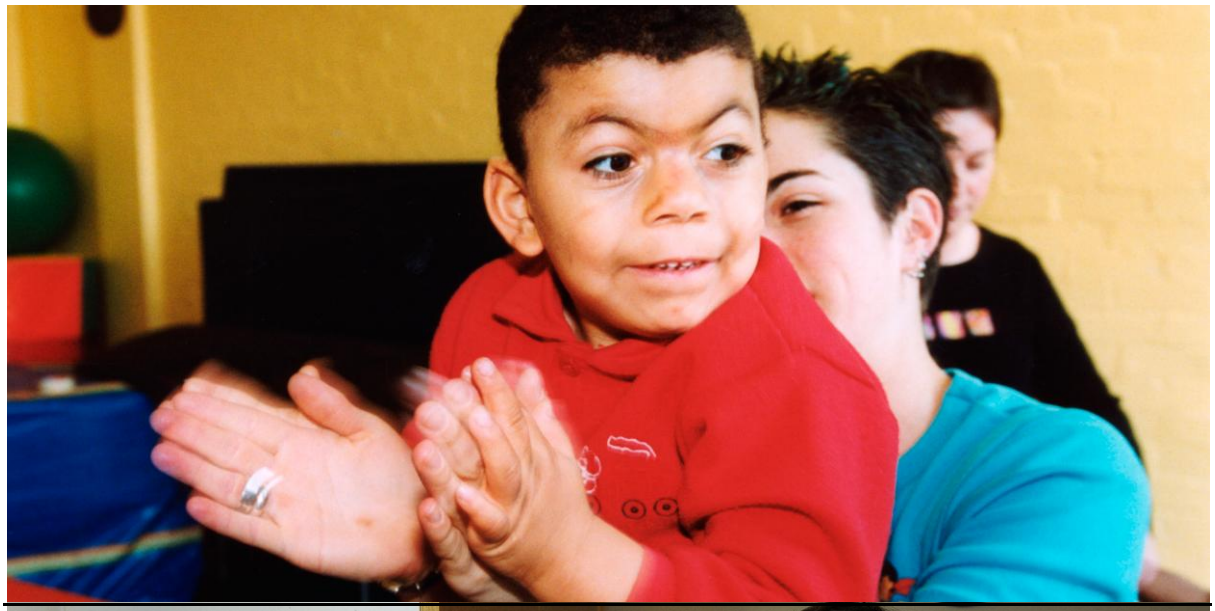
Transforming care for people with learning disabilities and/or autism

Supporting people in Surrey with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition



SURREY Joint Transforming Care Plan (DRAFT)

1. Mobilise communities

Governance and stakeholder arrangements

Describe the health and care economy covered by the plan

In Surrey there are:

- 5,700 children with learning disabilities and 2,700 with autism, of whom
- 647 are 16-17 year olds with learning disabilities and 98 with autism
- 21,400 adults 18 + with learning disabilities and 8,921 with autism of whom
- 4510 adults with learning disability and 2014 with autism are over 65

Of these we are aware of:

- 343 young people aged 16 -17 identified as likely to be eligible for adult social care – of whom 98 have Autism
- 4,000 adults are in receipt of Adult Social Care aged 18 and over, 609 of which are living out of county. 130 in receipt of health funded care
- 8 individuals within Specialised commissioning provision

It is recognised that of this total population of people with learning disability and/or autism there are currently 278 adults and further work is being undertaken to identify the number of children who have in addition behaviours that challenge.

To meet the needs of people with a learning disability and /or autism who display behaviours that challenge there are a range of support/services provided including:

- 43 strategic providers, providing residential, respite and supported living on a spot purchase basis, made up of voluntary and independent providers.
- A small statutory residential, respite and supported living provision within a block contract
- 250 other providers from whom we purchase support
- LATC Surrey Choices provision providing, day opportunities, employment, shared lives and short breaks moving to individual budgets 2016.
- 7 bedded NHS Assessment and Treatment service
- 7 bedded NHS Step Down Treatment unit (closing mid Feb 2016)
- Health funded community teams for people with a learning disability
- Health funded nurse liaison services in acute general hospitals, primary care and prisons

Commissioning Arrangements

Currently there are:

6 CCGs working together within the mental health and learning disability CCG collaborative

1 Local Authority operating under five area based directorates

11 District and Borough Councils

We currently have a non-formalised co-commissioning model

Blocks arising from these arrangements include:

- Separate budgets and commissioning arrangements
- Over reliance on residential care
- Geographic boundaries not aligned
- Lack of data sharing across organisations
- Children's and adult services not aligned in geography, and finance
- Cost of living in Surrey

Describe governance arrangements for this transformation programme

A Transforming Care Board (consisting of all key stakeholders) has been established to oversee the development and implementation of the Surrey Transforming Care Plan.
The project is led jointly by Jo Poynter, Area Director East Surrey Adult Social Care who has the LD lead for Surrey County Council, and Ros Hartley, Director of Strategy and Partnerships NHS North East Hampshire and Farnham Clinical Commissioning Group, representing all the CCG Chief Officers for the Partnership Area.

Partners on the Transformation Board include representatives from the following groups:

Individuals with learning disabilities and /or autism

Family experts

Advocacy

Children's services Commissioners

ASC Commissioners & Finance officer

CCG commissioners

NHSE Specialist Commissioner

CAMHS

Provider organisations

Surrey and Borders Foundation Trust (SABFT) (local inpatient services)

CTPLD

Voluntary sector community supports

Housing

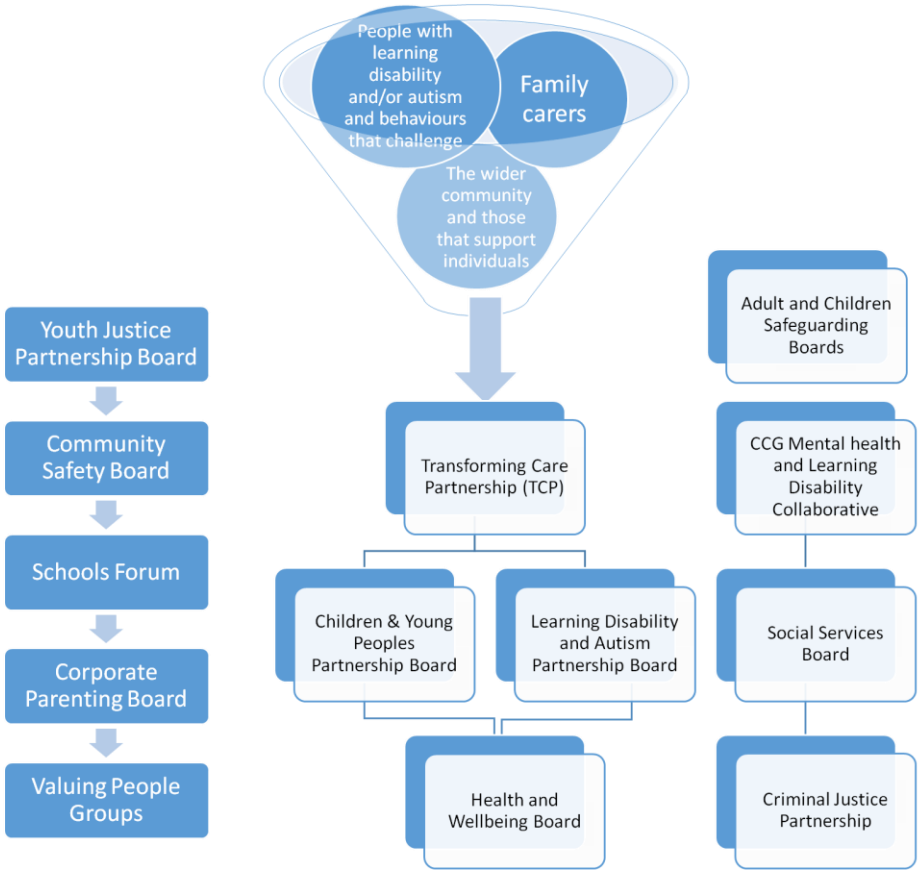
Safeguarding

LETB

Health care planners

Surrey Police, Youth Justice

The Transformation Board will report through the Partnership Board to the Health and Wellbeing Board.



Describe stakeholder engagement arrangements

In Surrey we regularly work alongside our stakeholders to deliver change these include:

- Valuing People Groups- local area groups including people with learning disability and autism, family carers and all local support networks
- Family Voice – parent forum for children and young people with disabilities
- Barnardo's
- Advocacy groups
- Adult Learning disability Partnership Board and Autism Partnership Board
- Strategic Provider network
- CAMHS
- Surrey & Sussex Criminal Justice Partnership

We have just completed the consultation on the five year commissioning strategy which this plan will form part of. This has included group sessions, face to face conversations, accessible survey monkey and large forum events to influence both the strategy and this plan.
The advocacy groups have been exploring the shift in power and are in-putting into both the strategy and this plan.

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

It was important that the plan was co-produced to accommodate the ideas, issues and concerns of all stakeholders, especially the people who will use services and their families.

The plan was based on input from members of the Transforming Care Board.

The advocacy and valuing people groups have been central to the co-design of the plan.

Co-design events for young people and their families are being set up over the next month to ensure they are involved in the development of the plan.

Engagement with partnership groups during consultation period will continue with regular agenda items at the partnership board meetings
Survey Monkey (see printed version of all feedback)

People with learning Disability and Autism were also very involved in the development of the National Service model with over 200 responses to the consultation.

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

Any additional information

2.Understanding the status quo

Baseline assessment of needs and services

Provide detail of the population / demographics

Cohort		
	In C	OoC
1. People with a learning disability and/or autism who have a mental health condition, such as severe anxiety, depression or a psychotic illness, and those people with personality disorders, which may result in them displaying behaviour that challenges.	4 NHS 5 CAMHS	1 NHS
2. People with an (often severe) learning disability and/ or autism who display self-injurious or aggressive behaviour, not related to severe mental ill-health, some of whom will have a specific neurodevelopmental syndrome with often complex life-long health needs and where there may be an increased likelihood of displaying behaviour that challenges.	2 NHS 197 LA 67 CHC 8 PHB	2 NHS 81 LA 10 CHC 19 children
3. People with a learning disability and/or autism who display risky behaviours which may put themselves or others at risk and which could lead to contact with the criminal justice system (this could include things like fire-setting, abusive, aggressive or sexually inappropriate behaviour)		1 NHS
4. People with a learning disability and/or autism, often with lower level support needs, from disadvantaged backgrounds (e.g. social disadvantage, substance abuse, troubled family background), who display behaviour that challenges, including behaviours which may lead to contact with the criminal justice system.		1 NHS
5. Adults with a learning disability and/or autism who have a mental health condition or display behaviour that challenges who have been in inpatient settings for a very long period of time, having not been discharged when NHS campuses or long-stay hospitals were closed.		
6. Children with Challenging behaviour placed in 52 week schools		Circa 17

Analysis of inpatient usage by people from Transforming Care Partnership

	2011	as at 31/03/16	as at 30/06/16	as at 30/09/16	as at 31/12/16	as at 31/03/17	as at 31/03/18	as at 31/03/19
NHS England commissioned inpatients		10	10	10	10	9	8	7
CCG commissioned inpatients	44	11 (6 in county 5 out of county)	8	4	4	7	7	7

Currently Surrey is well below the suggested in-patient usage, both CCG and specialist commissioned places. We aim to have all CCG commissioned places locally by 2019

Describe the current system

In 2015, Surrey maintained a SEN statement or Education Health and Care Plan (EHCP) for 5631 pupils. 823 children aged 0-19 were supported by the children with disabilities social care team.

The number of pupils with statements maintained by Surrey placed in Non-maintained and Independent (NMI) school provision is more than double the national average (England 6.9% and Surrey 15.1%) and just under double the regional averages. Many of these children and young people have ASD and are placed out of county or more than 20 miles from their family home.

During 2015/16, NHS Guildford and Waverley CCG led a Surrey-wide CAMHS procurement on behalf of each Surrey CCG and Surrey County Council. The scope of the procurement included both targeted (tier 2) and Specialist (tier 3) CAMHS for children and young people aged 0-8yrs old.

The contracts will commence from April 2016 and will include a new Behavioural, Emotional and Neurodevelopment (BEN) pathway and dedicated CAMHS adoption service, alongside an enhanced learning disability service, counselling provision, Parent Infant Mental Health Service, dedicated CAMHS service for Children in Care (locally known as 3 C's) and mental health support to care leavers.

In Adults services individuals from the cohorts are primarily having their needs met through services commissioned separately by health and social care funding streams. Co-commissioning is also part of the model that is being used, however this will further be developed to ensure that individual's needs are met holistically.

Currently practitioners are assessing an individual's needs and then identifying a provision to meet those needs. Too frequently the provisions are away from the family, friends and the community that they know. Although the number of individuals is small there is little provision within the geographical borders of Surrey that can meet their needs. The current care model is mainly residential provision away from Surrey. This move away to other counties does not provide a responsive individual way of meeting a person's needs.

ASC practitioners working alongside the Healthcare Planners will enable a range of options to be considered for each person in whichever cohort they have been identified as belonging to.
Consultation held on developing a model of funding for these complex people has considered a number of options and the preferred option, by those consulted, was identified as sitting with adult social care commissioners.
Further joint work with colleagues across mental health services will be essential in developing a greater resource bank of options for people.

Services are provided by a number of independent providers directly commissioned. Further work is needed to ensure that individual budgets and direct payments are made available to each cohort to enable greater choice.
Joint working with providers to create individual homes for people with specialised, creative and responsive support packages will enable people to move back nearer their family and friends.

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

Accommodation Status of Working Age Clients with A Learning Disability (source SALT 2015 / 15 Table LTS 004 tables 2a and 2b)

ACCOMMODATION TYPE	Total PEOPLE	% OF TOTAL	People as described in the cohorts	% of People as described in the cohorts
Rough Sleeper / Squatting	0	0.0%	0	0.0%
Night Shelter / Emergency Hostel / Direct Access Hostel (Temporary Accommodation accepting Self-Referrals)	2	0.1%	0	0.0%
Refuge	0	0.0%	0	0.0%
Placed in Temporary Accommodation by the Council (including Homelessness Resettlement)	3	0.1%	0	0.0%
Staying with Family / Friends as a Short Term Guest	2	0.1%	0	0.0%
Acute / Long Term Healthcare Residential Facility or Hospital (e.g. NHS Independent General Hospital / Clinic, Long Stay Hospital, Specialist Rehabilitation / Recovery Hospital)	8	0.3%	19	
Registered Care Home	899	31.5%	246	
Registered Nursing Home	12	0.4%	0	00.0%

Prison / Young Offenders Institution / Detention Centre	0	0.0%		
Other Temporary Accommodation	12	0.4%	0	0.0%
Unknown	84	2.9%		
TOTAL UNSETTLED ACCOMMODATION	1022	35.8%		
Owner Occupier or Shared Ownership Scheme	18	0.6%	0	
Tenant (including Local Authority, Arm's Length Management Organisations, Registered Social Landlord, Housing Association)	73	2.6%		
Tenant - Private Landlord	20	0.7%	0	
Settled Mainstream Housing with Family / Friends (Including Flat-Sharing)	1003	35.2%		
Supported Accommodation / Supported Lodgings / Supported Group Home (i.e. Accommodation Supported by Staff or Resident Care Taker)	671	23.5%	32	
Shared Lives Scheme	31	1.1%		
Approved Premises for Offenders released from Prison or under Probation Supervision (e.g. Probation Hostel)	0	0.0%		
Sheltered Housing / Extra Care Housing / Other Sheltered Housing	11	0.4%		
Mobile Accommodation for Gypsy / Roma and Traveller Communities	2	0.1%		
Total Settled Accommodation	1829	64.2%		
Total LD	2851	100.0%		

The above accommodation is provided by a range of housing, social care, health and private providers. This varies from very appropriate, Surrey has worked with providers over the past five years to develop individual bespoke housing options, to poor old fashioned more institutional provision which is not fit for purposes.

The In-House Social care services are under review as to the future, some of which are fit for purpose

and others not. There are 74 properties with charges to Secretary of state, district and boroughs or local authority as follows:

Provider	CCG area	SCC rel manager	Status
Affinity Trust	G&W	Debbie Aitken	Already supported living
Avenues Trust	ES	Jo Poynter	TBC
Care UK	G&W	None	Proposals made to change
CIC	ES	Mary Hendrick	Discussions underway
Dimensions	G&W, SH, NEHF	Andrew Price	Proposals made to change
Just Homes	G&W	Andrew Price	Proposals made to change
LCD	ES	Andrew Price	Discussions underway
Mencap	ES	Andrew Price	Reregister to SL
Prospect	ES/MID	Jo Poynter	TBC
Together Working for Wellbeing	NW	None	To discuss - MH services
United Response	G&W	None	Linked to Dimensions review
Welmede	NW	Andrew Price	Proposals made to change

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

Surrey has a good record of not using extensive amounts of hospital provision and in the last four years has reduced the usage of long term hospital stays to below the suggested national figures. However, all specialist commissioned places remain out of county, and many other placements both health and social care are within residential settings with many out of county. To implement the service model locally there needs to be a change giving the choice and control back to the individuals and their families, enabling them to have choice in where they live and an opportunity to remain local staying closer to their families and community. This means working alongside providers so enable services to provide support that meets individual needs either in their own home or for a short time in other local provision until they are able to return home. As hospitals are not homes and residential care is not within settled accommodation there is need in a strategic shift for how services are being commissioned and how they will be commissioned in future.

We have taken stock of the position in Surrey by assessing the current position against the principles set out in the Transforming Care Service model.

Principle	Current position in Surrey	Future goal
1. A good and meaningful life	Many people are supported to enjoy a good and meaningful life in Surrey. There is some high quality care and support provision delivered by ethical providers and the general standard of accommodation is reasonably good. However, we still have some larger, old-style residential services which are no longer fit for purpose. Some services are less personalised than they should be. All service specifications are based on the	• More people will have access to mainstream services. • People with challenging behaviours will have access to supported employment services • People with challenging behaviour will have access to meaningful daytime services

	TLAP "I statements" which were co-designed with individuals families, providers and other stakeholders.	
2. Person at the centre	Surrey has made good progress in ensuring that people are listened to and that their needs and wants are taken account of when choosing services and structuring support, but there is some way to go before we can say that all services are truly person centred.	• Introduce support navigators through match funding proposals • Cultural shift from power within the organisations to the individuals and their families • The HCP team being increased with an integrated workforce to ensure people receive twice yearly CTRs
3. Choice and Control	Surrey's children's services was a pilot site for the Education, Health and Care plans, with the child at the centre. (See Attached) Surrey has excellent accessible information and an accessible partnership board website. Surrey has a good model for delivering direct payments to individuals with the option of a pre-paid account. All adults in receipt of care have a personal budget, managed by, themselves, a third party broker or the council. In Surrey we have also been introducing personal health budgets for people with a learning disability. Part of our transformation plan is that we wish to integrate these approaches and provide a dedicated focus on developing Integrated Personalised Commissioning.	• Continue to work with children and their families of children whose behaviours present as challenging • Ensure people with Challenging Behaviour have access to Direct Payments • Introduce a local offer for Personal Health budgets and integrated personal commissioning budgets for people with complex needs • To engage with the voluntary sector to ensure a wide range of service provision. • Ensure local advocacy is reaching those with challenging behaviour
4. Support to my family and paid staff	We recognise that families are often the most important people in the lives of people with disabilities and autism. They have a major role to play in planning and delivery of the support received by their relative. In Surrey some families play an active role, but others feel excluded for the lives of their relatives when they reach adulthood. Carers, whether family or paid carers, have a demanding role. Some Surrey families say	• Ensure that the early intervention programme is meeting the needs of children with challenging behaviours • Ensure appropriate training available for families and paid staff • Work with local strategic providers to develop short

	they are well-supported, whilst other bemoan a lack of support. Paid carers, whether personal assistants or staff working for care providers, generally feel undervalued and are poorly rewarded for the skilled and challenging work they undertake.	term alternative models of care. • Develop a small group of strategic providers to meet the needs of people whose behaviours challenge. • Ensure people with learning disabilities and/or autism with behaviours that challenge are explicit within market position statements
5. Where I live and who I live with	There are some excellent recent examples in Surrey where people have chosen both where and with whom they live. However, many people in Surrey did not choose where they live, and even fewer chose who they live with.	• Ensure Personal Health budgets can be used to contribute towards housing costs • Joint working between commissioners and housing strategy colleagues to ensure strategic housing planning
6. Mainstream health services	Surrey has made good progress is supporting people to access mainstream health services. People generally have annual health checks, Health Action Plans and Hospital Passports. Hospitals, Prisons and Primary care have liaison workers who enhance the service delivered and the overall experience for disabled and autistic people.	• Ensure that people with a learning disability are offered an Annual Health Check • Ensure that people have the option of a Health Action Plan • Annual completion of the Green Light toolkit audit by mental health commissioners with action plans • Care & support pathways within mainstream primary and secondary NHS services are meeting the needs of people with learning disabilities and/or autism with behaviours that challenge
7. Specialist multi-disciplinary health services in	People receive support from specialist health services in the community such as the Community Behavioural Support Team, but they tend to be under-resourced and only have scope to play a reactive role in times of	• Ensure the availability of specialist integrated multi-disciplinary health and social care support in the community for people with

the community	crisis.	a learning disability and or/autism, for all ages (including an intensive 24/7 function • Interagency collaborative working between specialist and mainstream services • Introduce a community forensic liaison role to help divert people ending up in forensic pathway and services.
8. Specialist social care support in the community	Surrey has a range of specialist community social care support providers, including charities, housing associations and private organisations. Providers are generally ethical and progressive in nature and are committed to delivering good quality care and support. However, the provider community is fragile. Many services, particularly long-established residential homes, are underfunded, and staff shortages are having a detrimental effect on quality of care and organisational wellbeing.	• Mainstream services aimed at preventing or reducing anti-social or 'offending' behaviour make adjustments to meet the needs of people with a learning disability and/or autism • Access to specialist health and social care support for people with a learning disability and/or autism who may be at risk of/have come into contact with the CJS
9. Hospital		• Hospital admissions are supported by a clear rationale of assessment and treatment • Services are as close to home as possible • All stakeholders are working together to ensure discharge planning processes start from the point of admission • Support for families and carers exists within commissioning frameworks

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

3.Develop your vision for the future

Vision, strategy and outcomes

Describe your aspirations for 2018/19.

The Surrey Vision, set out in the Surrey Learning Disability and Autism Strategy, 2016-2020 (attached 1 page strategy summary) is to ensure that:

People with learning disabilities and/or autism have the right to the same opportunities as anyone else to live satisfying and valued lives. They should be able to have a place to live and to be involved in the design and delivery of the support they receive.

This Vision applies to all people with learning disabilities and/or autism in Surrey.

We view the Transforming Care Programme as an important and integrated part of our overall work to develop the quality of care and support for people with learning disabilities and/or autism in Surrey.

The Surrey Learning Disability and Autism Strategy sets out Strategic Goals which were developed through extensive consultation with many stakeholder groups, including people with disabilities and/or autism and their families. They are as relevant to the cohorts prioritised by this programme as they are to the wider population of people with learning disabilities and/or autism.

The Strategic Goals are listed below. Specific reference is made (in italics) where the Goals are of particular importance to the programme and the cohorts of people on which it initially focuses:

1. **Living my life**

   Individuals have a great start to life and age well, having opportunities to contribute to their local community. To support this goal we will:

   a. Ensure that people are supported to participate in purposeful activity including education, employment and volunteering.

      This is key to enabling people to achieve a good quality of life and is particularly important to people with complex needs and challenging behaviour in the priority cohorts who find it difficult to source meaningful activities.

   b. Ensure carers have their needs identified and met to help maintain their caring role.

      Surrey has an established network that enables carers to have a voice, provides training and recognises carers as equal partners. It is important to ensure this network supports carers of individuals with the most complex needs

   c. Promote the use of personal budgets and health budgets to develop opportunities.

      To achieve the shift in power there needs to be a programme of work exploring how to increase the number of individual budgets both health and social care to people whose behaviours are described as challenging

   d. Work with District and Boroughs to promote inclusion in local communities.

   e. Ensure people have local settled accommodation by developing housing options with providers and NHS through co-design.

      The priority cohorts have bespoke accommodation needs, but as discussed later in this plan there are particular issues around sourcing and developing appropriate accommodation in Surrey.

   f. Reduce the number of people living as inpatients in NHS facilities who could receive more

appropriate services in the community.

Bramdean, one of the two remaining inpatient units in Surrey, closed at the end of January 2016. The last such facility in Surrey, April Cottage, Assessment and Treatment unit is scheduled to be re-located. Some Surrey-funded people are in similar facilities in other counties. We aspire to re-settle all the people living in hospitals into appropriate community settings.

g. Work with providers to build a workforce of sufficient size and with appropriate skills and competencies.

This will be a major challenge in Surrey. The care workforce has suffered wage erosion over several years allowing private sector pay to overtake, care and support work has a poor image and there is virtually no unemployment in the County. Building a care workforce to support more challenging people in the community is a strong focus of this programme which needs to recognise staff training including coaching, mentoring and skills development in situ..

h. Fund provision at the long term cost of care.

Surrey has a comparatively large population of people with learning disabilities and/or autism and high level of overall spend, but many established services express concern about underfunding. We have to be creative and innovative in ensuring that we maximise value for every pound spent, but we also need to recognise that supporting people with complex needs can be expensive. This means that we need to be creative in how the money is spent as without appropriate funding for people with complex needs and behaviours that challenge peoples' needs and aspirations will not be met.

2. Staying healthy

Individuals have the right to support that enables them to stay well and receive the right care and treatment they need. To support this goal we will:

a. Ensure that people are informed, supported and have access to annual health checks, screening and health promotion (tailored to people with learning disabilities and/or autism).

b. Ensure that everyone has access to good quality health services which meet their needs. (Health services are expected to make 'reasonable adjustment' to meet individual needs)

c. Develop joined up health and social care, providing seamless care and support.

Seamless working between partners is critical to the achievement of all Strategic Goals in their application to the priority cohorts.

d. Provide local responsive alternatives to admission to hospital.

For people with complex needs and challenging behaviour this means specialist behavioural services with well trained, skilled, competent and resilient staff.

e. Develop a skilled workforce to meet needs when individuals have complex needs.

To support complex and challenging people in the community Surrey needs a Community Positive Behavioural Support team which can work with individuals both proactively to design and implement behavioural programmes and respond at times of crisis with positive interventions and boots on the ground. This needs a partnership approach alongside families.

f. Ensure carers have their health needs identified and met to help maintain their caring role.

3. Keeping safe

Individuals supported both in Surrey and out of county will experience quality services that are responsive to individuals' needs, keeping them safe and delivering value for money. To support this goal we will:

a. Work with friends, families and communities to prevent isolation and promote inclusive lives.

b. Ensure the community is educated to help stop discrimination and prejudice.

c. Ensure people have access to the right information, advice and advocacy to make informed choices about the support they need.

Access to information, advice and advocacy is important when supporting people to move to new community-based services, particularly when they lack capacity or do not have support from family and friends. A specific concern is the lack of advocacy support for people who live out of county.

d. Ensure people are cared for and safeguarded in their local community.

The cohorts prioritised by this programme can often not self-advocate and are at particular risk of harm and abuse.

e. Work with Police and Criminal Justice and liaison with mental health and safeguarding leads.

How will improvement against each of these domains be measured?

In the table below we specify the Surrey Strategic Goals which are most relevant to the cohorts of people prioritised in this programme, and which are central to the Surrey Transforming Care Plan. We also identify the key indicators which will be measured to determine the success of the programme in relation to these goals.

We acknowledge that there is a need to ensure that we collect data to enable central monitoring of progress and will update our indicators when this is finalised.

Relevant Strategic Goal	Indicators
1a. Purposeful activities	• Individuals participating in meaningful activities and reporting they feeling fulfilled with activities (annual review and survey)
1b. Family carers	• Families and carers feel supported (survey) • Local networks including families of individuals with complex needs.
1c. Personal budgets	• Number people with behaviours that challenge taking up Direct payments, personal health budgets or integrated personal budgets
1e. Develop housing options	• Number of secured tenancies for people with behaviours that challenge
1f. Reducing inpatient numbers	• Number of inpatients
1g. Building workforce	• Number of new staff recruited with the right qualities • Number of staff with behavioural and

	communications qualification • Number of Manager and Support Worker roles filled with people that meet the specified profile
1h. Funding at long term cost of care	• Surrey Cost and Pricing model in place • Surrey Cost and Pricing benchmarks developed and agreed
2c. Joined up health and social care	• Single commissioning team • Aligned/pooled budget
2d. Local responsive alternatives to admission	• "Blue light CTRs" prior to every admission • Behavioural Support Network activity • Short term accommodation/support usage • Criminal Justice Liaison role activity
2e. Positive Behavioural Support team	• Behavioural programmes available 24 hrs a day • Intensive Support Service number of prevented admissions
3c. Information, advice and advocacy	• Navigator in place to help people through the system • Provision of specialist advocacy services
3d. Ensure people are safeguarded	• Develop easy read safeguarding information • Number of alerts

The work planned in this programme to achieve the Strategic Goals, initially in respect of the priority cohorts but thereafter in respect of the wider population of people with learning disabilities and/or autism is set out in the plans in Section 5: Delivery.

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

Our guiding principle is that people who need and use support services are central to all work and activity in a sector which exists only to support them.

People with disabilities and/or autism have told us that the following aspects of life are important to them:

- Choice and control over care.
- Living in the community with support from family and carers.
- A fulfilling and purposeful everyday life.
- Receiving good care from all health services.
- Accessing extra health and social care support when needed.
- Being supported to stay safe.

In Surrey we are committed to supporting people with learning disabilities and/or autism to stay at the centre of their world.

Please complete the Year 1, Year 2 and Year 3 sections of the 'Finance and Activity' tab

and the 'LD Patient Projections' tab of the Transforming Care Activity and Finance Template (document 5 in the delivery pack)

Any additional information

4.Implementation planning

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

Overview of your new model of care

In recent years we have driven a shift away from old, traditional models of care such as treatment and assessment units and residential services, but we do not envisage that these older models will be replaced by new models. People are individuals, so we should not expect one size to fit all. We are moving away from the notion of preferred models towards what we might term a system – a system in which there is complete flexibility about how people will live and how their support needs will be met.

In our new system we will meet the needs of all current and potential individuals of care and support services with reference to the following guiding principles:

- Led by individuals requiring support. We wish to see a shift of power way from those who commission and provide support to those who utilise it.
- Local. Most people wish to live in localities with which they are familiar, close to family and friends, and able to access a known community infrastructure.
- Specialist. We recognise that people with challenging behaviour require specialist behavioural support.
- Preventative, proactive and progressive. By adopting preventative approaches and being proactive in support planning and delivery, we will enable people to achieve their potential and live more fulfilled lives. We seek to support people to make progress thoughout their life by supporting development and fostering independence. These approaches will save money too.
- Innovative. People should not be pigeon-holed into traditional models of care. Rather, they should be encouraged to seek innovative solutions which meet their individual needs and wants.
- Dynamic. Just as we should not expect that one size fits all we should not expect solutions to last a lifetime. Lives are not static. Peoples' needs and wants change over time.
- Teamwork. People have the best chance of achieving desired outcomes when all parties involved in their care and support are engaged and aligned.
- Positive culture and shared risk. Providers must take responsibility for the quality of the support they give, but they cannot be all things to all things to all people, and there are times that they need support, particularly in times of crisis. Difficult times are best navigated where the culture is honest, open, respectful, supportive and solution-focused.

What new services will you commission?

We will commission person-centred services which people are likely to choose as their preferred option for care and support and which meet assessed needs.

Based on feedback from individuals, families, advocates, providers, care managers and other

stakeholders, and assessments we have carried out, it is likely that the services we commission will also have the following characteristics:

- Local. Work with neighbours and the wider community to ensure that people are accepted in their local communities
- Bespoke. We will ensure that services are individually-led, based on what the individual and his advocates want.
- Small numbers. People generally don't want to live with lots of other people, and large numbers militate against personalisation.
- High quality accommodation, which is well-located, fit for purpose, well-maintained, robust and homely.
- High quality management and staffing. Commissioned services will need to demonstrate that they have high quality management and can build skilled and competent staff teams, a pre-requisite to supporting people to achieve positive outcomes.
- Desired outcomes. We will commission new services with organisations which are able to demonstrate how they support people to achieve desired outcomes. Great accommodation and excellent staff are vital, but organisations also need to be able to translate high quality inputs into desired outcomes.
- Behavioural specialism. Many people in the cohort covered by this programme require specialist behavioural input. Support providers will need the skills required to design and deliver specialist proactive support programmes which aim to minimise challenging behaviour and to make early and effective interventions at times of crisis.
- Activity programmes with proven positive outcomes, including art and drama therapy. A particular focus is to ensure that people with severe learning disabilities and high support needs are able to access high quality activities.
- Employment focus. We wish to support more people with learning disabilities to have the opportunity of employment, in the widest sense of the word.
- Organisational strength and resilience. We will look to commission services with providers who can demonstrate that they have the resources to provide positive support to service and individual when things are going well and when things are not going quite so well.
- Financial viability. In these cash-strapped times services must be efficient and deliver value for money. To be viable, though, services also need to be funded at the long-term cost of care, accommodating known forthcoming cost increases such as the Living Wage and pension auto-enrolment and facilitating future investment and service development.

With regard to existing models we recognise thatShared and ownership and Supported Living generally enables people to live the positive, self-directed lives they choose, but we also wish to promote innovative structures within a flexible system. We expect to see more and more cases where, for example:

- Care and support is shared between families and provider organisations.
- Support is provided by voluntary and community organisations.
- People share their lives with others whom they choose.
- Structures are put in place to support family carers, such as behavioural support and respite

care to facilitate short breaks.

We note that there is a specific and unmet requirement to commission bespoke services for people with autistic-spectrum disorders, notably those without learning disabilities.

We also note that there is strong need to develop a central behavioural support team which is able to provide support with proactive behavioural management strategies and importantly, specialist boots on the ground at times of crisis and potential placement breakdown.

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

There are a number of service characteristics which deter people from choosing those services, so we will resist commissioning services with those characteristics unless there is a compelling reason to do so. These characteristics include:

- Non-local, often out of county.
- Poor location within a locality. Negative factors here include lack of access to public transport (important for individuals, relatives and support staff)
- Number of individuals supported by the service. This is case and model-specific, but it is unlikely that services of more than 5 people would be commissioned.
- Potential staffing issues, either quality or quantity.
- Sub-standard accommodation. This could mean accommodation which is not fit for purpose, not well-maintained or simply not homely.
- Lack of organisational specialism and support. We would not commission services with organisations which could not demonstrate a strong record in supporting people with challenging behaviour.

With regard to historic models, we would expect to commission less traditional residential care, but we do recognise that this model can support some people very positively, so do not discount it entirely. We do not envisage that we will commission hospital-based services.

With regard to day provision, we do not envisage commissioning old-style institutional day care which tends to be location-specific. Rather, we plan to commission high-quality, community-based day activities which provide opportunities for training, development or leisure based on peoples' wishes, aspirations and needs.

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

We aspire to see all services in Surrey progress towards our vision in line with our guiding principles, so over time all services will change and operate differently. In particular we are keen to ensure that all support is person-centred and outcome-based.

In the first instance this programme is committed to prioritising radical change in areas of greatest need. These have been identified as:

- Supporting people who currently live in hospital to live in settled homes in the community with individual-led care and support which meets their needs and aspirations. Through reintegration into the community people will gain a renewed sense of citizenship.
- Supporting people in residential schools to move into settled homes in the community with community with individual-led care and support which meets their needs and wants. This will include more effectively preparing people for adulthood and the greater independence that should bring.

- Improving long term planning and care pathways. For some people long term planning means planning for their lifespan.
- Developing and improving preventative, proactive and progressive support services for people with challenging behaviour currently in receipt of community-based services.

We can only succeed in these high-priority areas if we reform the way we work. Historically we have worked in different silos, often with conflicting priorities. We have built walls between health and social care, between acute and community health provision, between children's and adult services. Moving forward we need to provide seamless, generic support from multi-disciplinary teams working with common aims and objectives. Without this we will fail to achieve our transformational objectives.

Beyond achieving high priority objectives, the programme will seek to ensure that the needs of all people with challenging behaviour currently in receipt of community-based care and support services are being met appropriately. At an early stage this will lead us to review provision in residential homes.

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

Surrey is committed to giving people the opportunity to manage their own finances in the belief that by exercising choice and consumer sovereignty individual needs will met and the care market will be shaped positively.

Personal budgets (including direct payments)

Personal budgets are currently agreed for all people in receipt of care outside residential care homes and funded by Surrey County Council. The budget is then managed in different ways. In some cases Surrey County Council manages the budget on behalf of the individual, whilst at the opposite end of the spectrum many people receive direct payments and control their cash in entirety.

We will continue to encourage the take up of direct payments and ensure that structures are in place to support people who wish to pursue this option. Our annual targets are:

Direct Payments = 100% offered with 50% take up

Personal Health Budgets = a handful of personal budgets have been taken up by people with a learning disability with CHC or the Healthcare Planner team. 100% offered 50% take up

Integrated Personal Budgets = In the future through this plan we will be looking to initiate a dedicated project to become a 'fast follower' in the Integrated Personalised Commissioning approach that will bring together the health and social care elements and shift the power putting people central to their own decisions, choices and control.

In line with the positive intentions set out in the Care Act 2014 we are also looking to extend personal budgets to people in residential care, with a view to implementing direct payments for some elements of residential care packages when this is permitted.

What will care pathways look like?

We are committed to implementing integrated systemic pathways in which appropriate support is provided to people in a dynamic way throughout their lives. This is critical to ensuring that people get the most out life, and is most cost-effective too.

The key aspects of this approach are:

- Identifying those people who may require support along a pathway from birth. This represents 'dynamic risk' management.
- Improving recognition and diagnosis of learning disabilities and autism at an early stage.
- Production of long term plans so that provision can be planned proactively rather than provided reactively. This is particularly important when people are approaching transition from children's to adult services, where effective and co-ordination can enable providers to build bespoke solutions.
- Provision of support from an early age which is individualised, realistic, consistent, proactive, preventative.
- Training all relevant parties at all stages to guarantee the relevance, quality and consistency of approach. This means training not just support staff, but also families, teachers, paediatricians, GPs, specialist hospital support staff and social care staff.
- Matching support to need at any given time.
- Design and implementation of positive behavioural support programmes aimed at minimising challenging behaviour.
- Ongoing monitoring, with a view to anticipating changes in behaviour, deescalating and avoiding crises.
- Funding flexibility, allowing level and type of support to change throughout a person's life according to need.
- Joint commissioning and joint working. It is not possible to optimise care pathways without all key partners adopting a joined up approach. In particular we need to ensure that information is shared and that all partners capture learning about individuals throughout their lives.

Flexible and structures allowing pathways to change and adapt quickly. For some people there will need to be a back-up plan should existing arrangements no longer meet needs

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

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. In Surrey there are positive examples of where providers have engaged with families and Social Services to develop services which are ready to come on-stream when people leave college. Providers are always keen to engage in discussions about

service developments from an early stage. Specific locations can be targeted, accommodation can be tailored and more readily adapted, staff can be recruited with specific skills and financial risks are minimised.

- Transitional services. People who leave residential colleges are not always fully prepared or skilled to face the challenges of adulthood. We are looking to explore the development of community-based services for young people from 16-25 to fill the gap. Other options to consider are 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. In Surrey we have a transition team which defines processes and takes accountability, but we need to ensure that this is effective and includes the specialism necessary to support the transition of people with complex conditions.
- 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.

How will you commission services differently?

Surrey is adopting a progressive approach to commissioning services. This is evident in several areas:

- Approach. Our commissioning practices are becoming more personalised and outcome-based in line with best practice in the discipline. This journey must continue until all our commissioning practices are personalised and outcome-based.
- Joint commissioning. We have strong intent to ensure that joint commissioning is practiced in all areas when required. Specifically, this necessitates joint commissioning by the CCGs and Social Services and by children's and adult services ensuring the money is clearly identified. It is incumbent on all parties to work according to our shared mission and to build and operate within effective working structures and processes to make joint commissioning in Surrey a reality.
- Partnership working. In commissioning services we are seeking to build strong, open, honest and trusting relationships with all parties involved in a person's care pathway. In particular we need to build strong links with:
  - Local education departments, schools and colleges who play such an important role in shaping a person's future.
  - The provider community, who often play the principle role in meeting peoples' support needs.
  - Local authority housing departments, an important source of housing and accommodation.

- Working with families. We recognise that families play the major role in supporting people through their childhood and often continue to do so into adulthood. They frequently act as the person's long-term advocate, fighting for the best interests of their relative. The role of families must be cherished within our commissioning and provision processes. Families must be afforded the opportunity to play a significant role. We must communicate and consult well with families, set expectations clearly and, where appropriate, facilitate their close involvement in care planning and delivery processes.
- Long term planning. As noted above we are committed to implementing integrated systemic pathways in which secure appropriate support is provided to people in a dynamic way throughout their lives. This is critical to ensuring that people get the most out life, and is most cost-effective too.

We will continue to work progressively to improve our commissioning practices in these important areas.

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

Sourcing accommodation for people with high support needs is difficult in Surrey. Property is expensive, demand is high, competition is strong, the availability of brown-field sites is limited and planning restrictions are tight.

The nature and quality of accommodation currently occupied by people with support needs is mixed. Surrey now has only one hospital, which is scheduled for closure. We do have a number of larger residential facilities which are no longer fit for purpose, but in the main people are housed in smaller homes, typically residential or group supported living services of up to six people, and in their own flats. Locations obviously vary in suitability. Some properties are sited in local communities, whilst others are remote from neighbours and community.

Moving forward we do not seek to be prescriptive about accommodation, which must be driven by individual needs and circumstances. That said, feedback from people with accommodation needs, other stakeholders and our assessment work indicates that, in general, we will need to work with partners to source and develop properties with the following characteristics:

- Individual accommodation, including supported flats. We know that some people in the cohort being addressed by this programme need or want to live alone.
- Core and cluster. This model, in which individual units also share some common space (and share support) is in demand because it helps people avoid social isolation and can be cost-effective too.
- Group supported living. Some people wish to live in groups. This can promote friendships and militates against social inclusion. It also cost effective because some support can be shared.
- Community locations. Accommodation which is well-located in communities encourages positive engagement with those communities and limits social isolation.
- Space. For some people having sufficient space is important, both inside and outside the property.
- Environmental resilience. Some people in the cohort can take a toll on their environments, creating a need for bespoke and resilient accommodation.
- Sound insulation. Some people in the cohort are known to be particularly vocal, so there is a

need for accommodation where noise can be made without impacting neighbours.

Sourcing accommodation in Surrey can be difficult. New build is often the preferred option to meet a bespoke requirement, but development sites are scarce. There is often competition from commercial developers who do this for a living! We need to find better ways to release sites for development from the NHS and local authorities, and to work with local housing departments to facilitate development and secure planning approval. Again, joined up working is key.

Buying, redeveloping and adapting existing properties has long been the most feasible way for providers to make accommodation available to people with disabilities. In some cases this has worked well, delivering high quality accommodation which is fit for purpose, but in other cases this accommodation is tired and no longer meets the standard. Looking forward, if providers are to acquire properties for redevelopment then all parties will need to be confident that the resulting accommodation will be fit for purpose for many years to come.

When considering the funding required to acquire and develop accommodation we see a mixed picture. The process for reinvesting NHS capital is frought with difficulties, and needs to be streamlined. The provider community, however, does have the ability to fund the purchase and development of accommodation, either from reserves or new borrowing, and can act quickly and decisively. We have also seen accommodation being provided by families, and encourage this as a positive way to bring new capital into the sector.

A key issue for all accommodation providers the financial risk which results from acquiring and developing a property. At the outset, the costs of purchasing and developing a property require funding in entirety and represent pure investment, with no guarantee of downstream income to offset. It must be seen as reasonable for providers to recoup that investment over time, through rent, Local Housing Allowance or care fees. Looking forward the rules regulating LHA are set to tighten, which could be a barrier to future development.

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

Supporting people who are currently residing in hospital to move to settled accommodation in the community is core to this programme. We have defined a workstream in the programme to address this requirement specifically and the activities we plan to undertake are set out therein.

We view the following aspects of resettlement to be of particular importance:

- Person-centred plans. Most people now have person-centred plans, but they vary in quality and often fall out of date. It is essential that people who are to be resettled have comprehensive and up-to-date person-centred plans to inform the resettlement process.
- Meaningful day activities, including employment.
- High quality, specialist support. Many people are in hospital because they have a diagnosis, condition or behaviour which makes it difficult to find safe and appropriate placements in the community. It will be necessary to ensure that the right services are in place.
- Positive Behavioural Support. To succeed in community placements many of the people currently residing hospital will need positive behavioural support, provided both by an external team and in-house resources. Support will need to be provided directly to people and to their support teams.
- Prevention. Preventative approaches are important to stop people entering hospital in the first

place, and re-entering hospital following resettlement. We envisage that a key role for the Community Positive Behavioural Support Team will be to provide behavioural guidance and direct support during periods of crisis to prevent re-admission.

- Integration and social inclusion. Hospitals are often detached from communities, but we would like to see replacement services fully integrated into local communities. For more able people there is a role for peer-to peer support to support the transition and build inclusion. We also recognise that transitions can be difficult, so in some cases trial periods might be appropriate.
- Information and communication. Good information, well communicated, helps people and families understand what lies ahead and promotes positive opportunities.
- Planning, project management and facilitation. Joint locality teams, drawing on people from the CCGs and NHS, must have appropriate resources, skills and specialism to support the resettlement programme.

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

This plan has been written in context with the Surrey SEND 20/20 plan which includes the EHCPs.
It forms part of the Learning Disability and Autism Strategy 2016-20.
It links with the CCG collaborative and the local joint commissioning boards.
And is designed as part of the overarching Families, Friends and communities project.
Work has started to ensure it is in the PHB ICB local work

Any additional information

5.Delivery

Plans need to include key milestone dates and a risk register

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

The Surrey Transforming Care Plan is structured to deliver solutions to the priority cohorts and, beyond that, the wider population of people with learning disabilities and/or autism.

Many of the activities will be scheduled to take place over a short-medium term timescale, but we need to keep in mind the importance of maintaining momentum in the long term. It might take 5-10 years before all people follow planned care pathways leading to accommodation and support which they choose, and which support them to live positive and meaningful lives in the community.

The Surrey Transforming Care Plan has the following workstreams:

1. **Prevention, Information, Advice and Advocacy workstream**

   (targeting Strategic Goal 3c – Information, advice, advocacy)

   Prevention starts with good information in the universal health and community settings

   Workstream activities will include:

   a. Providing information in accessible formats to facilitate better engagement within universal services

b. Defining clear accountabilities for communication and advice.

c. Designing and building infrastructures for disseminating information to all stakeholders (especially people needing services), including a 'navigator' to help people through the system.

d. Building on existing specialist advocacy services to ensure that all people who need and want advocacy support are able to receive it (including people who live out of county).

2. Workforce Development workstream

(targeting Surrey Strategic Goal 1g – Building workforce)

The cohort of people falling within this programme requires support from high calibre staff with strong values, great skills and specific competencies.

Recruiting staff of the right quality in sufficient numbers will be a significant challenge in Surrey, where workforce constraints are already impacting the supply and quality of support for people with disabilities. Surrey has virtually no unemployment, whilst providers in the sector are currently experiencing average staff vacancy rates approaching 10% and retention rates of around 30%.

To build a strong workforce to meet the needs of the cohort we plan to:

a. Specify the profile of people required in Manager and Support Worker roles.

b. Quantify the additional number of people needed in each role and specify where they will be required.

c. Work with other agencies to implement a programme to build the workforce. It is proposed that this work is managed on behalf of the sector by the Surrey Care Association because of the SCA is best-positioned to deliver workforce outcomes to meet the needs of its members. It is further proposed that this programme is joint-funded by Surrey County council, the Surrey CCGs and Surrey Care Association. The Programme activities will need to be wide-ranging and cover all fronts if we are to recruit the people we need. They will include:

- Raising the profile of care and support work through public relations, advertising and social media.
- Opening and facilitating channels of recruitment, including recruitment via schools and colleges, the internet and recruitment agencies.
- Organising targeted recruitment events, including open days, recruitment fairs and roadshows (for example in shopping centres and leisure centres).
- Opening channels of recruitment from EU countries. A Surrey recruitment office in Sofia, perhaps?

Key milestone: Project Terms of Reference drafted and agreed

Key milestone: Commissioning parties agree budget and authorise go-ahead

Key milestone: Project Manager appointed and project underway

d. Implement workforce training and development, with specific focus on:

- Management training. Care services are as only as good as their Managers, and these services will need excellent Managers.

- Proactive behavioural management and Positive Behavioural Support training.
- Reactive strategies for crisis intervention and de-escalation, including physical restraint as a last resort.
- Supervision processes
- Mentoring and peer support

One option being considered is setting up a local training and learning agency to facilitate and deliver training. Another attractive option is to set up an accredited training programme to ensure that staff working with this cohort are properly trained and certified.

e. Facilitate cross-organisation training, so that training specialism and excellence is shared.

f. Develop an iterative model of best practice to supporting staff to deliver excellent care. This will include structures for handovers, practice review, debriefing, reflecting, sharing best practice and team discussions.

3. Quality workstream

(targeting Surrey's high level Strategic Goals of 'Living My Life' and 'Stay Healthy', and the specific Strategic Goal 1a – Purposeful activities)

Quality is a broad concept and can be looked at in several ways. In this programme our particular focus is on optimising the outcomes people are able to achieve, what is often generically called 'quality of life.' Of course people are individuals, and it is for each of us to define what 'quality of life' means to us, so the aspiration here is about ensuring that people with learning disabilities and/or autism are supported to understand what 'quality of life' means to them as individuals, and to ensure that they then have the opportunities to bring their 'quality of life' aspirations to reality.

Whilst 'quality of life' is a very individual concept, however, people with disabilities and/or autism will share common views about the building blocks which build 'quality of life.' Many people, for example, will stress the important of relationships, and work, and going to the pub with their mates. With this mind we plan to develop a set of Surrey People Standards to define what 'outstanding' looks like in respect of how service provision supports people to achieve their 'quality of life' objectives. The Surrey People Standards (unlike some existing standards) need to be practical, accessible, individual-friendly and real. If we get it right, they be a great tool for:

a. Helping people articulate quality of life, what it means to them individually and what they should expect from support services.

b. Providers developing new services.

c. Providers and commissioners reviewing the quality of existing services and planning improvements.

d. Other stakeholders, including families, with an interest in assessing the quality of services.

Activities, in which co-design will be essential throughout, will include

a. Collating and reviewing available standards covering 'quality if life' outcomes (there has

already been some good work in this area, and we have no desire to re-invent the wheel. Existing national frameworks include the Fundamental Standards, Reach Standards and the Driving up Quality Code. Locally, a number of providers have developed their own quality standards).

b. Working with people with disabilities and/or autism to understand what is important to them in respect of 'quality of life.'

c. Developing Surrey People Standards which are agreed by all relevant stakeholder groups and representative bodies.

Key milestone: Surrey People Standards drafted

Key milestone: Surrey People Standards signed off by all stakeholder groups

Key milestone: Surrey People Standards rolled out

d. Developing useable tools for measuring and then improving service quality by applying Surrey People Standards.

e. Developing Integrated Personalised Commissioning based on the Surrey People Standards

Key Milestone: Project Manager for IPC recruited

Key Milestone: Cohort of people identified for IPC approach

4. Funding workstream

(targeting Surrey's Strategic Goal 1h: Funding at long term cost of care)

Surrey Health and Social Care commissioners will align all the money for these individuals into one place, ensuring funding for people with complex needs and challenging behaviours to meets peoples' needs and aspirations is maximised

To ensure services are properly funded we will:

a. Co-design a Surrey Cost and Pricing model with providers to be used transparently across the sector in order to enable fees and costs to be understood more clearly.

Key milestone: Surrey Cost and Pricing model developed

b. Populate the Surrey Cost and Pricing model with benchmark ranges, developed in conjunction with providers and agreed by the Surrey Care Association.

Key milestone: Surrey Cost and Pricing benchmarks developed and agreed

c. Work with providers to ensure that both current and new placements are priced and costed using the new model and that values fall within agreed ranges (accepting that there will be some justifiable variations).

Key milestone: New placements priced and costed with Surrey Cost and Pricing model

Key milestone: Existing placements re-costed with Surrey Cost and Pricing model

d. Agree an 'open book' approach with providers to give transparency to sector funding.

e. Work with providers to ensure that we maximise value across the sector. To do this we will:

- Support providers to buy goods and services as cheaply as possible (including

leveraging SCC and NHS buying power).

- Promote the sharing of services to obtain economies of scale.
- Facilitate market optimisation (for example by supporting providers to re-structure to fit market demand).

f. Work to secure that overall funding envelope required to provide high quality long term services to people with complex need and challenging behaviour.

5. Estates workstream

(targeting Surrey's Strategic Goal 1e – Develop housing options)

As we have noted, there are particular difficulties sourcing and developing appropriate accommodation in Surrey.

Most new accommodation will be delivered by housing and support providers, so the requirement of this programme is to support housing and support providers to develop accommodation of the right type in the right locations, and in sufficient quantity.

Workstream activities will include:

a. Understanding the accommodation needs of people in the priority cohorts, notably people living in hospitals in Surrey and elsewhere, and people coming through (or approaching) transition (to be captured in the assessment process) .

b. Working with providers to establish how these accommodation needs will be met.

Key milestone: Agreed plan of how accommodation needs of priority cohorts will be met

c. Working with the NHS, SCC and District and Borough Councils to source land and properties which could be re-developed.

d. Working to free NHS and SCC capital to supplement capital which will be made available via housing and support providers.

e. Implementation of provider accommodation (and service development) plans.

Key milestone: Accommodation developed by providers to meet needs

f. Beyond these short to medium term actions, which focus on the priority cohorts, there is a requirement for a much larger piece of work which reviews the entirety of the accommodation in Surrey currently available to the wider population of people with learning disabilities and/or autism in Surrey. At present we know this to be mixed in terms of fitness and quality, and that people often have little to choose from.

6. Service development workstream

(targeting the need for appropriate community-based provision and Strategic Goal 2d – Local responsive alternatives to admission)

The need to provide community-based provision for people who currently reside in hospital settings, or who are at risk of being admitted to hospital, is central to this programme.

Workstream activities will include:

a. Identifying people in the priority cohorts, notably people living in hospitals in Surrey and elsewhere, and people coming through (or approaching) transition.

Key milestone: Priority cohorts defined

b. Conducting individual-led assessments to understanding the service needs of the people in the priority cohorts (links to the Estates workstream). In this activity we must not assume that traditional support arrangements are the most appropriate, but explore a range of innovative options

Key milestone: Assessments complete and refreshed at timely intervals

c. Identifying providers with the organisational skills, competencies, resources and aspiration to develop new services for the priority cohorts.

Key milestone: Providers identified and engaged

d. Working with providers to understand and evaluate what provision is currently available .

e. Working with providers to promote the development of new services. This necessitates broking arrangements between people needing services and providers who are willing and able to develop them.

Key milestone: New services specified

f. Ongoing project management, support and facilitation to people, families, providers and other stakeholders to bring new services to fruition.

Key milestone: New services operational

g. Support the transition of people into new living and support arrangements.

Key milestone: People resettled through a detailed, informative and inclusive process

h. Development of crisis respite services. Assess need, specify, work with providers and commission.

7. Community Positive Behavioural Support Network (CPBSN) workstream

(targeting Strategic Goal 2e – Positive Behavioural Support Team)

There is an identified need to build a community-based behavioural team to provide both proactive and reactive support to providers who deliver services to people with complex needs and challenging behaviour in community settings.

Workstream activities will include:

a. Work with people, families and providers to understand the nature and scale of behavioural support needed.

b. Specify the mission, objectives, accountabilities and core activities of the CPBSN.

Key milestone: CPBSN specified

c. Specify where the CPBSN sits organisationally and to whom it reports.

d. Design CPBST (staffing, resources, infrastructure, policies, operating processes and procedures, performance management framework, quality cycle).

Key milestone: Detailed design of CPBSN complete

e. Build CPBSN.

Key milestone: CPBSN operational

8. Transition 0-25

(targeting all Strategic Goals ensuring all age coverage)

There is an identified recognition that this plan will only succeed if it is implemented as soon as there is a recognition of behaviours that challenge. The system needs to change within the childrens services to give the best possible life-long outcomes for individuals and their families.

Workstream activities will include implementing the SEND Development plan. The SEND 2020 programme has four key objectives, to:

a. transform the customer experience

b. rebuild the system around the customer

c. reshape the SEND local offer

d. develop inclusive practice.

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

1) **Prevention, Information, Advice and Advocacy workstream**

Mary Hendrick and Tom Moore

2) **Workforce Development workstream**

Sonya Sellar and Hannah Dwight

3) **Quality workstream**

Chris Hastings

4) **Funding workstream**

Jo Poynter, Dianne Woods, Neill Moore, Paul Goodwin and Martin Jacobs

5) **Estates workstream**

Andrew Price

6) **Service development workstream**

Lead link commissioners

7) **Community Positive Behavioural Support Network (CPBSN) workstream**

Positive Behavioural Support Network – Tom Moore

8) **0-25 SEND**

Frank Offer

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

The Surrey Transforming Care Plan will have many milestones. At this stage we view the following as key:

1) **Prevention, Information, Advice and Advocacy workstream**

Key milestone: Develop information in accessible formats to facilitate better engagement within universal services

Key milestone: develop communications plans

Key milestone: Develop information dissemination structure

2) **Workforce Development workstream**

Key milestone: Project Terms of Reference drafted and agreed

Key milestone: Commissioning parties agree budget and authorise go-ahead

Key milestone: Project Manager appointed and project underway

3) **Quality workstream**

Key milestone: Surrey People Standards drafted

Key milestone: Surrey People Standards signed off by all stakeholder groups

Key milestone: Surrey People Standards rolled out

4) **Funding workstream**

Key milestone: Pooled commissioning budget across Surrey Transforming Care Partnership

Key milestone: Surrey Cost and Pricing model developed

Key milestone: Surrey Cost and Pricing benchmarks developed and agreed

Key milestone: New placements priced and costed with Surrey Cost and Pricing model

Key milestone: Existing placements re-costed with Surrey Cost and Pricing model.

5) **Estates workstream**

Key milestone: Agreed plan of how accommodation needs of priority cohorts will be met

Key milestone: Accommodation developed by providers to meet needs

6) **Service development workstream**

Key milestone: Priority cohorts defined

Key milestone: Assessments complete

Key milestone: Providers identified and engaged

Key milestone: New services specified

Key milestone: New services operational

Key milestone: People resettled through a detailed, informative and inclusive process

7) **Community Positive Behavioural Support Network (CPBSN) workstream**

Key milestone: CPBSN specified

Key milestone: Detailed design of CPBSN complete

Key milestone: CPBSN operational

8) **0-25 (SEND) workstream**

Key milestone: transform the customer experience

Key milestone: rebuild the system around the customer

Key milestone: reshape the SEND local offer

Key milestone: develop inclusive practice.

What are the risks, assumptions, issues and dependencies?

The following key risks, issues and dependencies have been identified:

1. That the programme is not sufficiently individually led

   There is always a fear with programmes relating to people with disabilities and/or autism that they deliver solutions which are not truly individual-led, and that people will ultimately feel that solutions have been imposed on them rather than driven by them.

   A related risk is that rather than accommodation and services being sourced and developed in line with peoples' needs and aspirations, they are squeezed into what is already available.

2. Quality of assessments.

   There is a fear that assessments will not be sufficiently detailed, lacking sufficient detail about a person's behavioural history and the potential risks to the person and those supporting him.

3. Funding and provider viability

   NHS and Surrey County Council funding have been constrained for many years. The County Council has struggled to fund new services for a growing population of disabled people support needs and been compelled to restrict funding for existing services, resulting in a real-terms reduction of funding approaching 20% since 2008.

   Downstream, providers face significant and underfunded cost pressures, including the Living Wage and pension auto-enrolment, which are set to jeopardise the financial viability of many organisations.

   This is difficult backdrop against which to develop new high quality, bespoke services.

4. Recruitment

   Real terms funding cuts in recent years have driven care and support staff wages in Surrey towards the National Minimum Wage, whilst private sector wages have increased and unemployment has dwindled to almost nothing. Unsurprisingly provider organisations have seen staff vacancy levels double over the past three years, with current levels now approaching 10%. These circumstances have serious consequences. Many services are stretched, relying on agency staff to fit gaps. Both safety and quality of care are being adversely effected.

   We also recognise that staff needed to support a corhort of people some of whom have severe challenging behaviour require extraordinary skills and competencies. They are hard to find at

the best of times. Furthermore, care and support work remains undervalued by the community at large, and this work has a poor image in the labour market.

Providers will struggle to recruit staff to support new services unless the roles are funded at a level of pay which is attractive to people and competitive in the market.

5. Training and development

   There is a risk that we succeed in recruiting staff but fail to prepare them well or support them effectively in their challenging role. If we do not get this right staff will fail to meet needs and may leave the sector.

6. Accommodation

   There is a risk that appropriate property will not be built, sourced or developed. A particular concern is that forthcoming restriction in Local Housing Allowance will have an adverse impact.

7. Community receptiveness

   Setting up new community services can still meet resistance in local neighbourhoods.

8. Joint-working, co-production and risk sharing

   Historically there has been an adversarial relationship between stakeholders. Arguments over funding have inevitably caused friction between the Continuing Healthcare Team and Social Services, whilst relationships have often been strained between commissioners, providers and families. Effective joint working, including co-design and co-production, is critical to the success of this programme.

   A key aspect of this is the need to find ways to share risk with providers who are being invited to develop new services with high levels of financial, operational and reputational risk.

9. Short-termism

   There a danger that short-termism creates unrealistic expectations and drives inappropriate solutions. It is important that the solutions delivered by this programme are thr right ones for the people who need them, that they are resilient and that they meet peoples' need in the long term.

10. Focus on models

    There is a risk that stakeholders remain hung up on models of care rather than thinking creatively about how peoples' needs can be met.

11. Programme resilience

    The public sector is traditionally great at initiating projects but weak on delivery. This programme needs be sustained over a long period to achieve its desired aims and objectives

12. Placement breakdown due to Insufficient Specialist Health Support

    Individuals not maintained within their community setting due to lack of specialist support

What risk mitigations do you have in place?

We plan to mitigate identified risks as follows:

1. That the programme is not individual led

   We will ensure that people, their families and advocates are fully involved in both the design

and implementation of this programme and in the development of new services. We strongly uphold the importance of people exercising choice and control over all aspects of their care and support.

2. Quality of assessments

   We will ensure that assessments are thorough, robust and honest, and include a full history of previous behaviours and potential risks. As well as supporting people to undertake comprehensive assessments we will ensure that effective assessment review processes are in place

3. Funding and provider viability

   We fund services a level which meets the long term cost of care, provides a reasonable return to providers and secures viability.

4. Recruitment

   We will implement the Workforce Development Plan to open channels of recruitment into social care, and breaks down barriers. One are of concern is the unaffordability of local accommodation for staff, so we will explore possibility of social care staff accessing keyworker accommodation.

   We will focus on the recruitment of both exceptional Managers and support staff. We will ensure that the sector recruits people with strong values and the right skills and competencies and that provider recruitment processes are rigorous, with all necessary checks. We will support providers to build string bank lists and build positive relationships with staff agencies to ensure that the staff they provide are appropriately checked, skilled and competent.

5. Training and development

   We will support all providers to ensure that staff are given specific, consistent, relevant and high quality training and development. This will ensure that all staff are trained to the same high level. This is an important part of the Workforce Development Plan.

6. Accommodation

   We will act decisively in the priority areas set out in the Estates Plan.

   We will assess the likely impact of forthcoming changes to LHA

7. Community receptiveness

   We will support providers to work proactively with neighbours and local communities when setting up new services.

8. Joint-working, co-production and risk sharing

   All required stakeholders have indicated their support for this programme and are committed to joint working, co-design and co-production.

   We will explore how to share risks with providers with a view to giving them the confidence and support needed to develop new services.

   We will promote a culture which does not seek to apportion blame when things go wrong, but to provide support and ensure that lessons are learned and applied.

9. Short-termism

   We will focus on solutions which meet peoples' needs and wants in the long term.

10. Focus on models

    We will maintain our focus on needs-led solutions rather than getting hung-up on models of care.

11. Programme resilience

    We will ensure that this programme is given the leadership and resources to maintain momentum, sustain progress and deliver strong solutions.

12. Placement breakdown due to Insufficient Specialist Health Support

    Providers of care and support sufficiently trained to support each other.

Any additional information

6.Finances

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

End of planning template

Annex A – Developing a basket of quality of care indicators

Over the summer, a review led by the Department of Health was undertaken of existing indicators that areas could use to monitor quality of care and progress in implementing the national service model. These indicators are not mandatory, but have been recommended by a panel of experts drawn from across health and social care. Discussion is ongoing as to how these indicators and others might be used at a national level to monitor quality of care.

This Annex gives the technical description of the indicators recommended for local use to monitor quality of care. The indicators cover hospital and community services. The data is not specific to people in the transforming care cohort.1

The table below refers in several places to people with a learning disability or autism in the Mental Health Services Data Set (MHSDS). This should be taken as an abbreviation for people recorded as having activity in the dataset who meet one or more of the following criteria:

2. They are identified by the Protected Characteristics Protocol - Disability as having a response score for PCP-D Question 1 (Do you have any physical or mental health conditions lasting, or expected to last, 12 months or more?) of 1 (Yes – limited a lot) or 2 (Yes – limited a little), and a response score of 1 or 2 (same interpretation) to items PCP-D Question 5 (Do you have difficulty with your memory or ability to concentrate, learn or understand which started before you reached the age of 18?) or PCP-D Question 13 (Autism Spectrum Conditions)
3. They are assigned an ICD10 diagnosis in the groups F70-F99, F84-849, F819
4. They are admitted to hospital with a HES main specialty of psychiatry of learning disabilities
5. They are seen on more than one occasion in outpatients by a consultant in the specialty psychiatry of learning disabilities (do not include autism diagnostic assessments unless they give rise to a relevant diagnosis)
6. They are looked after by a clinical team categorised as Learning Disability Service (C01), Autistic Spectrum Disorder Service (C02)

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

Indicator No.	Indicator	Source	Measurement2
1	Proportion of inpatient population with learning a disability or autism who have a person-centred care plan, updated in the last 12 months, and local care co-ordinator	Mental Health Services Data Set (MHSDS)	Average census calculation applied to: • Denominator: inpatient person-days for patients identified as having a learning disability or autism. • Numerator: person days in denominator where the following two characteristics are met: (1). Face to face contact event with a staff member flagged as the current Care Co-ordinator (MHD_CareCoordinator_Flag) in preceding 28 days; and 2. Care review (Event record with MHD_EventType 'Review') within the preceding 12 months.
2	Proportion of people receiving social care primarily because of a learning disability who receive direct payments (fully or in part) or a personal managed budget (Not possible to include people with autism but not learning disability in this indicator)	Short and Long Term Support statistics	This indicator can only be produced for upper tier local authority geography. Denominator: Sum of clients accessing long term support, community services only funded by full or part direct payments, managed personal budget or commissioned support only. Numerator: all those in the denominator excluding those on commissioned support only. Recommended threshold: This figure should be greater than 60%.

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

3	Proportion of people with a learning disability or autism readmitted within a specified period of discharge from hospital	Hospital Episodes Statistics (HES) and Assuring Transformation datasets. Readmission following discharge with HES main specialty - Psychiatry of Learning Disabilities or diagnosis of a learning disability or autism.	HES is the longest established and most reliable indicator of the fact of admission and readmission. • Denominator: discharges (not including transfers or deaths) from inpatient care where the person is identified as having a learning disability or autism • Numerator: admissions to psychiatric inpatient care within specified period The consultation took 90 days as the specified period for readmission. We would recommend that this period should be reviewed in light of emerging readmission patterns. Particular attention should be paid to whether a distinct group of rapid readmissions is apparent. NHS England is undertaking an exercise to reconcile HES and Assuring Transformation data sets, to understand any differences between the two. At present NHS England will use Assuring Transformation data as its main source of information, and will be monitoring 28-day and 12-month readmission.
4	Proportion of people with a learning disability receiving an annual health check. (People with autism but not learning disability are not included in this scheme)	Calculating Quality Reporting Service, the mechanism used for monitoring GP Enhanced Services including the learning disability annual health check.	Two figures should be presented here. • Denominator: In both cases the denominator is the number of people in the CCG area who are on their GP's learning disability register • Numerator 1. The first (which is the key variable) takes as numerator the number of those on their GPs learning disability register who have had an annual health check in the most recent year for which data are available • Numerator 2. The second indicator has as its numerator the number of people with a learning disability on their GPs learning disability health check register. This will identify

			the extent to which GPs in an area are participating in the scheme
5	Waiting times for new psychiatric referral for people with a learning disability or autism	MHSDS. New referrals are recorded in the Referrals table of the MHSDS.	• Denominator: Referrals to specialist mental health services of individuals identified in this or prior episodes of care as having a learning disability or autism • Numerator: Referrals where interval between referral request and first subsequent clinical contact is within 18 weeks
6	Proportion of looked after people with learning disability or autism for whom there is a crisis plan	MHSDS. (This is identifiable in MHMDS returns from the fields CRISISCREATE and CRISISUPDATE)	Method – average census. • Denominator: person-days for patients in current spell of care with a specialist mental health care provider who are identified as having a learning disability or autism or with a responsible clinician assignment of a person with specialty Psychiatry of Learning Disabilities • Numerator: person days in denominator where there is a current crisis plan