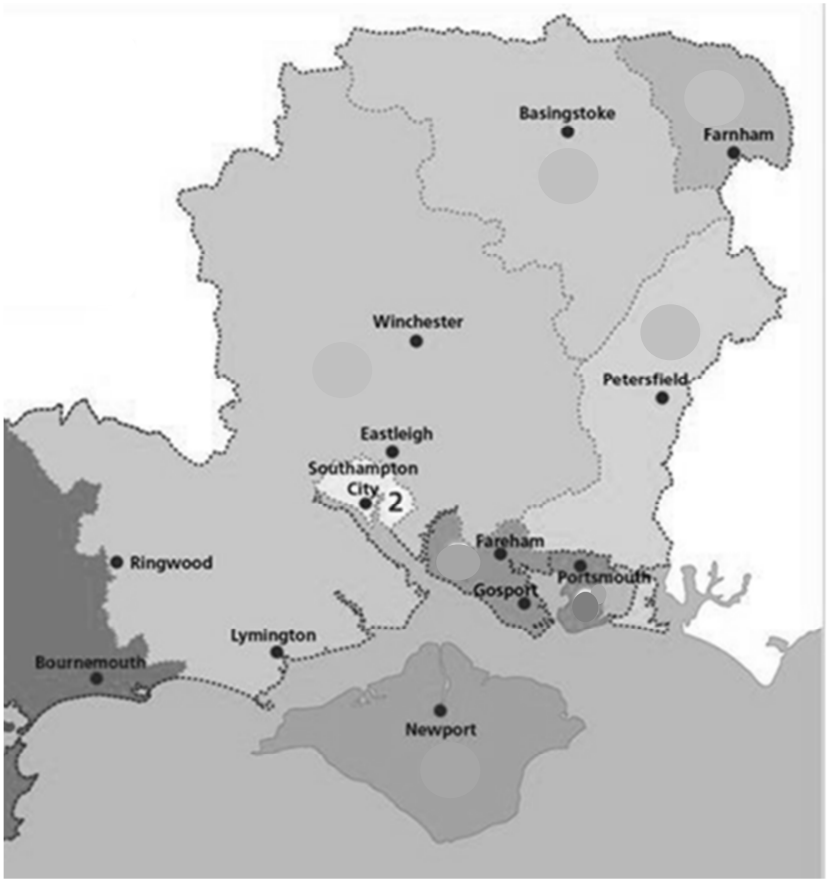
Southampton, Hampshire, Isle of Wight & Portsmouth (SHIP) Transforming Care Partnership Plan

June 2016



NHS West Hampshire Clinical Commissioning Group

NHS North Hampshire Clinical Commissioning Group

NHS North East Hampshire and Farnham Clinical Commissioning Group

NHS England

NHS Southampton City Clinical Commissioning Group

Hampshire County Council

NHS Fareham and Gosport Clinical Commissioning Group

SOUTHAMPTON CITY COUNCIL

NHS Isle of Wight Clinical Commissioning Group

NHS Portsmouth Clinical Commissioning Group

ISLE of WIGHT COUNCIL

Portsmouth CITY COUNCIL

NHS South Eastern Hampshire Clinical Commissioning Group

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1.7 – Co-production of Southampton, Hampshire, Isle of Wight & Portsmouth (SHIP)	• Co-production self-assessment framework tool • Co-production 'how are we doing' self-assessment tool
Implementation Planning: 4.4 - What existing services will change or operate in a different way?	Draft Risk Register and Protocol
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Southampton, Hampshire, Isle of Wight & Portsmouth (SHIP)
Transforming Care Partnership Plan

Executive Summary

The draft plan for the Hampshire & Isle of Wight Transforming Care Partnership (TCP) has been developed with the NHS England and the Clinical Commissioning Groups (CCGs) and local authorities from Southampton, Hampshire, Isle of Wight and Portsmouth. It was agreed at the inaugural Board Meeting that this TCP will be referred to as SHIP to represent the four geographic areas.

Our Vision is ***"To Build on a Child, Young Person's or Adult's unique strengths and abilities, getting it right for the person first time through ensuring there is the right care in the right place at the right time that is consistent across the SHIP TCP"***

Timescales for this first draft plan has prevented the SHIP TCP from consulting with the individual Learning Disability Partnership Boards (LDPBs) properly in time for submission, however it is intended to work with the local LDPBs, Advocacy and other established task/working groups with whom local areas have strong and established links these include; 'My Life, My Way' (IPC), 'My Life, a Full Life (IOW), Peer Advocacy, Parent Carer Networks, Local Involvement Groups, IPC (Portsmouth). Underpinning the TCP plan is the ethos of co-production and truly working in partnership with people with lived experience in reviewing and shaping the plans. This plan supports the principles as described in 'Building the Right Support' and supports the new service model.

SHIP TCP wants to prevent the 'revolving door syndrome' trying to fit people into a traditional solution that does not meet the person's needs that results in regular placement breakdown and more restrictive regimes being put in place. This plan aims to build on the person's unique strengths and abilities, not seeing them as a problem and get it right for the person first time. Complex people and those in crisis are often managed through reactive strategies rather having proactive strategies agreed and in place in the event of requiring intensive support, avoiding a hospital admission.

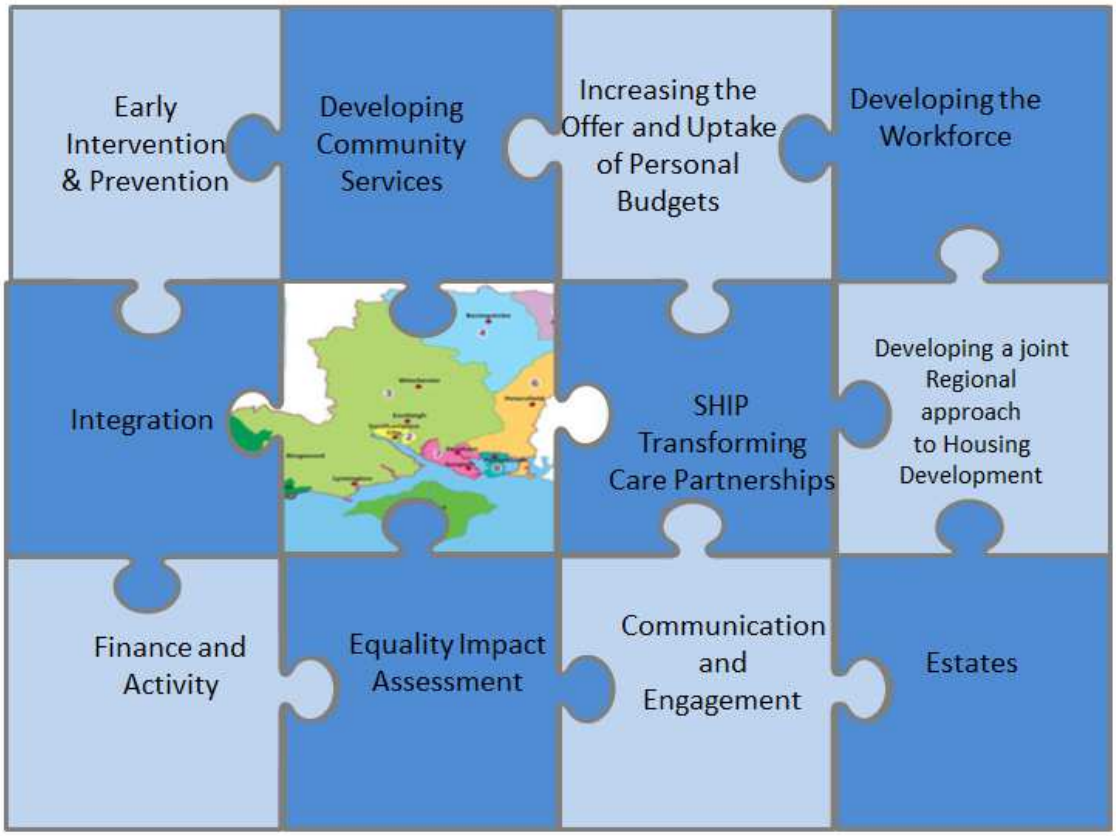
This plan focuses on Children, Young People and Adults with a Learning Disability and/or autism and includes;

- Young people in transition to adults
- Individuals at risk of admission to hospital
- Patients already in specialist learning disability hospitals
- People requiring adapted behaviour treatment programmes
- Those who are currently living in long 'unsettled' accommodation e.g. Residential Care, 38/52 week Education based placements
- People wanting to have a Personal budget (Blended from Health, Social Care and Education)

The SHIP TCP Plan identifies key areas of work required to meet the needs of Children, Young People and Adults with a learning disability and/or autism, the future model will focus on;

- Early intervention and prevention to avoid people being admitted to hospital, this includes supporting good physical health as well as mental health and having 'learning disability friendly GP practices'
- Reducing the number of inpatients in specialist learning disability units
- Reducing the Length of Stay for those individuals requiring assessment, diagnosis and treatment
- Training and development for support staff
- Increasing the offer and uptake of personal budgets
- Increasing the number of personal assistants available in the TCP region
- Working with providers in the use of Positive Behavioural Support
- Having robust care planning with relapse prevention strategies agreed with pre-agreed funding in place either directly funded or via personal budgets to help keep people well
- Establishing a TCP community forensic rehabilitation service
- Developing a joint Regional approach to Housing Development and a portfolio of housing options for individuals

SHIP Transforming Care Partnerships Workstreams



Currently the local health and social care economy spend circa £153.8 million; this figure includes people who are in specialist learning disability hospitals. As the work outlined above is progressed over the next 2 to 3 years, this will enable people to be supported within the local community and enable a reduction in the number of NHS England and CCG commissioned in-patient beds in specialist learning disability units.

The plan describes the current finance/activity and how CCG funding invested in community services will support people; however there is no information available to identify the alignment of NHSE budgets with the SHIP TCP plan.

The Key Targets/Milestones for the project are attached in **Appendix V** of this plan. In summary;

- **By end 2016** all patients who have been in hospital for more than 3 years will be discharged to local community services
- The SHIP TCP will reduce the reliance on in-patient services between now and the end of 2019 from 55 beds to 44 beds;
  - 4 Less **by end March 2017**
  - 5 less **by end March 2018**
  - 2 less **by end March 2019**
- Existing Community Learning Disability Health and Social Care Teams reconfigured to support Early Intervention and Prevention of people with investment aligned to support the function **by End March 2017**
- A new community forensic rehabilitation / relapse prevention service to be **established by end March 2017**
- The number of people with a 'Personal Budget' (Health, Social Care or Education Funded or those in receipt of blended funding) will increase from circa 5,135 individuals to 6,635 **by end March 2019**

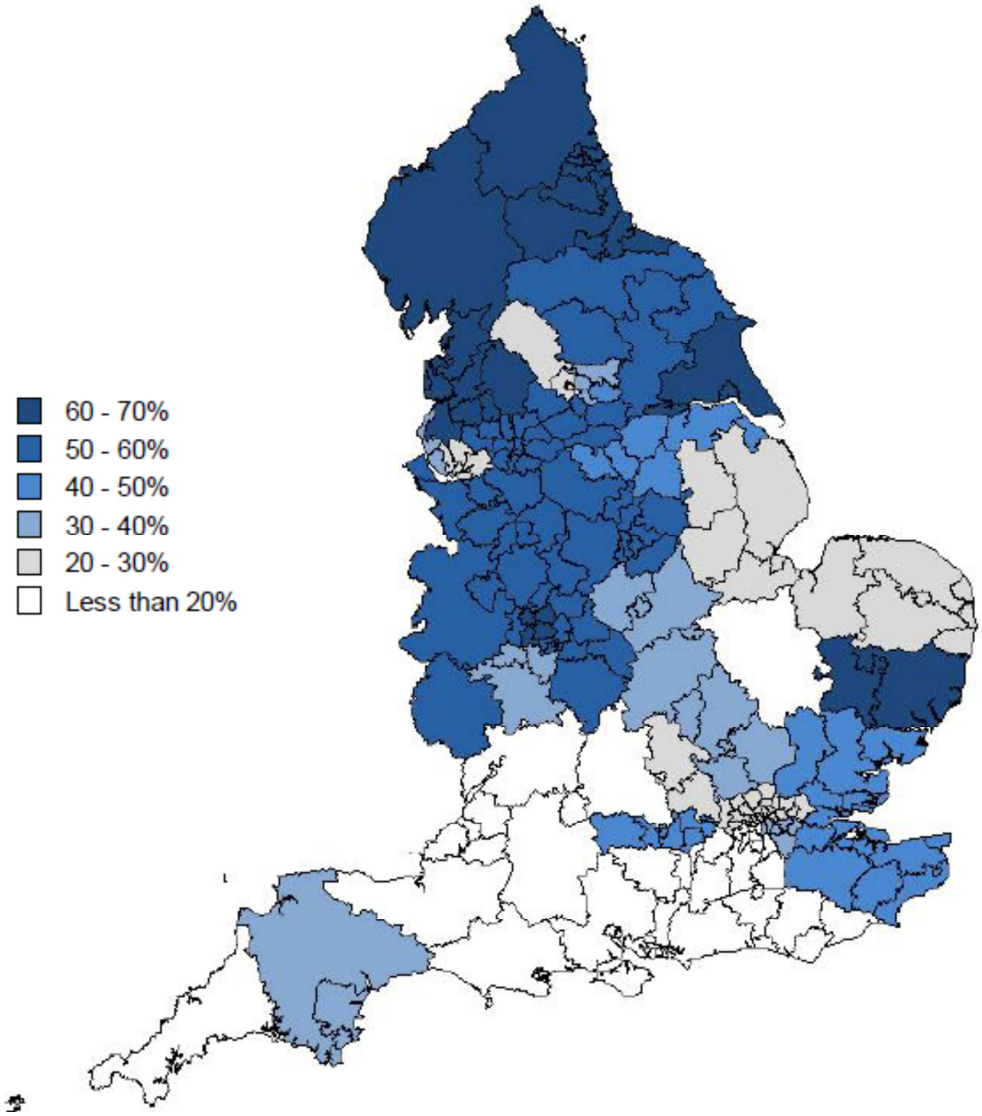
Background and National Context

In May 2011 BBC Panorama transmitted "Undercover Care: the Abuse Exposed", which showed Winterbourne view hospital staff mistreating and assaulting adults with learning disabilities. In December 2012 the Department of Health published its final report on the abuse that took place at the Winterbourne View Hospital. The report identified 63 actions to be completed by health and social care in relation to the findings of the investigation. The Winterbourne View Joint Improvement Programme was established to monitor progress by Clinical Commissioning Groups, Local Authorities and NHS England Specialist Commissioning in implementing the recommendations from the report. This programme of work is now known as Transforming Care Programme and requires Local Authorities, Clinical Commissioning Groups and NHS England to come together to build local community provision and to develop whole pathways through the establishment of Transforming Care Partnerships of which there are 49 in England. In Wessex Region there are two; Dorset and Hampshire & Isle of Wight, from hence referred to as SHIP.

Proposed Transforming Care Partnerships

Local Transforming Care Partnerships will be asked to consider the financial envelope they spend as a whole health and social care system on people with a learning disability and/or autism, and to use that money in a different way to achieve better results. This requires the aligning and pooling of budgets either across the TCP or within individual CCG areas. This will entail whole system redesign and transformation. This will include NHS England's Specialised Commissioning budget for learning disabilities and autism services. This will support the discharge of people with learning disabilities from in-patient units and the closure of all unnecessary beds in England by March 2019 35-50% of both secure and non-secure. Local planning assumptions indicate local areas will have no more than 10-15 beds per one million population CCG commissioned capacity and 20-25 inpatient beds per one million population for NHSE Commissioned beds. The map below shows the % reduction of inpatient numbers based on the mid-point between upper and lower rates for each Transforming Care Partnership. Locally SHIP TCP are on track to achieve this target.

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



The planning methodology for the SHIP Transforming Care Planning Template is based on six key stages;

Local Context

The SHIP TCP Plan will contribute to the delivery of the Five Year Health and Social Care Vision of person-centred, co-ordinated health and social care and support and will enable;

- A new way of working which aims to ensure the systems health and social care provision is sustainable within the resources available despite increasing demand.
- Services to be people centred and delivered in a way which meets their individual need
- Health and social care outcomes for people to be improved and will ensure that this is being delivered through careful monitoring and evaluation of our plan
- Services to be provided in an integrated way across health, social care and the independent and voluntary sector
- Commissioners to understand their service model now and in the future using the Principles outlined in 'Building the Right Support' Plan;

1. Mobilise Communities

1.1 Local Work Underway to support the Transforming Care Partnership Plan

Southampton, Hampshire, Isle of Wight and Portsmouth health and social care teams are already undertaking a number of work programmes to support the delivery of the Transforming Care Partnership Plan;

Early Intervention & Prevention

- Blue Light Meetings / Pre-Admission Care and Treatment Reviews (CTRs)
- Care & Treatment Reviews (CTRs)
- Developing 'At Risk' Registers
- LD Annual Health Checks
- Intensive Support / Early Intervention – an proactive and early response for people with a learning disability at a time when their specialist health needs challenge the capacity of existing community LD health services
- Developing the transition process between Children and Adults

Winterbourne View Joint Improvement Programme

- Repatriation of individuals back to local community services
- Reducing length of stay for individuals with a learning disability requiring an inpatient stay
- Developing the interface between NHS England commissioned services and CCG / Local Authorities

The Right Support for Individuals

- Upskilling of staff in the use of Positive Behaviour Support (PBS)
- Developing the provider market in terms of accommodation provided
- Quality assurance monitoring of providers
- Personal Health Budgets
- SEN Reforms and the introduction of Educational Health Care Plans (EHCPs)
- Integrated Personal Commissioning (Hampshire & Portsmouth)

Mobilising Communities : Transforming Local Work into Action;

In addition to the above, there are a number of local projects/initiatives within the individual areas which support the TCP Plan and through feedback learning it is intended to share learning from these across the TCP to improve services for people with a learning disability and having flexibility of how they are supported through the use of personal budgets;

In addition the new Care Bill introduced in 2015, is designed to create a new principle where the overall wellbeing of the individual is at the forefront of their care and support. It requires local authorities, CCGs, health and housing services, as well as other service providers, to deliver an integrated approach to the provision of care and support to ensure the best outcomes are achieved for the individual. There are also new areas of responsibility, such as social care in prisons, carer's needs being put on a statutory footing, adult safeguarding becoming a statutory function, having a statutory responsibility for providing information and advice as well as Personal Budgets, including Personal Health Budgets, being included within a legislative framework for the first time.

In July 2014, Simon Stevens announced the launch of the Integrated Personal Commissioning Programme (IPC) described as a "radical new option in which individuals could control their combined health and social care support". This involves developing a new approach to deliver integration at an individual level that is person centred for key groups at scale, with innovation around payment approaches to support this. Service users, carers, the voluntary sector, providers and commissioners will come together to provide leadership for a new integrated and personalised commissioning approach for people with complex needs. Hampshire and Portsmouth were selected as 2 of the 9 demonstrator sites in England. The IPC projects support the Principles of 'Building the Right Support' as outlined the New Service Model.

Hampshire – The IPC project renamed locally as 'My Life, My Way' and will build upon the work undertaken to date, sharing of the lessons learnt across the Transforming Care Partnership and aims to;

- Remove the 'cliff edge' for young people and their families going through transition to adulthood
- Shift power to people with a learning disability and their families by offering personal budgets to more people with a learning disability
- Reduce the number of crises leading to placement breakdown and hospital admission
- Reduce length of stay in learning disability inpatient units
- Reduce the use of institutional care and increase the use of supported living through joint housing strategies across health and social care

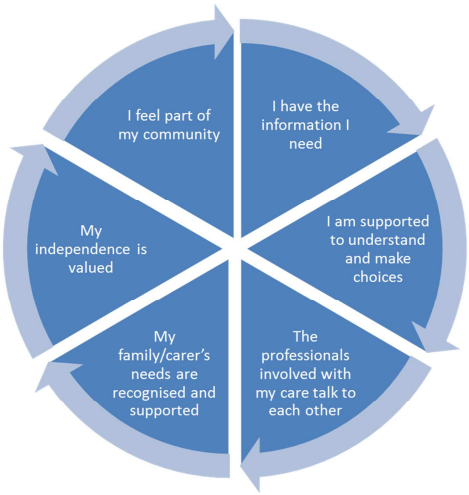
The Hampshire IPC project focuses on;

- People with a learning disability and or Autism aged 14 years and older who are;
    - In receipt of health and/or social care services
    - Registered with a disability with a Hampshire GP
    - People who are inpatients in either Assessment & Treatment Units or Forensic Rehab Units
    -

Southampton has been working with communities and providers through the Better Care programme to develop a plan which not only joins up care and support but also enables people to live well within their communities and the city as a whole.
Southampton's vision for the future of health and social care in the city is summarised as:

'I can plan my care with people who work together to understand me and my carer/family, empower me to take control and bring together services to achieve the outcomes important to me'

The key drivers behind the plan are the 'I' statements below.



Person centred care will be at the heart of everything we do. In support of this, the overall aims for integrated care in Southampton are:

- Intervening earlier and building resilience in order to secure better outcomes by providing more coordinated, proactive services
- Putting people and families at the centre of their care and support, meeting needs in a holistic way
- Providing the right care, in the right place, at the right time, and enabling people and families to be independent and self-resilient wherever possible
- Making optimum use of the health and care resources available in the community
    - Reducing duplication and closing gaps, doing things once wherever appropriate
    - Improving health, social and educational outcomes for children whilst identifying and responding proactivity to early signs of difficulty and preventing escalation

The Southampton model has a shared principle of moving from service delivery as a group of organisations to that of an integrated system or pathway organised around the 6 clusters identified in the city which are based around GP practice populations and natural neighbourhoods. These will have the following characteristics:

- Single core teams sitting in a matrix of specialist services
- Shared IT and information
- Shared estates – office hubs and front line service user hubs

- Locality/cluster focus across the whole system of care and support
- Community and voluntary sector as part of the team

One of the key aims of integrated cluster working is to promote integrated offering across both core and specialist services (including learning disability and autism).

The **Portsmouth** IPC projects overall goals are to:

Enable people with complex needs and their carers to have a better quality of life
And achieve the outcomes that are important to them and their families through greater involvement in their care, and being able to design support around their needs and individual circumstances.
Prevent crises in people's lives that lead to unplanned hospital and institutional care by keeping them well and supporting self-management as measured by tools such as 'patient activation' – so ensuring better value for money.
Ensure better integration and quality of care, including better user and family experience of care.

Portsmouth have developed a project to create an integrated care pathway, based around integrated locality teams, where a single personalised care plan approach, owned and understood by the individual, is developed. This existing project will be used as the initial basis for the Integrated Personal Commissioning programme, building on the work already in place, but expanding it to include the development of personal budgets and a supporting financial model using a capitation based approach. This will build on the existing work around Personal Social Care budgets and Personal Health budgets for Continuing Care and SEND Reforms.
The aim initially is to improve quality of care for older people in Portsmouth with multiple long-term conditions at most risk of avoidable hospital admissions, but for 16/17 and 17/18 Portsmouth will establish plans to develop personalised care for:

- **Children's services**: Building on the work of developing integrated health educational and care plans (as part of SEND reforms), develop the market place, engage families and stakeholders and offer a personal budget;

- **Learning Disabilities**: Implement person centered planning and an integrated approach to care and health needs for people with learning disabilities, develop the market place, engage service users and carers, and offer a personal budget;

- **Adult Mental Health**: As part of transforming Adult Mental Health, initiate an approach to recovery focused integrated care and health planning for people with mental health conditions, with a view to potentially offer personal budgets.

Isle of Wight - The joint aim of the Island's health and social care organisations is to promote longer, healthier and more independent lives for the people of the Isle of Wight. Primary, secondary and social care all have individual contributions to make to this, but we recognise our overall effectiveness and efficiency is dependent upon developing a highly integrated model of care. The people we serve need to be at the heart of all our decisions and be the

ultimate judge of everything we do.

We are committed to making our vision of person-centred, co-ordinated health and social care and support a reality on the Island. We want to improve the outcomes and experiences of people, families and carers which will be achieved by doing things differently, to collaboratively harness the capacity of organisations, people and communities to think creatively to help us build a sustainable health, social and community economy, fit for now and for future generations.

Putting the person at the centre of everything we do is key to the success of our vision. Using the "I" statements developed by National Voices and Making it Real as a basis for development by local people, we have defined what good will look like for our residents and communities:

- I will no longer be a patient or a client; I'll be a person
- I have access to a range of support that helps me to live the life I want and remain a contributing member of my community
- I feel valued for the contribution I make to my community
- I have access to easy to understand information about health, wellbeing, care and support which is consistent, accessible and up to date
- I am able to get skilled advice to plan my care and support
- I can plan ahead and keep control at times of crisis
- I have considerate support delivered by competent people

It is also recognised that as organisations, we need to respond differently to how we support people. The organisational "We" statements below, developed as a response to the local "I" statements, will be how we now prioritise and respond to people we work with on the Island:

- We will enable people to promote their own health and wellbeing supported by self-care and self-management
- We will see people as people and deliver co-ordinated support to individuals, their families and carers
- We will support people at times of crisis to have the right support as soon as possible, to enable people to return home and to their communities
- We will develop the infrastructure to deliver truly co-ordinated care and support
- We will support people with long term conditions and the elderly frail locally, based around GP practices

A key element of our future vision is to design and deliver a progressive prevention strategy which will support people to look holistically at their care and support needs at an early stage, finding the low intensity support that will help to prevent the deterioration of those needs. It will include a community information hub (Isle Help) which will bring together all third sector advice services within one service, providing a broad range of information and advice to enable people to be as informed as possible. Sitting alongside this will be an on-line community directory which will take a holistic approach to providing up-to-date information around key areas of people's lives, rather than focussing merely on conditions or presenting

need. It will provide details on the wide range of services and support groups that are available, including peer support, and will be easy to access and navigate.

The Island's User Led Organisation, People Matter, will play a key role in our prevention strategy. It will be a key player within the community information hub, providing specialist advice around personal budgets and employing Personal [care] Assistants (PAs). It also has an Independent Living Centre which enables people to look at aids and adaptations before purchasing any equipment. Uniquely, the centre provides OT support to those who do not meet the national eligibility criteria or do not want statutory service intervention. They also facilitate and support the IOW LDPG.

To support those people who have a greater level of need or who are in crisis, we have created an integrated Urgent Care Hub which has brought together a team of professionals who are able to communicate clearly and respond quickly and effectively to the health and social care needs of Island residents.

Critically, the relationship between Primary Care and services provided in the community will be the key to ensuring that case management is embedded in practice and communication between key professionals is enabled to the benefit of the most vulnerable people in our community and good risk stratification tools are used to identify those residents most at risk of hospital admission or A&E attendances.

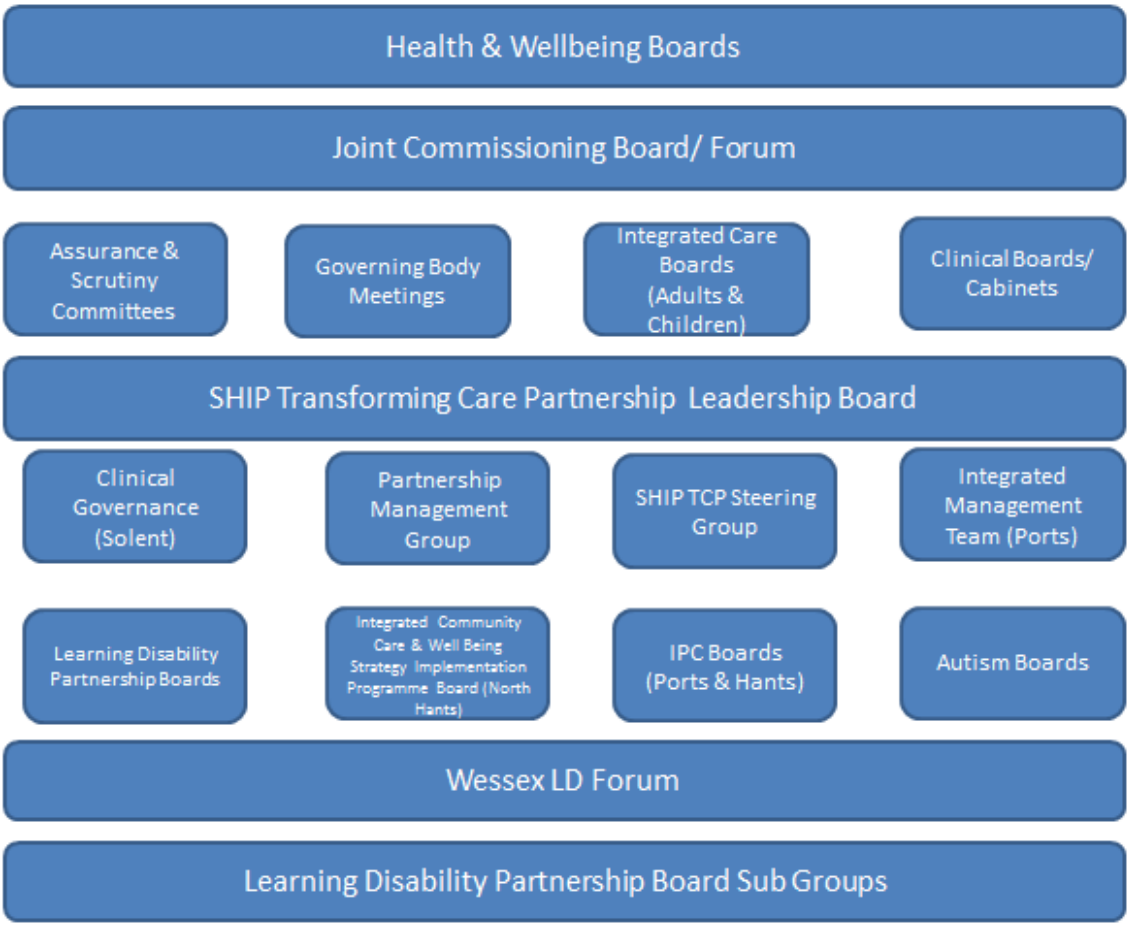
We have developed a joint Carers Strategy which has been developed through extensive consultation with a wide range of carers across the Isle of Wight. It identifies what's important to carers and how those priorities will be delivered. We have made the commitment that carers will be:

- respected as expert care partners and will have access to the integrated and personalised services they need to support them in their caring role
- able to have a life of their own alongside their caring role
- supported so that they are not forced into financial hardship by their caring role
- supported to stay mentally and physically well and treated with dignity
- children and young people will be protected from inappropriate caring and have the support they need to learn, develop and thrive, to enjoy positive childhoods and to achieve against all the Every Child Matters outcomes

Fundamental to the delivery of our vision is the need to ensure that people are safe. This requires a robust approach to safeguarding, whilst ensuring that the individual has a personalised experience that is outcomes focussed. We need to ensure that we work on a partnership basis, ensuring that people are fully engaged in the process and feel listened to. Alongside our desire to deliver an integrated approach to safeguarding vulnerable people, we will work with partner agencies, included CQC, to ensure that there is a level of quality assurance which provides reassurance that services and organisations offer quality care and support.

1.2 Governance & Assurance

Within the SHIP Transforming Care area there are already established governance arrangements such as Health & Wellbeing Boards, Assurance & Scrutiny Committees, Clinical Boards, Integrated Care Boards, and Learning Disability Partnership Boards. The SHIP TCP will report updates and progress against the plan to their local governing boards and to NHS England (Wessex) which has an established Learning Disability Forum for the Wessex Area.



The four Safeguarding Adults Boards in SHIP have produced a multi-agency framework and a Memorandum of Understanding (MOU) relating to information sharing. The Framework provides guidance on managing cases relating to Adults where there is a high level risk but the circumstances may sit outside the safeguarding framework but for which a multi-agency approach may be beneficial. This aims to provide an effective, coordinated and multi-agency response to these 'critical few' cases in order to facilitate;

- Timely information sharing around risk
- Identification and holistic assessment of risk
- Development of shared risk management plans
- Shared decision making and responsibility
- The adult's involvement and engagement in the process
- Improved outcomes for the adult at risk

Multi-Agency-Risk-Management-Framewo

1.3 Health and Care economy covered by the plan;

Local Demographics;

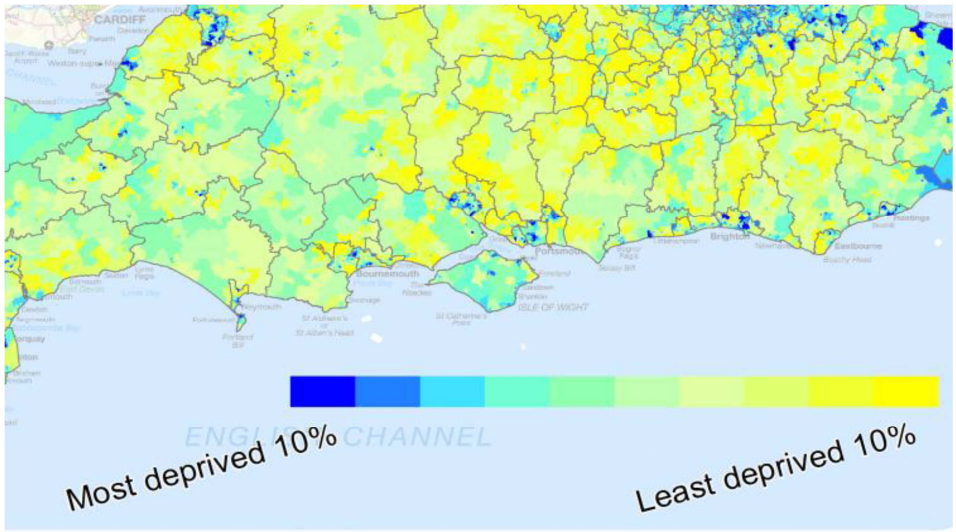
The Hampshire and Isle of Wight (SHIP) Transforming Care Partnership (TCP) geographical region has a wide range of communities from sparsely populated rural areas to high density city areas and is unusual in that this includes the Isle of Wight which is not connected by road to the mainland and travel is via Ferry/Hovercraft links and has a total estimated population of just over 1.9 million;

NHS Southampton CCG	241,895
5 Hampshire CCGs	1,339,011
NHS Isle of Wight CCG	139,105
NHS Portsmouth CCG	207,945
TOTAL	1,927,956

Population forecasts are estimated to rise to 2,039,981 in 2021, an increase of approximately 5.81% across the SHIP TCP.

Portsmouth has the highest density of population outside of London. The Indices of Deprivation published 2015 (based on tax year 2012/13) identify areas within the TCP as being the 'Most Deprived' as well as having a larger number of 'Least Deprived' areas. Assessment is measured against seven domains of deprivation plus two supplementary indices; the Income Deprivation Affecting Children Index and the Income Deprivation Affecting Older People Index.

- Income Deprivation
- Employment Deprivation
- Education, Skills and Training Deprivation
- Health Deprivation and Disability
- Crime
- Barriers to Housing and Services
- Living Environment Deprivation



Distribution of the Index of Multiple Deprivation 2015

The Southampton, Hampshire, Isle of Wight & Portsmouth (SHIP) Transforming Care Partnership comprises;

1x County Council;
- Hampshire
- With links to Surrey CC for the North East Hants & Farnham Area

3x Unitary authorities;
- Southampton
- Isle of Wight
- Portsmouth

11x District & Borough Councils;
- Basingstoke & Deane Borough Council
- East Hampshire District Council
- Eastleigh Borough Council
- Fareham Borough Council
- Gosport Borough Council
- Hart District Council
- Havant Borough Council
- New Forest District Council
- Rushmoor Borough Council
- Test Valley Borough Council
- Winchester City Council

- 8 Clinical Commissioning Groups;
  - Isle of Wight CCG - 17 GP Practices
  - Portsmouth CCG - 23 GP Practices
  - Southampton CCG - 44 GP Practices
  - Fareham & Gosport CCG - 21 GP Practices
  - North Hampshire CCG - 25 GP Practices
  - North East Hampshire & Farnham CCG - 24 GP Practices
  - South East Hampshire CCG - 26 GP Practices
  - West Hampshire CCG - 51 GP Practices

- 1 NHS England Area Team - Wessex

Within the SHIP TCP there are 8,453 people with a learning disability registered with GP practices between ages of 0 to 65 and over. (Further GP data provided in **Appendix I**)

Population Data	SHIP Area			
	Southampton	Hampshire	Isle of Wight	Portsmouth
How many people have a learning disability?				
Aged 0-13	184	195	41	37
Aged 14-17	134	189	45	25
Aged 18-34	792	1,664	313	139
Aged 35-64	1046	2,238	430	302
Aged 65 & Over	170	371	77	61
Total	**2,326**	**4,657**	**906**	**564**
	Data extracted from GP clinical systems using the Read codes as stated in the technical guidance for the LD enhance service scheme	**Taken from GP QOF registers via Hampshire Health Record**		**Data provided by 15 out of 24 practices in Portsmouth**

The majority are within the 35 to 64 age range. This age range also has the highest recorded number at 57% of people with a learning disability with an Autistic Spectrum Disorder. (See Diagrams 1 and 2 below)

Diagram 1

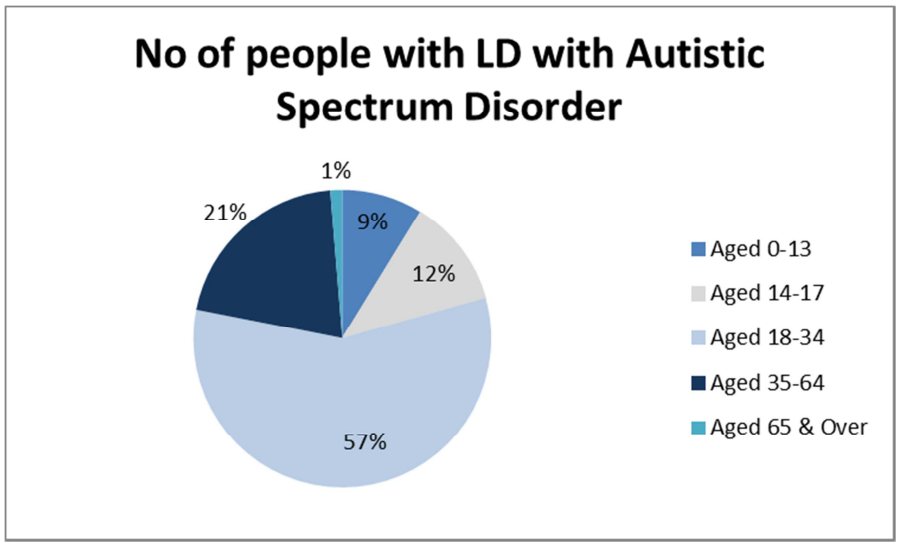


Diagram 2

Current care economy;

The SHIP TCP is a nett importer of people with a learning disability. A review of Residential Care commissioned beds identified less than 50% of available capacity was purchased by local Health and Social Care Commissioners with the remainder from out of area teams such as London Boroughs and neighbouring counties. Portsmouth is a nett importer of people with a learning disability plus a nett exporter of in-patients as there are no beds on Portsea island. This is a similar picture in the Southampton area. The Isle of Wight has locked rehab, low or medium secure provision, it has one assessment treatment bed on Osborne Ward, Sevenacres.

For some time support outside of the family home has predominantly been within residential care homes whereby people have little flexibility over how they wish to be supported. The closure of the Local Based Hospital Units (LBHU) and Campus re-provision programme enabled individuals through Department of Health (NHS) capital funding to move from long term 'in-patient' status to more bespoke models of support within their own homes either on a single occupancy basis or sharing with a small number of people. Unfortunately since this time new service provision has been market led by providers seeing predominantly residential care homes being established with one or two small annexes attached to these services. This has led to very little choice for people in where they choose to live, who they live with and who supports them. This is a particular issue for young people coming through Transition from aged 14 and impacts on long term life planning for individuals.

> *"I want to be able to make housing choices and be in control of my own life."*
>
> *Feedback on Hampshire LD Plan - The Right Place To Live*

Individuals receive a wide range of support mainly from commissioned services, however it is important to recognise the support provided to people by families, friends, third sector organisations. The types of support are summarised below; **Support Status**
At Home with Family
At Home no Support
At Home with support; - Domiciliary Care - Supported Living (including nursing) - Live in carers - Extra care housing
Shared Lives; - Living with Shared Lives carers on permanent basis
Residential Care; - In main residence - In annexe on site - With core support staff - With core support staff and additional 1:1 / 2:1
Day Services; - Local Authority Managed - Independent Centres
Education Facilities; - School placement up to 19 - Specialist Units 19-25
Foster Carers
Children's Homes for looked after children
Secure Children's units
Hospitals; - Non-Secure (ATU) - Forensic Rehab - Low secure - Med secure - CAMHS (tier 4)
Replacement Care (respite care) - Short Breaks - Shared Lives - Children & Young People's Respite e.g. (Jack's Place / Naomi House)

Feedback from stakeholders indicate a lack of suitable housing provides limited choices to people, often resulting in placements for people within residential care which may not enable the flexibility of support to participate in activities outside of the home at a time that is suitable to them or having to accompany other residents on activities which may not be at their choosing.

Increasing the application and take up of personal budgets is also restricted by the lack of suitably trained staff/personal assistants and the willingness of staff to work for an individual in receipt of a personal budget rather than a larger domiciliary/supported living support provider.

"I am a person. I have my own feelings and thoughts. I want these to be respected and followed through. I want to live my life my own way, not just have my care needs met. You would be amazed at what I can achieve. But I need you to support me and give me the confidence I need to do it. With you beside me I can really go places that might have seemed impossible."

Feedback from Hampshire LD Plan - Marcia

Supported People;

Provides housing related support to vulnerable people including:

- People with mental health problems
- Young people at risk

In 2010 the ring-fence for the supported people budget was removed and this budget is now within the general formula settlement for local authorities (general social care).

Autism;

The national strategy 'Fulfilling and Rewarding Lives' and subsequent update 'Think Autism' (2014) represent a shared approach towards a common goal i.e. a society that not only accepts and understands autism, but also provides real opportunities for people with autism to live fulfilling and rewarding lives".

The Department for Education (DfE) provided funding resource during 2013-15 for;

- 'Ambitious about Autism' to work with the Association of Colleges and a number of FE Colleges on transition into further education for young people with autism
- Autism Education trust to provide tiered training across early years schools and further education

There is joint working by CCGs/Local Authorities with a number of key stakeholders within the TCP in relation to raising awareness of Autism, diagnosis and support to individuals these include; Autism Hampshire, Local Parent Voice Networks, , Surrey & Borders, Hampshire Constabulary, voluntary sector organisations, parents/carers and local schools/colleges. This aims to provide better co-ordination between agencies and to work in partnership with the child or young person with autism and their family/carers.

Estimated Number of People with Autism				
	Southampton	**Hampshire**	**Isle of Wight**	**Portsmouth**
Total Number	2,453	10,020		2,359

Mobilising Communities : Transforming Local Work into Action;

Hampshire has an established Autism Partnership Board (HABP) is currently undertaking a public consultation in relation to services for people with autism and are working with the third sector to gather views via the sounding board.
http://actionhampshire.org/communities/soundingboard

Diagnostic assessment and post diagnostic support for adults with suspected autism under the statutory guidance associated with the Autism Act 2009 and offering diagnostic assessment and post diagnostic support for adults with suspected ADHD, formalising and enhancing current shared care arrangement with GP's, for a minimum period three years from October 2016-2019

Table 1: Estimated number of adults with autism by Clinical Commissioning Group (CCG) area (numbers are rounded to nearest 10)

CCG Area	Males with autism (1.8% population)	Females with autism (0.2% population)	Total number of people who have autism
North Hampshire	1,410	160	1,570
Fareham and Gosport	1,340	160	1,500
South Eastern Hampshire	1,430	170	1,600
North East Hampshire and Farnham[4]	1,140	130	1,270
West Hampshire	3,650	430	4,080
Hampshire County Council area	**8,970**	**1,050**	**10,020**

Supporting map of CCG's boundaries seen in Appendix 1

If this accurately reflects prevalence, local data shows that only a very small proportion of people with autism in Hampshire are known to local services.

[2] The Office for National Statistics: http://www.ons.gov.uk/ons/rel/npp/national-population-projections/2010-based-projections/stb-2010-based-npp-principal-and-key-variants.html
[3] Aged 19 years or above
[4] Farnham is in Surrey - its population is not included in the statistics shown

Portsmouth is currently working with a number of key stakeholders including Autism Hants, Portsmouth Parent Voice and Surrey & Borders to plan the new Strategy Plan for Portsmouth 2016-2020, building on the recent consultation work around priorities for Portsmouth people with Autism. A new Portsmouth Autism Community Forum to be launched in a few months will undertake much of the consultation work

Estimated number of people with autism-spectrum conditions						
Portsmouth, 2012 to 2035						
Age band	2012	2015	2020	2025	2030	2035
0-14	384	405	432	435	421	415
15-19	160	153	148	167	183	181
20-64	1,483	1,482	1,476	1,461	1,472	1,499
65+	302	319	343	377	419	455
Total	**2,331**	**2,359**	**2,397**	**2,440**	**2,495**	**2,551**

Southampton's Autism Strategy Group meets quarterly. They have recently signed off the new strategy, ensuring Think Autism is being progressed.
Southampton's 2014 ONS mid-year population estimate was 245,290. Based on a raw prevalence of 1% approx. 2,453 people in the city will have an ASD. As detailed in the table below:

Estimated Number of people with Autism	
0-14 years	413
15-24 years	492
Over 25 years	1,548

Isle of Wight has an established Autism strategy implementation group who meet bi-monthly to oversee the implementation of the strategy. Membership includes:

- People Matter (the IOW user lead organisation)
- Parents
- Voluntary Sector
- Autism Hampshire
- Local National Autistic Society Branch
- Commissioning from both health and social care
- Representation from Autism Inclusion Matters

Children & Young People;

The formation of a Children's Trust and the production of a Children and Young People Plan (CYPP) were statutory requirements under the Children Act 2004. Whilst some of the statutory guidance on the Children's Trust have since changed the 'duty to co-operate' and the requirement for each local authority to have a children's trust board remain in place. The CYPPs have been developed through consultation with children and young people via Care Ambassadors, Youth Voice Meetings etc. The SHIP area

Children's Trusts each have a shared commitment to improve the lives of children and young people and identifying as early as possible whether a child or family need support, enhancing parental capacity, helping them to access services.
There are a number of maintained / academy schools within the SHIP TCP, most of whom cater for children with a learning disability / statement of Special Education Need (SEN). In addition there are a number of schools with a resourced provision for children with needs arising from a diagnosis of Autism Spectrum Condition. In Hampshire there 26 Special Schools.

In 2015 the SEN Reforms brought about the introduction of Educational Health Care Plans (EHCPs) requiring joint working across Education, Health and Adult Services for those aged 0 to 25 to develop with individuals, central to this process is the involvement from parents/carers and the young person themselves in 'my story'. There are established Transition teams within the TCP areas.

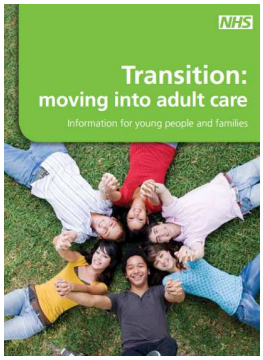
In July 2013, a strategic legal agreement was entered into by Hampshire County Council and the Isle of Wight Council for a 5 year period working with Children's Social Services and Education. This joint working is also seeing closer alignment and standardisation of the EHCP processes which supports the principles of 'Building the Right Support'.

> *"The five –year strategic partnership between the Isle of Wight and Hampshire county Council is providing essential stability and is driving demonstrable improvements across children's services and on the island"*
>
> *Ofsted Report (September 2014)*

SHIP also have a number of specialist Independent Education centres for either 38 or 52 week placements for young people and Independent Day provision which are also commissioned by other commissioners from out of the area. This is also a problem for SHIP commissioners for young people in transition who are in out of County educational placements as often these continue as there are limited alternatives/opportunities available in the local area.

Transition;

Across SHIP local areas have their own transition plans:



The transition from children's services to adult services is a crucial period in a person's lifetime care pathway.
For people to be supported effectively through transition we need to ensure that the process has the following elements:

- Planning. A young person's pathway should be planned from birth, but it is particularly important that detailed planning for adulthood starts early, around age 14. Where a person will want to live and how they will receive support should be considered when people start residential college, not when they leave.

- Early provider engagement. The SHIP area have will work with providers to ensure further engagement with families and Social Services to develop services which are ready to come on-stream when people leave college. Specific locations can be targeted, accommodation can be tailored and more readily adapted and staff can be recruited with specific skills.

- Transitional services. People who leave residential colleges are not always fully prepared or skilled to face the challenges of adulthood. We will explore the short break services to enable continuity of planning when people leave residential college and five-day college placements to ease transition.

- Joint working. The work of children's and adult services must be joined up.

- Process management and accountability. Transition sometimes lacks clear processes or accountability, both of which are essential.

- Information. The quality of information and how it is shared is critical to transition. We must capture accurately who is coming through the system and ensure that information about support and services is shared effectively with people, families and other stakeholders.

- Brokerage. Brokerage must function effectively to link people who need services with those who provide it. One possible initiative is that the provider community could undertake their own brokerage to ensure that voids are filled and need met.

- Advocacy. People need to be able to access good advocacy support through transition. This is particularly important for people who do not benefit from family support.

Mobilising Communities : Transforming Local Work into Action;

Hampshire - There are circa 30,000 children in receipt of a statement of SEN need of which circa 6,500 have an Educational Health Care Plan. 782 children are open to the Disabled Children's Teams. Within these numbers currently circa 7000 children access the short breaks service (further information is available via the link http://www3.hants.gov.uk/shortbreaks -
Hampshire also promote the use of the Gateway Card scheme in Hampshire, which is free and will give access to activities, play schemes and buddy schemes available through our short breaks programme. People can register for a Gateway Card at: http://www3.hants.gov.uk/gatewaycard

In addition there are three local authority run respite units that provide overnight breaks for young people with disabilities as well as independent respite centres such as Naomi House/Jack's Place.

Portsmouth are developing a joint commissioning strategy with education to provide co-ordinated support for children and young people with disabilities and special educational needs, including:

- Cognition and learning,
- Communication and interaction difficulties (including speech language and communication difficulties and autism)
- Sensory and physical difficulties,
- Social emotional and mental health difficulties

Isle of Wight have developed a draft transition protocol following a development workshop on 28th September 2015 and taking into consideration the views shared during the workshop from parents/carers and professionals to clarify the role of each agency to simplify and promote better understanding of the processes involved in accessing support leading up to and during transition from Children to Adult Services. This is currently being consulted on;

https://www.iwight.com/Residents/Care-Support-and-Housing/Adults-Services/Adult-Social-Care-Preparation-for-Adulthood/Transitions-Protocol-Consultation

Isle of Wight Clinical Commissioning Group, Isle of Wight Council and their partners from both the health and voluntary sector are committed to "promoting, protecting and improving our children and young people's mental health and wellbeing". Whilst there are already areas of very high quality provision on the Island it is recognised that dramatic and significant changes and improvements are needed in order to ensure that all children and young people on the Isle of Wight, including those with particular vulnerabilities such as

learning disability and autism, can easily access high quality, outcome focussed, evidence-based services appropriate to their need, when required.

Over the next five years children and young people, residing on the Isle of Wight will be supported in having good mental health and to build emotional resilience, in order to help them fulfil their goals and ambitions and to make a positive contribution to society. The work that needs to be done will fit in with the 'My Life a Full Life Programme' (MLAFL) and is reflected in the Isle of Wight Local Transformation Plan for Children & Young People's Mental Health & Wellbeing which can be accessed via the following link: Isle of Wight Transformation Plan for Children and Young People's Mental Health (2015-2020).

The MLAFL programme will fundamentally change and improve the lives of people on the Island. MLAFL is about organisations working together in partnership with the voluntary and private sector, the Isle of Wight Clinical Commissioning Group (CCG), the Isle of Wight Council (IWC), the Isle of Wight NHS Trust (IW NHS Trust) and One Wight Health (a GP membership organisation) providing for people's individual needs to enable them to take control of their lives and plan for their future health and social care needs. This work is based on the partners five year vision for integrated health and social care on the Island.

Southampton – are currently working with the educational sector to ensure that there is more provision within the city for Residential and non-residential educational placements, with a stronger focus on preparing for adulthood outcomes.

Child and Adolescent Mental Health Services;

Within the SHIP TCP there local CAMHS services are commissioned to support children and young people up to the age of 18. Types of problems CAMHS can help with include; depression, eating difficulties, low self-esteem, anxiety, obsessions or compulsions, sleep problems, self-harming and the effects of abuse or traumatic events. CAMHS can also diagnose and treat serious mental health problems such as bipolar disorder and schizophrenia.

The Transforming Care work programme has expanded the work of the Winterbourne Joint Improvement Programme to include Children and Young and has a project for 'C&YP with Learning Disabilities and / or Autism – CAMHS LD' this has four main elements for completion by April 2016 these include;

- Ensuring that Care and Treatment Reviews (CTRs) are implemented for children & young people who have a mental health condition or behaviours that challenge either at risk of admission to hospital or who have been admitted to hospital (including Assessment and Treatment Units (ATUs), CAMHS and secure services)
- Identification of young people with learning disabilities and autism in 52 week residential schools, in particular those young people leaving their school in 2016. Ensuring there is appropriate transition planning in place (through effective health engagement in the Education health and Care Planning Process)
- Development of a community pathway for children and young people which will outline how children, young people and families should be supported, based on best practice, on what young

people and their families say works, and wherever possible make sure they are supported before things become too difficult

- The roll out of a grant programme to support innovative projects that provide early support and intervention for children and young people with learning disabilities and/or autism and their families

It is intended the four main elements of the above project will be met through existing work in relation to the CTR programme (including 'Blue Light Meetings' and Pre-admission' CTRs) and developing local risk registers. The development of community pathways and support provision will include expanding the number of young people being offered a personal budget to enable greater flexibility of support to meet an individual's needs.

Mobilising Communities : Transforming Local Work into Action;

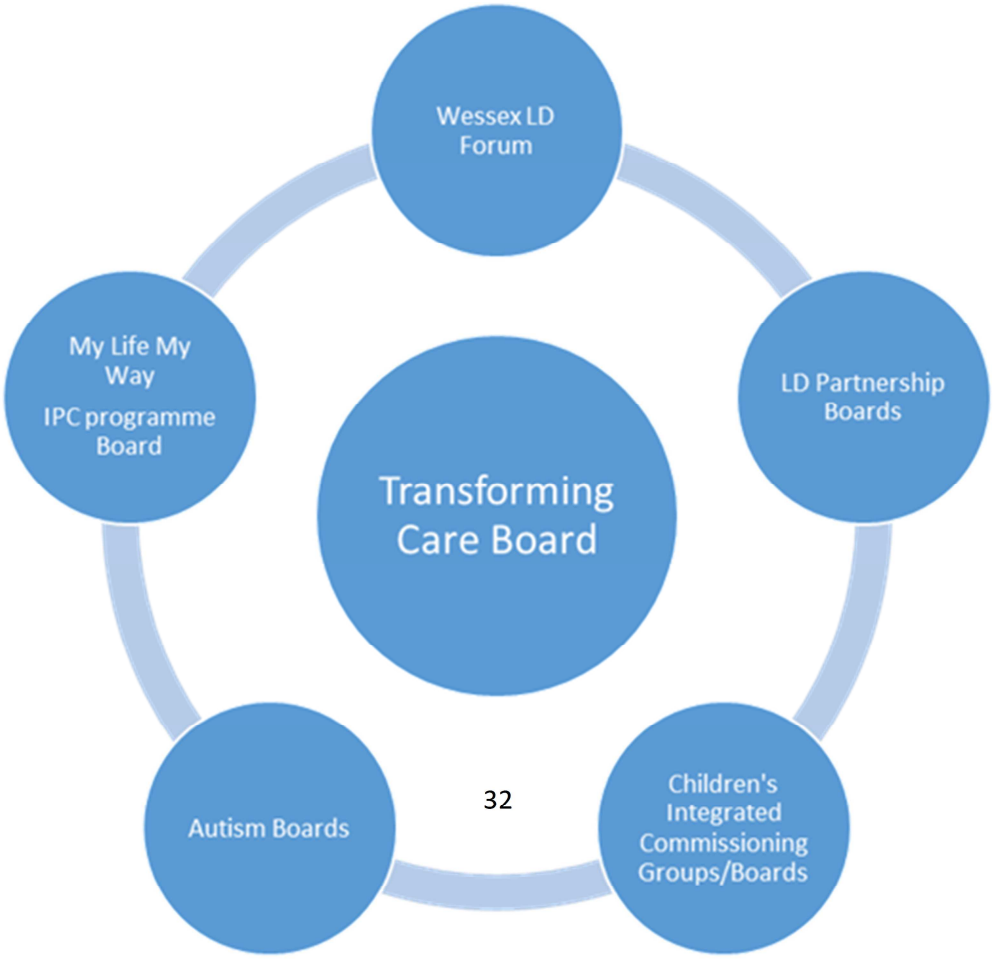
NHS England uses the 'My Shared Pathway' Recovery and Outcomes model putting individuals at the heart of their recovery. There are key steps;

- Where am I now? – a full assessment of current life situation
- Where do I want to get to? – identifies goals and objectives outline destinations for the recovery journey
- How do I get there? – focusing on the development of care and support plans and ways to help individuals achieve their goals
- How can I tell how I'm doing? – monitors progress and looks at how this is measured and assessed

1.4 Governance arrangements for this transformation programme

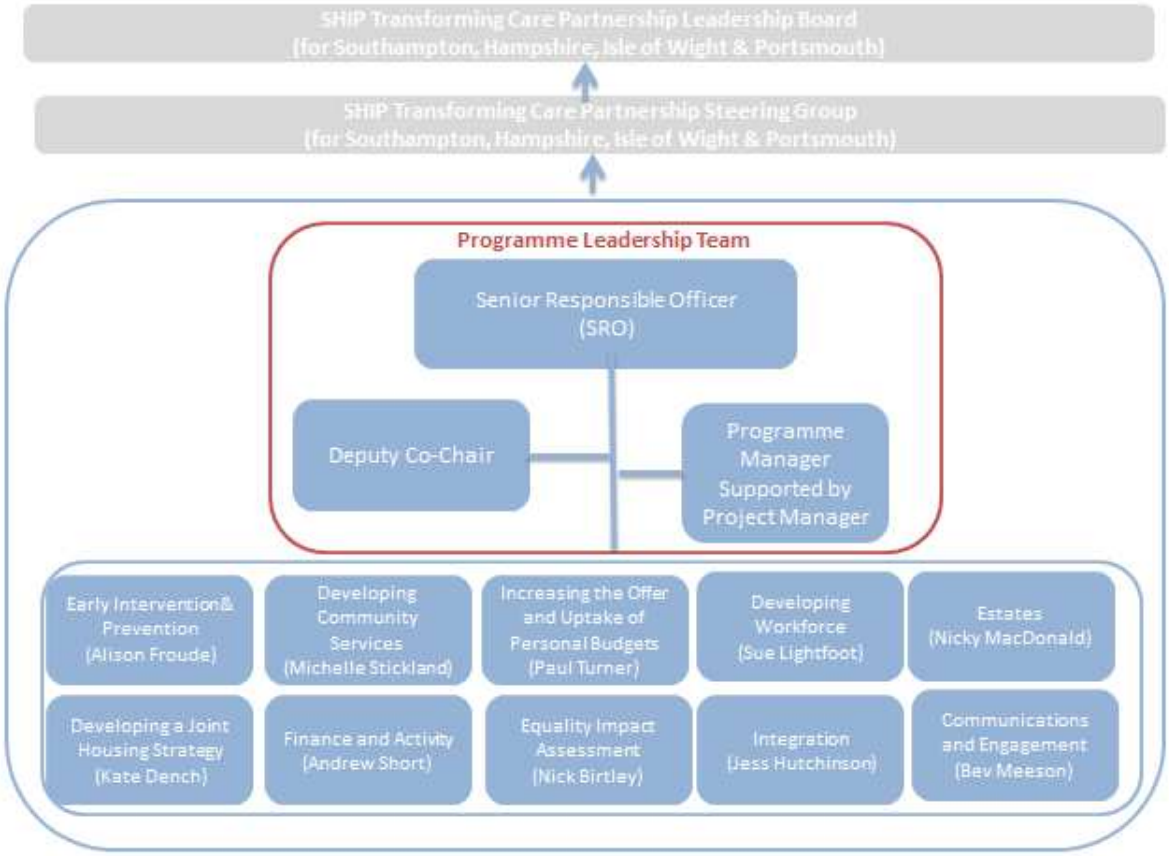
Southampton, Hampshire, Isle of Wight and Portsmouth's collaborative arrangements are detailed in the diagram below. Key features of this include:

- A multi-agency Transforming Care Board to provide a single place for collaborative decision-making by commissioners, clinicians and relevant professionals and experts
- The representation of parents and carers to ensure service user/carer involvement and participation
- Work stream Sub groups via the IPC programmes to drive and manage progress in developing and implementing this plan



1.5 Transforming Care Governance

The SHIP TCP has senior multi-agency leadership from commissioners and people with lived experience. Following consultation with the eight local CCCGs (SHIP 8), Heather Hauschild has been appointed as the Senior Responsible Officer and this project will be hosted by West Hampshire CCG. The Transforming Care Governance structure is as below; The Leadership Board will have oversight of the plan to ensure effectiveness of systems/proposals; quality and assurance check control and escalation for decision making. The Steering Group will provide assurance to the Leadership Board and will ensure operational delivery of the plan.



The draft job descriptions provided to Transforming Care Partnership Boards for individual roles and are provided below;

Senior Responsible Officer (SRO)

2) Transforming Care Example Job Descript

Deputy Chair

2) Transforming Care Example Job Descript

Programme Manager

2) Transforming Care Example Job Descript

Terms of Reference

The following Terms of Reference documents have been provided for The Leadership Board and The Steering Group


SHIP LD
Transforming Care Pa


SHIP LD
Transforming Care Pa

Project Manager

- The Project Manager is given the responsibility and the authority to manage the project on a day to day basis on behalf of the Project Board within the constraints laid down by the Board
- The Project Manager's prime responsibility is to ensure that the project produces the required products, to the required standard of quality and within the specific constraints of time and cost. The Project Manager is also responsible for the project producing a result that is capable of achieving the benefits defined in the TCP Plan

Core Project Team

The core project team represents the key service leads from different perspectives and as such the Senior Users within the project. Their role is:

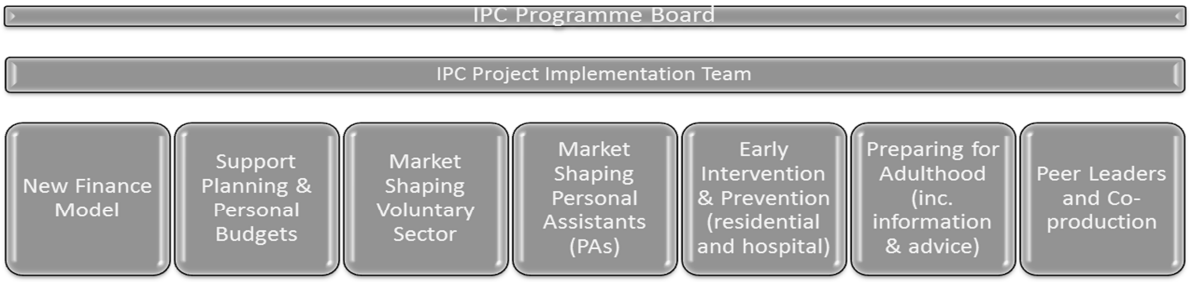
- To help shape the project
- To direct and facilitate the completion of work in their area within the time, quality and cost requirement of the project
- To communicate broader messages about the SHIP Transforming Care Partnership Plan within their respective organisations/services
- To be responsible for specifying the needs and benefits required of those who will use the projects products
- To be responsible for liaison within the core, wider project team and support services as necessary to ensure the products can be delivered and timescales met
- To monitor the solution to ensure it meets the requirements of the user and broader IPC and other local strategy requirements
- Where resource constraints exist they will be required to facilitate these to meet the requirements of the project, or raise an issue to be escalated through the Change Board for resolution
- Project Support
- This role supports the Project Manager and is key in co-ordinating all documentation for the

review, scheduling meetings, providing assistance to the Project Manager and general administrative support, such as setting up and maintaining project files and maintaining standards throughout the project lifecycle

Other Key Stakeholders;

In addition to those listed, other key stakeholders who will be consulted on changes to the SHIP TCP Plan include but are not limited to; Police, Probation, MAPPA, Youth Offending Teams, Looked after Children Team, District Housing Departments, Colleges, SEN Schools, Surrey & Borders NHS Trust, Care & Support Providers.

To deliver the work streams the local transforming care partnership aims to interface with the local Hampshire IPC Programme 'My Life, My Way', this has an established Programme Board, Project Implementation Team and individual work streams as illustrated below;



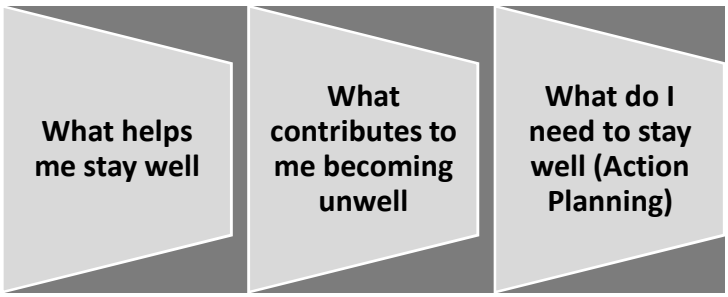
1.6 Stakeholder engagement arrangements

Timescales for this first draft plan has prevented the SHIP TCP from consulting with the individual Learning Disability Partnership Boards (LDPBs) properly in time for submission, however it is intended to work with the local LDPBs, Advocacy and other established task/working groups with whom local areas have strong and established links these include; 'My Life, My Way' (IPC), 'My Life, a Full Life (IOW), Peer Advocacy, Parent Carer Networks, Local Involvement Groups, IPC (Portsmouth). Members from the TCP Board will attend each LD Partnership Boards on a regular basis and a suite of briefing documents will be developed to ensure consistency of information provided and that the approach for co-producing local services is the same.

Underpinning the TCP plan is the ethos of co-production and truly working in partnership with people with lived experience in reviewing and shaping the plans. This supports principles 2 and 3 of the 'Building the Right Support' support model.

The SHIP TCP truly values the input from people with lived experience and recognises the difficulties in being able to manage caring roles to attend meetings. In order to support participation it is intended to follow the NHS England guidance 'Working with our Patient and Public Voice Partners: reimbursing out of pocket expenses and involvement payments' whereby out of pocket expenses will be covered for costs incurred relating to travel, accommodation and carer support and those involved as Patient and Public Voice Adviser roles.

To help us to understand what helps a person stay well and not be at risk of a hospital admission, person centred thinking will be used and will include asking;



It is important that people with lived experience are engaged with developing the SHIP TCP plan and people who are currently in specialist learning disability hospitals will be included through attending patient council meetings and specific events at each of the hospital sites within the SHIP area. Stakeholder engagement will also be with people who have previously been in hospital as well as their families/carers. True co-production is about people who use services, carers and professionals working together as equals.

An Indicative map of SHIP Stakeholders is provided below:

Mobilising Communities : Transforming Local Work into Action;

The **Hampshire** 'My Life, My Way' has parent/carers who are equal partners on the Project Board and truly help shape local service design. In addition the project has funded 5 young peer leaders from the Self Advocacy Youth (SAY) group, who in turn are setting up groups in schools in Hampshire in order to really engage directly with young people.

Isle of Wight – This was taken to LDPG last week to start the conversation. This has also been too Been to Joint Adult Care Board (JACB), CCG Executive Board, CCG Governing Body and going to Health and Wellbeing Board.

1.7 Co-production of the SHIP Plan

The SHIP TCP have a strong and vibrant advocacy movement which co-produces Commissioning Plans with the Learning Disability Partnership Boards in relation to; Health, Transition, Transforming Care, The Right Support, My Day, Where I live are some of the areas of work with local involvement / delivery groups across the region. This plan is about people who use services and will be developed with people who have lived experience and families/carers as equal partners.

The Hampshire 'My Life, My Way' programme has developed a 'Co-production Agreement' (see **Appendix II**) and have a commitment to follow 5 Steps to Co-production 2010/12. It is proposed to adapt this agreement for the TCP Plan.

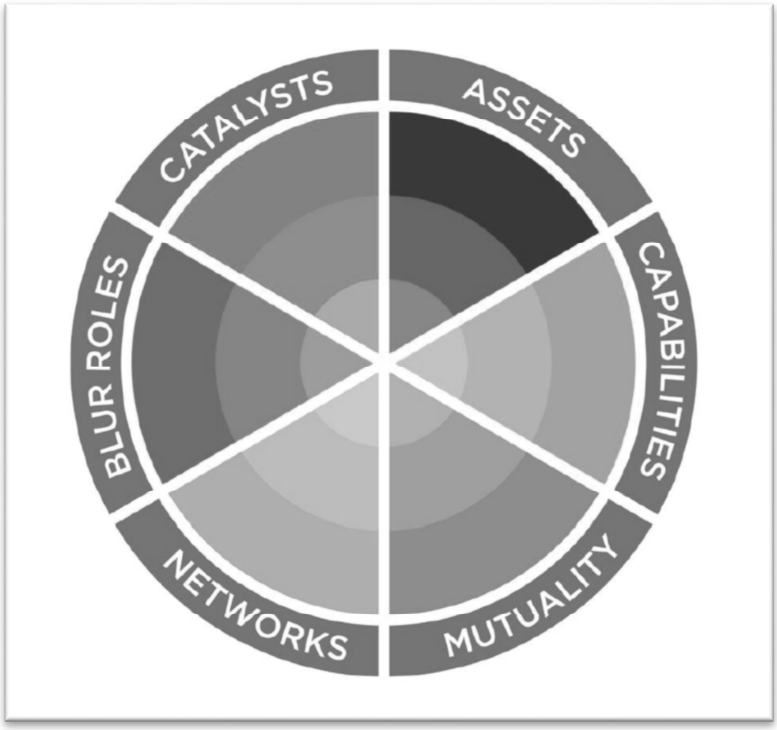
> *Co-production is about people who use services, carers and professionals working together as equals. Being equal means nobody is more important than anyone else.*
>
> *SCIE Co-production in social care*
>
> *A way of working, whereby everyone works together on an equal basis to create a service or come to a decision which works for them all*
>
> *National Co-production Advisory Group and Think Local Act Personal*

To ensure this plan represents true co-production, self-assessment will be undertaken during the project using tools from 'Think Local Act Personal' such as the Inclusion North and Tricia Nicoll Consulting's co-production self-assessment tool. This provides four areas to be considered;

- treating people as assets and using the skills and strengths they have to design and run services - using the gifts and skills people have to offer
- Valuing work differently – making sure people are not just seen as, treated as or expected to behave as 'people who need help'. Support that works to build on people's assets and building self-esteem to identify how people can support others enabling them to feel needed and valued
- promoting reciprocity or 'give and get' so that people who use services have a chance to 'give' as well as 'get' support
- Building social networks so that people get more connected - remembering that people build and sustain communities and you have to be present to be included. Services supporting people to become or stay part of their local communities NOT cut them off from any but paid contact.

The Co-production Self-assessment Framework: A working reflection tool for practitioners by New Economics enables evaluation of how a current service or project works and the way the broader system operates in relation to the following key components of co-production;

1. **Assets:** transforming the perception of people from passive recipients of services and burdens on the system into one where they are equal partners in designing and delivering services
2. **Capacity:** altering the delivery model of public services from a deficit approach to one that recognises and grow people's capabilities and actively supports them to put them to use at an individual and community level
3. **Mutuality**: offering people a range of incentives to engage which enable us to work in reciprocal relationships with professionals and with each other, where there are mutual responsibilities and expectations
4. **Networks:** engaging peer and personal networks alongside professionals as the best way of transferring knowledge inside and outside of 'services
5. **Shared roles:** removing tightly defined boundaries between professionals and recipients, and between producers and consumers of services, by reconfiguring the way services are developed and delivered



In order for us to measure co-production we have locally developed the attached templates.

Co-production Self-assessment Fran

Co-Production how are you doing Self ref

Mobilising Communities : Transforming Local Work into Action;

Co-production and engagement with people with a learning disability, advocacy groups and families /carers is established practice within the SHIP TCP region enabling new models of care and support to be truly developed with 'experts by experience' and meeting local need. This ethos of co-production underpins the TCP Plan. Current citizen based partnership working/development include;

Southampton – The Learning Disability Partnership Board have had two sessions regarding the national model on 30th November 2015 then again on 25th January 2016. Busy People (Southampton's Self Advocacy group) and Southampton Mencap Carers sit on the board, and are fully engaged in plans .The LDPB have agreed to six priority areas which encompass the national model and also overlay with the Preparing for Adulthood outcomes. Those are;

- Person centred approaches and quality
- Carers
- Health
- Employment
- Community Inclusion
- Independence

The four main action plans in relation to the LD Health and Social Care Assessment Framework, Autism, Challenging Behaviour and SEND reforms for Southampton are being reviewed to ensure they are aligned and consolidate key actions.

In order to refresh the local strategy, two consultation workshop events were held to find out from service users, families, carers, advocates, professionals and wider stakeholders how the City is progressing in respect to its approach to supporting people that have (or may have) autistic spectrum conditions. The workshops were themed around the 15 Priority Challengers for Action which were detailed in 'Think Autism – Fulfilling and Rewarding Lives, the strategy for adults with autism in England: an updated (April 2014) and gave attendees the opportunity to comment on the priority challenges in respect of Southampton. The feedback was put into a document which was circulated widely to various networks in order to obtain more views in order to inform the Strategy refresh.

Hampshire launched the new LD Plan in July 2014 which co-produced by people with a learning disability for people with a learning disability including people who were in-patients. The Partnership Board monitors progress against the plan for Adults to ensure that people with a learning disability receive the same opportunities as everyone else and the right support to live their life the way they choose not matter how complex their needs.

Funding for the Hampshire 'My Life, My Way' programme has been used to set up Self Advocacy / Peer groups for young people in order that they can participate in co-producing new ways of working / local plans and these were established by the local Regional Advocacy Group. This programme looked at where to start to make the greatest benefit for people and to change hearts and minds. The solution to start small but think big! This involved starting with a small number of young people and their families using the planning model as the foundation stone, families were offered an independent facilitator over two informal gatherings using the Think Local Act Personal (TLAP) approach to care and support planning and planning live i.e. planning in real time together, in the same room, supporting and sharing with each other and creating individual care and support plans.

> *"..it is uplifting to take part in a process which engages with my child in a proactive and creative way, thinking about the things he can do rather than the things he can't do, and identifying real aspirations and positive outcomes that offer a route to true, active progression. In our view by identifying what is most useful now, we also identify ways to improve outcomes, increase independence, stay safe, and save money in the longer term."*
>
> *Feedback from whole life planning sessions by Wendy*

The need has been recognised to strengthen the young person's and adult's network in Hampshire. Hampshire Advocacy Regional Group (HARG)has been funded as part of the IPC project to establish a network to enable young people and adults with disabilities to have a voice and enable them to direct key elements of the 'My Life, My Way' project.

8 groups will be identified across the county, representing all groups of children and young people with a disability and aged between 13 and 25. HARG will co-produce and deliver this work with peer expert co-workers, from groups facilitated by HARG organisations. They will recruit new peer expert co-workers from the network as it develops. There will be an offer of working together with children and young people at the groups to provide;

- Opportunities to develop self-advocacy skills
- Information about policy and service developments.
- Opportunities to take part in consultations
- Opportunities to take part in co-production activities i.e. IPC programme
- Develop links to the Hampshire Youth Council
- Reports to other organisations about the views of group members

The network will also have the opportunity to meet together and share information with each other and other participation networks, i.e. Hampshire Youth Council,

The FACES (Friendship, Assertiveness, Choice, Empowerment and Social Skills) programme in Hampshire won the Putting People First category in the Great South East Care Awards. FACES trains staff to help people with a learning disability to develop life and social skills, helping them voice what is important to them. Over 50 people are currently supported under this project. This has been extended to people with high support needs. FACES gives people with learning disabilities the skills and confidence to make their thoughts, feelings and choices known. FACES are part of Hampshire's approach to helping people to live more independently, with greater choice and control over their lives and the care and support that they receive.

Hampshire is currently undertaking a public consultation in relation to services for people with Autism and are working with the third sector to gather views via the sounding board. http://actionhampshire.org/communities/soundingboard this includes resources in easyread.

The **Isle of Wight** undertook a full public consultation to identify the needs and aspirations of people with autism and mental health and are currently ensuring the co-production of the Isle of Wight transition policy.

People with Autism and family carers have been involved in writing the Autism Strategy and developing the action plan. Most of Autism Implementation Matters (AIM) attends the Autism Strategy Implementation Group and acts as the link between both groups. The Autism Strategy Implementation Group also has membership from third sector organisations, CCG's, healthwatch and Parents/Carers of adults and children with Autism.

"Together we will open doors to a world where all people can keep on learning and growing"
To make this happen, we will:
- Listen and involve people with a learning disability,
- Encourage, enable and help people to have a voice and take risks.
- With training and support, enable people to reach and take responsibility for their chosen dreams, needs and hopes,
- Shape our services to create new opportunities. *IOW LD Partnership Board*

In addition on the Isle of Wight a new way of working across health and social care is underway. The 'My Life A Full Life' programme is collaboration between the CCG, NHS Trust and Local Authority. This new initiative works in partnership with local people, voluntary organisations and the private sector to deliver a more co-ordinated approach to the delivery of health and social care initially for older people and those with long terms conditions, however as this develops it is considering other areas of delivery which could benefit from this approach to improve individuals' experience of health and social care support services on the Island.

Portsmouth have a well-established parent/carers' co-production group and a young people's co-production group, 'Dynamite' which meet regularly and work in partnership with professionals to identify gaps in provision, good practice and to shape provision for children and young people with disabilities and special educational needs going forward.

Portsmouth has recently re-established their Partnership Board. Feedback from a workshop on 4th November identifies 'What we can Change' and includes;

- assistive technology to help independence
- flexible hours
- the right to support workers – young / autism / older – different needs
- creative practice led by choice not need
- funding for an evening facilitator and weekend life
- communication
- raise aspirations – staff, service users
- robust recruitment
- good support plans

> *"We should be treated equally and our views respected, and we should be helped to live the lives we choose. You need to make sure we are safe in services if we need support or care"*
>
> *Portsmouth LD Partnership Board*

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

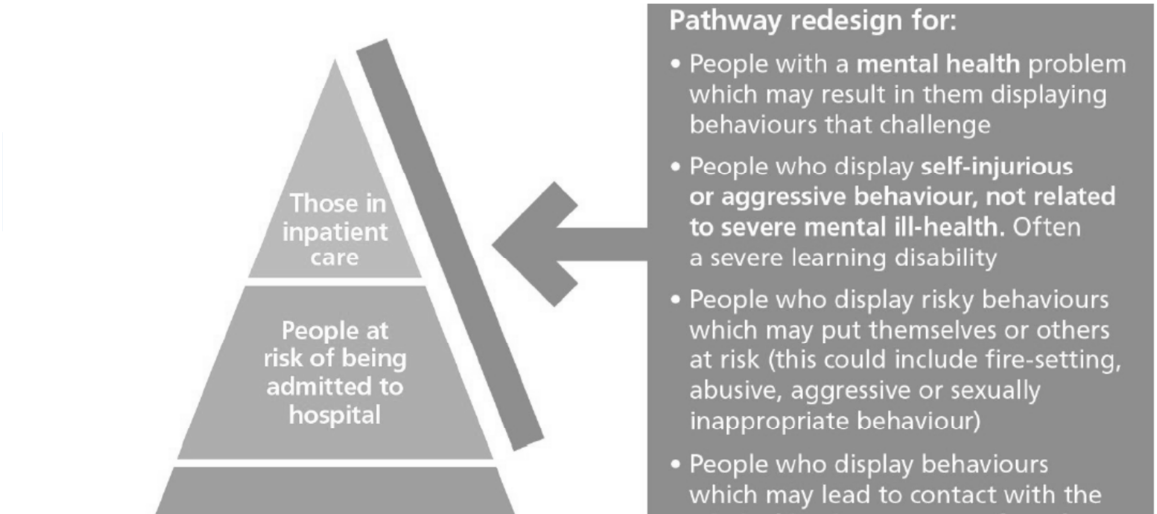
This plan covers the SHIP Transforming Care Partnership and covers the following CCGs;

- Isle of Wight CCG
- Portsmouth CCG
- Southampton CCG
- Fareham & Gosport CCG
- North Hampshire CCG
- North East Hampshire & Farnham CCG
- South East Hampshire CCG
- West Hampshire CCG

2.Understanding the Status Quo

2.1 Population / Demographics;

Children, Young People and Adults with a learning disability and/or autism who display behaviour that challenges are a diverse group of people each having widely dissimilar needs and are described as being a highly heterogeneous group. The pathway redesign requires TCPs to consider the various elements and components of services for this group of individuals and identify five needs groupings;



NHS Southampton CCG*	241,895	2,326	237 (based on diagnosis)
5 Hampshire CCGs*	1,339,011	4,657	Circa 3,500
NHS Isle of Wight CCG	138,392	906	593 open to services 540 in receipt of direct services
NHS Portsmouth CCG*	207,945	564	
TOTAL	**1,927,243**	**8,453**	

In order to serve and meet the needs of Children, Young People and Adults with a learning disability and/or autism transformation is required and co-production has to be the foundation for developing robust services, expanding the offer of personal budgets to individuals and collaboration across Health, Social Care, Children's Services, Education, Hospitals, Housing Departments and the Criminal Justice System.

The SHIP TCP Plan identifies key areas of work required; early intervention and prevention to avoid people being admitted to hospital, upskilling of support staff, increasing the number of personal assistants available in the TCP region, working with providers in the use of Positive Behavioural Support and having robust care planning with relapse prevention strategies agreed with pre-agreed funding in place either directly funded or via personal budgets to help keep people well.

Services will meet the needs of Children, Young People and Adults with a learning disability and/or autism who are supported from local community based services and out of area e.g. within residential schools, care homes, hospitals and secure children centres and 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 or 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

– It will also continue with the work undertaken to date to discharge people from specialist learning disability hospitals and build upon the joint working between NHS England and the Ministry of Justice to facilitate discharge of patients subject to restriction orders

Within the SHIP TCP there are 8,453 people with a learning disability known to services, an overview is provided in the table below. (See **Appendix I** for breakdown of population data).

CCG	Total population	LD/autism population in area*	LD/autism known to services
NHS Southampton CCG*	241,895	318 C&YP 2,008 Adults **Total - 2,326**	237
5 Hampshire CCGs*	1,339,011	384 C&YP 4,273 Adults **Total - 4,657**	Circa 3,500
NHS Isle of Wight CCG	138,392	86 C&YP 820 Adults **Total - 906**	593 open to services 540 in receipt of direct services
NHS Portsmouth CCG*	207,945	62 502 **Total - 564**	889
TOTAL	**1,927,243**	**8,453**	
	*Source: Hampshire County Environment Department's 2014 based Small Area Population Forecasts **Source IOW JSNA 2013	Based on JHSCAF data as at 31st March 2014	Based on numbers known to either Health and/or Social Care Teams

Due to the timescales to produce the first draft plan it has not been possible to review commissioned services across Children, Young People and Adults with a learning disability and/or autism. To develop this plan it is necessary to work with local stakeholders to gather information and lived experience to identify how people are currently supported, where they are supported, how they would like to be supported and if there are services in the local area to enable people to have personal budgets. This will also include understanding why breakdown in placements have occurred. This will enable the TCP Project Board to;

- Identify people 'at risk' of hospital admission or to long term institutional type care (residential)
- Develop a risk stratification to enable health, education and social services to meet the local population need
- Develop a local learning disability early intervention and prevention charter
- Ensure service gaps are addressed
- Work with providers to identify and understand their education/workforce development needs including relating to positive behavioural support
- Develop a joint Regional approach to Housing Development for the TCP area

Understanding the Status Quo : Transforming Local Work into Action;

Hampshire - 782 children open to Disabled Children's teams in HCC, vast majority of whom will have a learning disability. 89 are looked after and 176 receive an overnight short break in a residential setting/home and circa 50 CYP have overnight breaks in 'Family Link' foster placement / fostering respite in addition there are 47 in external high cost 38 or 52 week placements provision – external placements and may be within the county (TCP boundary)

2.2 Analysis of inpatient usage by people from Transforming Care Partnership

Local in-patient bed availability for Learning Disabilities

The Hampshire and Isle of Wight Transforming Care Partnership area is a nett importer of in-patients (Adults) into Assessment and Treatment units and Forensic Rehab and low secure services. There are currently only two providers Southern Health NHS Foundation Trust (SHFT) and Partnerships in Care (PiC). In February 2015 the low secure ward at Mildmay Oaks (formerly Vista Healthcare) was closed and following extensive refurbishment work this has re-opened and NHSE have indicated they will commission 6 beds within this unit. Currently there are 81 beds within the SHIP area. An overview of the in-patient bed capacity within the area is provided below;

Provider Name	Unit Name	Location	No of Beds	M or F	Type	Commissioned by
Local In-patient Beds						
SHFT	Woodhaven - Ashford	Tatchbury	6	M	Low Secure	NHSE
SHFT	Woodhaven - Cypress	Tatchbury	6	M	Forensic Rehab	CCG
SHFT	Willow	Moorgreen	6	M/F	ATU	CCG
PiC	Mildmay Oaks - Bramshill	Winchfield	14	M	Low Secure	NHSE (5 commissioned)
PiC	Mildmay Oaks - Eversley	Winchfield	8	M	ASD	CCG
PiC	Mildmay Oaks - Heckfield	Winchfield	8	F	Locked Rehab	CCG
PiC	Mildmay Oaks - Winchfield	Winchfield	18	M	Low Secure	NHSE
PiC	Knightsbridge House	Fareham	13	M	ATU	CCG
IOW NHS	Sevenacres	Isle of Wight	1	M/F	ATU	CCG
CAMHS	Leigh House	Winchester	1	M/F	CAMHS	NHSE
Total Number of Beds			**81**			
SHFT	*Evenlode*	*Oxford*	*10*	*M*	*Low Secure*	*NHSE*

Use of in-patient beds by TCP CCGs

Hampshire and Isle of Wight CCGs commissioners endeavour to commission in-patient placements within the local area, however this is not always possible where capacity is full or whether individuals do not meet the criteria for local services e.g. physical health and being at risk of harm from other patients or the complexity of presentation and the compatibility with existing patients.

The introduction of Care and Treatment Reviews (CTRs) has enabled CCGs to review the care and treatment for patients and discharge plans. This has been complemented by the new Pre-Admission CTR where there is a planned admission to an in-patient service e.g. in the event of a radical medication reduction plan as well as the 'Blue Light Meetings' to respond to people who are in crisis and at risk of going into hospital. These are recorded and reported to NHSE on a weekly basis together with current patient numbers and planned discharge dates.

In-patients beds within specialist learning disability hospitals are commissioned on both a block and spot basis based on a bed day rate with additional support e.g. 1:1 charged separately. For some individuals community day opportunities are funded to provide work based skills training either at local colleges or vocational training centres e.g. car mechanics, computer maintenance etc. There are no in-patient services in Portsmouth or Southampton. Current patient numbers for the area are provided in the table below;

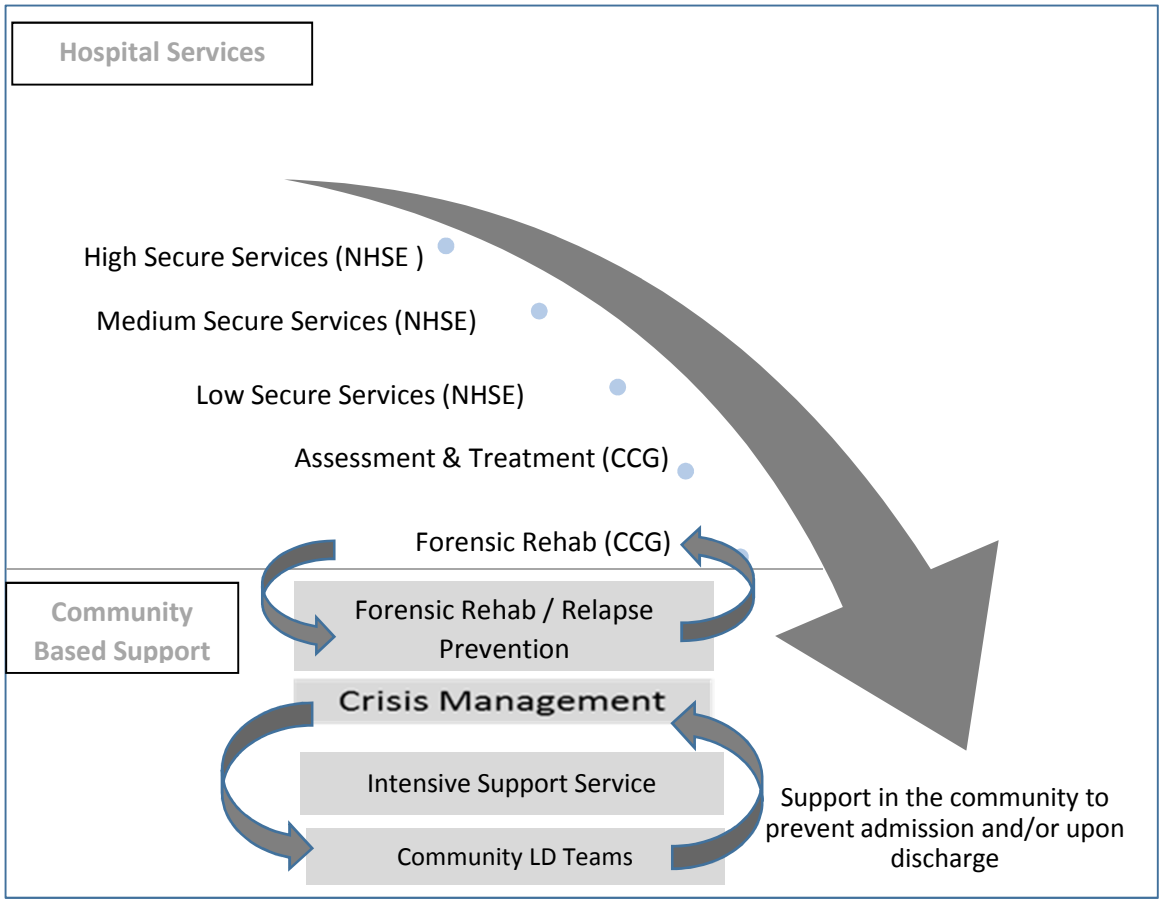
In-patient Statistics	Southampton	Hampshire	Isle of Wight	Portsmouth	NHSE
Current No of In-patients					
Adults	1	14	0	1	
CAMHS					3
NHSE Secure Beds - Adults	5	18	7	5	40
No of patients in NHS in-patient services					
Adults	0	7	0	0	
No of patients in Independent in-patient services					
Adults	0	7	0	0	
No of patients in the Hampshire & IOW area					
Adults	0	11	0	0	
No of patients in out of area hospitals					
Adults	0	3 Newcastle Buckinghamshire Devon (moving to Lincolnshire)	0	0	43
Totals	**1**	**14**	**0**	**1**	**43**
Overall Total	**54**				

As well as the SHIP TCP being a nett importer of people with a learning disability into Assessment and Treatment units and Forensic Rehab and low secure services, the area is also a nett importer into residential care homes with less than 50% of available capacity being commissioned by local health and social care teams. A recent admission was following a failed placement commissioned in Hampshire from an out of area local authority and due to 'Responsible Commissioner' guidance the CCG in which they

were registered with a GP becomes responsible for funding. There is a suggested protocol for commissioners to inform local health teams when they place people out of their home area, however this is not always followed.

Discharge from specialist in-patient learning disability services is also impacting on commissioning decisions due to funding responsibility under Section 117 aftercare. Who Pays? Determining responsibility for payments to providers (August 2013) states "it is then the responsibility of the CCG in the area where the patient moves to pay for their aftercare under section 117 of the Act 21 as agreed with the appropriate local social services authority". This has a detrimental effect of those individuals being discharged as Case Management/Care Co-ordination is then transferred to a new team who may not know the person thus providing a lack of consistency. This issue will be addressed within Early Intervention and Prevention work within this plan and developing the 'At Risk' register and will build upon the joint working between NHS England and the Ministry of Justice to facilitate discharge of patients subject to restriction orders.

CCG and NHS England Commissioners with partners from the Criminal Justice System aim to develop one model of care whereby individual needs are considered holistically through identification of those at risk of offending and who may present with other needs e.g. mental health issues, substance misuse, financial and relationship problems. Often when a person with a learning disability offends they may not link the consequence of their behaviour and therefore an adapted behaviour programme is required as part of the treatment programme.



2.3 Overview of Current Commissioned Health & Care Services

Community Learning Disability Health Team Activity

CCGs commission Community Learning Disability Team from local mental health trusts i.e. Isle of Wight NHS Trust, Solent NHS Trust and Southern Health NHS Trust, in addition there is some investment into Surrey and Borders Partnership Trust who serve the North East Hampshire and Surrey area. An overview of the local CLDT activity is provided below;

Community Activity	**Southampton**	**Hampshire**	**Isle of Wight**	**Portsmouth**
CLDTs Face to Face Contacts	5,649 Per annum	19,794 Per annum	To be confirmed	3,600 per (300 per month)
Community Health Teams – Community Nurses	361 Per annum			3,600 per annum (300 per month)
Intensive Support Team	377 Per annum	548 Per annum		1,200 per annum (100 per month)
LD Enhanced Team	373 Per annum	N/A		N/A
LD Outpatients	6,298 Per annum	1,645 Per annum		N/A
LD Autism & ADHD	£ investment into service	N/A		N/A
Totals	**6,760**	**23,086**		**8,400 per annum (700 per month)**

Health Facilitation is included within CLDT contracts, this provides support to GP practices for how to make reasonable adjustments for people with a learning disability and/or autism and to enable people to be offered a LD annual health check and to have a health action plan to enable good physical health.
An overview of the current care economy is provided in section 1.3 of this plan and this describes services provided for Children, Young People and Adults with a learning disability and/or autism who;

- Have a mental health condition which may result in them displaying behaviour that challenges
- Display self-injurious or aggressive behaviour
- Display risky behaviours which may put themselves or others at risk
- May not traditionally be known to health and social care services

SHIP TCP wants to prevent the 'revolving door syndrome' trying to fit people into a traditional solution that does not meet the person's needs that results in regular placement breakdown and more restrictive regimes being put in place. This plan aims to build on the person's unique strengths and abilities, not seeing them as a problem and get it right for the person first time. Complex people and those in crisis are often managed through reactive strategies rather having proactive strategies agreed and in place in the event of requiring intensive support, avoiding a hospital admission.
Current commissioning arrangements with residential care require changes to when a provider can serve

notice on a placement, often these are 28 days, 7 days or in rare instances 24 hours. This exacerbates situations for individuals as not only are they experiencing either a deterioration in their mental health and presenting with challenging behaviour they are moved out of what may have been their home for a long time to somewhere unfamiliar to them and then possibly moved again to longer term accommodation to admitted to a hospital setting.
Young people in transition often continue within an out of County educational setting as there are limited alternatives available and usually planning has commenced too late to develop bespoke services for individuals.

CCGs and NHS England commission services for people with a learning disability following the committing of an offence. They are given a hospital order by the courts to an LD Forensic inpatient service (secure or non-secure) for treatment under an adapted behaviour programme which are usually for a period of one year but tend to commence at specific times within the calendar year e.g. if you are admitted in October you may not commence your treatment programme until January the following year. Currently there is no community forensic service provision which could commence whilst an inpatient and continue once discharged to the community thus enabling the individual to access progressive independence enhancing life skills. An illustration of the proposed CCG/NHSE forensic pathway is provided in section 2.2 of this plan.

Due to the timescales to produce the first draft plan it has not been possible to review the provider base for commissioned services across Children, Young People and Adults with a learning disability and/or autism. To develop this plan and we will work with local stakeholders to gather information and lived experience to understand what the challenges are, gaps and how people can be supported and to have a personal budget that helps to keep them well.

National Outcome Measures;

Local Authorities and CCGs are required to undertake a Joint Health and Social Care Assessment for people with a learning disability and a further assessment for those with Autism. The assessment framework identifies areas for improvement in relation to learning disabilities (see diagram 3 below). The main area is increasing the provision of annual health checks and resulting health action plans to above the assessed rate of 50%. The only area within the TCP meeting this measure is the Isle of Wight. Hampshire is the only area for which there are is no designated learning disability liaison function in one or more acute provider trusts, this has been identified as an area for improvement/development within 2.5 of this plan 'The Case for Change'. Analysis of the full assessment is provided in **Appendix III**.

Joint Health and Social Care Assessment Framework 2014;

Areas for Improvement RAG rated as Red on the JHSCAF	CCG Areas			
	Southampton	Hampshire	Isle of Wight	Portsmouth
Staying Healthy – Health Action Plans (Q.4): Fewer than 50% of Annual Health Checks generate specific health improvement targets (Health Action Plan)	X	X		X
Staying Healthy – Primary / Secondary Care Communication (Q6): There is no local area team/clinical commissioning group wide system for ensuring LD status and suggested reasonable adjustments are included in the referral		X		
Staying Healthy – Acute LD Liaison Function (Q7): No designated learning disability liaison function or equivalent process in place in one or more acute provider trusts per site.		X		
Staying Healthy – Reasonable Adjustments in primary care (Q8): Considering NHS commissioned primary care services- dentistry, optometry, community pharmacy and podiatry		X		
Staying Healthy – Offender Health and the Criminal Justice System (Q9): There is no systematic collection of data about the number of people with LD in the criminal justice system. There is no systematic learning disability awareness training for staff within the criminal justice system. The local offender health team does not yet have informed representation of the views and needs of people with learning disability.		X		
Keeping Safe (Q.1): Less than 90% of all care packages including personal budgets reviewed within the 12 months covered by this self-assessment			X	

Keeping Safe (Q.2): Less than 90% of health and social care commissioned services for people with learning disability 1) have had full scheduled annual contract reviews 2) demonstrate a diverse range of indicators and outcomes supporting quality assurance			X	X

Diagram 3

Results from the Autism assessment framework identifies areas for improvement in relation to autism awareness training, reasonable adjustments ensuring local housing strategies recognise the need of people with Autism. An overview of the key areas for improvement is provided in Diagram 4 below. Analysis of the full assessment is provided in **Appendix IV.**

Autism Self-Assessment Framework 2014

Areas for Improvement RAG rated as Red on the ASAF	CCG Areas			
	Southampton	Hampshire	Isle of Wight	Portsmouth
Planning (Q4) : Does your local JSNA specifically consider the needs of children and young people with autism?			X	
Planning (Q6) : Do you collect data on the total number of people currently known to social care services with a diagnosis of autism (whether new or long-standing) meeting eligibility criteria for social care (irrespective of whether they receive any)?				X
Planning - Reasonable Adjustments (Q10): Have reasonable adjustments been made to general council services to improve access and support for people with autism – Red: Only anecdotal examples	X		X	
Training (Q4) : Do CCGs ensure that all primary and secondary healthcare providers include autism training as part of their ongoing workforce development?	X	X		X
Training (Q6): Criminal Justice Services. Do staff in the local court services engage in autism awareness training?	X	X	X	
Training (Q7) : Criminal Justice Services. Do staff in the local probation service engage in autism awareness training?			X	
Diagnosis (Q9) : In your local diagnostic pathway does a diagnosis of autism automatically trigger an offer of a Community Care Assessment (or re-assessment) if the person has already had a current community care assessment?	X			X

Housing & Accommodation (Q1): Does the local housing strategy specifically identify autism?			X	X
Housing & Accommodation (Q2): Do you have a policy of ensuring that local housing offices all have at least one staff member who has training in autism to help people make applications and fill in necessary forms?		X		X

Diagram 4

2.4 Overview of Current Housing, Accommodation & Estate

Over the past number of years there have been a variety of schemes to move people out of long stay hospitals e.g. LBHU & Campus re-provision. This resulted in people moving into their own accommodation with individual support in their own homes or sharing with other people. For the majority of individuals this has been a positive experience, however for some they have had to move due to compatibility issues with people they lived with. For these houses the NHS hold legal charges with Registered Social Landlords (RSL) either at the full market value of the property regardless of the capital granted or at a fixed capital sum.

Local NHS Foundation Trusts have a number of properties within their portfolios which have been used as Registered care homes or hospitals. Upkeep of these is managed by the local Foundation Trust. Any change in use or disposal is between the Foundation Trust and NHS Property Services however there have been occasions whereby the Foundation Trust has given notice to the RSL and then vacated the property. This has raised difficulties in being able to release the Foundation Trust from legal agreements as they are no longer fit for purpose due to changes in the NHS from Primary Care Trusts to CCGs. Locally Hampshire is working with NHS Property Services to seek authorisation to dissolve agreements and to recycle the capital monies back to the local area for the learning disability population.

Local commissioners are working with residential care providers to de-register and provide supported living accommodation thus providing assurance of tenure to individuals rather than being at risk of a provider giving very short notice e.g. 7 days to leave a property. This results in temporary moves to alternative accommodation which is unsettling to a person which has resulted in deterioration in mental health and being sectioned under the Mental Health Act requiring a hospital admission.

To develop a portfolio of housing options for individuals the SHIP TCP working with local housing departments, will develop a joint Regional approach to Housing Development. This will include working with the Housing and Support Alliance http://www.housingandsupport.org.uk/home who have launched a programme of support for commissioners and providers which helps people to move from specialist learning disability hospital units and how people can be supported to remain in their communities with the housing and support that works for them. This work will support Principle 5 of 'Building the Right Support'.

"How can Hampshire make sure people with complex needs are involved in planning housing?"

Feedback Hampshire LD Plan – The Right Place to Live

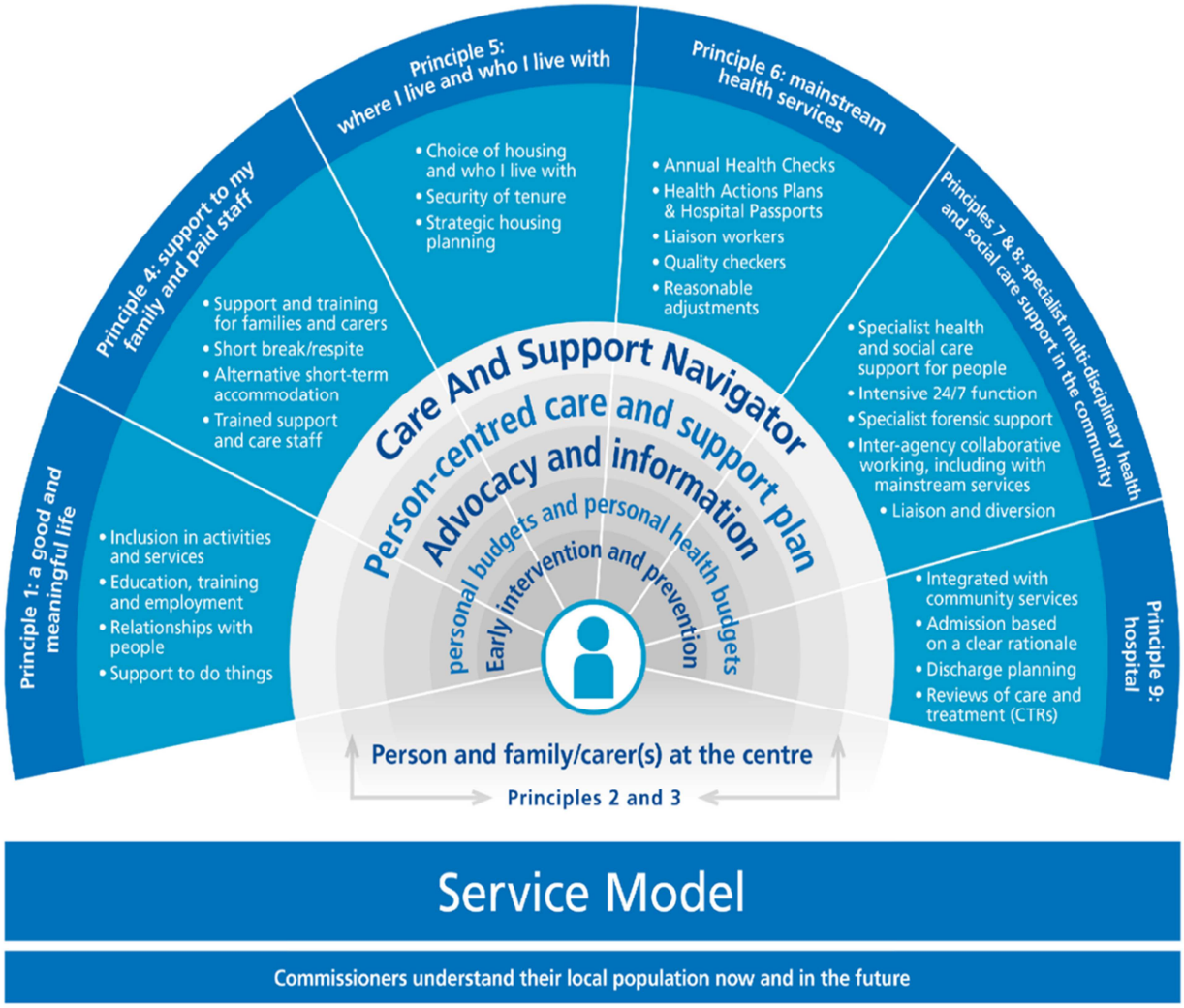
2.4 Case for Change for the SHIP Transforming Care Partnership

The SHIP TCP care model for the delivery of support planning and personal budgets strives for co-production, truly working with families and people with a learning disability in an open way, designing new ways of working and helping drive cultural change. This is based on the New Service Model as outlined in 'Building The Right Support'. The benefits envisaged for this plan include;

- Reduced number of people with learning disabilities being admitted to inpatient beds through the development of more flexible, local and person centred alternatives e.g. crisis support, short term accommodation etc.
- Reduced length of stay for those requiring an in-patient admission
- People with a learning disability and their family to have a better quality of life and achieve the outcomes that are important to them and their families through greater involvement in their care, and being able to design support around their needs and circumstances
- Building carers and family resilience reducing the need for formal care
- Services involving and being guided by people with lived experience
- Giving a focus for Adult Services, Children's Services, SEN, CCGs and NHS England to plan earlier and more collaboratively for people with complex needs, minimising inconsistencies in provision for people through the use of personal budgets.
- Changing commission patterns with improved outcomes as well as improved financial management of young people and adults with complex needs, through the creation of a greater range of support options that maximise shared support and social capital with greater and longer engagement with families
- Identifying and promoting different routes in employment
- Better co-ordination of activities that help young people develop independent living and life skills
- Developing joint commissioning and aligning/pooling budgets
- Multi agency early intervention and prevention offer to people to complement self-management and innovative contingency planning

The SHIP TCP will undertake local workshops with families, people who use services, voluntary sector and statutory partners to identify;

- Existing pathways in each of the four areas; Southampton, Hampshire Isle of Wight and Portsmouth to identify the interaction points with different partners/organisations
- Identify the 'hotspots' (potential barriers) that require targeted work
- Identify the value and non-value areas of the pathway and recommend proposed changes
- Develop the future pathways and undertake testing new areas of working
- A co-produced charter across local services developed with stakeholders that is based on best practice and meets the needs of the local population



The Hampshire 'My life, My Way' with the Portsmouth IPC and Isle of Wight, 'My Life, A Full Life' projects will form a key part of the Transforming Care Partnership Plan for Hampshire with people with a learning disability and supports the delivery and outcomes for people based on the principles of the new Service Model;

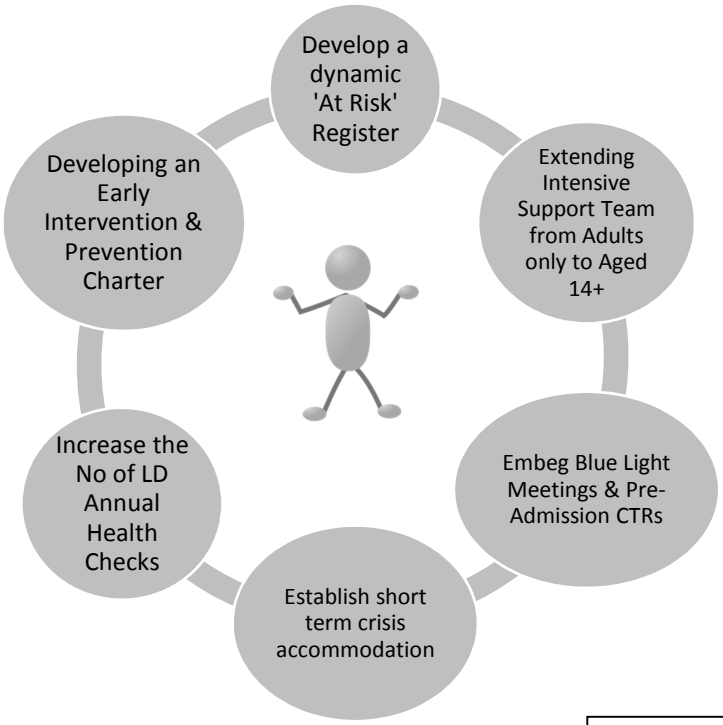
- Principle 1 – **A good and meaningful life** – People are supported to participate in activities that meet their goals and aspirations and have control over what activities their budgets are spent on
- Principle 2 – **person-centred, planned, proactive and coordinated** - through Personalised care & support planning e.g. 'whole life planning'
- Principle 3 – **Choice and Control** - for people by being in control of their budgets and being able use these flexibly to meet needs
- Principle 4 – **Support from and for their families/carers as well as paid support and care staff** - Building carers and family resilience reducing the need for formal care and developing the local workforce for 'Personal Assistant' by working with Skills for Health and Health Education England
- Principle 5 – **Housing** – Enabling people to choose where they live and who they live with. Transforming Care Plans ask local Partnerships to describe how local estate/housing bases need to change?
- Principle 6 – **Mainstream NHS Services** – IPC will enable early intervention and prevention planning to form part of a support package to enable proactive strategies and funding to be agreed and in place to support someone if it is predicted they are likely to go into crisis using the 'At Risk' register criteria.
- Principle 7 – **Specialist health and Social Care support in the Community** – Individualised support planning will include how people can be supported to receive annual health checks, work with their Health Action Plans and completing Health passports and can include interventions for an individual that provide a therapeutic benefit e.g. attending trampolining to enable an individual to maintain fitness, deep muscle tone and wellbeing resulting in a reduction in challenging behaviour and the need for additional support.
- Principle 8 – **Support to stay out of trouble** – People who are subject to S.117 under the Mental Health Act can use a personal budget to support them either with tenancy support or with buying relapse prevention support.
- Principle 9 – **Hospital** – The Transforming Care Partnerships asks Local Authorities, CCCGs, NHS England & other key stakeholders to come together to building local community provision to develop whole pathways reducing the use of inpatient services. TCPs are required to produce TC Plans that demonstrate how people will be managed in the community through Early Intervention and Prevention work to crisis support and where a hospital admission is required that this is appropriate and agreed by all agencies using the Blue-Light Meeting and Care & Treatment Review process.

The key areas identified by the SHIP TCP for development to enable people to be supported in their communities and to avoid inappropriate hospital admissions are grouped into five areas of work;

- Early Intervention and Prevention
- Developing Community Services
- Developing the Workforce
- Increasing the offer and update of Personal Budgets
- Housing

Early Intervention & Prevention;

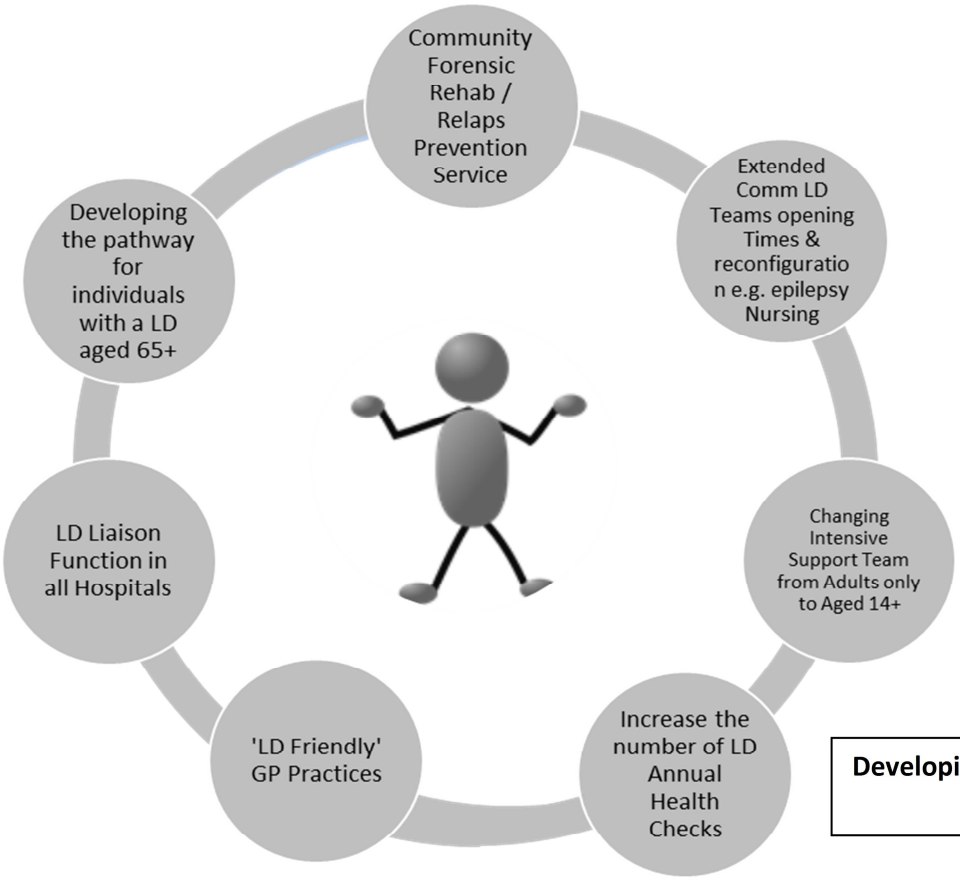
- Extending the scope of the Intensive Support Service from Adults only to all ages, providing services outside of normal working hours i.e. until 22:00 in the evenings 7 days a week
- Development of short term accommodation for those in crisis who cannot remain in existing housing.
- Active 'At Risk' Register Monitoring; establishing criteria for registers and developing proactive strategies for individuals, pooled/aligned monies to enable support to be provided which a person is in crisis.
- Early Intervention and Prevention Charter – developing a joint charter across the SHIP TCP
- Increasing the update of LD Annual Health Checks; working with GP practices to understand the barriers to providing annual health checks and how people can be supported to have Health Action Plans that are meaningful and help people to keep well.



Early Intervention & Prevention

Developing Community Services;

- SHIP wide Community Forensic Rehabilitation Service; working with local NHS Foundation Trusts and people who are / have been inpatients to develop the service whereby people receive care and treatment either in their own homes or in short term accommodation instead of having to go to hospital for adapted behaviour treatment programmes. Pooled/aligned budget across partners for the service.
- Extending the scope of the Intensive Support Service from Adults only to those aged 14 years and above, development of short term accommodation for those in crisis who cannot remain in existing housing.
- LD Acute Hospital Liaison function; ensuring this is provided in each acute trust in the TCP region
- Increasing the update of LD Annual Health Checks; working with GP practices to understand the barriers to providing annual health checks and how people can be supported to have Health Action Plans that are meaningful and help people to keep well.
- Developing the pathway for those aged 65+ with a learning disability; working with support providers to identify appropriate models of care, working with CQC and providers regarding registration of services
- Investment into local health and social care community teams for support planning, reviews for people in receipt of commissioned support or Personal Budgets
- Changing operating times of local community teams providing services outside of normal working hours i.e. until 22:00 in the evenings 7 days a week
- Reconfiguration of existing Epilepsy community nursing and/or investment for this function within CLDTs



Developing Community Services

Developing the Workforce;

- Training and development; for staff / personal assistants to build more robust support for people who are complex and whose behaviour is challenging and for families/carers
- Working with local agencies to promote caring/personal assistants as a career with continuous personal/professional development pathways.
- Extending the FACES (Friendship, Assertiveness, Choice, Empowerment and Social Skills) programme across the SHIP TCP
- Working with providers in the use of positive behaviour support rather than physical interventions
- Developing a career pathway for the Personal Assistant workforce
- Having 'Learning Disability Friendly' GP Practices

Increasing the offer and uptake of Personal Budgets;

- Increasing the uptake of personal budgets including; direct payments, personal health budgets, Educational Health Care Plans (EHCPs) and IPCs – one plan, one budget
- Support to increase the number of Personal Assistants
- Aligning/pooling commissioning budgets across health and social care and developing Section 75 agreements for local joint commissioning arrangements
- Training for support planning co-ordinators / trusted assessors
- Better Care planning; whole life planning for individuals and where appropriate whole families where there is more than one sibling with a learning disability.

Housing;

- Portfolio of housing options for individuals; this will require capital funding to enable the purchase and/or development of buildings that offer greater flexibility of how a person is supported.

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

Any additional information

	Southampton	Hampshire	Isle of Wight	Portsmouth
No of people with learning disabilities in receipt of Continuing Health Care (CHC)?	103	156	20	27
Section 117 – No of people with learning disabilities in receipt of care funded through an arrangement under Section 117 of the Mental Health Act?	12	35	7	5
Data extracted from JHSCAF 2014				

3.Develop your vision for the future

Vision, strategy and outcomes

3.1 SHIP Transforming Care Aspirations for 2018/19

SHIP TCP wants to prevent the 'revolving door syndrome' trying to fit people into a traditional solution that does not meet the person's needs that results in regular placement breakdown and more restrictive regimes being put in place. This plan aims to build on the person's unique strengths and abilities, not seeing them as a problem and get it right for the person first time. People with complex needs and those in crisis are often managed through reactive strategies rather having proactive strategies agreed and in place in the event of requiring intensive support, avoiding a hospital admission. Underpinning the TCP plan is the ethos of co-production and truly working in partnership with people with lived experience in reviewing and shaping the plans. This plan supports the principles as described in 'Building the Right Support' and the new service model and will enable improved quality of life, quality of care and reduced reliance on in-patient services. Aspirations for 2018/19 will see a reduction in the number of beds commissioned by CCGs and NHSE and people will be supported in the local community.

The Key Targets/Milestones for the project are attached in **Appendix V** of this plan. In summary;

- **By end 2016** all patients who have been in hospital for more than 3 years will be discharged to local community services
- The SHIP TCP will reduce the reliance on in-patient services between now and the end of 2019 from 55 beds to 44 beds;
- Less **by end March 2017**
- less **by end March 2018**
- 2 less **by end March 2019**
- Existing Community Learning Disability Health and Social Care Teams reconfigured to support Early Intervention and Prevention of people with investment aligned to support the function **by End March 2017**
- A new community forensic rehabilitation / relapse prevention service to be **established by end March 2017**
- The number of people with a 'Personal Budget' (Health, Social Care or Education Funded or those in receipt of blended funding) will increase from circa 5,135 individuals to 6,635 **by end March 2019**

Delivery of the above will enable;

Improved Quality of Life;

1) Through whole life planning there will be an understanding of what keeps people well and what is required when they become unwell
2) Personalised care and supported planning approach to encompass education, employment, health and social support and the whole family
3) Remove the 'cliff edge' for young people and their families going through the transition to adulthood
4) To shift power to people with a disability and their families
5) Enable people to be supported how they want to be supported and when to maximise what people do in their life
6) More provision in the region so that people can be closer to home
7) Market development and shaping to suit the needs of people with a learning disability and/or autism
8) Increase investment in non- institutional settings and pathways that are fit for purpose
9) Increased physical health will increase people's life expectancy

Improved Quality of Care;

10) Prevention and early intervention
11) Community forensic intervention rather than just a hospital based model of care
12) Seamless care across the pathway, no stopping and starting based on commissioner boundaries
13) Development of the workforce to implement the new model of care
14) Personal Budgets will put people in control of their support
15) Robust good quality care will prevent breakdown in support packages

Reduced reliance on inpatient services ;

16) Having robust early intervention and prevention strategies in place for people who are at risk of a hospital admission
17) Increase in more appropriate day services/daytime opportunities, respite offers and advocacy/self-advocacy that enables people to keep well
18) A joint housing plan between health and social care that begins to be implemented in year one to provide a greater range of housing for shared lives, independent living, domiciliary care , supported living,
19) Consistency and equity of provision across the TCP partnership

3.2 Measuring improvement against each of these domains

National Measures;

The SHIP TCP Plan will support delivery against all of the Principles as outlined in 'Building the Right Support' and 4 of the NHS Outcomes Framework Domains and indicators;

Domain 2 – Enhancing quality of life for people with long-term conditions

Doman 3 – Helping people to recover from episodes of ill-health or following injury

Domain 4 – Ensuring people have a positive experience of care

Domain 5 – Treating and caring for people in safe environment and protecting them from avoidable Harm

It will also support the Adult Social Care Outcomes Framework (ASCOF) which measures how well care and support services achieve the outcomes that matter most to people.
This plan will support local health and care systems when considering their transformation footprint for the Sustainability & Transformation Plans, required to deliver the NHS Five Year Forward View.

Local Measures;

Co-production will be measured using the two self-assessment tools as described in 1.7 of this plan to measure the involvement of people with a learning disability and/or autism in the development of the plan, work streams identified and evaluation process of the TCP Plan.

The TCP Plan will be evaluated utilising the Health Equality Framework (HEF), outcomes tool based on the determinants of health inequalities designed to help commissioners, providers, people with learning disabilities and their families understand the impact and effectiveness of services.

To demonstrate the effectiveness of change compared to how services are currently delivered, it is anticipated the Patient Outcomes Evaluation Tool (POET) will be used to evaluate the provision of Personal Budgets.

Measures will be developed with leads from local Better Care Fund and Vanguard sites across the SHIP region to improve the health of Children, Young People and Adults with a learning disability and/or autism to identify the wider determinants of poor health outcomes, improve the provision of early intervention and prevention and increasing the workforce capacity to deliver more robust care and support for people who wish to manage a Personal Budget.

The Plan will support local Health and Wellbeing Strategies as outlined below;

Southampton	Hampshire	Isle of Wight	Portsmouth
H&WB Strategy (2013-16) are grouped into three themes which are; **Building resilience and preventative measures to achieve better health and wellbeing:** Developing a focus on health improvement priorities to help people improve their lifestyles and to reduce suffering from many long-term conditions **Best start in life :** Good outcomes in the early years, childhood and adolescence are a strong predictor of the health and wellbeing experiences of individuals throughout their life **Living and Ageing Well:** Life expectancy continues to increase and more people are living longer with long-term conditions. It is important that people not only live longer but retain their health and independence for as long as possible. The evidence is that people who retain more control over their lives and remain as independent as they can be to stay healthier for longer.	H&WB Strategy 2013-18 This sets out four areas of work which are; **Starting well:** so every child can thrive **Living well:** empowering people to live healthier lives **Ageing well:** supporting people to remain independent have choice, control and timely access to high quality services **Healthier communities:** helping communities to be strong and support those who may need extra help	H&WB Strategy 2013-16. Our priorities and plans are; **Children and young people have the best possible start in life** **People are helped and supported to prepare for old age and to manage long-term physical and mental health conditions and disabilities.** **People make healthy choices for healthy lifestyles** **Sustainable economic growth for the Island supports improved employment opportunities** **The Isle of Wight is a better place to live and visit**	H&WB Strategy 2014-17 main vision is Improving and protecting the health and wellbeing of Portsmouth people. There are 5 work stream priorities which are: **Best start** - Improve outcomes for pre-birth to 5 age group, support effective learning; better understand emotional wellbeing. **Promoting prevention** - **Create sustainable healthy environments**; improve mental health & wellbeing; tackle smoking, alcohol and substance misuse. **Supporting independence** - developing lifestyle hubs; implementing high impact volunteering and Better Care Fund initiations for intervention and prevention. **Intervening earlier** - Safeguarding; delivering CCG priorities; improving dementia services. **Reducing inequality** - Tackling poverty; tackling health related barriers and sustaining employment; addressing issues in the Public Health Annual report.

3.3 Supporting people who display behaviour that challenges

"Behaviour can be described as challenging when it is of such an intensity, frequency, or duration as to threaten the quality of life and/or the physical safety of the individual or others and it is likely to lead to responses that are restrictive, aversive or result in exclusion".

(Challenging behaviour – a unified approach; RCPsych, BPS, RCSLT, 2007)

According to the Challenging Behaviour Foundation, "Challenging behaviour is often perceived as a 'problem' or 'illness' to be 'treated', 'cured' or 'stopped'. The problem is seen as being part of the person rather than focussing on what needs to change around the person, such as their environment or how people support them."

The SHIP TCP Plan aims to support people through the use of thorough person centred planning, involving their families/circle of support to fully understand them, how they communicate and how they can be supported using Positive Behaviour Support (PBS). People will also be offered Personal Budgets to enable greater flexibility in how they are supported, where and by whom. This plan supports 'The Challenging Behaviour Charter - Rights for All' which ensures people with behaviour that challenges have access to the same rights, opportunities and support as everyone else. including;

1) People will be supported to exercise their human rights (which are the same as everyone else's) to be healthy, full and valued members of their community with respect for their culture, ethnic origin, religion, age, gender, sexuality and disability.
2) All children who are at risk of presenting behavioural challenges have the right to have their needs identified at an early stage, leading to co-ordinated early intervention and support.
3) All families have the right to be supported to maintain the physical and emotional wellbeing of the family unit.
4) All individuals have the right to receive person centred support and services that are developed on the basis of a detailed understanding of their support needs including their communication needs. This will be individually-tailored, flexible, and responsive to changes in individual circumstances and delivered in the most appropriate local situation.
5) People have the right to a healthy life, and be given the appropriate support to achieve this.
6) People have the same rights as everyone else to a family and social life, relationships, housing, education, employment and leisure.
7) People have the right to supports and services that create capable environments. These should be developed on the principles of positive behavioural support and other evidence based approaches. They should also draw from additional specialist input as needed and respond to all the needs of the individual.
8) People have the right not to be hurt or damaged or humiliated in any way by interventions. Support and services must strive to achieve this.
9) People have the right to receive support and care based on good and up to date evidence.

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

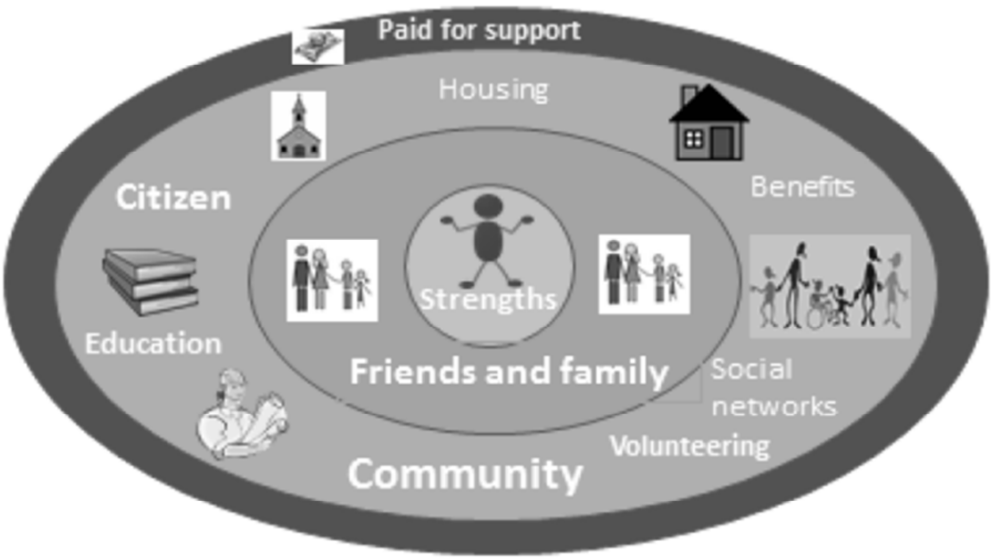
3.4 Any additional information

The plan describes the current finance/activity and how CCG funding invested in community services will support people; however there is no information available to identify the alignment of NHSE budgets with the SHIP TCP plan. This has been highlighted under 'Risks'.

4.1 Overview of the New SHIP TCP Model of Care

In Hampshire there is a cross agency initiative 'Think Differently' which is already changing the culture and barriers fostering collaborative working across statutory and voluntary sector partners. This initiative is a workforce development programme across the whole of the County across all care groups, changing culture and challenging mind sets, focusing on the citizenship model and recognising people as assets, strengthening the values and principles of person centred planning and personalisation. This initiative sees the shift in focus from what a person cannot do to what can a person do for themselves and their circle of support do thus promoting greater independence and control for the individual rather than the traditional model of 'over supporting' people. The illustration below illustrates how this will look for people, whereby support is developed from the person's strengths, their circle of support, the community as a resource base and then what support needs to be commissioned or paid for from a Personal Budget. This model is supported by the five key shifts that define Integrated Personal Commissioning;

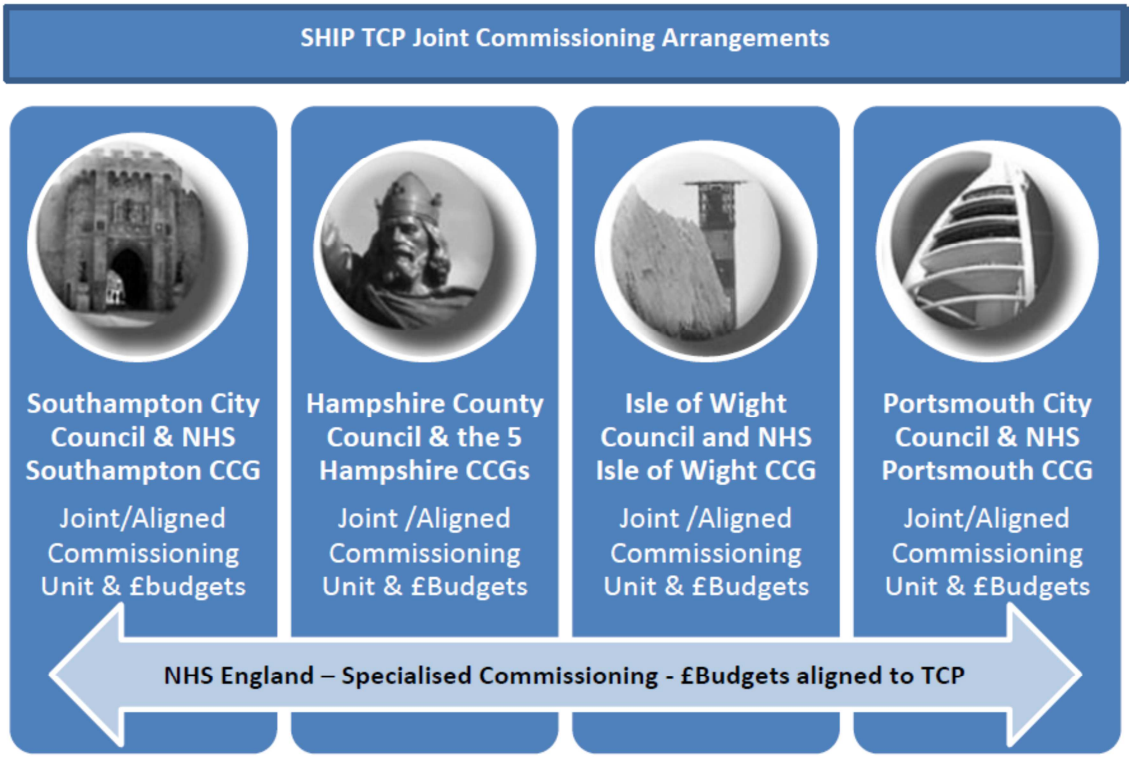
- A proactive approach to improving your experience of care and preventing crisis
- A different conversation with the people involved in your care focussed on what's important to you
- A shift in control over the resources available to you, your carers and family
- A community and peer focus to build your knowledge, confidence, and connections
- A wider range of care and support options tailored to your needs and preferences



To support people as described above, five key areas have been identified for development to enable people to be supported in their communities and to avoid inappropriate hospital admissions as described in 2.5 of this plan;

- Early Intervention and Prevention
- Developing Community Services
- Developing the Workforce
- Increasing the offer and uptake of Personal Budgets
- Housing

The SHIP TCP 'Integration' Project objectives aim to align pooled budgets under either formal Section 75 agreements or Lead Commissioning agreements.



4.2 What new services will be commissioned?

Community Services;

- Extending the scope of existing the Intensive Support Service from Adults only to all ages
- SHIP wide Community Forensic Rehabilitation Service; working with local NHS Foundation Trusts and people who are / have been inpatients to develop the service whereby people receive care and treatment either in their own homes or in short term accommodation instead of having to go to hospital for adapted behaviour treatment programmes. Pooled/aligned budget across partners for the service.
- LD Acute Hospital Liaison function; ensuring this is provided in each acute trust in the TCP region

- Developing the pathway for those aged 65+ with a learning disability
- Investment into local health and social care community teams for support planning, reviews for people in receipt of commissioned support or Personal Budgets
- Changing operating times of local community teams
- Reconfiguration of existing Epilepsy community nursing and/or investment for this function within CLDTs

Training & Development;

- For staff / personal assistants to build more robust support for people with complex needs and whose behaviour is challenging and for families/carers
- Extending the FACES (Friendship, Assertiveness, Choice, Empowerment and Social Skills) programme across the SHIP TCP
- Positive Behaviour Support Training for Providers, Personal Assistants and people with a Personal Budget
- Training and resources (stickers etc.) for 'Learning Disability Friendly' GP Practices
- Training for support planning co-ordinators / trusted assessors

In order to have real partnership working in local areas it will be necessary for local health and social care organisations to align/pool budgets and where appropriate to enter into Section 75 agreements.

4.3 What services will the TCP stop commissioning, or commission less of?

Through developing local community services, this will enable a reduction in the number of CCG and NHSE commissioned beds and a reduced length of stay for those individuals who require an in-patient admission.
There will also be a reduction in the number of residential care commissioned placements as services are de-registered to supported living models of support or where people are enabled to move to their own home with their own tenancy or have shared ownership.

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

Early Intervention and Prevention

At the heart of this plan is the early intervention and prevention work stream. The Transforming Care Programme, require CCGs working with local authorities and Mental Health Trusts to manage 'At Risk' Registers. This will include identifying those factors which could indicate a placement breakdown was more likely. Research such as "Predicting Placement Breakdown: Individual and environmental factors associated with the success or failure of community residential placements for adults with intellectual disabilities (Phillips and Rose 2010) suggest these predictors include;

- Previous admission to psychiatric inpatient services or assessment and treatment services
- Anti-social behaviour such as 'tantrums' and verbal aggression
- Sexual delinquency
- Psychiatric diagnosis

- Mild LD and outward directed behaviour
- Senior staff attributing control to the service user
- Staff support levels being lower and culture in terms of supervision, training, leadership etc.

The SHIP TCP recognise that it is important to recognise the purpose of the 'At Risk Register' and what this means for individuals in terms of outcomes, this will include;

- Early Intervention and prevention – knowing individuals and ensuring that a crisis plan is in place, that people are aware of this and ensuring planning of clinical work to support the person (this may include clinical work or issues such as accommodation/environmental factors, provider support etc.)
- Reviewing/monitoring of support packages and the use of suitable standards to achieve this e.g. Periodic Service Reviews, framework contracts etc.
- Analysis – identifying service gaps
- Planning and developing resources e.g. training for support staff

To develop the 'At Risk' template three key criteria will be included; Systems, Individual and Behaviour ;

<u>Systems</u>

- Family factors e.g. social deprivation, mental health needs of family members, parents having a learning disability, schooling, being placed away from the home environment, being a looked after child, parental stress, parental/family cares age
- National factors and guidance e.g. decrease in use of antipsychotics and how local services are implementing this
- Funding streams regarding an individual e.g. CHC, being funded by external CCG/Local Authority in Hampshire, 117 (this may indicate complexity of need)
- Change of service provider
- Engagement by the service provider or family with statutory services
- Compatibility within current service provision
- Environment – deprivation, inappropriate provision to the identified needs of the individual, specific provider issues (e.g. overarching safeguarding concern)

<u>Individual</u>

- Motivation of individual to engage with health and social care professionals
- Safeguarding relating to the individual
- Diagnosis of individual (e.g. comorbidity, specific syndromes or diagnosis which may increase likelihood of the person presenting with challenging behaviour e.g. Prader Willi), personality disorder, autism)
- Change in physical or mental health within the individual (may include dementia), person lacking in sleep
- Deprivation of Liberty being in place(DOLs) and restrictive practices – use of physical intervention, use of medication and frequent prn, use of seclusion, polypharmacy
- Contact with Criminal Justice System or contact with the police

- Difficulties around communication
- Life limiting condition
- At point of being discharged from services e.g. health input being reduced
- Individual service user journey/pathway
- Complex epilepsy
- Life events and cyclical events (e.g. Christmas, parents aging/death, loss of a social role e.g. job)
- Use of physical intervention

Behaviour

- Increase in behaviour that challenges
- Aggression to others
- Severity of impact of any behaviour to others on to self
- Aggression to property
- Self-neglect
- Non-compliance with medication
- Loss of placement/tenancy, threats of eviction
- Number of placements an individual has experienced
- Contact with police/criminal justice system

To support risk management/contingency planning, there are processes already in place such as Care Programme Approach (CPA),Multi-Agency Public Protection Arrangements (MAPPA), Periodic Service Reviews (PSR) etc. (Please see document below for example of draft Risk Register and protocol).


Draft Risk Register and Protocol.pdf

'I have support workers that do keep me company but keep me lonely'

Feedback to the Hampshire LDPB

Developing Community Services;

- Community Learning Disability Teams providing services outside of normal working hours i.e. until 22:00 in the evenings 7 days a week, developing crisis support
- Intensive Support Services - extending the scope of the Intensive Support Service from Adults only to those aged 14 years and above
- SHIP wide Community Forensic Rehabilitation Service; working with local NHS Foundation Trusts and people who are / have been inpatients to develop the service whereby people receive care and treatment either in their own homes or in short term accommodation instead of having to go to hospital for adapted behaviour treatment programmes. Pooled/aligned budget across partners for the service.
- Adult Services and Community Health Teams will jointly manage the 'At Risk' Register MDT working
- Improved physical health care; Ensure LD Hospital Liaison available across all acute trusts within the SHIP TCP, increase provision and take up LD Annual Health Checks.
- Developing the pathway for those aged 65+ with a learning disability; working with support

providers to identify appropriate models of care, working with CQC and providers regarding registration of services. Work with local housing departments to include this cohort in their local housing plans.

Local TCPs are asked to consider the money they spend as a whole health and social care system on people with a learning disability and/or autism, and to use that total sum of money in a different way to achieve better results. This will require the aligning/pooling of budgets and where appropriate to enter into Section 75 agreements between health and social care commissioners.

The SHIP TCP will work with local children, young people and adults to determine what it is they wish to do during the day (activities). The current local offer will be expanded by working in partnership with local voluntary sector organisations to respond to the individual.

Activates will include:

- Education and training
- Day services
- Work based opportunities
- Volunteering
- Community access e.g. libraries, discovery centres, community cafes, community hubs.

4.5 Increasing the uptake of more personalised support packages

Due to the timescales to submit this plan it has not been possible to undertake a full review of PHBs, Direct Payments or Educational Health Care Plans. An overview of these is provided in the tables below, however it is intended the number of people with a 'Personal Budget' (Health, Social Care or Education Funded or those in receipt of blending funding) will increase from circa 5,135 individuals to 6,635 by end March 2019.

Personal Health Budgets	**Southampton**	**Hampshire**	**Isle of Wight**	**Portsmouth**
No of PWLD Offered a PHB	-	-	14	-
No of PWLD who have a PHB	6	17	13	25
Total No of PHBs		101		75
Type of Budget;				
Direct Payment	4 = part PHBs 2 = Full PHBs	101 PHBs; 81% direct payment 10% Notional & Direct 9% Notional 0% Third Party	4	9
3rd Party Budget			9	3

No of people in receipt of Direct Payments from the Local Authority	Southampton	Hampshire	Isle of Wight*	Portsmouth
Direct Payment Only	39		297	49
Part Direct Payment	41		17	34
Managed Personal Budget			22	0
No of people in receipt of a personal budget who have a personal assistant	-		121	11*
Notes			*figures from IOW SALT return 31.03.15 (relates to accommodation and employment status of LD clients)	*Those on prepaid card only

No of People in receipt of Education, Health & Care Plans (EHCPs)	Southampton	Hampshire	Isle of Wight	Portsmouth
No of EHCPs	790	Circa 3,500	95	190
No of pupils with statement of special education needs		30,000*	442	859
% of SEN Population	2.5%	-	0.6% of Total Education Numbers	3.1%
Notes	Southampton figures are from the January 2015 school census	*includes those with a statement/LDA and EHCP		

To support the offer and uptake of Personal Budgets the following actions will be taken within the local areas;

- Offer PHBs to more PWLD and to extend the offer to people who are not CHC eligible
- Decommissioning some elements of block contracts e.g. therapies, SALT etc.
- To bring the Personal Health Budget projects and IPC demonstrator site projects together and offer people the integrated personal commissioning approach e.g. 'blended budgets'
- To establish joint commissioning arrangements e.g. section 75 agreements and aligned/pooled budgets
- Joint commissioning approach for providers

The Personal Budget offer across the SHIP TCP will offer;

- A single joint assessment of need (whether Health , Social care , Education)
- Person centred life and support planning undertaken by the voluntary sector
- The personal budget being managed via:
  - A direct payment to the person or Responsible Person
  - A third party organisation
  - A statutory agency managing this budget on their behalf
  - An Individual Service fund
  - The local authority to purchase commissioned services

Provisional plans to increase Personal Health Budgets are indicated in the following table:

Plans for increase in PHB's	**Southampton**	**Hampshire**	**Isle of Wight**	**Portsmouth**
15/16	**6**	**17**	**13**	**25**
16/17	**20**	**100**	**20**	**75**
17/18	**25**	**200**	**10**	**75**
18/19	**20**	**200**	**10**	**50**
Totals	**71**	**517**	**53**	**225**

Implementation Planning : Transforming Local Work into Action;

Independent Lives has a 3 year contract with **Hampshire** County Council for Personal Planning and Direct Payments for Adults and Children & families with disabilities, they are using their expertise and experience to work with Hampshire Advocacy Regional Group, service users and carers and other stakeholders to co-produce a single personal centred life and support model centred life planning for people with complex needs and limited communication HARG.

Isle of Wight - PHB referrals are only currently considered for people who are already eligible for Continuing Healthcare Funding and are living at home with a care package.

J is 17 years old and currently lives at home with his mother and younger brother. He has a diagnosis of Athetoid Cerebral Palsy, is doubly incontinent, has asthma, is non-weight bearing, has a learning disability and displays autistic traits in nearly all aspects of daily living. He requires full 24 hr support at all times as he is at high risk of choking and requires very careful positioning and moving.

J leaves school next year and so a care plan was agreed under a personal health budget to enable him to remain at home with his family, access person centred day time activities and ensure regular respite breaks for his mother, who is his main carer. J requires the support of two for all personal care tasks and so the recruitment of a team of skilled carers who know him well and understand his needs was essential.

Time has been spent at this transition stage getting to know and understand J. Links were then made with Blue Sky Arts and a specialist local farm to devise a bespoke care package for him. His mother and school have been very involved in this and his mother now has the confidence in the carers employed and the outcomes from the activities he will be undertaking.

Isle of Wight CCG – PHB Team

T is 18 and has a diagnosis of Epilepsy, Autism, Learning Disability, Colitis and Hyperactive. There is an inter-relationship between his epilepsy and behaviours which is extremely complex and requires significant levels of support on a daily basis. He receives care for 20 hours per week from 2 carers, but his parents provide the bulk of his care. He receives animal therapy, and swimming sessions but the pool needs to be booked for him alone given his behaviours.

The PHB has enabled the provision of sensory cabin in his garden so that he will be able to have access at all times of the day and night, to help manage his unpredictable behaviours linked to his autism and seizure activity. Total cost was £30k, with part funding (£10K) from the LA Housing Department, offering a designed space that will give him the quiet and visual calm required, with him having more control over his environment as the home environment is unpredictable as others have to live there also.

The cabin will enable T to minimise his sensory overload - this will support his future development assisting him to be more socially interactive and communicate his needs/feelings or emotions more.

Isle of Wight CCG

4.6 Future SHIP TCP Care Pathways

The vision of the SHIP TCP Plan is to have equity of service provision across the area focusing on;

- Early Intervention and Prevention
- Achieving better health outcomes
- Local service planning
- Improved physical health
- Inclusion in service monitoring & evaluation
- Access to appropriate opportunities for life-long learning
- A more inclusive society with 'learning disability friendly' places e.g. GP practices
- Robust Community Services for both commissioned health and social care support and services available to people who have a Personal Budget
- A skilled local workforce whereby Positive Behavioural Support is enabled as a way of life for individuals and not as a means of managing behaviour that challenges
- People no longer being managed inappropriately in the criminal justice system
- A joint Regional approach to Housing Development that offers people a portfolio of housing options that meets individual needs

Further information is provided in section 2.5 of this plan 'Case of Change' and in section 4.4 which describes how current commissioning arrangements will change.

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

The SHIP TCP Plan aims to support Children and Young people through the use of thorough person centred planning, involving their families/circle of support to fully understand them, how they communicate and how they can be supported using Positive Behaviour Support (PBS). This plan aims to remove the 'cliff-edge' for Young People as they move through Transition to Adults. C&YP will be at the heart of service planning and design.
Existing services such as Intensive Support will be extended to those aged 14 and above and will require CAMHS and local Mental Health Trusts to work together to deliver seamless mental health services to Young People.

This plan will ensure C&YP are included in developing;

- Early Intervention and Prevention Plans
- Improved physical health
- Robust Community Services for both commissioned health and social care support and services available to people who have a Personal Budget
- A skilled local workforce
- A Housing Strategy that offers people a portfolio of housing options and that enables young people to access housing below the age of 18.

C&YP will be offered Personal Budgets to enable greater flexibility in how they are supported, where and by whom and will enable Young people to retain services and support staff as they transition to

adulthood. As described in section 1.3 (page 28).

4.8 How will you commission services differently?

This is described in Sections 4.1, 4.2 and 4.2 of this plan.

4.9 How will the SHIP TCP local estate/housing base need to change?

The SHIP TCP recognises the lack of housing options for people, currently there is a greater provision of residential care opposed to single person services, extra care models or supported living accommodation. Local commissioners are trying to change the local provider marker by working with residential care homes to de-register and provide supported living accommodation thus providing assurance of tenure to individuals rather than being at risk of a provider giving very short notice e.g. 7 days to leave a property. This results in temporary moves to alternative accommodation which is unsettling to a person which has resulted in a deterioration in mental health and being sectioned under the Mental Health Act requiring a hospital admission.

An key outcome for this plan is to develop a portfolio of housing options for individuals the SHIP TCP working with local housing departments, will develop a joint Regional approach to Housing Development. This will include working with the Housing and Support Alliance http://www.housingandsupport.org.uk/home who have launched a programme of support for commissioners and providers which helps people to move from specialist learning disability hospital units and how people can be supported to remain in their communities with the housing and support that works for them. This work will support Principle 5 of 'Building the Right Support'.

Locally Hampshire is working with NHS Property Services to seek authorisation to dissolve existing legal charges on properties and to recycle the capital monies back to the local area for the learning disability population.

To deliver the Community Forensic Rehabilitation service it has been identified that accommodation will be required in order to support people. This bid includes capital funding required within the finance and activity schedule as well as capital required for more supported living models of accommodation.

The following objectives have been identified to develop the housing provision:

- To identify current housing options and through co-production collate information and map what type and where people want accommodation in the SHIP region.
- Hold a Housing Workshop within the first year to understand the current situation and the need. This will involve service users.
- Develop a portfolio of sufficiently high quality housing options for individuals, working with local housing departments.
- Establish a programme of de-registration of residential care settings to supported living

models of care and support.

- Provide clear easy read guidance for individuals and their families/carers that outlines the local options available, how to access this accommodation and what ongoing support will be provided e.g. tenancy advice etc.
- Develop a common application/bidding process for local authority housing with reasonable adjustments i.e. type of photo id required and proof of residency that breaks down barriers and delays to accessing accommodation.
- Work with the Housing and Support Alliance http://www.housingandsupport.org.uk/home who have launched a programme of support for commissioners and providers which helps people to move from specialist learning disability hospital units and how people can be supported to remain in their communities with the housing and support that works for them.
- Work with NHS Property Services to seek authorisation to dissolve existing legal charges on properties and to recycle the capital monies back to the local area for the learning disability population.

4.10 Repatriation/Re-settling of People

Commissioners have been actively facilitating discharges for people with a learning disability to local based services. This has seen the repatriation of people back to the local area either to bespoke support services or a hospital transfer to a local based hospital. Care and Treatment Reviews have been valuable in determining the purpose of why someone is in hospital, what treatment they are receiving, discharge plans and most importantly how they have been involved in their own care planning as well as their Families/Carers and where appropriate friends.

Putting people and their families/carers at the heart of care and support planning enables the right housing options to be identified to support discharge and ensuring the level of support will enable an individual to keep well and prevent a re-admission to hospital.
In future people who are in hospital will be offered Personal Budgets for their Sec.117 aftercare support needs given them the same flexibility and choice as people who have not been detained under the Mental Health Act.
The Early Intervention and Prevention work stream will ensure care planning includes any relapse prevention plans and direct access to services when they are needed without having to be referred to services.

Table: Number of people with a Learning Disability who have been in hospital for more than three years

Fareham & Gosport CCG	North East Hampshire & Farnham CCG	North Hampshire CCG	South East Hampshire CCG	West Hampshire CCG	Portsmouth CCG	Southampton CCG	Isle of Wight CCG
0	0	3	0	2	1	1	0

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

The SHIP TCP Plan for people with a learning disability and/or autism will support both national and local plans including but not limited to;

National;

- Transforming Care Programme (formerly Winterbourne View Joint Improvement Programme)
- Autism Strategy - Fulfilling and Rewarding Lives' and subsequent update 'Think Autism' (2014)
- Delivery against 4 of the NHS Outcomes Framework Domains and indicators
- Adult Social Care Outcomes Framework (ASCOF)
- NHS Five Year Forward View – Sustainability and Transformation Plans
- Increasing the offer and uptake of Personal Budgets
- Building the Right Support and the new model of care
- SEN Reforms (EHCPs)
- Mental Health Crisis Concordat - Parity of Esteem & No Health without Mental Health

Local Plans;

- Learning Disability Plans
- Autism Strategies
- Joint Health and Wellbeing Board strategies
- IPC Demonstrator site work
- Developing the 'local offer' for Children, Young People and Adults
- Better Care Fund & Vanguard Site Plans
- HIOW Devolution for the People of Hampshire & The Isle of Wight: A Prospectus for discussion with Government

5.Delivery

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

The aim of the SHIP TCP Plan is to have equity of service provision across the area focusing on;

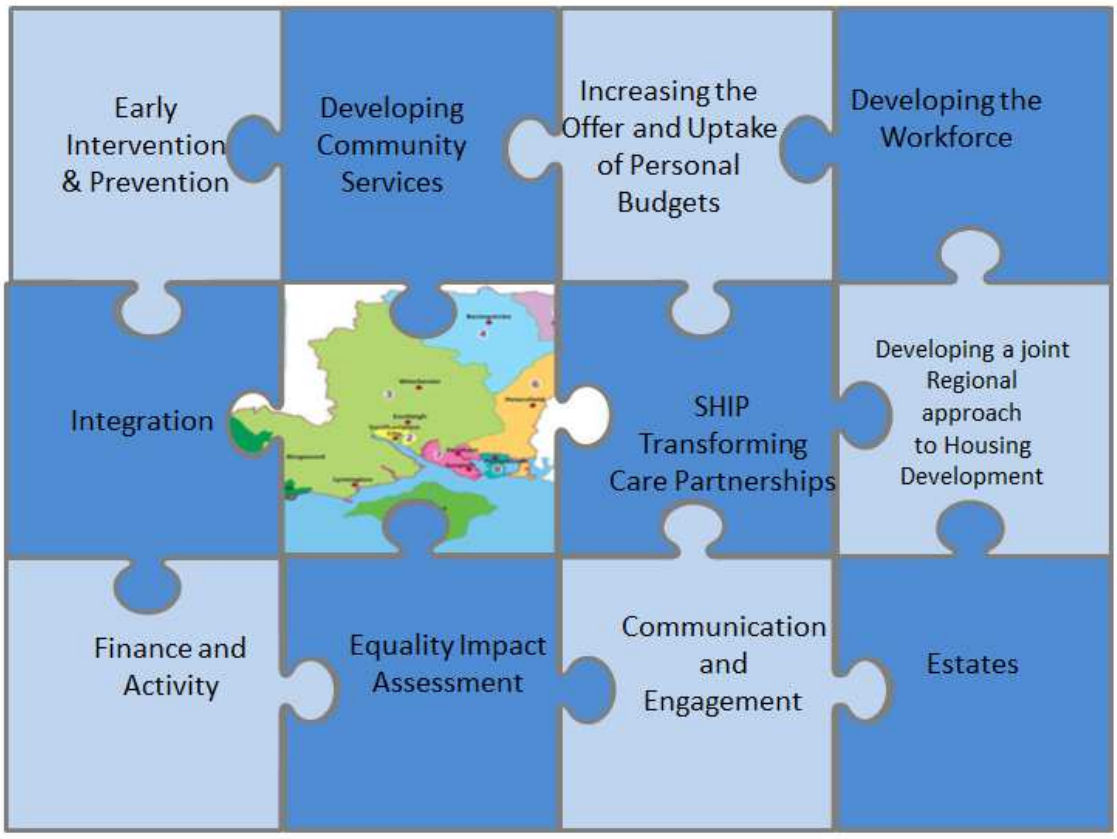
- Early Intervention and Prevention
- Improved physical health
- A more inclusive society with 'learning disability friendly' places e.g. GP practices
- Robust Community Services for both commissioned health and social care support and services available to people who have a Personal Budget
- A skilled local workforce whereby Positive Behavioural Support is enabled as a way of life for individuals and not as a means of managing behaviour that challenges
- A Housing Strategy that offers people a portfolio of housing options

Draft Project Briefs / Initiation Documents have been drafted which outline the Scope, Objectives, Method of Delivery, Assumptions, Interfaces etc. Due to the timescales for the submission of this revised draft plan, some further plans need to be developed;

Work Programmes & Plans	
Early Intervention & Prevention	SHIP TCP - Early Intervention & Prevei
Developing Community Services	SHIP TCP Plan - Developing Communit
Increasing the Offer and Uptake of Personal Budgets	SHIP TCP Plan - Personal Budgets PID
Workforce Development	v2 SHIP TCP Plan - Developing the Workf
Developing a joint Regional approach to Housing Development	(V2) SHIP TCP Plan - Developing a Joint Hc

Communication and Engagement	SHIP TCP Plan - Communications and I
Estates Plan	SHIP TCP Plan - Estates PÍD.doc
Equality Impact Assessment	SHIP TCP Plan - Equality impact asses
Finance and Activity	SHIP TCP Plan - Finance and Activity I
Integration	SHIP TCP Plan - Integration PÍD.doc

SHIP Transforming Care Partnerships Workstreams



Workforce development - In order to ensure this meets the needs of the local population this needs to be co-produced with people who have lived experience. The local plan will include;

- Training and development; for staff / personal assistants to build more robust support for people who are complex and whose behaviour is challenging and for families/carers
- Working with local agencies to promote caring/personal assistants as a career with continuous personal/professional development pathways.
- Extending the FACES (Friendship, Assertiveness, Choice, Empowerment and Social Skills) programme across the SHIP TCP
- Working with providers in the use of positive behaviour support rather than physical interventions
- Developing a career pathway for the Personal Assistant workforce
- Having 'Learning Disability Friendly' GP Practices
- Developing an accredited training module for health and social care commissioners with Health Education Wessex

Estate Plans – The SHIP TCP will need to engage with current NHS Mental Health Providers and Independent Hospitals to develop these plans and will be required to work with NHS Property Services in relation to those properties which the NHS hold a legal charge to enable capital receipts to be re-invested back to the local area.
This plan will also link to the 'Devolution for the People of Hampshire & Isle of Wight Prospectus' in the development of a rationalisation programme for NHS sites and assets to bring services closer to communities, exploring how to further develop single, locality based 'public service' hubs and 'pump priming' service reconfiguration through estates development funds.

Communications & Engagement – This will be developed via the SHIP TCP Board and will include people with lived experience and local advocacy organisations to ensure people with a learning disability and/or autism are really involved in the TCP Plan.

Equality Impact Assessment – This will be undertaken with the support of Nick Birtley, Inclusion and Equality Lead for West Hampshire CCG and in partnership with Children, Young People and Adults with a learning disability and/or autism and their families/carers. This will ensure people with a learning disability are not disadvantaged through new commissioning approaches.

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

The SHIP TCP Board is described in Section 1.5 of this plan.
The individual workstreams and leads for these programmes of work were agreed at the inaugural Transforming Care Partnership Board on 15th February 2016;

Early Intervention & Prevention	Jess Hutchinson & Alison Froude (HCC)
Developing Community Services	Michelle Stickland (WHCCG)
Increasing the Offer and Uptake of Personal Budgets	Paul Turner (WHCCG)
Workforce Development	Sue Lightfoot (IOWCCG) and Dr Jennifer Dolman (Health Education Wessex)
Developing a joint Regional approach to Housing Development	Kate Dench (SCC & SCCG)
Communication and Engagement	Beverley Meeson (WHCCG)
Estates Plan	Nicky MacDonald (SHFT)
Equality Impact Assessment	Nick Birtley (WHCCG)
Finance & Activity	Brain Maxton (WHCCG)
Integration	Jess Hutchinson (HCC)

The resulting project plans/business cases will identify the key enablers to success and resources required.

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

The key areas for development will be agreed at the SHIP TCP Board, finance and activity is provided in the template provided showing a reduction in the use of in-patient beds by CCGs and NHSE over a 3 year period. The work stream plans will identify key milestones to indicate when services will open/close and will include;

- agreeing the milestones for re-configuration of existing services
- commissioning new services
- dis-investment from existing 'block contracts'
- agreeing de-registration of residential providers to supported living schemes
- accelerating discharge plans where appropriate for people who are currently in hospital

5.4 What are the risks, assumptions, issues and dependencies?

Each of the key work programme plans will identify risks, assumptions, issues and dependencies specifically in relation to;

- Early Intervention and Prevention
- Developing Community Services
- Developing the Workforce
- Increasing the offer and update of Personal Budgets
- Housing

Risks as described in the attached risk register.

SHIP TCP Risk Register.xls

5.5 What risk mitigations do you have in place?

As described above in Section 5.4 the key work programme plans will identify risks, issues and mitigation required to manage risk. These will be developed over the next few weeks following the SHIP TCP Board when the key work programmes are agreed. These will include;

- Reputational
- Legal
- Safety
- Financial & Delivery
- Contingency

6.Finances

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

TCP Activity and finance annexes upda

Appendix 1

Joint Health & Social Care Assessment Framework – Local Area Data				
Population Data	**SHIP Area**			
	Southampton[1]	**Hampshire[2]**	**Isle of Wight**	**Portsmouth[3]**
How many people have a learning disability?				
Aged 0-13	184	195	41	37
Aged 14-17	134	189	45	25
Aged 18-34	792	1,664	313	139
Aged 35-64	1046	2,238	430	302
Aged 65 & Over	170	371	77	61
Total	**2,326**	**4,657**	**906**	**564**
How many people have LD with complex or profound disability?				
Aged 0-13	22	5	5	-
Aged 14-17	26	5	5	-
Aged 18-34	56	8	42	7
Aged 35-64	54	38	76	18
Aged 65 & Over	8	11	15	-
Total	**166**	**67**	**143**	**25**
How many people with LD with Autistic Spectrum Disorder?				
Aged 0-13	40	36	13	6
Aged 14-17	30	75	15	8
Aged 18-34	94	424	82	22
Aged 35-64	22	145	45	11
Aged 65 & Over	-	5	-	9
Total	**186**	**685**	**155**	**56**

1 Data extracted from GP clinical systems using the Read codes as stated in the technical guidance for the LD enhance service scheme
2 Taken from GP QOF registers via Hampshire Health Record
3 Data provided by 15 out of 24 practices in Portsmouth

Appendix II

My Life My Way Co Production Agreement

My Life My Way is the Hampshire Integrated Personal Commissioning programme. This is partners working together in Hampshire to help children, young people and adults who have a disability and their families live the lives they want. Everyone involved has signed up to working together to make this happen.

Co- production is;
Co-production is about people who use services, carers and professionals working together as equals. Being equal means nobody is more important than anyone else.

SCIE Co-production in social care

A way of working, whereby everyone works together on an equal basis to create a service or come to a decision which works for them all.

National Co-production Advisory Group and Think Local Act Personal

How we will work

- Everyone involved is committed to co-production and will work to make it happen.
- Everyone involved has an equal right to have a say and be listened to.
- We will make sure we have different ways for people to be involved that work for them.
- When there are decisions to be made everyone can say what they can agree to and what they can't.
- Sometimes we may not all agree on a decision, we will record when this happens.
- We will follow the Memorandum of Agreement that Hampshire County Council and Parent Carer Network have in place and the 5 Steps to Co-production 2010/2012.
- We will follow the Top Ten tips from the National Co-production Advisory Group (NCAG) and Think Local Act Personal (TLAP)
- New partners will be asked to sign up to our co production agreement.
- The Co-Production group will check that we are all working together to make My Life My Way happen.

January 2016

Appendix III

Joint Health & Social care Assessment Framework- Local Area Data

	SHIP Area			
	Southampton	**Hampshire**	**Isle of Wight**	**Portsmouth**
Staying Healthy – GP registers (Q1): The Learning Disabilities Quality and Outcomes Framework register in Primary Care.				
Staying Healthy – Long Term Health Conditions (Q2): Finding and Managing Long Term Health Conditions: obesity, diabetes, cardiovascular disease, epilepsy.				
Staying Healthy – Annual Health Checks (Q3)	**188**	**1467**	**353**	**200**
Staying Healthy – Health Action Plans (Q4): Health Action Plans are generated at the time of Annual Health Checks (AHC) in primary care.				
Staying Healthy - Cancer Screening (Q5)	**352**	**687**	**107**	**84**
Staying Healthy – Primary / Secondary Care Communication (Q6): Primary care communication if LD status to other healthcare providers.				
Staying Healthy – Acute LD Liaison Function (Q7): Learning disability liaison function or equivalent process in acute settings.				
Staying Healthy – Reasonable Adjustments in primary care (Q8): Considering NHS commissioned primary care services- dentistry, optometry, community pharmacy and podiatry.				
Staying Healthy – Offender Health and the Criminal Justice System (Q9)				
Keeping Safe – Individual health and social care package reviews (Q1): Commissioners know that all funded individual health and social care packages for people with learning disability, across all life states, are reviewed regularly.				
Keeping Safe – Learning disability services contract compliance (Q2): Contract compliance assurance for services primarily commissioned for people with a learning disability and their family carers.				
Keeping Safe – Monitor Assurances (Q3): Assurances given regularly in Monitor Assessment Framework for Foundation Trusts.				
Keeping Safe – Adult Safeguarding (Q4): Assurance of safeguarding for people with a learning disability.				
Keeping Safe – Involvement of Self-Advocates and Carers in training and recruitment (Q5)				

Appendix III

Joint Health & Social care Assessment Framework- Local Area Data

	SHIP Area			
	Southampton	**Hampshire**	**Isle of Wight**	**Portsmouth**
Keeping Safe – Compassion, dignity and respect (Q6): This item us answered by family, carers and self-advocates. Family carers and people with a learning disability agree that providers treat people with compassion, dignity and respect.				
Keeping Safe – Commissioning Strategy Impact Assessments (Q7): Commissioning strategies for support, care and housing are the subject of Impact Assessments and are clear about how they will address the needs and support requirements of people with learning disabilities.				
Keeping Safe – Complaints lead to changes (Q8): Commissioners can demonstrate that all providers change practice as a result of feedback from complaints, whistleblowing experience.				
Keeping Safe – Mental Capacity Act and Deprivation of Liberty Safeguards (Q9): Appropriate use of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).				
Living Well – Effective joint working (Q1): Effective joint working across health and social care.				
Living Well – Local amenities and transport (Q2)				
Living Well – Arts and Culture (Q3)				
Living Well – Sport and leisure (Q4)				
Living Well – Employment (Q5): Supporting people with learning disability into and in employment				
Living Well – Transition to Adulthood (Q6): Preparing for Adulthood in Education, Health and Social Care				
Living Well – Involvement in service planning and decision making (Q7): People with learning disabilities and family carers are involved in service planning and decision making.				
Living Well – Carer satisfaction rating (Q8)				

Appendix III

Joint Health & Social Care Assessment Framework – Local Area Data

Screening Data	SHIP Area			
	Southampton[4]	Hampshire[5]	Isle of Wight	Portsmouth[6]
Cancer Screening: Cervical cancer screening in each case enter the number of women are there in the age range 25 to 64 inclusive who have not had a hysterectomy				
Eligible women aged 25-64 – all whether or not they have a learning disability	132,570	266,122	32,609	34,561
Eligible women aged 25-64 – all whether or not they have a learning disability who have had a cervical screening test within the prescribed period	82,786	180,012	22,500	22,437
Eligible women with a learning disability aged 25-64	624	1,090	211	144
Eligible women with learning disability aged 25-64 who have had a cervical screening test within the prescribed period	204	314	59	42
Cancer Screening: Breast Cancer Screening				
How many women are there in the age range 50-69 inclusive (includes women with and without learning disability)	44,764	183,817	21,193	14,160
How many eligible women are there in the age range 50-69 inclusive (includes women with and without learning disability) who have been screened in past three years?	23,162	94,888	12,500	8,920
How many women are there in the age range 50-69 inclusive with learning disability?	284	515	84	65
How many eligible women are there in the age range 50-69 inclusive with learning disability who have been screened in past three years?	112	204	33	32
Cancer Screening: Bowel Cancer Screening				
How many people are there in the age range 60-69 inclusive (includes people with and without learning disability); Eligible people 60-69	43,982	166,380	21,440	12,479
How many people are there in the age range 60-69 inclusive (includes people with and without learning disability) Eligible people aged 60-69 and screened in the past two years?	15,354	76,656	9,414	4,795
How many people are there in the age range 60-69 inclusive with learning disability?	234	412	75	71
How many people are there in the age range 60-69 inclusive with learning disabilities and screened in the past two years?	36	169	15	10

4 Data extracted from GP clinical systems using the Read codes appropriate to screening
5 Taken from GP QOF Registers via Hampshire Health Record
6 Data provided by 15 practices out of 24 in Portsmouth

Appendix III

Joint & Social Care Assessment Framework - Local Area Data

Secondary Care Data	SHIP Area			
	Southampton[7]	Hampshire[8]	Isle of Wight	Portsmouth[9]
General Hospital Services				
Inpatient Secondary Care How many HOSPITAL PROVIDER SPELLS of inpatient Secondary Care were received under any consultant speciality EXCEPT the psychiatric specialities (Speciality Codes 700-715) between 1st April 2013 and 31st March 2014? Persons with LD	196	317	80	176
Inpatient Secondary Care How many HOSPITAL PROVIDER SPELLS of inpatient Secondary Care were received under any consultant speciality EXCEPT the psychiatric specialities (Speciality codes 700-715) between 1st April 2013 and 31st March 2014? All persons	36,834	323,229	24,598	46,329
Outpatient attendances How many secondary care Outpatient ATTENDANCES were received by people under any consultant speciality EXCEPT the psychiatric specialities (Speciality codes 700-715) between 1st April 2013 and 31st March 2014? Persons with LD	377	997	643	0
Outpatient attendances How many Secondary care Outpatient ATTENDANCES were received by people under any consultant speciality EXCEPT the psychiatric specialities (Speciality Codes 700-715) between 1st April 2013 and 31st March 2014? All persons	72,878	2,021,558	13,882	149,162
A&E Attendances How many ATTENDANCES at Accident & Emergency between 1st April 2013 and 31st March 2014? Persons with LD	239	245	329	0
A&E Attendances How many ATTENDANCES at Accident & Emergency between 1st April 2013 and 31st March 2014? All persons	64,539	316,880	40,705	33,639
A&E people with 3 or more attendances How many PEOPLE have attended Accident & Emergency 1st April 2013 to 31st March 2014 more than 3 times? (only required for persons with LD) Persons with LD	59	158	28	0

7 Data Source – Clarity patients web tool

8 Taken from GP QOF Registers via Hampshire Health Record

9 A&E do not have a code for LD – only overall numbers available

Appendix III

Joint & Social Care Assessment Framework- Local Area Data

Wider Health Data	SHIP Area			
	Southampton[10]	Hampshire[11]	Isle of Wight	Portsmouth[12]
General Health and Healthcare				
BMI Recorded On the 31st March 2014 – How many people are there aged 18 and over with learning disabilities who have a record of their body mass index?	1,726	3,107	535	361
BMI 30 and Over On the 31st March 2014 – How many people are there aged 18 and over with learning disabilities who have a body mass index in the obese range (30 or higher)?	166	1,105	209	178
BMI less than 18.5 On the 31st March 2014 – How many people are there aged 18 and over with learning disabilities who have a body mass index in the underweight range (where BMI is less than 18.5)? (Note threshold changed from SAF 2014 to align with national obesity observatory work and international standards)	22	5	27	6
Coronary Heart Disease How many people with learning disabilities aged 18 and over are known to their doctor to have coronary heart disease? As per the QOF Established Cardiovascular Disease Primary Prevention Indicator Set	50	25	8	11
Diabetes On the 31st March 2014 – How many people of any age with learning disabilities are known to their doctor to have diabetes (include both type 1 and type II diabetes)? As per the QOF Established Diabetes Indicator Set	192	254	60	53
Asthma On the 31st March 2014 – How many people of any age with learning disabilities are known to their doctor to have asthma? As per the QOF Established Asthma Indicator	446	235	147	91
Dysphagia On the 31st March 2014 – How many people of any age with learning disabilities are known to their doctor to have dysphagia?	234	116	26	11
Epilepsy On the 31st March 2014 – How many people of any age with learning disabilities are known to their doctor to have epilepsy? As per the QOF Established Epilepsy Indicator Set?	188	416	147	126

10 Data extracted from GP clinical systems using the Read codes appropriate to the LTC. Also using Clarity patients web tool
11 Taken from GP QOF Registers via Hampshire Health Record
12 Data provided by 15 out of 24 practices in Portsmouth

Autism Self-Assessment Framework - Local Area Data

Appendix IV

	SHIP Area			
	Southampton	**Hampshire**	**Isle of Wight**	**Portsmouth**
Planning (Q4) - Is Autism included in the local JSNA?				
Planning (Q4) - Does your local JSNA specifically consider the needs of children and young people with autism?	Yes	Yes	No	Yes
Planning (Q5) – Have you now started to collect data on those people referred to and/or accessing social care and/or health care and does your information system report data on people with a diagnosis of autism, including as a secondary condition, in line with the requirements of the social care framework?				
Planning (Q6) – Do you collect data on the total number of people currently known to social care services with a diagnosis of autism (whether new or long-standing) meeting eligibility criteria for social care (irrespective of whether they receive any)?	Yes	Yes	Yes	No
Planning (Q6) - The total number of people meeting social care eligibility criteria with autism?	286	927	133	0 data not available
Planning (Q6) - The number of people meeting social care eligibility with autism who also have learning disabilities?	129	675	98	0 data not available
Planning (Q6) - The number of people meeting social care eligibility criteria with autism who also have mental health problems?	17	180	5	0 data not available
Planning (Q6) - The numbers assessed as having autism but not meeting eligibility criteria?	0	68	29	0 data not available
Planning (Q7) - Does your local Joint Strategic Commissioning Plan reflect local data and needs of people with autism?	Yes	Yes	Yes	Yes
Planning (Q8) – Is your local CCG(s) (including the support service) engaged in the planning and implementation of the strategy in your local area?				
Planning (Q9) - How have you and your partners engaged people with autism and their carers in planning?				
Planning (Q10) – Have reasonable adjustments been made to general council services to improve access and support for people with autism?				
Planning (Q11) – In your area have reasonable adjustments been promoted to enable people with autism to access public services?				
Planning (Q12) – How do your transition processes from Children's services to Adult services take into account the particular needs of young people with autism?				
Planning (Q12) - How many children with autism are currently identified and receiving assistance in the transition ages (14 to 17) in the year to end of March 2014?	5	315	57	14
Planning (Q12) - How many children with autism have been through the transition process in the year to the end of March 2014?	-	81	25	13
Planning (Q13) – How does your planning take into account the particular needs of older people with autism?				

Autism Self-Assessment Framework - Local Area Data				Appendix IV
	Southampton	Hampshire	Isle of Wight	Portsmouth
Training (Q1) - Have you got a multi-agency autism training plan?	Yes	Yes	Yes	Yes
Training (Q2) – Is autism awareness training being made available to all staff working in health & social care?				
Training (Q3) – Is specific training being/been provided to staff that carry out statutory assessments on how to make adjustments in their approach and communication?				
Training (Q4) - Do CCGs ensure that all primary and secondary healthcare providers include autism training as part of their ongoing workforce development?	No	No	Yes	No
Training (Q5) - Criminal Justice Services. Do staff in the local public service engage in autism awareness training?	Yes	Yes	Yes	Yes
Training (Q6) - Criminal Justice Services. Do staff in the local court services engage in autism awareness training?	No	No	No	Yes
Training (Q7) - Criminal Justice Services. Do staff in the local probation service engage in autism awareness training?	Yes	Yes	No	Yes
Diagnosis (Q1) - Have you got an established local autism diagnostic pathway?				
Diagnosis (Q1) - Does the pathway meet people with autism's needs regardless of whether or not the person meets the LD criteria?			Yes	Yes
Diagnosis (Q2) - If you have got an established local autism diagnostic pathway, when was the pathway put in place?	2013/14	2011	2013/14	2013
Diagnosis (Q3) - In the year to end of March 2014, how many people were referred out of area for diagnosis despite a local diagnostic pathway being in place	0	0	0	0
Diagnosis (Q4) - In weeks, how long is the average wait between referral and assessment? (Note this should include all people referred irrespective of prioritisation streams)	4 weeks	18	13 weeks	10
Diagnosis (Q5) - How many people have been referred for an assessment but have yet to receive a diagnosis?	26	74	32	8
Diagnosis (Q6) - In the year to the end March 2014 how many people have received a diagnosis of an autistic spectrum condition?	54	132	33	10
Diagnosis (Q7) - How many of the people receiving a diagnosis in the year to end March 2014 had moved on to appropriate services by end September 2014?	54	132	33	10
Diagnosis (Q8) - How would you describe the local diagnostic pathway i.e. integrated with mainstream statutory services with a specialist awareness of autism for diagnosis or a specialist autism specific service?	Specialist	Specialist	Specialist	Specialist
Diagnosis (Q9) - In your local diagnostic pathway does a diagnosis of autism automatically trigger an offer of a Community Care Assessment (or re-assessment) if the person has already had a current community care assessment?	No	Yes	Yes	No
Diagnosis (Q10) – Can people diagnosed with autism access post diagnostic specific or reasonably adjusted psychology assessments?				
Diagnosis (Q11) – Can people diagnosed with autism access post diagnostic specific or reasonably adjusted speech and language therapy assessments?				

Autism Self-Assessment Framework - Local Area Data **Appendix IV**

	Southampton	Hampshire	Isle of Wight	Portsmouth
Diagnosis (Q12) – Can people diagnosed with autism access post diagnostic specific or reasonably adjusted occupational therapy assessments?				
Diagnosis (Q13) - Is post diagnostic adjustment support available with local Clinical Psychology or other services?	Yes	Yes	Yes	Yes
Care & Support (Q1) - No of adults assessed as being eligible for adult social care services and in receipt of a personal budget?	119	1201	85	2075
Care & Support (Q1) - No of those reported in 1 who have a diagnosis of Autism but not learning disability?	20	641	25	-
Care & Support (Q1) - No of those reported in 1 who have both a diagnosis of Autism AND Learning Disability	99	560	60	-
Care & Support (Q2) – Do you have a single identifiable contact point where people with autism whether or not in receipt of statutory services can get information signposting autism friendly entry points for a wide range of local services? (3 answers provided; General, Single & Autism-specific)	Autism-specific	Autism-specific	Autism-specific	Autism-specific
Care & Support (Q3) – Do you have a recognised pathway for people with autism but without a learning disability to access a community care assessment and other support?	Yes	Yes	Yes	Yes
Care & Support (Q4) – Do you have a programme in place to ensure that all advocates working with people with autism have training in their specific requirements?				
Care & Support (Q5) – Do adults with autism who could not otherwise meaningfully participate in needs assessments, care and support planning, appeals, reviews or safeguarding processes have access to appropriately trained advocate?				
Care & Support (Q6) – Can people with autism access support if they are non-Fair Access Criteria eligible or not eligible for statutory services?	Yes	Yes	Yes	Yes
Care & Support (Q7) – How would you assess the level of information about local support across the area being accessible to people with autism?				
Care & Support (Q8) – Where appropriate are carers of people assessed as having autism and eligible for social care support offered assessments?				
Housing & Accommodation (Q1) – Does the local housing strategy specifically identify autism?				
Housing & Accommodation (Q2) – Do you have a policy of ensuring that local housing offices all have at least one staff member who has training in autism to help people make applications and fill in necessary forms?	Yes	No	Yes	No
Employment (Q1) – How have you promoted in your area the employment of people with Autistic Spectrum?				
Employment (Q2) – Do autism transition processes to adult service have an employment focus?				
Criminal Justice (Q1) – Are the Criminal Justice Services (police, probation and, if relevant court services) engaged with you as key partners in planning for adults with autism?				
Criminal Justice (Q2) – Is access to an appropriate adult service available for people on the autistic spectrum in custody suites and nominated ‘places of safety’				

Appendix V

Key Milestones/Targets	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan – Mar 18	Apr to Jul 18	Aug to Dec 18	Jan to Mar 19	Apr to Dec 19
Early Intervention & Prevention																										
Draft Dynamic register of people 'at risk' of a hospital admission or a move to long term institutional type care (residential)																										
Agreed 'at risk' criteria for inclusion on the register and understood by community health and social care teams and agreed contingency plans																										
Agreed data and information governance methodology for collection and managing of data																										
Map existing pathways and identify the interaction points with different partners/organisations and the value and non-value areas																										
Business Case extending scope for Intensive Support Team from Adults only to those aged 14+																										
IST Service Specification development co-production workshop																										
Intensive Support Service extended from Adults only to those aged 14+																										
Hold Health & Prevention Fair for people with LD and/or Autism																										
New IST Specification negotiated into local contracts																										
Parity of Esteem Manager employed by WHCCG																										
Parity of Esteem Manager leads a review of existing health checks and works with Local Authorities and CCGs to develop alternative opportunities in e.g. Community Team Venues																										
Parity of Esteem Manager leads a review of transition arrangements and brings forward a set of recommendations for review to the TCP Board																										

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Key Milestones/Targets	Apr-16	May 16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan – Mar 18	Apr to Jul 18	Aug to Dec 18	Jan to Mar 19	Apr to Dec 19
Reducing the Number of In-patient Beds																										
Paper outlining the work to commission 4 less beds and business case for recycling funding to go to the SHIP TCP area.																										
Consultation via local stakeholder groups for parents and carers to co-design and co-produce new local model following decommissioning of beds																										
By end of year 2017 reduction of 4 beds from 55 to 51																										
By end of Year 2018 reduction of 5 beds from 51 to 46																										
By end of Year 2019 reduction of 2 beds from 46 to 44																										
Develop one discharge pathway between NHS England and SHIP CCG Commissioners																										
By end 2016 where appropriate all long stay patients to be discharged and repatriated back to local community based services																										
Engagement & Communication																										
Review current communication and stakeholder involvement and develop a co-produced communication plan																										
Engagement and Communication Work Plan signed off by TCP Board																										
Liaise with stakeholders to create case studies produced in accessible formats to inform the development of the charter																										
LD led focus groups to develop a co-produced charter across local services developed with stakeholders that is based on best practice and meets the needs of the local population																										

Develop and implement a tool to measure quality and customer satisfaction																											

Appendix V

Key Milestones/Targets	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan– Mar 18	Apr - Jul 18	Au- Dec 18	Jan -Mar 19	Apr -Dec 19
Developing Community Services																										
LD Hospital Liaison Function in all acute trusts across SHIP *(dependant on funding)*																										
Undertake satisfaction survey and review data for current LD Acute Liaison Services																										
Visit LD Friendly Practice in New Forest																										
Define what an LD Friendly Practice looks like																										
LD Annual Health Check Awareness Campaign																										
No of people having a LD Annual health check at 55% or above																										
Map existing Community pathways including Primary Care and Acute Hospitals and identify the interaction points with different partners/organisations and the value and non-value areas																										
Workshop with stakeholders to co-produce local service requirements that reflect local need across the SHIP area																										
Undertake a survey around the current Epilepsy service and identify the gaps																										
Review of Epilepsy community nursing to identify gaps in service and make recommendations of how local services can be re-configured																										
Extended CLDT/CAMHS opening times																										
Business Case for LD Hospital Liaison Function to be signed off by TCP Board and local Boards where appropriate																										
Parity of Esteem Manager implements a project for 'LD Friendly' GP Practices																										
Meet with Forensic Service Clinician's to see how they would like the Community Forensic Service to work and run																										
Speak to Advocacy colleagues to how they think the Community Forensic service should work																										

Speak to inpatients- this can't be done to soon as may disable their Forensic treatment. Jayne Jazz may be able to help us with this part.	
Speak to those with lived experience in the community about what could have been different if their Forensic treatment was in the community o JB o SW	
Community Forensic Rehabilitation / Relapse Prevention Service in Place	
Map services for PWLD and/or autism aged 65+ to identify the interaction points with different partners/organisations a& the value/non-value areas	
Develop a pathway for people with a LD aged 65+ using the model developed by the Strategic Clinical Network	
Developing the Workforce	
Identification of workforce development needs and how commissioners can support the ongoing development of the local workforce	
Identification of support services to TCP to develop the local workforce	
Business Case to be signed off by TCP for Workforce Development	

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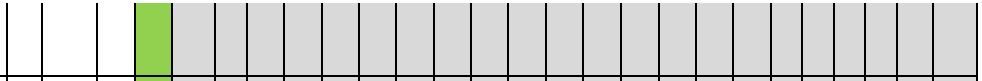
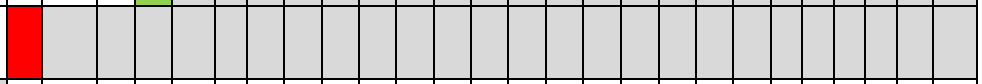
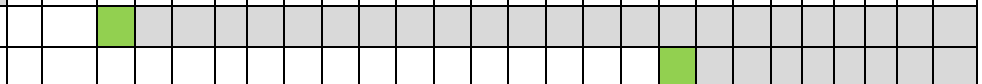
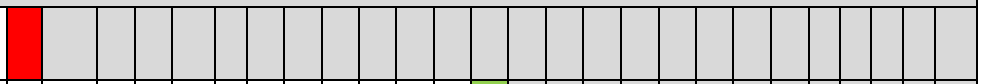
Increasing the offer and uptake of personal budgets																										
Develop a single joint assessment of need across Health, Social Care & Education																										
Person Centred Life Planning Tools developed																										
Planning Co-ordinators recruited and trained																										
Review local offers in each of the SHIP areas and identify gaps in services																										

Develop a workforce strategy for Personal Assistants (PAs) with the 'Workforce Development' workstream	
Identifying services to be de-commissioned from contracts e.g. therapies, SALT	
Health, Social Care and Education linked data sets for each of the SHIP areas	
Developing a Joint Housing Strategy	
Map current housing/accommodation provision across SHIP	
A co-produced Joint Housing Strategy for Young People and Adults with a learning disability and/or autism	
Finance & Activity	
Identify NHSE funding and agreeing how this will align with CCG and Social Care Budgets	
Develop Joint Commissioning Arrangements e.g. Section 75 agreements and aligned/pooled budgets to enable