in the council incurring expenditure which is, or the making of savings which are significant having regard to the council's budget for the service or function which the decision relates; or

(b)to be significant in terms of its effects on communities living or working in an area comprising two or more wards or electoral divisions in the area of the council.

Lancashire County Council

For the purposes of paragraph (a), the threshold for "significant" is £1.4million.

The onus is on individual Members to look at Cabinet and Cabinet Member decisions using the link provided above and obtain further information from the officer(s) shown for any decisions which may be of interest to them. The Member may then raise for consideration by the Committee any relevant, proposed decision that he/she wishes the Committee to review.

Consultations

N/A

Implications:

This item has the following implications, as indicated:

Risk management

There are no significant risk management or other implications

Local Government (Access to Information) Act 1985
List of Background Papers

Paper	Date	Contact/Directorate/Tel

N/A

Reason for inclusion in Part II, if appropriate

N/A