Thurrock: A place of opportunity, enterprise and excellence, where individuals, communities and businesses flourish

Health and Wellbeing Board

The meeting will be held at **2.00 pm** on **7 January 2016**

Committee Room 1, Civic Offices, New Road, Grays, Essex, RM17 6SL

Membership:

Councillors Barbara Rice (Chair), John Kent, Brian Little, Bukky Okunade and Joycelyn Redsell

Mandy Ansell, Acting Interim Accountable Officer, Thurrock NHS Clinical Commissioning Group
Dr Anjan Bose, Clinical Representative, Thurrock CCG
Lesley Buckland, Lay Member Thurrock CCG
David Bull, Director of Planning & Transportation
Graham Carey, Independent Chair, Thurrock Safeguarding Adults Partnership Board
Dr Anand Deshpande, Chair of Thurrock NHS CCG Board
Jane Foster-Taylor, Executive Nurse Thurrock NHS CCG
Roger Harris, Director of Adults, Health and Commissioning, Thurrock Council
Kristina Jackson, Chief Executive Thurrock CVS
Kim James, Chief Operating Officer, Healthwatch Thurrock
Carmel Littleton, Director of Children's Services, Thurrock Council
Sean O'Callaghan, Vice Chair of Thurrock Community Safety Partnership
Clare Panniker, Chief Executive Basildon and Thurrock Hospitals Foundation Trust
David Peplow, Chair of Local Safeguarding Children's Board
Andrew Pike, Director of Commissioning Operations, NHS England - Essex and East Anglia Region
Ian Wake, Director of Public Health
Tania Sitch, Integrated Care Director Thurrock, North East London Foundation Trust

Agenda

Open to Public and Press

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Queries regarding this Agenda or notification of apologies:

Please contact Ceri Armstrong by sending an email to
Direct.Democracy@thurrock.gov.uk

Agenda published on: **29 December 2015**

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DECLARING INTERESTS FLOWCHART – QUESTIONS TO ASK YOURSELF

Breaching those parts identified as a pecuniary interest is potentially a criminal offence

Helpful Reminders for Members

- *Is your register of interests up to date?*
- *In particular have you declared to the Monitoring Officer all disclosable pecuniary interests?*
- *Have you checked the register to ensure that they have been recorded correctly?*

When should you declare an interest *at a meeting?*

- **What matters are being discussed at the meeting?** (including Council, Cabinet, Committees, Subs, Joint Committees and Joint Subs); or
- If you are a Cabinet Member making decisions other than in Cabinet **what matter is before you for single member decision?**

Does the business to be transacted at the meeting

- **relate to; or**
- **likely to affect**

any of your registered interests and in particular any of your Disclosable Pecuniary Interests?

Disclosable Pecuniary Interests shall include your interests or those of:

- your spouse or civil partner's
- a person you are living with as husband/ wife
- a person you are living with as if you were civil partners

where you are aware that this other person has the interest.

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What is a Non-Pecuniary interest? – this is an interest which is not pecuniary (as defined) but is nonetheless so significant that a member of the public with knowledge of the relevant facts, would reasonably regard to be so significant that it would materially impact upon your judgement of the public interest.

Pecuniary

If the interest is not already in the register you must (unless the interest has been agreed by the Monitoring Officer to be sensitive) disclose the existence and nature of the interest to the meeting

If the Interest is not entered in the register and is not the subject of a pending notification you must within 28 days notify the Monitoring Officer of the interest for inclusion in the register

Unless you have received dispensation upon previous application from the Monitoring Officer, you must:

- **Not participate or participate further in any discussion of the matter at a meeting;**
- **Not participate in any vote or further vote taken at the meeting; and**
- **leave the room while the item is being considered/voted upon**

If you are a Cabinet Member you may make arrangements for the matter to be dealt with by a third person but take no further steps

Non- pecuniary

Declare the nature and extent of your interest including enough detail to allow a member of the public to understand its nature

You may participate and vote in the usual way but you should seek advice on Predetermination and Bias from the Monitoring Officer.

Vision: Thurrock: A place of **opportunity**, **enterprise** and **excellence**, where **individuals**, **communities** and **businesses** flourish.

To achieve our vision, we have identified five strategic priorities:

1. Create a great place for learning and opportunity

- Ensure that every place of learning is rated “Good” or better
- Raise levels of aspiration and attainment so that residents can take advantage of local job opportunities
- Support families to give children the best possible start in life

2. Encourage and promote job creation and economic prosperity

- Promote Thurrock and encourage inward investment to enable and sustain growth
- Support business and develop the local skilled workforce they require
- Work with partners to secure improved infrastructure and built environment

3. Build pride, responsibility and respect

- Create welcoming, safe, and resilient communities which value fairness
- Work in partnership with communities to help them take responsibility for shaping their quality of life
- Empower residents through choice and independence to improve their health and well-being

4. Improve health and well-being

- Ensure people stay healthy longer, adding years to life and life to years
- Reduce inequalities in health and well-being and safeguard the most vulnerable people with timely intervention and care accessed closer to home
- Enhance quality of life through improved housing, employment and opportunity

5. Promote and protect our clean and green environment

- Enhance access to Thurrock's river frontage, cultural assets and leisure opportunities
- Promote Thurrock's natural environment and biodiversity
- Inspire high quality design and standards in our buildings and public space

Minutes of the Meeting of the Health and Wellbeing Board held on 12 November 2015 at 2.00 pm

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Present: Councillors Barbara Rice (Chair), John Kent, Bukky Okunade and Joycelyn Redsell

Mandy Ansell, Acting Interim Accountable Officer, Thurrock NHS Clinical Commissioning Group
Jane Foster-Taylor, Executive Nurse, Thurrock NHS Clinical Commissioning Group
Roger Harris, Director of Adults, Health and Commissioning, Thurrock Council
Kristina Jackson, Chief Executive, Thurrock CVS
Kim James, Chief Operating Officer, Healthwatch Thurrock
David Peplow, Chair of Thurrock Local Safeguarding Children's Board
Ian Wake, Director of Public Health, Thurrock Council

Apologies: Councillor Brian Little, Dr Anjan Bose, Lesley Buckland, David Bull, Graham Carey, Dr Anand Deshpande, Carmel Littleton, Malcolm McCann, Brid Johnson, Chief Superintendent Sean O'Callaghan, Clare Panniker, Andrew Pike

In attendance: Ceri Armstrong, Directorate Strategy Officer Thurrock Council
Jill Moorman, Safeguarding Manager Adult Social Care Thurrock Council (item 10)
Richard Parkin, Head of Housing Thurrock Council
Michelle Stapleton, Director of Integrated Care NELFT
Malcolm Taylor, Strategic Lead Learner Support Thurrock Council

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Before the start of the Meeting, all present were advised that the meeting may be filmed and was being recorded, with the audio recording to be made available on the Council's website.

1. Minutes

The minutes of the meeting held on the 1st October 2015 were approved as a correct record.

2. Urgent Items

Success Regime
Roger Harris updated Board members that he was still unsure of the scope of the Success Regime and what the process for taking it forward was. It was

likely that the focus would be on the Hospitals in Essex and their combined debt.

Mandy Ansell commented that a consultancy firm was to be appointed imminently to design the ‘how’ part of the Success Regime.

Councillor Rice stated that she wanted the Chairs of Southend and Essex Health and Wellbeing Boards along with Directors of Adult Social Care to be invited to a meeting to discuss the Regime.

RESOLVED:

That the update on the NHS Success Regime in Essex be noted; and

That the Chairs of Essex and Southend Health and Wellbeing Boards and Directors of Adult Social Care be invited to attend a meeting in Thurrock to discuss the forthcoming Success Regime.

Coach House Residential Care Home

Kim James updated the Board that a date had been set for a meeting and would be after Christmas.

Residents now felt listened to and involved, and conversations were also taking place with a number of different providers to explore options for the future.

RESOLVED:

That the update on the Coach House Residential Care Home be noted.

Health and Wellbeing Board Self-Assessment

Ceri Armstrong asked all Board members to complete the self-assessment in advance of the Board’s development session organised for the 10th December. Completing the self-assessment by the deadline would enable the necessary analysis to take place prior to the development session.

RESOLVED:

Members of the Board are to complete the self-assessment in advance of the Board development session.

Public Health Grant 2015-16

Ian Wake stated that the Government had now published the outcome of the consultation on in-year reductions to the Public Health Grant. Whilst the majority of respondents had wanted the fair share taken in to consideration, the option that had been chosen was a flat rate reduction. Thurrock would have its Grant reduced by £655,000.

RESOLVED:

That the update on the Public Health Grant be noted.

3. Declaration of Interests

No interests were declared.

4. Item in Focus - Primary Care Transformation

Ian Wake provided a presentation on Primary Care Transformation. The presentation focused on plans for Tilbury. Key points from the presentation included:

- Tilbury has a fairly young population with a high fertility rate;
- It is one of the most deprived areas and already suffers from overcrowding;
- Levels of working-age benefit claimants are far higher in Tilbury wards than the Thurrock average or the national average;
- The same applies to employment support allowance;
- There is a very high prevalence of smoking and obesity and high levels of teenage pregnancy;
- Disease registers and interventions are poor – particularly when Long-Term Conditions are identified;
- Levels of under-doctoring is a significant issue;
- Out of 6,000 people from five practices in Tilbury going to Accident and Emergency in one year, only one in ten of these people needed to be there; and
- Ensuring that people were getting the care or support they needed at the right part of the system could have saved £418,000.

Ian stated that the vision was for the development of Health and Wellbeing Centres. These would focus more on the wider determinants of health and would include services and solutions to improve lifestyles. The Centres would allow the co-location of clinical services with non-clinical services.

Comments from members of the Board included:

- Concern about GPs charging for referrals to weight management;
- Concern over the reduction in school nurses and the impact of this on issues such as sexual health;
- The need to ensure consideration of safeguarding as this is significant in deprived areas;
- The need to feed projections on population growth in to Basildon Hospital's review of maternity services;
- Concerns over the impact of cuts to the public health grant – and the effect this will have on obesity management and sexual health in particular;
- The need for partners to work together to find a solution – e.g. Basildon Hospital are keen to look at different ways of working.

5. Joint Health and Wellbeing Strategy - Progress Report

Ceri Armstrong and Ian Wake updated the Board on Progress made with the refresh of the Health and Wellbeing Strategy.

A steering group had been established to provide direction to the development of the Strategy, four draft priorities had been developed, and an outcomes framework would also be developed.

As the development of the Strategy was fast moving, the Board were asked to delegate agreement to changes to the Strategy's development to the Steering Group and the Board's Chair between meetings. This was agreed.

Councillor Rice added that the Strategy's focus needed to be on addressing inequalities across the Borough, and that the outcomes framework must link to reducing these inequalities.

An engagement approach had been developed with input and advice from Thurrock CVS and Healthwatch Thurrock. This included ensuring that there was ongoing dialogue with Thurrock people about how best to improve and maintain their health and wellbeing.

Initial activity on the priorities would start on the 23rd November and finish on the 22nd January.

The Board agreed the Strategy Engagement Plan.

As the Strategy would be taken to Full Council in March, the Board was asked to agree a special Board meeting in February for the purpose of signing off the final Strategy.

RESOLVED:

To agree the Health and Wellbeing Strategy Engagement Plan;

To note progress on the development of a refreshed Health and Wellbeing Strategy;

To agree to delegate agreement to changes to the Strategy's development to the Health and Wellbeing Strategy Steering Group and Health and Wellbeing Board Chair; and

To agree to scheduling a special Board meeting in February for the purpose of signing of the final Strategy.

6. Online Data Portal - Proposal

Ian Wake presented the proposal for an Online Data Portal.

Ian told the Board that it was important to have 'one version of the truth' – i.e. one data and intelligence set that everyone used.

Kim James stated that Healthwatch collated data about unmet need, and Ian confirmed that the data could be added to the portal.

The proposals were met positively by the Board.

RESOLVED:

That an online data portal be built.

7. Special Educational Needs and Disabilities - update on key areas of development

Malcolm Taylor presented the report and provided an overview of the Special Educational Needs and Disabilities reforms and key areas of development. This included a SEN transformation plan which had been published in September 2014.

Malcolm reported that between 1st September 2014 and 1st October 2015 there have been 354 reviews of statements held and that these are in the process of being converted to Education Health and Care Plans.

Councillor Redsell asked if the number of children requiring a special education placement had expanded, and Malcolm reported that children with autism were been supported at Treetops and that few children accessing Treetops lived outside the Borough.

Councillor Okunade noted the good progress that had been made on the transformation to the new arrangements.

Councillor Kent noted that there was a new inspection regime for the service, and Malcolm commented that challenge was expected as this was a new area of inspection and a new approach. It was hoped that Her Majesty's Inspectorate would allow arrangements to evolve and embed.

RESOLVED:

That progress made in the implementation of the new reforms in relation to Special Educational Needs and Disability be noted.

8. Transformation Plan for the Emotional Wellbeing and Mental Health of Children and Young People in Thurrock, Essex and Southend

Malcolm Taylor presented the Transformation Plan to the Board.

The Plan had been developed as part of the Collaborative Commissioning Agreement established between the seven Clinical Commissioning Groups and three Local Authorities across Essex, Thurrock and Southend.

The Plan has high profile and is likely to attract £3.3 million of funding for Essex, Southend and Thurrock.

RESOLVED:

That the Board ratify the key recommendations and priorities of the Transformation Plan

9. Safeguarding Adults Board - Annual Report 2014 - 2015

Jill Moorman, Thurrock Adult Social Care's Safeguarding Manager, attended to present the Thurrock Safeguarding Annual Report.

Jill reported that referrals were a third lower during 2014-15 than the previous year. They had risen again during 2015-16. Deprivation of Liberty referrals had also increased and everyone who lacked capacity in a residential home was now entitled to a DoL assessment. For Thurrock, this meant carrying out between 30-40 per month.

The Board thanked Jill for an excellent report.

RESOLVED:

That the content of the Safeguarding Adults Annual Report 2014-15 be noted.

10. Recommendations from the Essex Mental Health Strategic Review

Roger Harris presented the recommendations from the Essex Mental Health Strategic Review to the Board.

Roger updated the Board that the review had been commissioned by all 7 CCGs in Essex in response to the viability of Mental Health Trusts in Essex. Both Trusts had lost a significant amount of business recently.

The recommendations made included recommendations about both commissioning and provision.

Roger stated that his preference was not for a centralised Mental Health commissioning team.

RESOLVED:

The recommendations of the Essex Mental Health Review be noted;

To note that decisions on implementing recommendations from the Review be made formally at the CCG Boards and to the Thurrock Cabinet if there are any significant changes to the way MH services are commissioned or provided; and

That the Board reiterates its previous view that commissioning decisions should only be taken at a local level i.e. Thurrock; and that any decisions on a wider geographical area will only be taken where there is a clear, strong case that will benefit Thurrock residents.

11. Work Programme

RESOLVED:

That the Board's Work Programme be noted.

The meeting finished at 4.00 pm

Approved as a true and correct record

CHAIR

DATE

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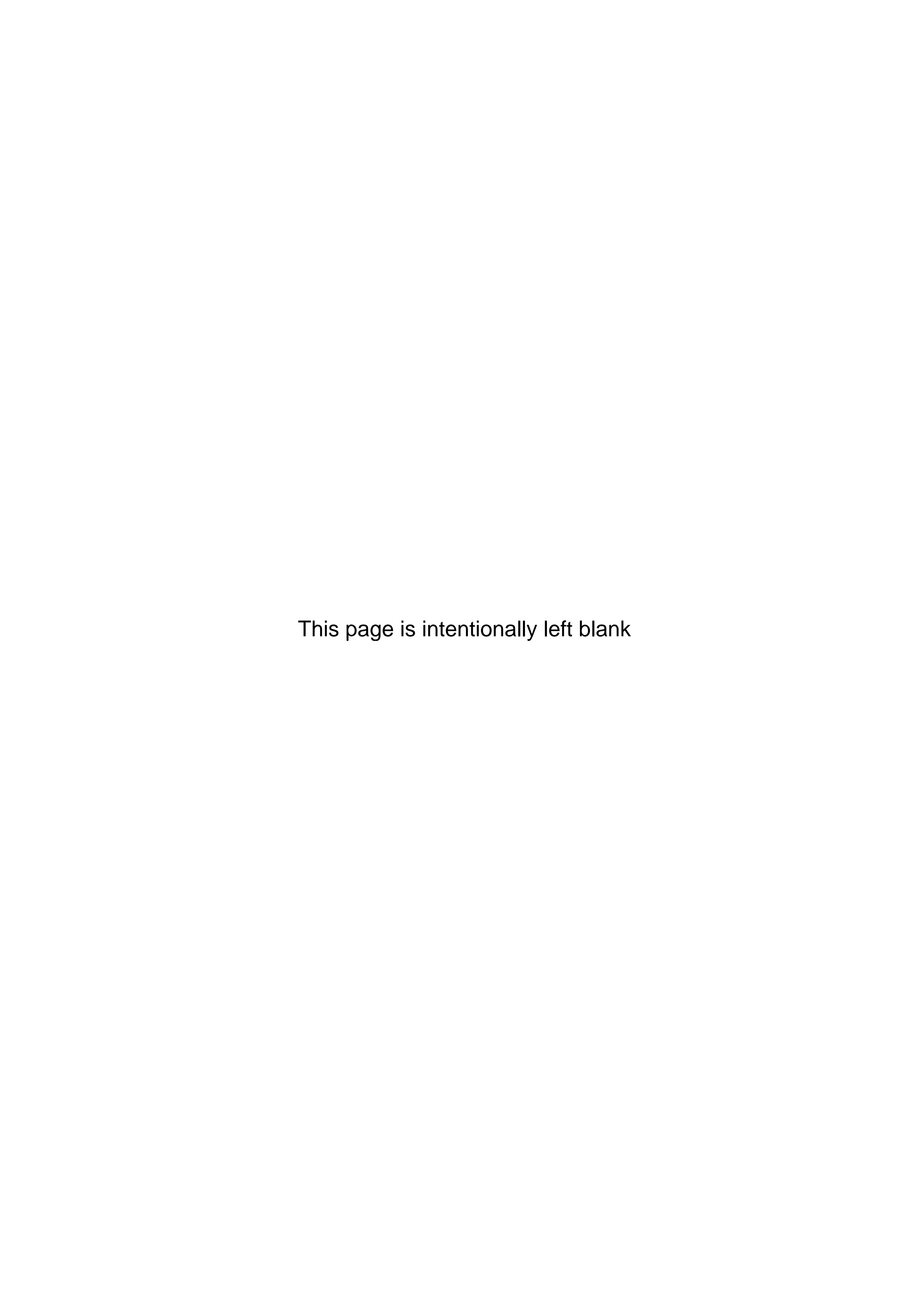
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7th January 2016	ITEM: 5
Health and Wellbeing Board	
Economic Development Strategy Refresh - Update	
Wards and communities affected: All	**Key Decision:** Key
Report of: Tim Rignall, Economic Development Manager	
Accountable Head of Service: Matthew Essex, Head of Regeneration	
Accountable Director: Steve Cox, Assistant Chief Executive	
This report is Public	

Executive Summary

Thurrock's ambitious growth agenda is backed by more than £6bn of private sector investment and aims to deliver 18,500 new homes and 26,000 new jobs by 2021. The Thurrock Economic Development Strategy 2007 (EDS) was created to provide strategic guidance to the Council and its partners in their attempts to create the required economic conditions to achieve these ambitious goals.

Recent progress on development the refreshed Strategy includes:

- Work has been undertaken to refresh the economic baseline for Thurrock to understand the extent to which progress had been made against the economic challenges identified in the 2007 EDS; and
- To make sure that the Council, and its partners, are in the best position to focus attention (and resources) on the most pressing issues, an analysis has been undertaken to map out key changes brought about since the previous EDS.

The two pieces of work will aid consideration of how successful previous interventions have been, to assess how relevant these key economic challenges remain and to identify areas of focus moving forward. It should be noted that the review period has been marked by one of the most severe economic downturns on record and that as such the achievements highlighted are even more notable. In line with the previous EDS, the updated analysis shows that Thurrock boasts some clear economic strengths and opportunities, as well as a number of challenges.

This work will now inform the development of the refreshed strategy and a timeline for this has been identified.

1. Recommendation(s)

1.1 To note the report.

2. Introduction and Background

2.1 In November 2008 Thurrock Council adopted the Thurrock Economic Development Strategy (EDS) as the key guidance document for economic growth and jobs led regeneration in Thurrock.

2.2 The purpose of the strategy is to create conditions that will stimulate business growth, inward investment and increase sustainable employment and it identifies the key opportunities and challenges that influence the economy of Thurrock.

2.3 Work has been undertaken to update the economic baseline for Thurrock. This baseline has been used to inform an assessment of progress against each of the key challenges identified in the Thurrock EDS.

2.4 This report sets out performance in relation to each of the key economic challenges for Thurrock identified in 2007, highlights some of the emerging issues to be addressed by the refreshed strategy and sets out the timetable for the refresh to be completed.

3. Issues, Options and Analysis of Options

Thurrock EDS – Progress against economic challenges

3.1 The 2007 Economic Development Strategy (EDS) set out a number of key economic challenges for Thurrock:

- The need for new employment;
- A relatively unbalanced employment base;
- A relatively weak skills base;
- A relatively limited educational offer;
- A relatively low rate of enterprise; and
- A number of infrastructure constraints.

3.2 To make sure that the Council, and its partners, are in the best position to focus attention (and resources) on the most pressing issues, it is important to map out the key changes brought about since the previous EDS. This will aid consideration of how successful previous interventions have been, to assess how relevant these key economic challenges remain and to identify areas of focus moving forward.

3.3 The analysis attached at appendix 1 sets out performance in relation to each of the key economic challenges for Thurrock identified in 2007 for which data is readily available. In line with the previous EDS, the updated analysis shows that Thurrock boasts some clear economic strengths and opportunities, as well as a number of challenges.

3.4 It should be noted that the review period has been marked by one of the most severe economic downturns on record and that as such some of the achievements are perhaps even more notable. Some of the obvious highlights are:

- Thurrock saw its local employment rate decline after the economic downturn in 2007/08 – falling from 75.4% of residents in 2007, to just 70.0% of working age residents in 2011. However, following a sharp rise in 2012/13, the employment rate has settled considerably above the national average. In the 12 months to December 2014, 73.4% of working age residents in Thurrock were in employment - above the England (72.5%) average and only slightly below the rate for Essex County (74.1%).
- The unemployment rate in Thurrock rose sharply after the onset of the economic downturn, peaking at 11.4% of economically active residents in Thurrock in the 12 months to March 2012 (9,400 people). It has declined since then. In the 12 months to December 2014, 6.0% of economically active residents in Thurrock were unemployed (5,000 people). The unemployment rate is now in-line with the rates for Essex County (6.0%) and England (6.2%) as a whole.
- Between 2007 and 2013, there was an increase of 5,000 jobs in Thurrock (from 63,000 to 68,000). When compared to regional and national economic performance, jobs growth has been comparatively strong.
- Putting Thurrock's jobs growth in a wider context the area has performed well in relation to many other parts of the country since 2007. London has seen the highest growth in workforce jobs at 13.4%. However, at 7.9%, Thurrock saw a significantly higher rate of jobs growth than the South East (3.7%) and Eastern (3.5%) regional averages. This was also above the rate of jobs growth in both neighbouring Essex County (5.5%) and nationally (3.8%).
- There has been a significant shift towards attainment at the highest qualification levels (NVQ3 and above) among working age residents, and away from qualifications at the lowest levels (NVQ1 and below). In total there are 14,200 more working age residents qualified at Level 3 and above in 2014 than in 2007, and 10,500 fewer residents aged 16-64 whose highest level of qualification is at NVQ Level 1 or below.
- In 2013/14, 57.9% of key stage 4 students in Thurrock achieved 5 A*-C grades at GCSE including English and maths. This was above the Essex County (56.5%) and England (53.4%) averages. This is a significant improvement on local performance in 2007/08, when only 42.6% of KS4 students in Thurrock achieved 5 A*-C grades at GCSE including English and maths.
- Thurrock has seen considerable growth in active enterprises in recent years. The number of active enterprises registered in the local area increased by 1,030 from 2007-2013. The number of Thurrock based enterprises increased throughout the period, even during the recession, and have picked up further in recent years. The extent of Thurrock success in growing its business base can be seen when comparing local performance with other areas of the country. At 25.0%, Thurrock saw a

higher rate of business growth in between 2007 and 2013 than for any region in England, including London (23.4%). This was also significantly above the Essex County (6.3%) and national (7.7%) averages.

- Complimenting this, Thurrock has generally seen growth in business space. Compared to national trends, there has been particularly strong growth in industrial and retail space since 2007, reflecting major investments in the local area. This suggests that Thurrock may have gone some way to rectifying the issue of inadequate provision since 2007.

Continuing and future challenges

3.5 Whilst recognising a number of significant achievements the analysis also helps in pointing to a number of areas which might provide the focus for the refreshed EDS:

- There is a significant productivity challenge. The Thurrock economy was worth around £2.8bn (unadjusted for inflation and local price variations) in 2013, equivalent to £17,300 per head of population - 12.2% below the Essex County average of £19,700 and 28.2% below the England average of £24,100.
- Unemployment at 6% remains significantly above pre-recession levels, 3.3% of economically active residents in 2007, or 2,600 people.
- Whilst jobs growth has been strong further work will be needed to ensure that full benefit is realised from investment in the growth hubs to meet the 26,000 jobs target by 2021.
- Between 2007 and 2013 Thurrock's industrial structure remained somewhat uneven: that is to say, within the local economy there remain particularly strong concentrations of employment in a few key areas of activity and a relatively low share of employment in most other industrial groups. Further work is needed to diversify the economic base to make it more resilient.
- Thurrock still has relatively low proportions of residents who are qualified at NVQ Level 3 and above – 40.5% of working age residents in 2014, compared to 53.2% nationally. There is also a relatively high proportion of working age adults with low or no qualifications, including 12,600 Thurrock residents aged 16-64 with no qualifications – making up 12.2% of working age residents, compared to just 8.6% nationally.
- A relatively low proportion of Thurrock students went on to a sustained education destination (54% compared to 64% for England). Although this was an improvement on 2009/10, when 51% of Thurrock students were registered in a sustained education destination.
- There continues to be a relatively low proportion of Thurrock young people going on to Higher Education.
- Of all of the VAT registered businesses registered in 2011, nearly three-quarters (74.8%) were still trading in 2012. This was significantly above the 24-month survival rates for businesses born in 2008 and only marginally below the England average (75.5%). At the same time, this was still lower than the rate for businesses born in Thurrock in

2007 (79.4%), suggesting there remains scope for survival rates to improve further.

Timeline for refresh of the EDS Strategy

3.6 A revised strategy will be considered by the Council's Cabinet on 13 January 2016. The timeline and activity plan to develop the Strategy is summarised below:

Date: Week comm.	**Activity**
19/10/2015	Agreement of stakeholder lists for discussions
26/10/2015	Information review - Discussions with Council officers and partners to include finance, planning, regeneration and economic development. This will be on a workshop and 1:1 basis.
2/11/2015	Discussions with stakeholders in the six growth hubs to include business representatives, South Essex College and Members. At the same time identify new projects and priorities.
9/11/2015	Draft first version of report and present to stakeholders.
16/11/2015	Review report comments, complete amendments and produce second draft. Workshop with PTR O&S Members to discuss draft
23/11/2015	Report and strategy entered into Cabinet process
13/01/2016	Cabinet

4. Reasons for Recommendation

4.1 The Council has acknowledged that regeneration and growth is a priority. This strategy is part of a suite of key strategies which will guide the development of policies and programmes to deliver the vision for Thurrock defined within the Community Strategy.

5. Consultation (including Overview and Scrutiny, if applicable)

5.1 Consultation with stakeholders has taken place as per the timetable in 3.6.

6. Impact on corporate policies, priorities, performance and community impact

6.1 The strategy will support all the corporate policies and priorities – including the delivery of the outcomes contained within the refreshed Health and Wellbeing Strategy.

6.2 An earlier report on the EDS suggested that the Community Regeneration Strategy and Economic Development Strategy would be merged into one key strategy document through this process.

7. Implications

7.1 **Financial**

Implications verified by: **John Smith**
Accountant, Corporate Finance

There are no direct financial implications associated with this report, however the delivery programmes that support economic growth will help to generate additional National Non Domestic Rates collections, thus increase the amount of retained rates achieved by the Council. This will support the achievement of objectives defined within the Thurrock Corporate Plan and Medium Term Financial Strategy.

7.2 **Legal**

Implications verified by: **Ann Osbourne**
Planning and Regeneration Solicitor

There are no legal implications of this report which is for noting.

7.3 **Diversity and Equality**

Implications verified by: Becky Price
Equalities and Cohesion Officer

This strategy is a key route to securing local benefit from Thurrock's growth programme, and will underpin the achievement of the Councils vision and priorities defined in the Thurrock Community Strategy.

7.4 **Other implications** (where significant) – i.e. Staff, Health, Sustainability, Crime and Disorder)

None

8. **Background papers used in preparing the report** (including their location on the Council's website or identification whether any are exempt or protected by copyright):

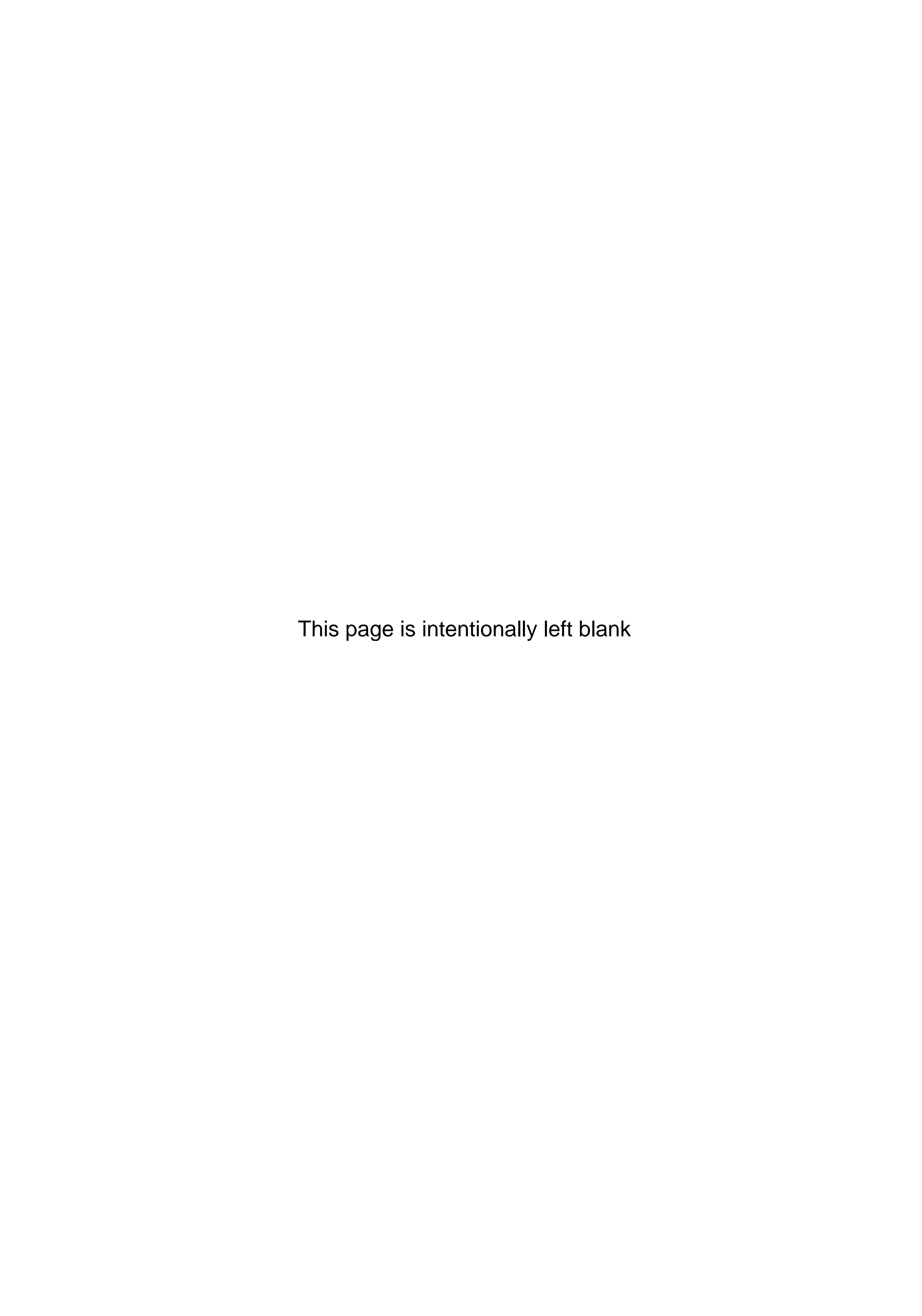
- Thurrock EDS: Progress against priority areas (attached as Appendix 1).
- Draft Thurrock Economic Baseline (currently available from the Economic Development Team, Civic Offices, New Road, Grays RM17 6SL).

9. Appendices to the report

- Thurrock EDS: Progress against priority areas (attached as Appendix 1).

Report Author:

Tim Rignall
Economic Development Manager
CEDU



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Thurrock EDS: progress against priority areas

The 2007 Economic Development Strategy (EDS) set out a number of key economic challenges for Thurrock. These related to areas such as jobs growth, skills and employment and enterprise performance.

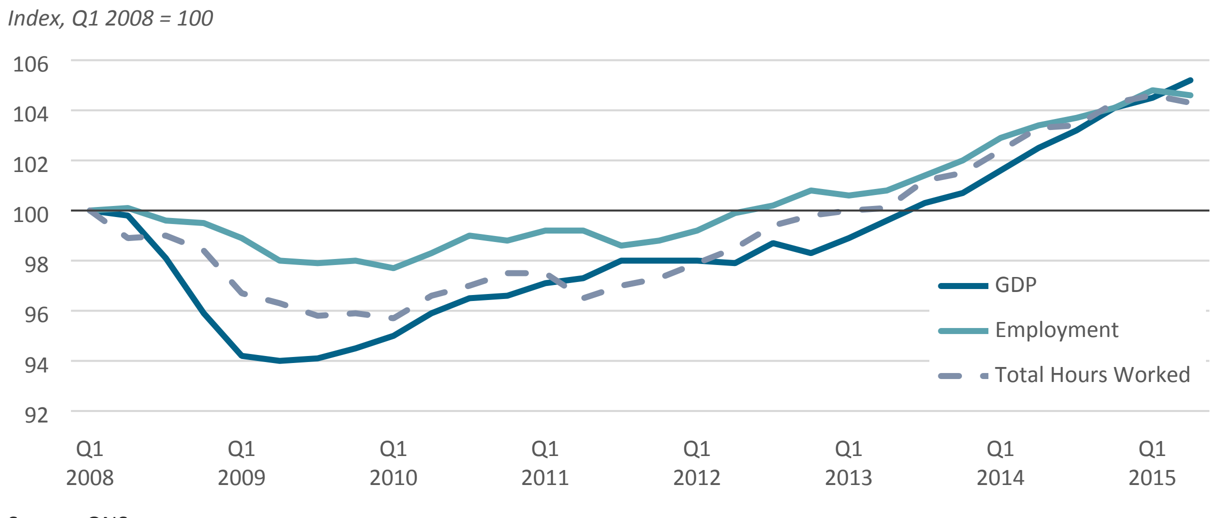
In line with the previous EDS, our updated analysis shows that Thurrock boasts some clear economic strengths and opportunities, as well as a number of challenges. To make sure the Council is in the best position to focus attention (and resources) on the most pressing issues, it is important to map out the key changes brought about since the previous EDS. This should help the Council to consider how successful previous interventions have been and to assess how relevant these key economic challenges remain.

This note sets out performance in relation to each of the key economic challenges for Thurrock identified in 2007 for which data is readily available. It should also be noted that this period has been marked by one of the most severe economic downturns on record.

National economic context

During the 2008 to 2009 economic downturn UK Gross Domestic Product (GDP) fell by around 6% and did not return to its pre-downturn levels until mid-2013. The number of people employed also fell following the downturn, but by just 2.3%.[1] With employment proving more resilient than GDP, the UK produced less output on average per worker employed, indicating a significant decline in the UK's productivity (output per hour worked).

Figure 1: Index of GDP (chained volume measure), employment and hours since Quarter 1 (Jan to Mar) 2008, seasonally adjusted



Source: ONS

In recent periods economic performance has picked up. With unemployment falling towards pre-recession levels for most workers (youth unemployment remains elevated) and signs of rising pay growth in recent data, evidence of a tightening labour market has started to emerge.

[1] ONS (2015) - GDP and the Labour Market – Q2 2015 Quarterly Update

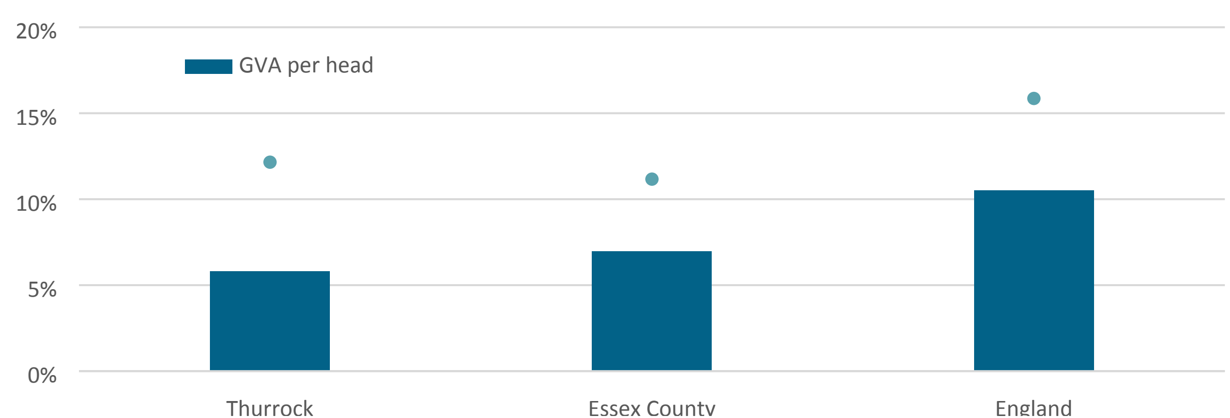
Thurrock's economic performance

Output

The Thurrock economy was worth around £2.8bn (unadjusted for inflation and local price variations) in 2013, equivalent to £17,300 per head of population - 12.2% below the Essex County average of £19,700 and 28.2% below the England average of £24,100.

As **Figure 2** shows, growth in economic output (GVA[2]) has been below average in recent years. Between 2007 and 2013, nominal GVA growth was relatively similar in Thurrock (12.2%) and Essex Country (11.2%), but below the England average (15.9%). And, taking into account population change, growth in nominal GVA per head in Thurrock (5.8%) was significantly lower than for both Essex County (7.0%) and England (10.5%) during this time.

Figure 2: Percentage change in nominal GVA and GVA per head 2007-2013



Source: ONS

Employment

As **Figure 3** shows, in-line with national trends, Thurrock saw its local employment rate decline after the economic downturn in 2007/08 – falling from 75.4% of residents in 2007, to just 70.0% of working age residents in 2011. However, following a sharp rise in 2012/13, the employment rate has settled considerably above the national average. In the 12 months to December 2014, 73.4% of working age residents in Thurrock were in employment - above the England (72.5%) average and only slightly below the rate for Essex County (74.1%).[3]

[2] Gross Value Added (GVA) is a measure of the increase in the value of the economy due to the production of goods and services. It is measured at current basic prices, which include the effect of inflation, excluding taxes (less subsidies) on products (for example, Value Added Tax). GVA plus taxes (less subsidies) on products is equivalent to Gross Domestic Product (GDP).

[3] ONS (2015) Annual Population Survey

Figure 3: Employment rate (% of residents aged 16-64 in employment)

Source: ONS APS

In total, there were 76,600 working age residents in employment in Thurrock in the 12 months to December 2014. Despite a fall in the last year, the *number* of residents in employment is estimated to have increased by 4,500 or 6.2% between 2012 and 2014, and 1,400 or 1.9% between 2007 and 2014.[4] At the same time, the employment *rate* remains 2.0 percentage points below 2007 levels (indicating that population growth has outpaced employment growth).

Unemployment

In keeping with employment trends, the unemployment rate in Thurrock rose sharply after the onset of the economic downturn, peaking at 11.4% of economically active residents in Thurrock in the 12 months to March 2012 (9,400 people). It has tended to decline since then. In the 12 months to December 2014, 6.0% of economically active residents in Thurrock were unemployed (5,000 people). The unemployment rate is now in-line with the rates for Essex County (6.0%) and England (6.2%) as a whole. At the same time, unemployment remains significantly above pre-recession levels (3.3% of economically active residents in 2007, or 2,600 people).

[4] ONS (2015) Annual Population Survey

Figure 4: Unemployment rate (% of economically active residents aged 16+)

Source: ONS APS

Thurrock's EDS priorities

"The need for new employment"

The 2007 EDS stated that: "The overarching challenge for Thurrock is to create new jobs" and included a headline target to create 26,000 more jobs in the local economy by 2021. An increase in job opportunities was considered vital to the Thurrock's "economic, social and environmental sustainability", particularly in light of the area's growing population.[5] **Table 1** outlines in more detail the potential for jobs growth in key industrial sectors, as set out in 2007.

Table 1: Potential employment growth in Thurrock 2007-2021

'Core' Sectors	
Port, Logistics and Transport	10,000
Retail	3,000-11,000
Construction	1,300
Total: core sectors	**14,300 - 22,300**
'Opportunity' Sectors	
Business Services	2,000
Recreation & Leisure	1,800
Environmental Tech, Recycling and Energy	1,000-1,500
Creative Industries	1,000
Public Sector Services	2,000
Total: opportunity sectors	**7,800 - 8,300**
Total	
Total: overall	**22,100 – 30,600**

Source: Thurrock Economic Development Strategy 2007

[5] Thurrock Economic Development Strategy (2007)

As **Figure 5** shows, between 2007 and 2013, there was an increase of 5,000 jobs in Thurrock (from 63,000 to 68,000). Extrapolating trend growth from 2007-2013 would see an increase of 11,800 jobs by 2021.[6] This ouwld be short of the 2007 target, although recent investments in the local economy (e.g. London Gateway, Port of Tilbury, Lakeside) may offer potential for faster jobs growth in the coming years.

Figure 5: Jobs growth in Thurrock 2007-2013 (cumulative)

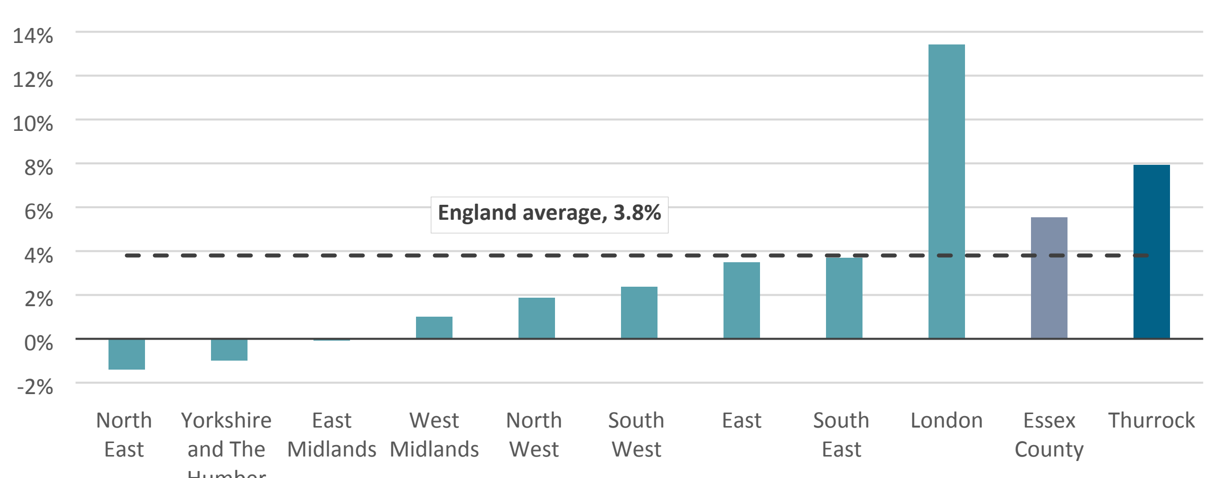
6,000
5,000
4,000
3,000
2,000
1,000
0

2007-08 2008-09 2009-10 2010-11 2011-12 2012-13

Source: ONS Jobs Density

Moroever, putting Thurrock's jobs growth in a wider context, it is evident that the area has performed relatively well in relation to many other parts of the country since 2007. **Figure 6** shows the percentage change in workforce jobs between 2007 and 2013. As can be seen, London was the region that saw the highest growth in workforce jobs at 13.4%.[7] However, at 7.9%, Thurrock saw a significantly higher rate of jobs growth than the South East (3.7%) and Eastern (3.5%) regional averages.[8] This was also above the rate of jobs growth in both neighbouring Essex County (5.5%) and nationally (3.8%).

Figure 6: % Jobs growth 2007-2013



Source: ONS Jobs Density

[6] ONS (2015) Jobs Density
[7] This is one of the defining trends since 2007: while the economic recovery has been relatively 'jobs rich', jobs growth has been heavily focused on London. England has seen total jobs rise by around 1.01m from 2007-2013 (from 26.6m to 27.6m) – with 635,000 of these jobs (62.9%) created in London. Source: ONS (2015) Jobs Density
[8] ONS (2015) Jobs Density

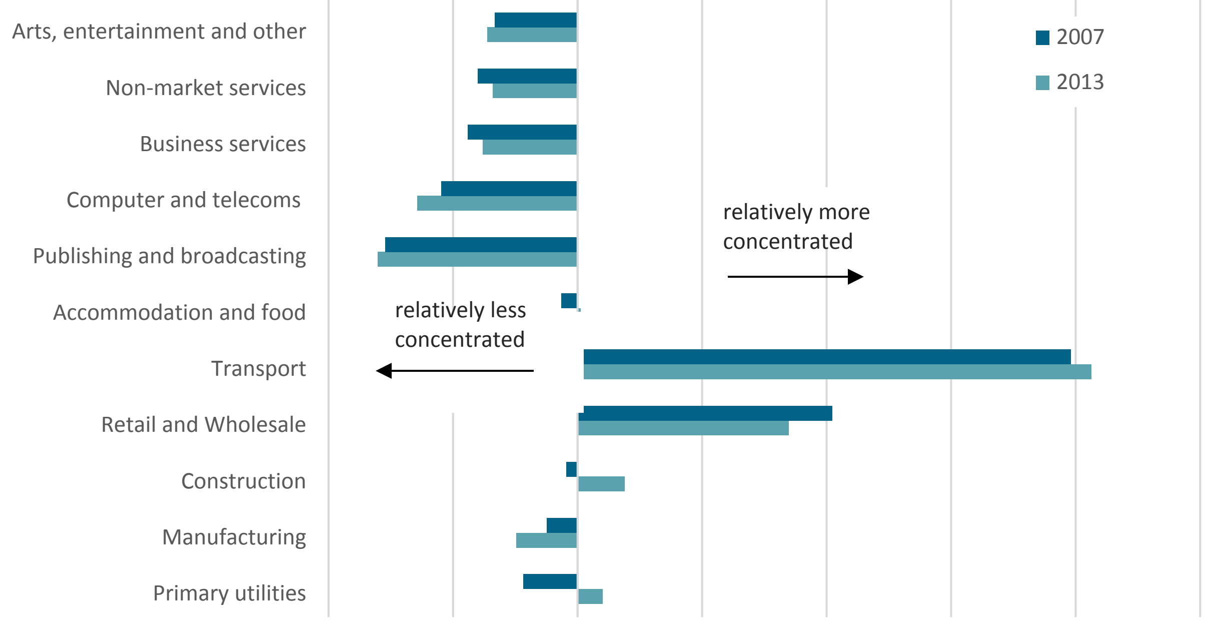
Without a significant uplift in job creation in the coming years, Thurrock does not appear to be on track to meet the 26,000 jobs target by 2021. However, when compared to regional and national economic performance, jobs growth has been comparatively strong in recent years.

"A relatively unbalanced employment base"

The EDS acknowledged that the Thurrock economy has historically been driven by the presence of several large sectors which have dominated the business base in employment terms, particularly: transport; logistics; port functions; and retail. The EDS set out the challenge to diversify the economy to be "less dependent upon a relatively narrow range of sectors". At the same time, increased diversification could not be at the expense of the area's "core sectors".[9]

To establish how successful Thurrock has been in diversifying its economy, **Figure 7** sets out a detailed sectoral analysis of local employment, based on location quotients.[10]

Figure 7: Location Quotient, 2007 and 2013 (vs UK)



Source: East England Forecasting Model

As the chart shows, between 2007 and 2013 Thurrock's industrial structure remained somewhat uneven: that is to say, within the local economy there remain particularly strong concentrations of employment in a few key areas of activity and a relatively low share of employment in most other industrial groups. More specifically, compared to the national (UK) average:

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[9] The core employment growth sectors were the sectors already strong in Thurrock, generating natural growth and employment. The opportunity employment growth sectors were sectors less established, where future growth would need to be induced by partners - Thurrock Economic Development Strategy (2007)

[10] A location quotient (LQ) is a ratio that compares an area to a larger reference area according to some characteristic or asset. It can reveal what makes a particular area "unique" in relation to the national average. An LQ of greater than one implies relative concentration of employment (compared to the UK average); an LQ of less than one implies a relative lack of concentration in a given sector.

- There is a particularly high concentration of employees in the transport grouping, and this has become more concentrated since 2007 (LQ of 3.1 in 2013, up from 3.0 in 2007).
- The share of employees in retail and wholesale was also very high, with an LQ of 1.8 (although, down from 2.0 in 2007), while construction has become more important to the local economy since 2007 (LQ of 1.2, up from 1.0 in 2007).
- Employment is less concentrated in most other sectors, most significantly in the higher value-added business services and computer and telecoms sectors. These sectors had LQ's in 2013 of 0.6 and 0.4 respectively. This has not changed significantly since 2007.

Why does the concentration of industries matter?
To an individual, it matters because the pattern of geographical concentration of industries influences the economic opportunities available in the area in which they live. For example, a potential employee faces a very different labour market in Thurrock to other parts of Greater Essex.

To policy makers, the geographical concentration of economic activity matters because it may have an impact on the potential for economic growth in the economy (depending on the sectors). Economic inequalities can also result from an uneven economic geography.

"A relatively weak skills base"

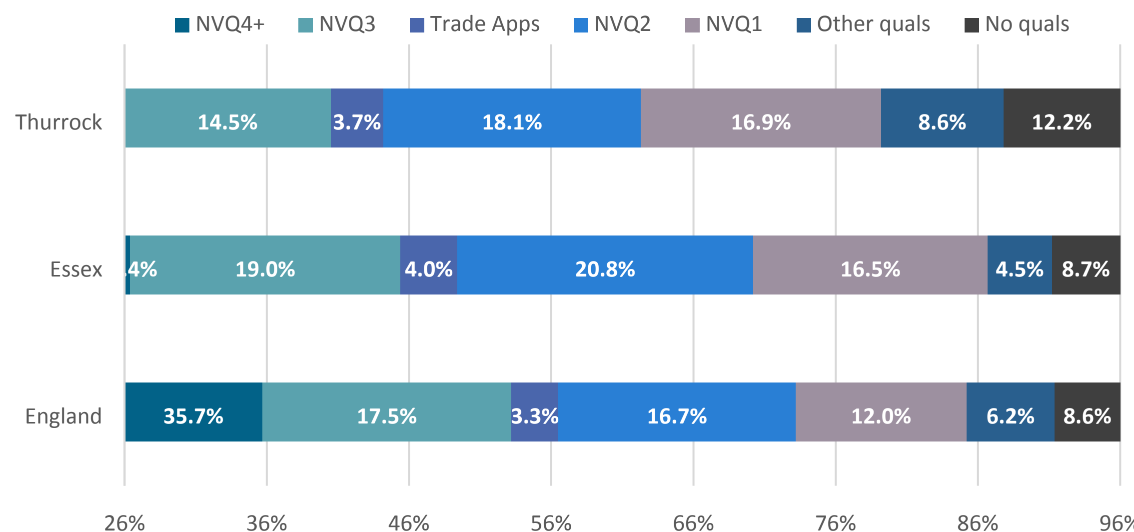
The 2007 EDS highlighted a relatively low level of higher level qualifications in the Thurrock labour force, particularly with regards to Level 3 qualifications and above. It also noted relatively low rates of progression from secondary school to further and higher education (FE and HE) and called for a "platform for uplift" in the quality of the local skills base, ensuring these are relevant to the business base.[11]

Adult skills

Looking at data for 2014, Thurrock still has relatively low proportions of residents who are qualified at NVQ Level 3 and above – 40.5% of working age residents in 2014, compared to 53.2% nationally.[12] There is also a relatively high proportion of working age adults with low or no qualifications, including 12,600 Thurrock residents aged 16-64 with no qualifications – making up 12.2% of working age residents, compared to just 8.6% nationally.

[11] Thurrock Economic Development Strategy (2007)
[12] ONS (2015) Annual Population Survey

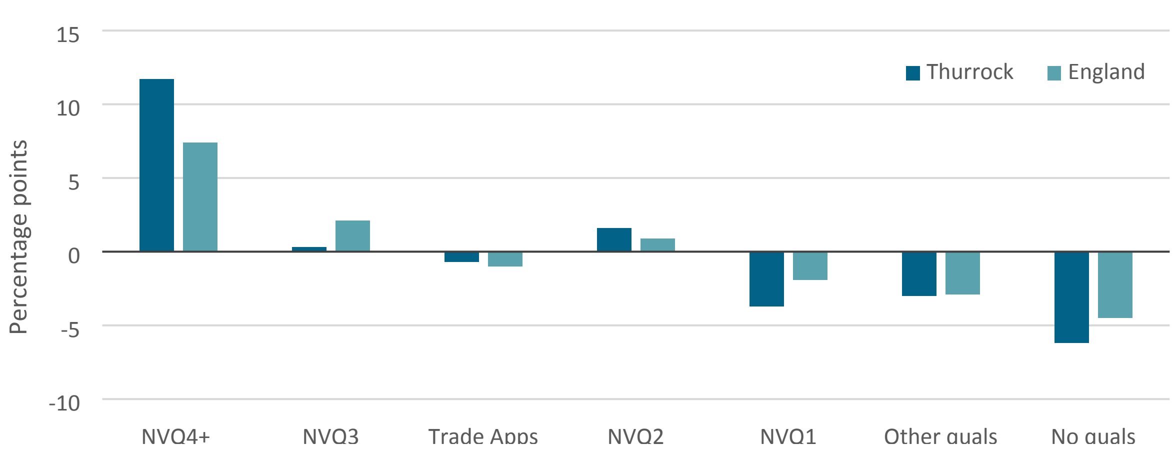
Figure 8: Qualifications profile 2014 (% residents aged 16-64 by highest level of qualification)



Source: ONS APS

However, there have been considerable **improvements in qualifications attainment in recent years**. Between 2007 and 2014 there was a significant shift towards attainment at the highest qualification levels (NVQ3 and above) among working age residents, and away from qualifications at the lowest levels (NVQ1 and below). In total there are 14,200 more working age residents qualified at Level 3 and above in 2014 than in 2007, and 10,500 fewer residents aged 16-64 whose highest level of qualification is at NVQ Level 1 or below (including 'other qualifications'). While these trends have also taken place nationally, they have been particularly marked in Thurrock - as **Figure 9** shows.

Figure 9: Change in % of residents aged 16-64 by qualification (pp, 2007-2014)



Source: ONS APS

This matters because if Thurrock's residents are to benefit from the jobs available in the local economy, they need to have in-demand skills. And employment rates vary significantly by qualification level: 84.4%

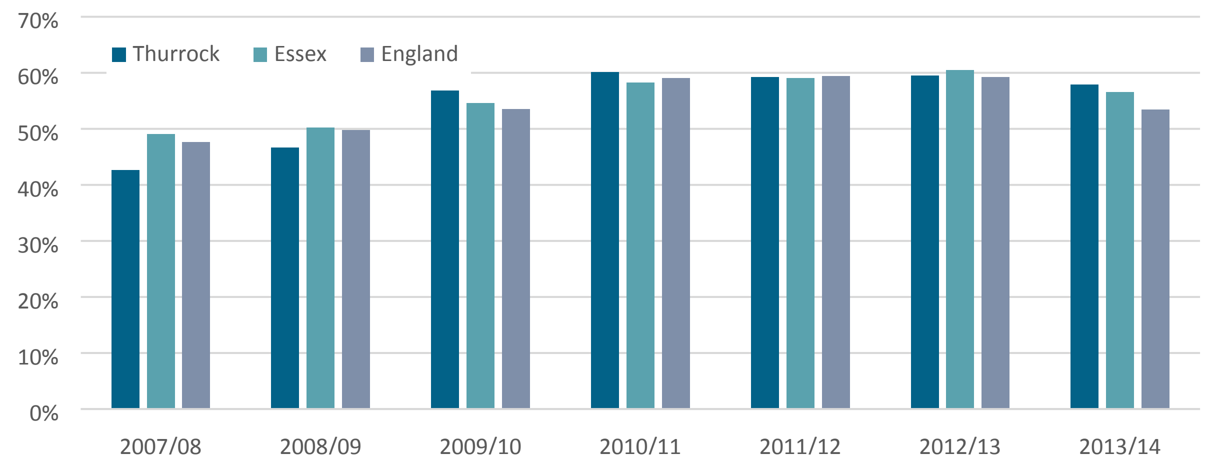
working age residents qualified at NVQ4+ were in employment in 2014, compared to 63.1% of those qualified at NVQ1 and below (including 'other qualifications').[13]

Education attainment

One contributory factor to improving adult skills is improvements in education performance in Thurrock at GCSE level. In 2013/14, 57.9% of key stage 4 students in Thurrock achieved 5 A*-C grades at GCSE including English and maths. This was above the Essex County (56.5%) and England (53.4%) averages.[14]

As **Figure 10** reveals, this is a significant improvement on local performance in 2007/08, when only 42.6% of KS4 students in Thurrock achieved 5 A*-C grades at GCSE including English and maths. It should also be noted that figures for 2013/14 are not directly with earlier years due to major education reforms (which could explain the small decline in performance in the most recent year).[15]

Figure 10: Percentage of pupils at the end of Key Stage 4 achieving at GCSE and equivalents (5 A*-C grades including English & maths)



Source: Department for Education

Destinations of school leavers

Looking at the destinations of students following A Levels or other level 3 qualifications (in the key stage 5 cohort), 71% of Thurrock students continued, or remained, in an education or employment destination in 2012/13, in-line with the national rate.

[13] ONS (2015) Annual Population Survey

[14] Department for Education (2015) Performance Tables

[15] In particular, two major reforms have been implemented which affect the calculation of key stage 4 (KS4) performance measures data in 2014: Professor Alison Wolf's Review of Vocational Education recommendation; and, An early entry policy to only count a pupil's first attempt at a qualification.

Table 2: Percentage of students, in 2011/12, who entered an A Level or other Level 3 qualification, going to, or remaining in, an education or employment destination in 2012/13 (state-funded)

Area	Thurrock	Essex	England
Sustained education or employment/training destination			
Sustained education destination	54.0%	59.0%	64.0%
Sustained Employment and/or Training destination	16.0%	12.0%	6.0%
Education/employment/training combination destination	1.0%	1.0%	1.0%
Percentage not recorded in the measure			
Destination not sustained	12.0%	8.0%	9.0%
Destination not sustained / recorded NEET	3.0%	3.0%	2.0%
Activity not captured in data	14.0%	17.0%	18.0%
UCAS acceptance for deferred entry	---	3.0%	3.0%

Source: Department for Education

Looking more closely though, a relatively low proportion of Thurrock students went on to a sustained education destination (54% compared to 64% for England). Although was an improvement on 2009/10, when 51% of Thurrock students were registered in a sustained education destination,[16] a relatively high proportion of students did not have a sustained destination or were recorded as Not in Employment Education or Training (NEET).

More specifically, 310 people aged 16-18 were Not in Employment Education or Training in Thurrock at the end of 2014, 5.2% of the people in this age group known to the authority, compared to 4.6% for Essex County.[17]

"A relatively limited educational offer"

The 2007 EDS identified that Thurrock did not offer "significant breadth in availability and delivery of FE and HE". The strategy sought to support the development of an education and learning offer that was strong in both depth and breadth.

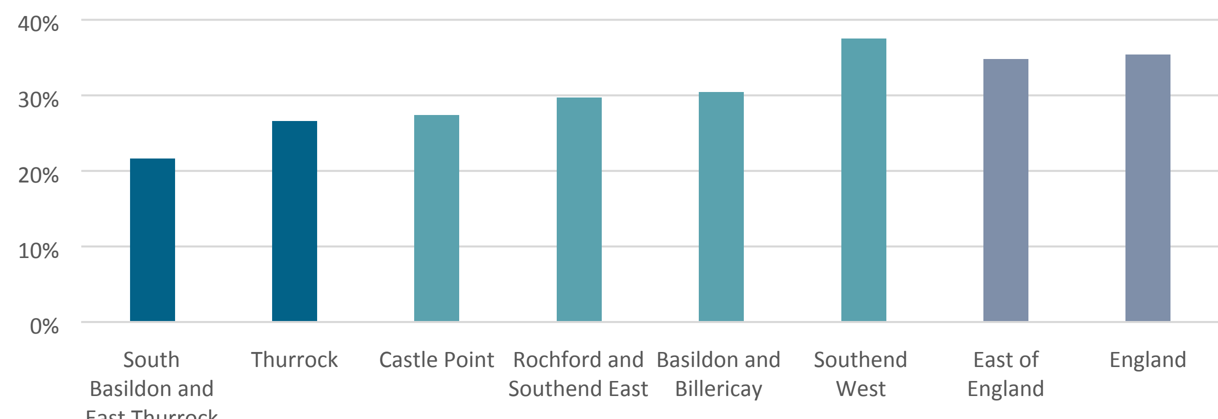
UCAS applications

There continues to be a relatively low proportion of young people going on to Higher Education. **Figure 11** shows 18 year old application rates for the parliamentary constituencies in South Essex compared to the East of England and England averages. It shows a significant variation within the South Essex, with the lowest application rates among 18 year olds in South Basildon and East Thurrock (21.6%) and Thurrock (26.6%). This was far below the England average of 35.4%.

[16] Department for Education (2012) destinations of key stage 4 and key stage 5 pupils.

[17] Department for Education (2015) NEET data by local authority

Figure 11: January deadline application rates in 2015 for UK 18 year olds



Source: UCAS Analysis and Research

Apprenticeships

There has also been an expansion in the number of apprenticeships, reflecting national trends. Compared to 2007/08, there was a 120% increase in the number of apprenticeship starts in 2013/14. Apprenticeships play an important role in matching skills to business and employer needs.

Table 3: Apprenticeship starts in Thurrock, by level

Year	Intermediate	Advanced	Higher	Total starts*
2007/08	370	180	0	540
2008/09	400	190	0	600
2009/10	480	180	0	670
2010/11	810	340	0	1,150
2011/12	870	390	0	1,270
2012/13	770	520	20	1,310
2013/14	750	410	30	1,190
2014/15	650	450	30	1,130
Change 2007/08 – 2014/15	**280**	**270**	**30**	**590**
% Change 2007/08 – 2014/15	**75.7%**	**150%**	**n/a**	**109.3%**

* Rounding may mean intermediate + advanced + higher ≠ total starts.
Source: BIS FE data library: apprenticeships

"A relatively low rate of enterprise"

The 2007 EDS pointed towards low but improving rates of enterprise formation in Thurrock, combined with relatively high rates of business failure. The challenge set out in the EDS was to facilitate higher rates of sustainable business formation by building on an improving enterprise base and supporting Thurrock businesses to grow, develop and diversify.

Thurrock has seen considerable growth in active enterprises in recent years. Using data from the ONS Business Demography series, the number of active enterprises registered in the local area increased by

1,030 from 2007-2013.[18] The number of Thurrock based enterprises increased throughout the period, even during the recession, and has picked up further in recent years.

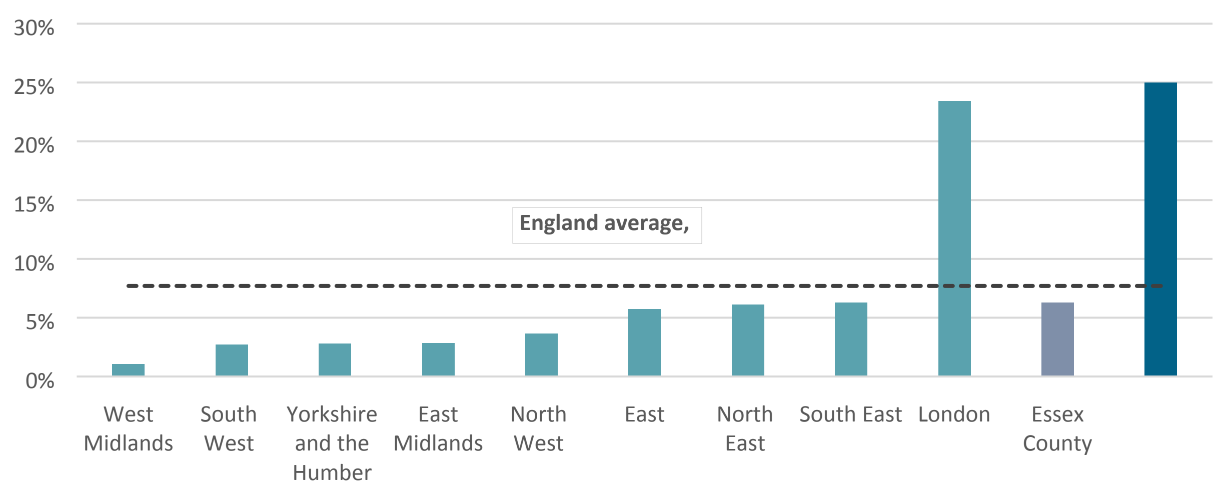
Figure 12: Active enterprise growth in Thurrock 2007-2013 (cumulative)

1,200
1,000
800
600
400
200
0
2007-08 2008-09 2009-10 2010-11 2011-12 2012-13

Source: ONS Business Demography

The extent of Thurrock success in growing its business base can be seen when comparing local performance with other areas of the country. At 25.0%, Thurrock saw a higher rate of business growth in between 2007 and 2013 than for any region in England, including London (23.4%). This was also significantly above the Essex County (6.3%) and national (7.7%) averages.

Figure 13: % growth in active enterprises 2007-2013



Source: ONS Business Demography

Figure 15 (overleaf) illustrates in more detail the nature of business performance, showing Thurrock consistently outperforming the national average in terms of new business registrations between 2007 and 2013, while the rate of business failures was marginally below the national average in most years (with the exception of 2009-2010).

[18] ONS (2015) Business Demography. Note: this definition of an active business is based on activity at any point in the year, whereas ONS Business Counts is based on an annual snapshot at a point in time.

Figure 14: Business births and deaths 2007-2013 (% of active enterprises)

Source: ONS Business Demography

Looking more closely at business survival, as **Table 4** shows, survival rates in Thurrock worsened following the economic downturn, but have generally improved since the recession. Of all of the VAT registered businesses registered in 2011, nearly three-quarters (74.8%) were still trading in 2012. This was significantly above the 24-month survival rates for businesses born in 2008 and only marginally below the England average (75.5%). At the same time, this was still lower than the rate for businesses born in Thurrock in 2007 (79.4%), suggesting there remains scope for survival rates to improve further.

Table 4: Survival rates of businesses born since 2008, Thurrock and England (%)

Year of birth / age in years	Thurrock						England					
	2007	2008	2009	2010	2011	2012	2007	2008	2009	2010	2011	2012
1 year	94.4	92.7	92.6	89.0	93.7	94.7	95.4	92.1	90.9	86.8	93.1	91.1
2 year	79.4	73.7	72.1	75.2	74.8	--	81.3	73.9	73.9	72.5	75.5	--
3 year	57.9	53.3	58.2	57.8	--	--	62.9	57.9	59.7	57.1	--	--
4 year	48.6	43.8	48.4	--	--	--	51.9	48.8	48.9	--	--	--
5 year	42.1	37.2	--	--	--	--	44.4	41.2	--	--	--	--

Source: ONS Business Demography.

A wider range of metrics, available only at LEP level, shows the South East LEP area having a proportion of 15.8% of its businesses being 'fast-growing', compared to the national average of 16.0%.[19]

"A number of infrastructure constraints"

Complimenting this, Thurrock has generally seen growth in business space. The EDS called it *"imperative"* that Thurrock was able to offer quality, sustainable and flexible sites offering opportunities for future growth and development.[20] Between 2007 and 2012, Thurrock saw an increase of:

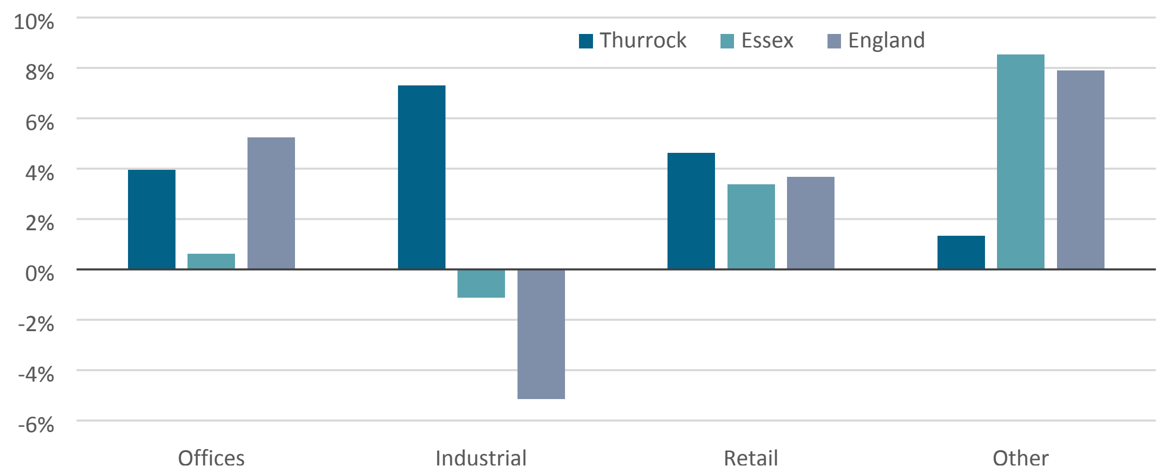
- 86,000 m^2 of industrial floorspace;

[19] Enterprise Research Centre (2015) Growth Dashboard – June 2015.
[20] Thurrock Economic Development Strategy (2007)

- 19,000 m^2 of retail floorspace;
- 3,000 m^2 of office floorspace; and
- 1,000 m^2 of 'other' floorspace

As **Figure 16** shows, compared to national trends, there has been particularly strong growth in industrial and retail space since 2007, reflecting major investments in the local area. This suggests that Thurrock may have gone some way to rectifying the issue of inadequate provision since 2007, although this data does not reveal anything about the quality and suitability of floorspace being provided. It also indicates that the growth in office lagged behind the England average during this period.

Figure 15: % change in business floorspace, by type (2007-2012)



Source: VOA

7th January 2016	ITEM: 6
Health and Wellbeing Board	
Well Homes Project	
Wards and communities affected: All	**Key Decision:** Non-key
Report of: Louisa Moss, Housing Enforcement Manager	
Accountable Head of Service: Dermot Moloney, Business Improvement Manager	
Accountable Director: David Bull, Interim Director of Housing	
This report is Public	

Executive Summary

Housing is now explicitly referenced as part of the local authorities' new duty under the Care Act. It is defined as a 'health related service' and for the first time the suitability of someone's living accommodation is listed as part of the definition of well-being.

The care and support 'landscape' will continue to evolve, although the desire to establish the role of housing, in developing integrated care and support is likely to remain a constant. The Well Homes project has been nationally recognised as an example of 'integration in action', focused on what makes residents feel better at home.

It is a new approach to delivering housing services in the private sector and looks at a more holistic response to the full range of home based hazards. Through targeted partnership working to the most vulnerable residents, it tackles health inequalities caused by poor quality housing conditions and improves access to a wider variety of services, including local health services. The principle lead services are the Private Housing Service and Public Health. To date, 83% of Well Homes clients are reported as saying they feel healthier and safer at home.

Recommendation(s)

1.1 The Health and Wellbeing Board note the on-going progress made by the Well Homes project.

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1.2 The Health and Wellbeing Board agree for the Well Homes project

to explore ways of finding ways of sustaining the project beyond the funding period (2015-2017) and to be an integral part of any new social care ‘prevention’ delivery programmes.

2. Introduction and Background

2.1 The Well Homes project started in August 2014 and is a small operational scheme, operating with one Well Homes Advisor who is supported by a range of local partners. The project is focused on Thurrock’s largest housing sector i.e. the private sector, with includes both owner occupation and private rented housing. The project defines a ‘Well Home’ as a healthy, safe and secure place to live.

2.2 The project grew out of a Health Impact Assessment carried out on Thurrock’s private housing stock by the Building Research Establishment (BRE). The assessment provided information about housing risk, hazards, harm and costs and it is this information which focused the work of the Well Homes project: The key findings included at total of 8,500 severe housing hazards, the most common were:

- 3,000 Fall hazards
- 2,000 Excess cold hazards

2.3 The Health Impact Assessment also calculated the real cost of poor private housing in Thurrock, for the most vulnerable residents, using the BRE’s Housing Health calculator. This calculator measures the quantitative health impact of housing hazards, identified under the Housing Health and Safety Rating system, which is a process used by Private Housing Officers in their inspection work. The assessment found that if no work was carried out to reduce the total number of category 1 housing hazards in the private stock, the estimated annual cost to the NHS, for treating accidents and ill health caused by these hazards, would be £953,000.

2.3 With reference to the BRE’s findings, a ‘Thurrock Well Homes’ index and mapping tool was developed, so that Lower Super Output Areas with the most housing-related need were identified, enabling the Well Homes project to target its work.

The Well Homes index

2.4 Thurrock’s Well Homes index mapped the local data from the BRE assessment and from other government and health statistics, to include:

- Income, Health Deprivation and Disability
- Living Environment
- % Housing Benefit
- % Households in Fuel Poverty
- % Category 1 housing hazards e.g. falls
- % overcrowding

2.5 In the second year, 2015-16, the ‘Well Homes’ index was reviewed with more emphasis on mapping those residents who were considered at higher risk of poorer health outcomes, and therefore are more likely to see an improvement to their health following a Well Homes intervention. The ‘refreshed’ index was set up to supports that group of the population, aged 65 and over, those with a respiratory, cardiovascular or mental health long term condition, or those on a low income.

2.6 To date (November 2016) the Well Homes project has reached 1739 people and carried out 653 Well Homes Assessments.
Appendix A details the Well Homes headline statistics (November 2015).

2. 7 The Well Homes project is gradually building up its network and raising its profile, with the aim of increasing the referrals coming into the service, however, it currently remains a service that focuses its work in the ‘hotspot’ areas as determined by the Well Homes index.

2.8 The Well Homes assessment itself covers a range of home and health questions to determine whether specialist help should be sought from a wider range of partner agencies. Services available include energy efficiency checks, gardening, handyperson, adaptations, health checks, as well as a full housing inspection where serious hazards are identified. All these services are already provided by existing agencies, but the difference made by the Well Homes project, is that they are brought all together for the resident in ‘one conversation’, focused on what makes them feel better at home.

2.9 A full range of Well Homes offers have been set up and are used to support low income clients, to access services to reduce any identified home hazards e.g. electrics, boilers (excess cold), balustrading/steps/clearance (falls).

2.10 The Well Homes assessments are carried out by the Well Homes Advisor, who continues to be trained by the project’s partners, to maximise the outcomes for residents. The training programme includes:

- Monetary advice and maximising income
- Independent living knowledge and referral networks
- Housing Health & Safety Assessment process
- Community Safety, Crime prevention/Neighbourhood Watch, Domestic Abuse
- Trading Standards - Bogus callers, loan sharks
- Fire Safety and prevention with Essex Fire Service.
- Making Every Contact Count (MECC)
- Hate Crime Ambassador Accreditation.

2.11 100% of residents who have used the Well Homes service, thought that the WHA’s knowledge was either very good or good.

The Well Homes Partners

2.12 The Well Home project has developed a referral network of individuals and agencies all experienced in working with vulnerable groups. Not only have they supported the training of the advisor, but these partners continue to provide a range of specialist support. Examples of these local partners include:

- Public Health, Private Housing, Social Care
- Home Improvement Agency – Papworth Trust
- Community Safety Partnership – through it strengthening communities work.
- Essex Fire service
- Local energy providers, contractors, electricians, builders
- Thurrock Lifestyle Solutions – gardening/handyperson services

2.13 The partnerships in year 2 (2015-16) have developed further with the setting up of new integrated ways of working to include;

- The sponsorship of a Well Homes Apprentice who works with Thurrock Lifestyle Solutions. The sponsorship supports the apprentice to learn more about the Well Homes programme and to increase his housing knowledge, which will compliment his qualification in social care.

- A new partnership agreement with Essex Fire and Rescue Service where all their home safety technicians have been trained to be Well Homes Advocates. To date, over 20% of the residents that have been visited by the fire service have been referred onto the Well Homes service, for further intervention work.

- The Well Homes service is now part of the 'housing offer' for all domestic abuse clients and homeless prevention clients. This will enable our most vulnerable residents to gain further support and advice, on how to keep safe and well at home.

Well Homes 'the detail'

2.14 Processes/procedures/reporting/evaluation outcome/letters/client packs/surveys/financial offers/discounts are all in place, which allows a consistent and clearly understood approach to the various work streams.

2.15 The data collected links into the JSNA and the analysis can then be compared with national statistics.

Well Homes 'the recognition'

2.16 The Well Homes project was recognised in 2015 by the Kings Fund, NHS Alliance, the Chartered Institute of Environmental Health Officers and Strategic Excellence Network, as an example of 'integration in action' and

Thurrock through its Private Housing Service has showcased the project using both presentations and workshops. Information has also been shared with other local authorities who are looking at similar ways of working, including neighbouring Essex districts.

3. Issues, Options and Analysis of Options

Funding

3.2 The operational arm of the Well Homes project is carried out by the Private Housing Service.

The funding arm of the Well Homes project 2014-2017, is Public Health. The annual cost of the service totals £45,000. The funding is used to commission a Well Homes Advisor and some limited administration support.

3.3 In addition to this revenue funding, Housing Renewal capital monies, which are ring-fenced to improve private homes, have been carried forward, to support the Well Homes project. The capital monies are critical to the scheme, so as to enable the continuation of the Well Homes financial offers, discounts and incentives, for the most vulnerable residents.

3.4 External funding continues to be explored for specific work e.g. The Office of the Police Crime Commissioner has already supported the Well Homes project through its National Initiatives Fund and provided £6,000 for the purchase and installation of security measures.

3.6 The long term success of the Well Homes project will be dependent on the need to continually raise awareness of the project outcomes, And to evidence the link between reduced hospital admissions/ GP spend and the project.

3.7 The Well Homes work over the last 15 months has reduced 137 housing hazards. The cost of the majority of the identified hazards are small e.g. lack of handrails to staircase (fall hazard), the harm is quickly reduced and the savings i.e. payback period for the NHS is quick. Using the BRE housing health calculator, as detailed in section 2.3, it has been estimated that the project has begun to reduce the costs to the NHS and has so far, saved the NHS, £290,555. This 15 month cost evaluation provides a value for money outcome, when compared with the annual funding costs of the service (£45,000).

3.8 A new Well Homes specification and outcomes performance framework was developed in 2015 resulting in the commissioning of a new Well Homes Provider. This new approach to service delivery has further increased the efficiencies of the service.

4. Reasons for Recommendation

4.1 The Well Homes project offers a prevention programme at a local level, where 71% residents who have used the service said it has improved their health and well-being. It deals not only with health and housing hazards in the home, but saves money and reduces the burden on the NHS and other public services.

4.2 The project has been operational for 15 months, but is already gathering momentum with 98% residents, who have used the service, telling us it is a good idea and 94% believing it will make a difference. The need to explore ways to increase the scale of the project and or embed its way of working into other work streams will support the new prevention duties of the Care Act.

5. Consultation (including Overview and Scrutiny, if applicable)

5.1 The project communicates with residents in the identified hotspot areas via letters and door to door visits. To date over 2,000 letters and visits have been made.

5.2 Wider consultation has and continues to focus, on raising awareness. Examples of local activity to date include:

- Web pages/Press releases/tweets
- GP newsletters
- Presentations/visits/outreach work
- Team briefs to e.g./ LAC/Thurrock Mind/CAB
- Local schools
- Library
- Children Centres
- Thurrock Asian Association/ Eastern European retail outlets

6. Impact on corporate policies, priorities, performance and community impact

6.1 The Well Homes project compliments the Council's corporate priority 'improve health and wellbeing'. The Care Act implementation is a key priority for the Council and its prevention duties are a critical element of the Health and Social Care Implementation Programme.

7. Implications

7.1 Financial

Implications verified by: **Julie Curtis, HRA and Development Accountant**

Members are aware of the financial pressures that the Council is under at this time. As such, any project work must be kept within existing budget parameters and every effort to maximise third party contributions should be made.

7.2 **Legal**

Implications verified by: **Martin Hall, Prosecution Solicitor**
Legal Services

There could be future legal implications, with the need to take enforcement action against rogue landlords. The Landlord's repairing obligations should be emphasised. Data protection issues should be considered and applied.

The Care Act, Guidance and Regulations contain statutory requirements that the Council will need to comply with and housing should continue to work with its partners and legal to assess the full implications of the Act.

7.3 **Diversity and Equality**

Implications verified by: **Natalie Warren, Community Development and Equalities Manager**

Information gathered through the Well Homes project will be used to carry out a Community and Equalities Impact Assessment, which will help to ensure the project is accessible to all residents and is having a positive impact on communities. It should try to capture strands of diversity to better understand if there are implications in the Private Rented Sector which may be particularly disadvantaging certain groups within Thurrock.

Housing will continue to work with the Care Act Project and Engagement Groups to identify equality and diversity implications arising from the implementation of the Act in Thurrock.

7.4 **Other implications** (where significant) – i.e. Staff, Health, Sustainability, Crime and Disorder)

None

8. **Background papers used in preparing the report** (including their location on the Council's website or identification whether any are exempt or protected by copyright):

- J:\THURROCK\EXCHANGE\Well Homes: BRE Private Sector Stock Profile and Health Impact Reports

9. Appendices to the report

- Appendix A: Well Homes Activity

Report Author:

Louisa Moss, Housing Enforcement Manager, Housing

Thurrock Well Homes Project

SERVICE TO DATE REPORT

Well Homes Activity	Nov-15	Well Homes So far! Year 1 + Year 2 To Date
Total TWH Assessments Completed	34	653
Total Number of People Reached	82	1739
Total Referrals to Thurrock Council Services (homelessness, DV, social services)	23	562
Total Referrals to Thurrock Lifestyle Solutions Services (handy-person, gardening)	15	376
Total Referrals to Private Housing Service (Private Rented Property Inspection Requests)	2	158
Total Referrals to Private Housing Service (Well Homes offers: gas check, quick fix grants, etc)	10	116
Total Referrals to Home Improvement Agency	1	30
Total Referrals to Energy Services	9	251
Total Referrals to Income / Debt Services		42
Total Referrals to Health and Lifestyle Services	10	232
Total Referrals to Essex Fire and Rescue Services	7	187
Total Referrals to Education and Employment Services		20
Total Referrals to Local Area Co-ordinator		28
Total Number of Referrals	77	2224
Total Referrals from External Agencies	9	66

Private Housing Service - Well Homes Activity	Nov-15	PH Well Homes Total Year 1 + Year 2 To Date
Total Number of Category 1 Hazards removed from privately rented properties	11	86
Total Number of privately rented properties improved	14	73
Total Number of Category 1 Hazards removed from owner occupied properties	2	51
Total Number of owner occupied properties improved	39	65
Total Number of Well Homes Offers Completed	4	27
Electrical Safety Check	4	9
Gas Safety Check	4	9
Well Homes Loans	1	4
Electrical Safety Grant / Loan	0	5
Gas Safety Grant	1	6
Security Measures / Grants	37	39
Quick Fix Grants	0	4
Savings to NHS by Private Sector Housing Service activity (£)	£21,633	290,555
Savings to NHS and Society by Private Sector Housing Service activity (£)	£53,783	705,129
Total Number of long term vacant properties identified for future action	0	8
Landlords accredited through London Landlord Accreditation Scheme	0	10

NOVEMBER 2015 PUBLICITY, PROMOTION AND OTHER WORK

On The Ground

* Meet and greet event held at Beehive in Grays inviting partner agencies to learn about the service at an informal buffet lunch
* Meeting with Healthwatch
* Meeting with Neighbourhood watch
* Referals from Fire service and other outside agencies increasing
* Winter warm packs being distributed to most vulnerable families
* Linking well homes to Warm Zones work

Making A Difference

Quotes from 28 day survey

**** CE felt that Karen was a lovely lady who went through all her health issues and concerns very thoroughly***
**** PM said he was referred to the stop smoking clinic and has finally given up smoking, thought the service was brilliant***
**** JC said she feels so much safer when opening her door as it is now well lit, very happy with the service***
**** CK said "done a really good job and if it wasn't for Karen would still be in totally unsuitable property"***
**** JS said "I have given the details to my sister as it is such a good service"***

Promotional Work

* Attended team meeting with Staff at Hathaway school and promoted Well Homes
* Attended Meeting with Sure start in Purfleet and promoted service, referals sent out to all sure starts in Thurrock
* FM crisis officer promoted well homes to FIP and referal forms and leaflets sent out to all staff to use service
* Well homes promoted by Floating support officer at KCA and Open door

Case Study

THURROCK WELL HOMES CASE STUDY – MISS R – OLD HILL AVENUE, LANGDON HILLS

I visited Miss R this month and completed a Well Homes Assessment.
Miss R was referred to the well homes service by the fire service, following their previous visit to fit smoke alarms check fire safety at the property. Miss R (age 77) lives alone in her own very old "plot lands" bungalow at the end of an unmade road in the Thurrock council area of Langdon Hills, she is very independent but due to her health problems she is struggling to cope in her own home. The bungalow was also in a poor state of repair and there was no heating of any kind. There was also very bad damp problems, related to the lack of heating and foundations. During the assessment Miss R explained to me that she is now strugging with her mobility and is having particular problems with the steps down from her kitchen to her bathroom, as ther is no handrail and also with accessing her bath, she is waiting for an operation to replace her knee joints. Following the assessment I referred Miss R to age concern for assistance to apply for attendance allowance and to TLS to supply and fit an outside PIR security light to improve her home security. I also referred Miss R to occupational therapy for an assessment for help with her mobility/bathing issues. I raised the case with private sector housing and

Janet Donnelly visited Miss R to assess the property. Due to the assessed risk/harm of extreme cold Miss R was offered central heating via the well homes scheme. Miss R is currently in contact with the other agencies that she has been referred to

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7th January 2016	ITEM: 7
Thurrock Health & Wellbeing Board	
Learning Disability Services : Transforming Care Partnership	
Wards and communities affected: All	**Key Decision:** Non-key
Joint Report of: Thurrock Council and Thurrock CCG Catherine Wilson Strategic Lead Commissioning Thurrock Council	
Accountable Head of Service: N/A	
Accountable Director: Roger Harris – Director Adults Health and Commissioning / Mandy Ansell – Acting (Interim) Accountable Officer Thurrock CCG	
This report is Public	

Executive Summary

In February 2015, NHS England alongside the Local Government Association (LGA) and the Association of Directors of Adult Social Services (ADASS) together publicly committed to a national programme of change for Learning Disability services - for both health and social care. This announcement forms the continued response to the abuse that took place at Winterbourne View.

The latest document published by ADASS and NHSE on October 30 2015, called Building The Right Support sets out the expected outcomes and changes to be implemented and delivered nationally and regionally. The overarching outcomes that the transformation is expected to achieve are:

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

1. Recommendation(s)

1.1 That the Health & Well-Being Board notes the Transformation Care Programme and the local response.

1.2 That the Health and Well Being Board is aware that the Transforming Care Partnership was established on 15th December 2015.

1.3 That the Health and Well-Being Board receives back the full implementation plan.

2. Introduction and Background

2.1 Prior to the publication of this document in October 2015, all 10 health and social care partners across Essex (the 7 CCGs and the 3 top-tier local authorities including Thurrock) had already initiated a number of discussions to explore the potential benefits, challenges and feasibility of delivering learning disability transformation across Thurrock, Southend and Essex. This early start has been viewed nationally very positively and creates the potential opportunity to bid for some of the capital and transformation funding that the national programme has made available.

2.2 The national plan, Building the Right Support, states:

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

The document also recognises that as a society we have made significant improvements in this respect since Valuing People Now, but that the system in some instances is still over-reliant on in-patient responses to crisis rather than a community response ensuring each person is at the heart of the care and support they may require.

The evidence which is included in the national paper Building the Right Support, demonstrates that the whole Essex region performs in the middle range against the identified indicators – i.e. how many people with learning disabilities end up in hospital after a crisis. This should not create complacency especially given the fact that all regions will be looking to deliver step change over the next 3-4 years.

2.3 Building The Right Support and the initial discussions regionally indicate that the following areas need to be actioned and/or considered:

- Setting up a local Transforming Care Partnership that supports integrated commissioning that covers the 7 CCGs and the 3 Local Authorities in Essex.
- Pooling or aligning of budgets both between CCGs and local authorities at a local level and elements of this subsequently to be pooled across the whole of Essex, whilst continuing to recognise responsibility for NHS Continuing Healthcare
- NHS England Specialist Commissioning budgets will be aligned alongside these regionally pooled funds. For people who have been in hospital the longest, the NHS will provide a dowry to help with moving people home, guidance regarding this is expected shortly but there is to be no new money
- Short or medium term investment into community support to deliver a shift in the system away from in-patient care towards community based prevention

- Integrated Community Learning Disabilities processes that assess and support all Adults with Learning Disability. These would be managed locally, but elements particularly specialist health roles may be procured across Essex
- Appropriate integrated commissioning and contract management arrangements should be considered
- Re-procurement of specialist health resources through a contract that supports the flexibility and transformation expected.

2.4 Following on from the original plan further guidance was issued on the 17th November 2015. It was confirmed that Local Authorities, Clinical Commissioning Groups (CCGs) and NHS England specialised commissioners are to come together to form Transforming Care Partnerships (TCPs) to build up community services and close unnecessary inpatient provisions over the next 3 years by March 2019.

This guidance outlines what commissioners are now required to do.

Based on national planning assumptions, it is expected that no area should need more inpatient capacity than is necessary at any time to care for:

- 10-15 inpatients in CCG-commissioned beds
- 20-25 inpatients in NHS England-commissioned beds

Both per million populations

2.5 To deliver on these planning assumptions it is essential that areas build up capacity in communities and redesign pathways in order to better support people at home. An important component of partnership preparations will be analysis to inform plans for commissioning intensive community support services.

To support local areas with transitional costs, NHS England will make available up to £30 million of transformation funding over three years, with national funding conditional on match-funding from local commissioners.

In addition to this, £15 million capital funding will be made available over three years.

2.6 TCPs have to produce a draft implementation plan by 8th February 2016. This should allow for areas to commission at sufficient scale to manage risk, develop commissioning expertise and commission strategically for the relatively small number of individuals whose packages of care can be very expensive.

Each plan will be reviewed by local panels, including expert clinical input, in order to provide useful feedback. Panels will include NHS England and LGA/ADASS representatives together with people with a learning disability and/or autism, their families/carers. Panels may want to probe some areas of the plan in more detail, via calls/meeting with key individuals in February 2016.

To support the TCP to deliver these changes, a bespoke package of support will be put in place to help areas plan for transformation.

What have we done across Essex?

2.7 Across Essex we have established a TCP Board chaired by Simon Leftly (Director of Adult Services for Southend). We have agreed representation on this Board from all three Council's and all 7 CCGs. We have established a clear governance structure and an engagement plan. The Board is now meeting and has dates set up across 2016 – we have been quick off the mark here as some areas haven't even got agreement yet over who should form the membership of their TCP.

2.8 Within Thurrock we have been doing extensive work across the CCG and local authority to ensure that people are moved out of hospital based care into an appropriate based community setting. There remains only 1 further individual to move on and although this is a complicated process the recent announcement of a "dowry based" form of funding support will help those discussions.

2.9 All TCPs are required to develop a joint transformation plan by 8th February 2016. This will only be our initial response as a more detailed consideration will be required over what service model is best across Essex for specialist learning disability services. It is likely that the TCP Board will want to procure those services – especially Assessment and Treatment beds and some sub-forensic services – but we have not agreed yet that any local services e.g. adult social care, will be part of that tender. It may be that the NHS element of the procurement will go ahead and part of the service model will be strong links into local, community based provision.

3. Issues, Options and Analysis of Options

N/A

4. Reasons for Recommendation

4.1 To ensure that the Health and Well Being Board are informed regarding Building the Right Support, the Transforming Care Partnership and progress with implementation.

5. Consultation (including Overview and Scrutiny, if applicable)

5.1 Reference groups for people who use services, carers and professionals are being established as the work moves forward.

6. Impact on corporate policies, priorities, performance and community impact

6.1 Changes to provision will influence policies and community impact particularly refocusing provision within the community for people with learning disability this will be monitored closely.

7. Implications

7.1 Financial

None at present but finance will be fully involved as the programme of work develops.

Implications verified by: Mike Jones

7.2 Legal

None at present but legal will be fully involved as the programme develops

Implications verified by: Roger Harris

7.3 Diversity and Equality

Equality impact assessments and consultation will be key to ensure that people are fully included and the extent of any proposed changes are evaluated appropriately

Implications verified by: Roger Harris

7.4 **Other implications** (where significant) – i.e. Staff, Health, Sustainability, Crime and Disorder)

N/A

8. **Background papers used in preparing the report** (including their location on the Council's website or identification whether any are exempt or protected by copyright):

9. Appendices to the report

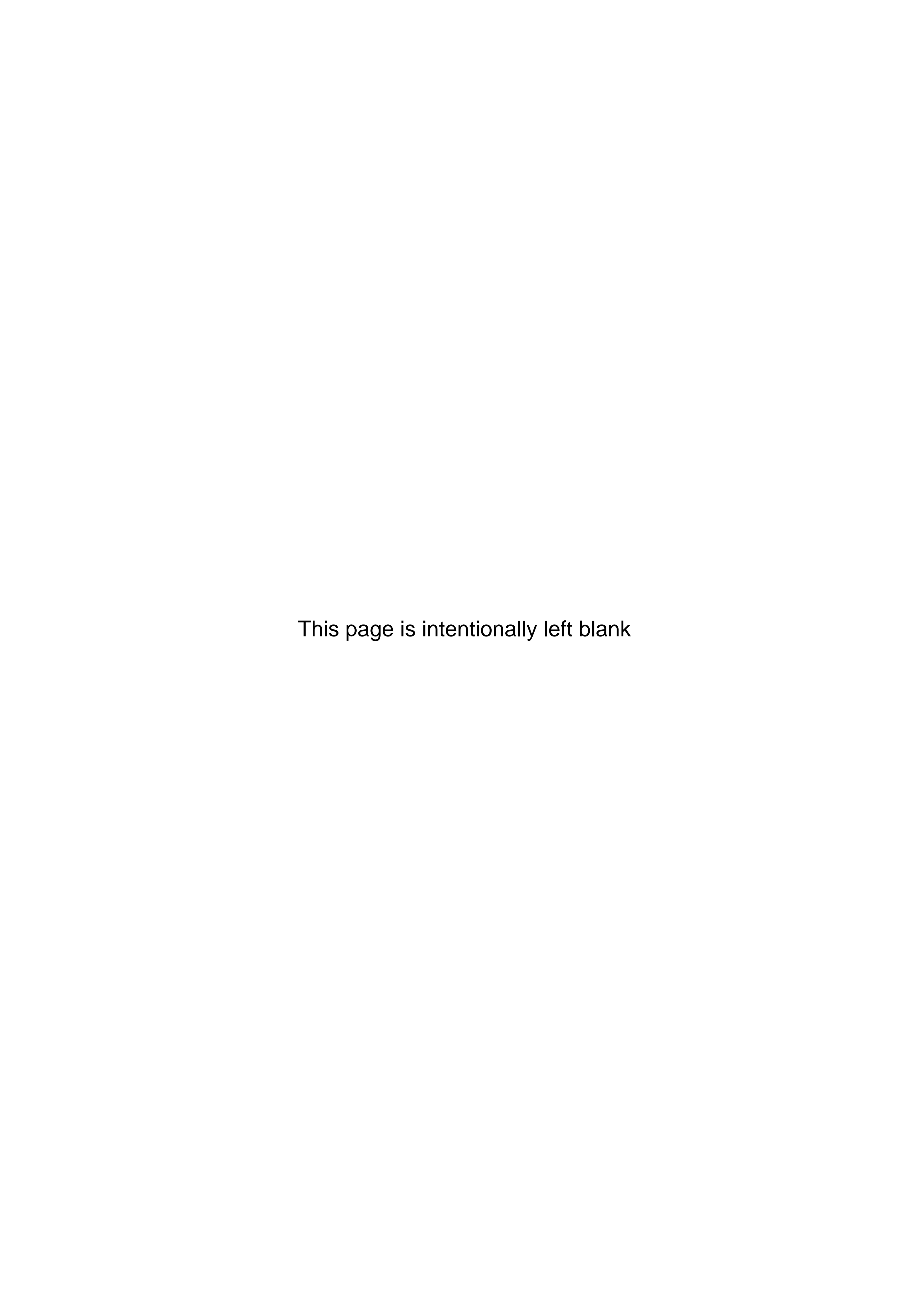
Appendix 1 - Building the Right Support National Plan

Report Author:

Catherine Wilson

Strategic Lead – Commissioning & Procurement

Adults, Health & Commissioning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Building the right support

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

October 2015

Building the right support

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

Version number: 1

First published: 30 October 2015

Updated:

Prepared by: Anthony Houlden, Commissioning Policy Manager

Classification: OFFICIAL

Gateway reference: 04303

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Foreword

Children, young people and adults with a learning disability and/or autism have the right to the same opportunities as anyone else to live satisfying and valued lives, and to be treated with dignity and respect. They should have a home within their community, be able to develop and maintain relationships, and get the support they need to live healthy, safe and rewarding lives.

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

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

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

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

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

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

Jane Cummings,
Chief Nursing Officer, England

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

Sarah Pickup, Deputy Chief Executive, Local Government Association

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

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

1. Executive summary

The journey to date

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

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

1.3 To make this permanent we need a change in culture, a shift in power to individuals and a change in services. We need to see people with a learning disability and/or autism as citizens with rights, who should expect to lead active lives in the community and live in their own homes just as other citizens expect to. And we need to build the right community based services to support them to lead those lives, thereby enabling us to close all but the essential inpatient provision.

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

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

The new services we need

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

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

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

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

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

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

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

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

Delivering change

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

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

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

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

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

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

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

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

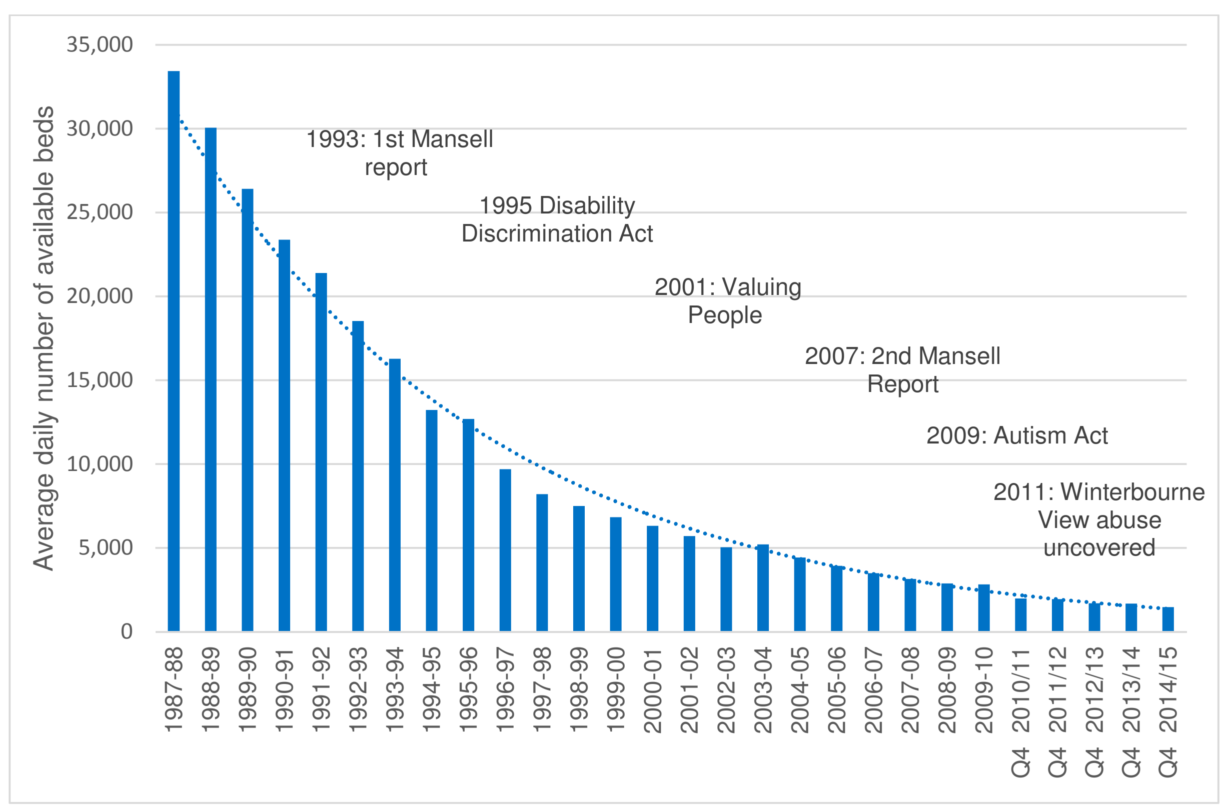
2. The journey to date

Background

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

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

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



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

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

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

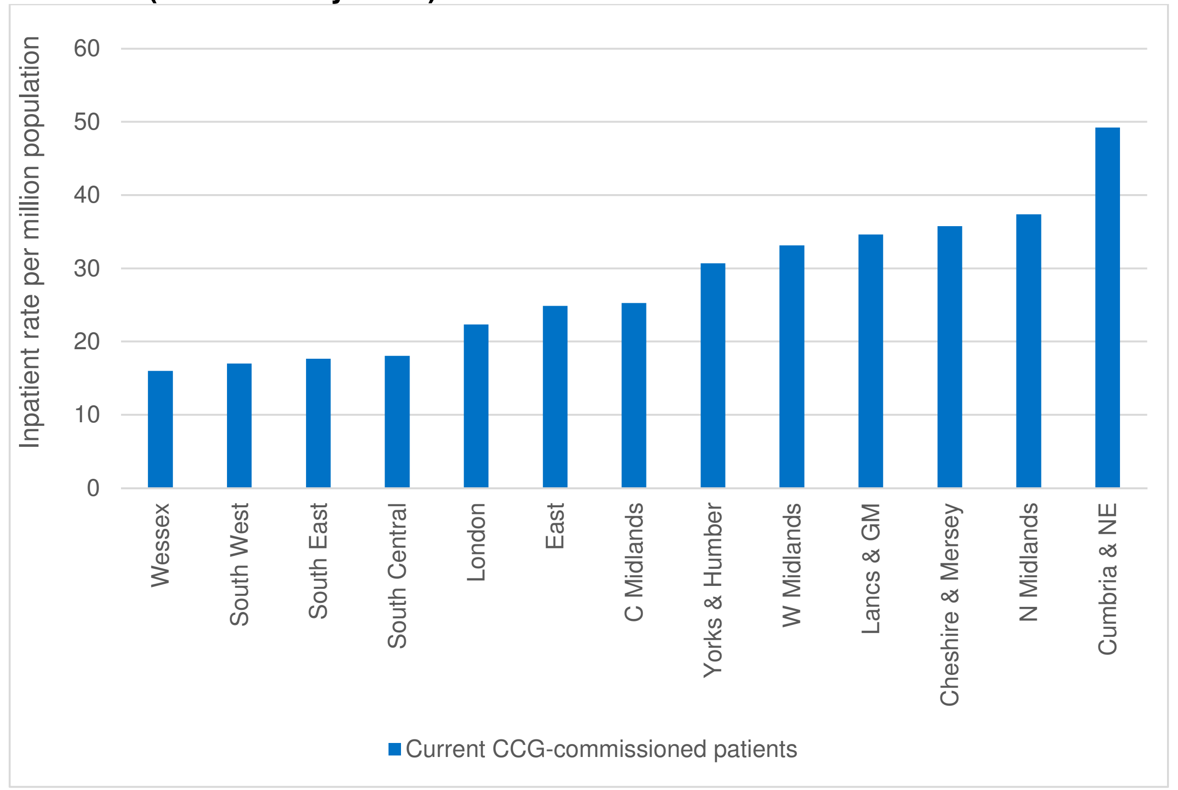
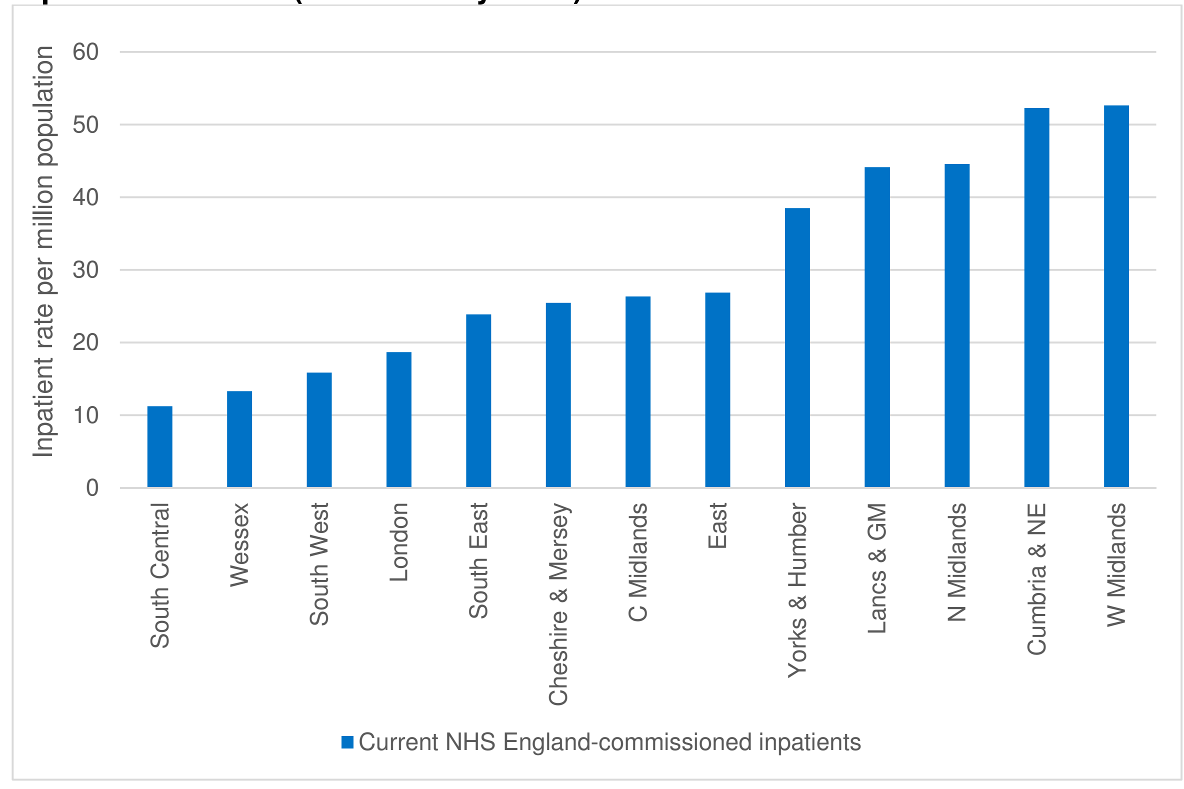


Figure 3: Geographical variation in reliance on *NHS England-commissioned* inpatient services (as at 31 July 2015) [5]



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

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

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

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

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

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

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

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

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

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

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

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

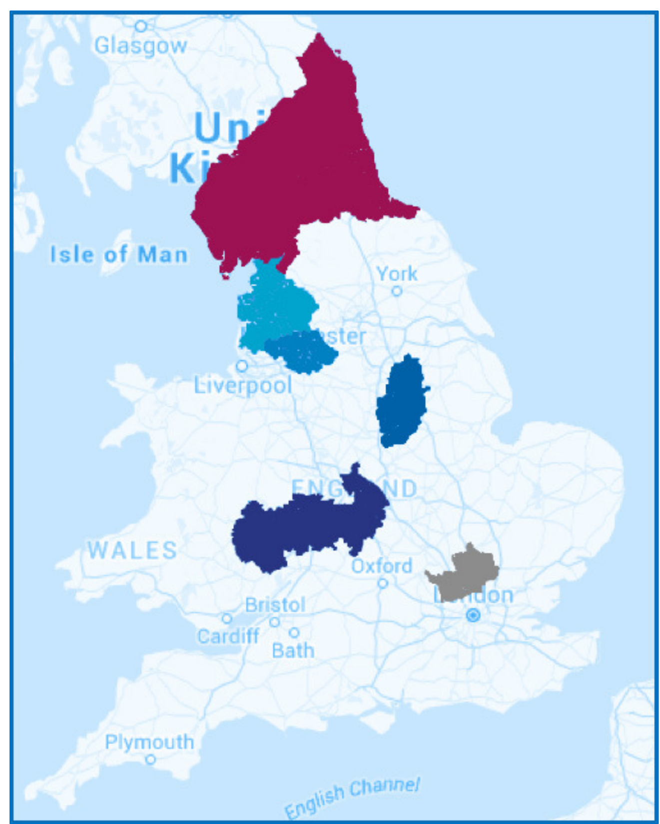
2.9 Six 'fast track' areas have begun that process, and this plan sets out how we will now support the rest of the country to follow suit.

Fast tracks

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

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

Figure 4: Fast track areas



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

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

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

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

Greater Manchester

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

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

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

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

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

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

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

Lancashire

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

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

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

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

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

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

- **Calderstones Partnership NHS Foundation Trust**

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

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

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

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

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

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

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

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

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

Cumbria and the North East

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

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

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

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

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

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

Hertfordshire

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

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

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

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

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

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

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

Nottinghamshire

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

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

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

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

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

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

Arden, Herefordshire and Worcestershire

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

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

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

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

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

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

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

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

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

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

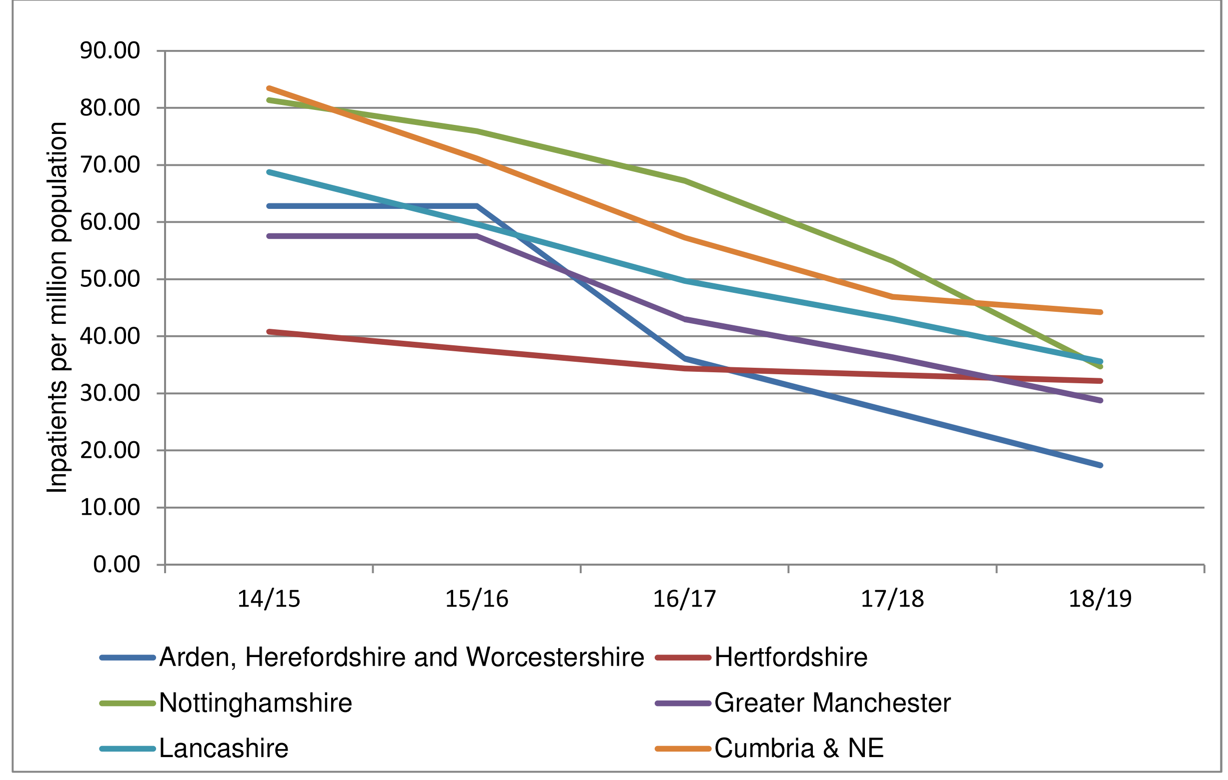
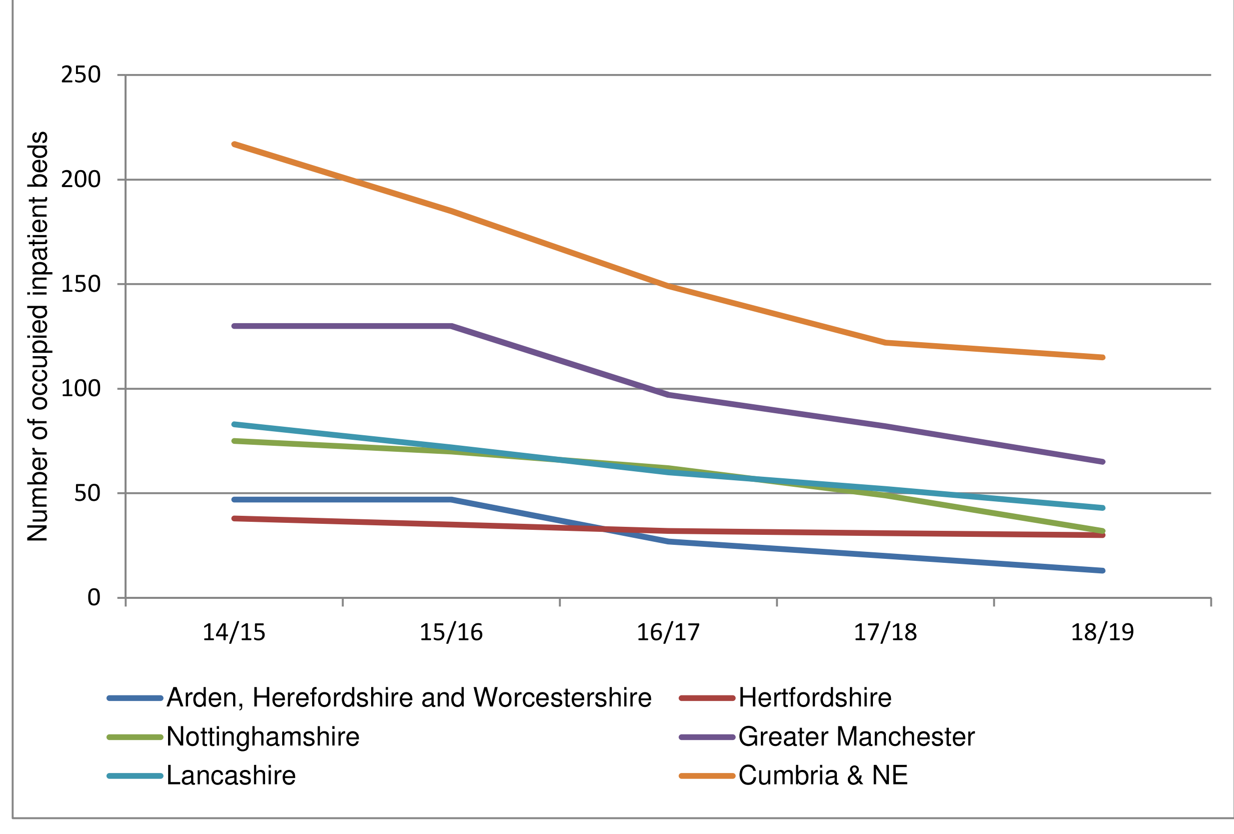


Figure 6: Projected *total* bed usage across fast tracks (chart shows projected number of inpatients originating from the fast track site)[11]



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

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

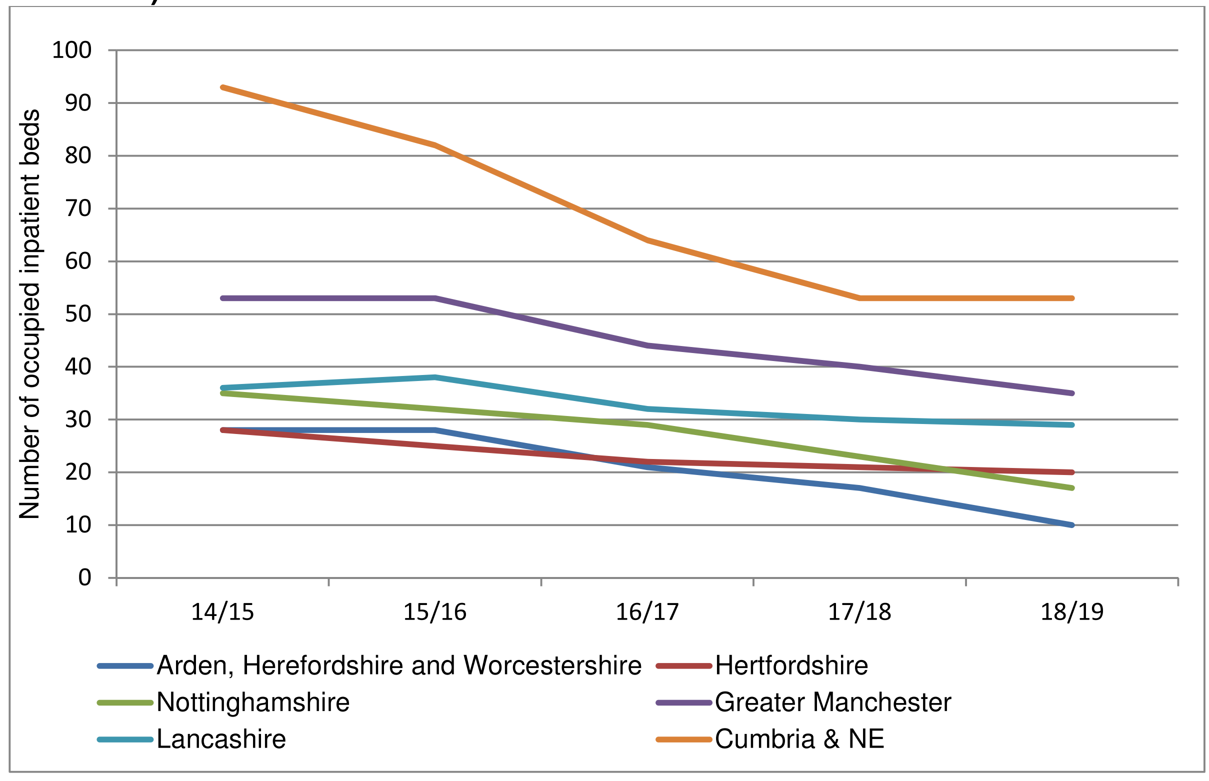
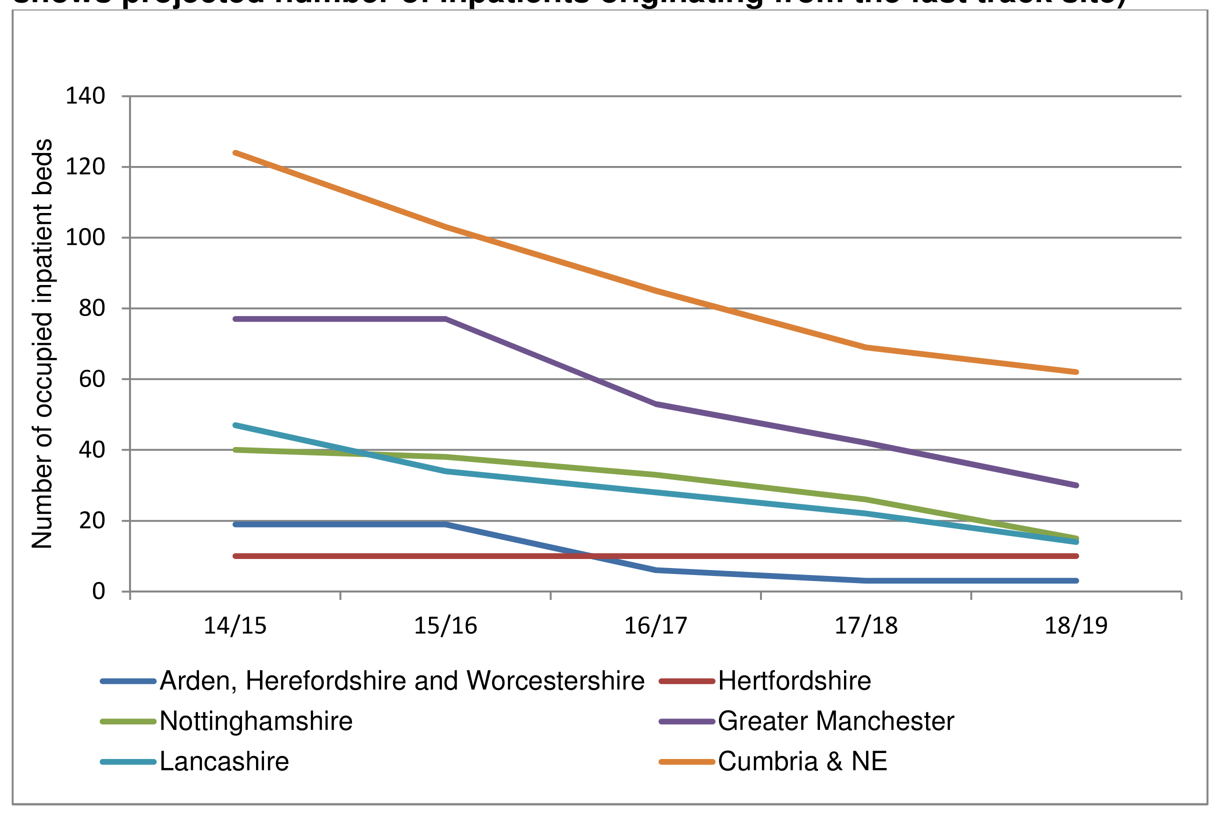


Figure 8: Projected usage of *CCG-commissioned* beds across fast tracks (chart shows projected number of inpatients originating from the fast track site)[13]



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

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

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

3. The new services we need

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

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

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

Improving services for a heterogeneous group

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

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

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

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

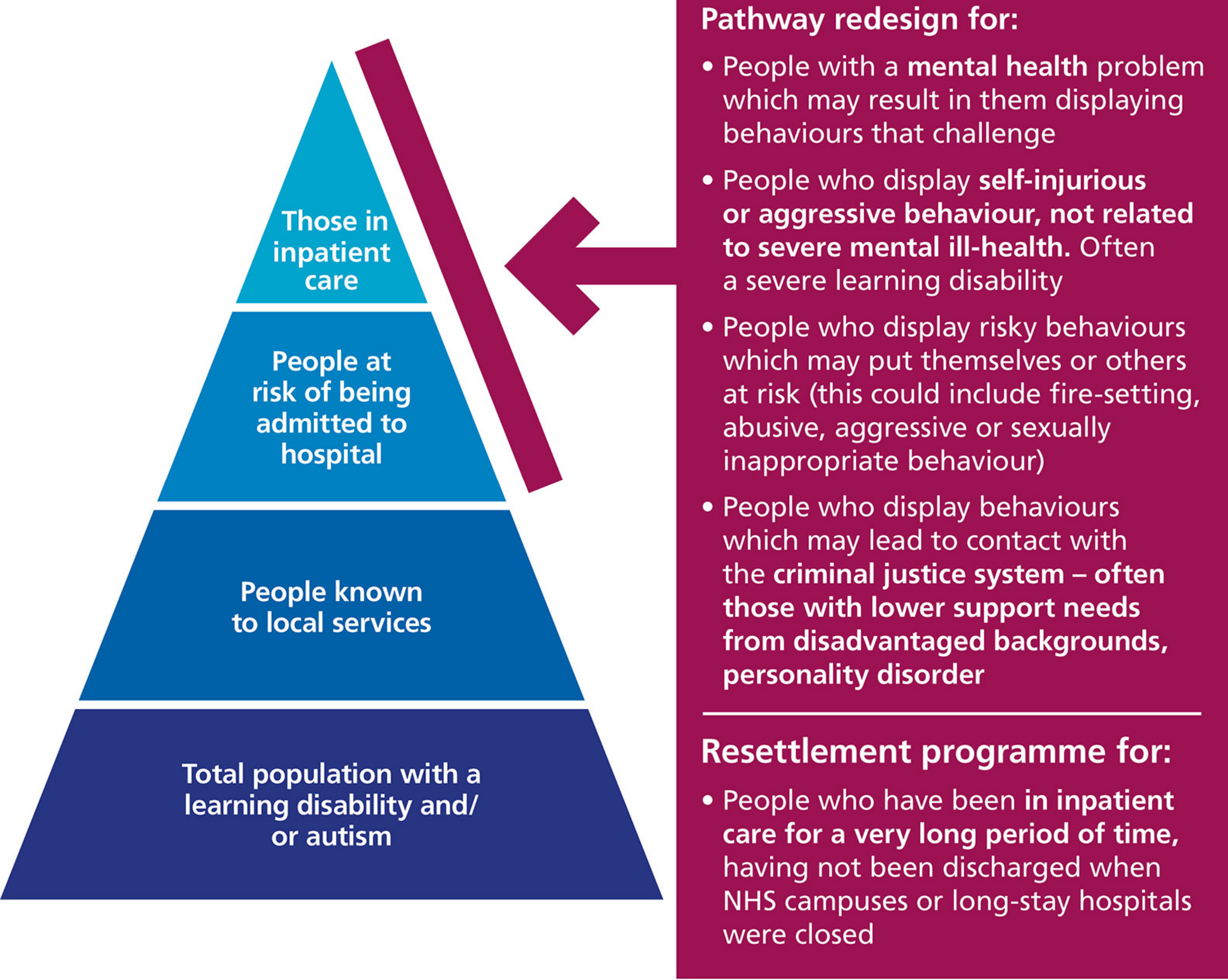
3.8 In many cases, it will involve close collaboration not just between the NHS and social care, but also with parts of the criminal justice system, building on recent joint work between NHS England and the Ministry of Justice to facilitate the discharge of patients subject to restriction orders - currently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

3.9 Transformation will mean redesigning services to better meet a range of common sets of needs. For instance, it will mean better serving children, young people or adults with a learning disability and/or autism who:

- Have a mental health condition such as severe anxiety, depression, or a psychotic illness, and those people with personality disorders, which may result in them displaying behaviour that challenges
- Display self-injurious or aggressive behaviour (not related to severe mental ill health), some of whom will have a specific neuro-developmental syndrome where there may be an increased likelihood of developing behaviour that challenges
- Display risky behaviours which may put themselves or others at risk and which could lead to contact with the criminal justice system (this could include things like fire-setting, abusive, aggressive or sexually inappropriate behaviour)
- Often have lower level support needs and who may not traditionally be known to health and social care services, from disadvantaged backgrounds (e.g. social disadvantage, substance abuse, troubled family backgrounds) who display behaviour that challenges, including behaviours which may lead to contact with the criminal justice system

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

Figure 9: People for whom we need new services



The service model

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

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

The National Service Model

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

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

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

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

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

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

7. People with a learning disability and/or autism should be able to access **specialist health and social care support in the community** – via integrated specialist multi-disciplinary health and social care teams, with that support available on an intensive 24/7 basis when necessary.

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

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

Principle 1: a good and meaningful life
- Inclusion in activities and services
- Education, training and employment
- Relationships with people
- Support to do things

Principle 4: support to my family and paid staff
- Support and training for families and carers
- Short break/respite
- Alternative short-term accommodation
- Trained support and care staff

Principle 5: where I live and who I live with
- Choice of housing and who I live with
- Security of tenure
- Strategic housing planning

Principle 6: mainstream health services
- Annual Health Checks
- Health Actions Plans & Hospital Passports
- Liaison workers
- Quality checkers
- Reasonable adjustments

Principles 7 & 8: specialist multi-disciplinary health and social care support in the community
- Specialist health and social care support for people
- Intensive 24/7 function
- Specialist forensic support
- Inter-agency collaborative working, including with mainstream services
- Liaison and diversion

Principle 9: hospital
- Integrated with community services
- Admission based on a clear rationale
- Discharge planning
- Reviews of care and treatment (CTRs)

Care And Support Navigator

Person-centred care and support plan

Advocacy and information

personal budgets and personal health budgets

Early intervention and prevention

Person and family/carer(s) at the centre

Principles 2 and 3

Service Model

Commissioners understand their local population now and in the future

Reduced need for inpatient services

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

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

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

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

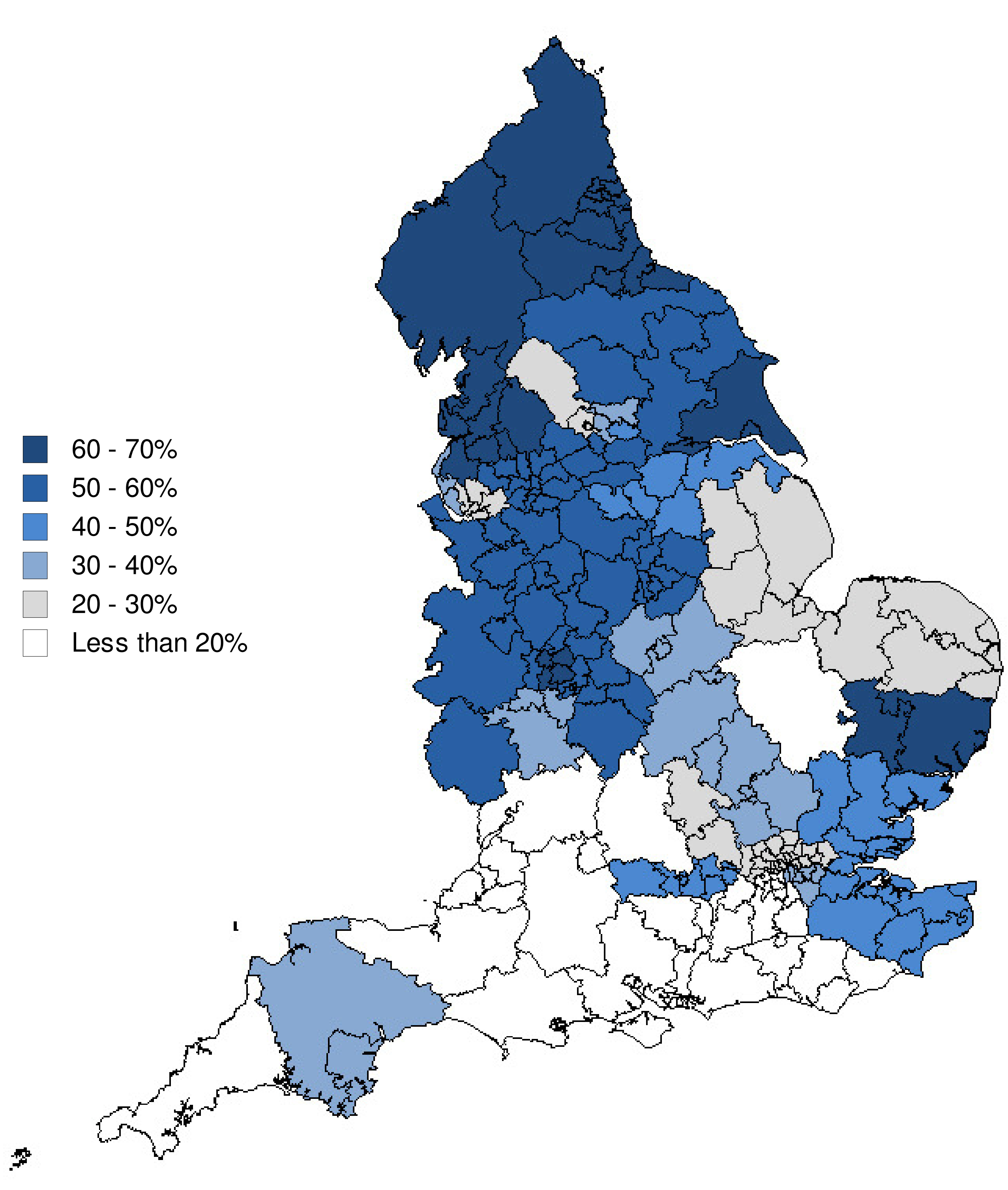
3.16 These planning assumptions are based on what fast track areas have told us they believe is possible, 'sense-checked' against current geographical variation in usage of inpatient services (see figures 2 and 3 below).

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

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

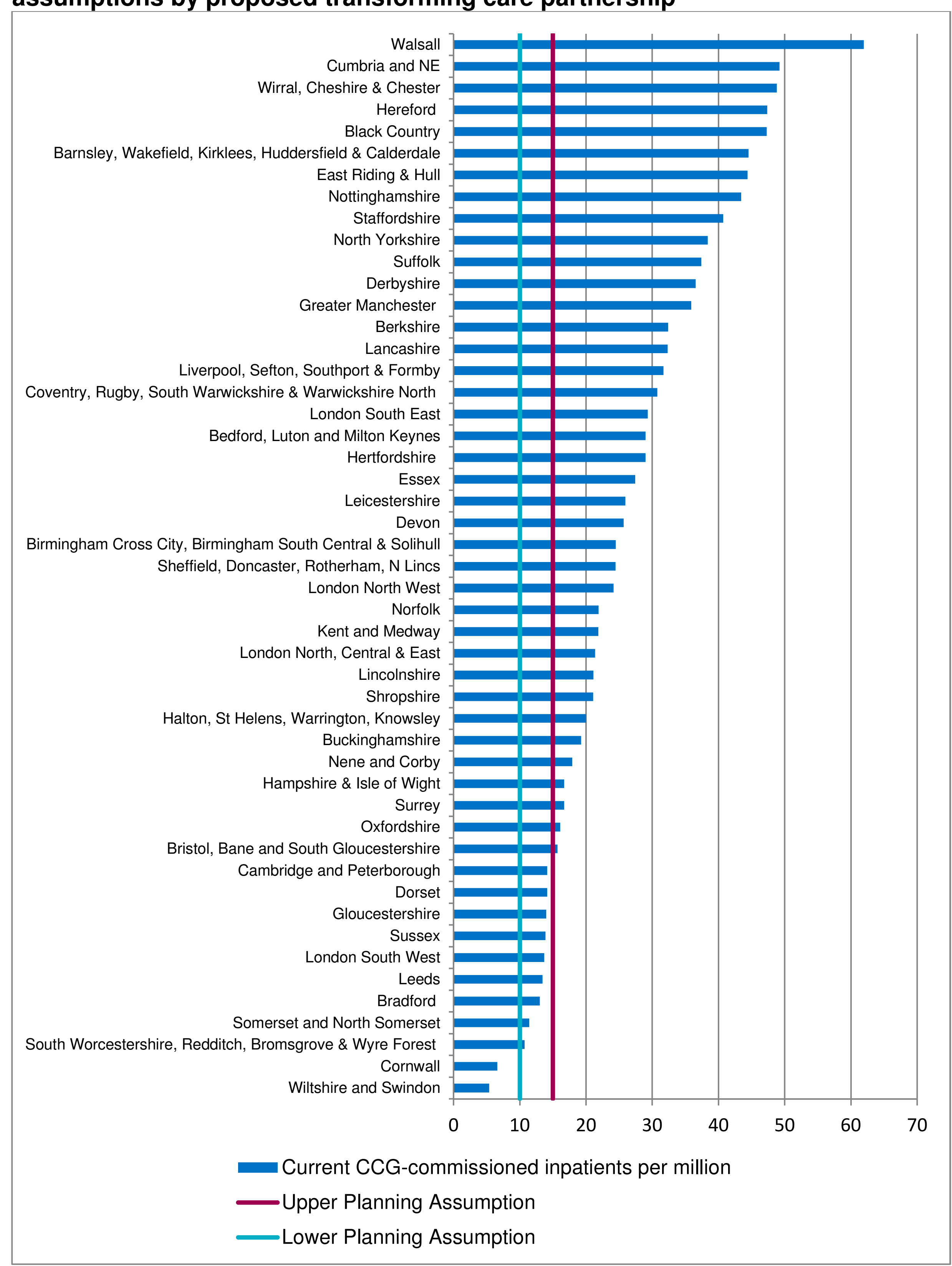
3.18 Taken together, that means closing, at a minimum, between 35% - 50% of inpatient provision nationally. In some areas more reliant on hospital care the change will be even more significant, as the following map and charts illustrate.

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



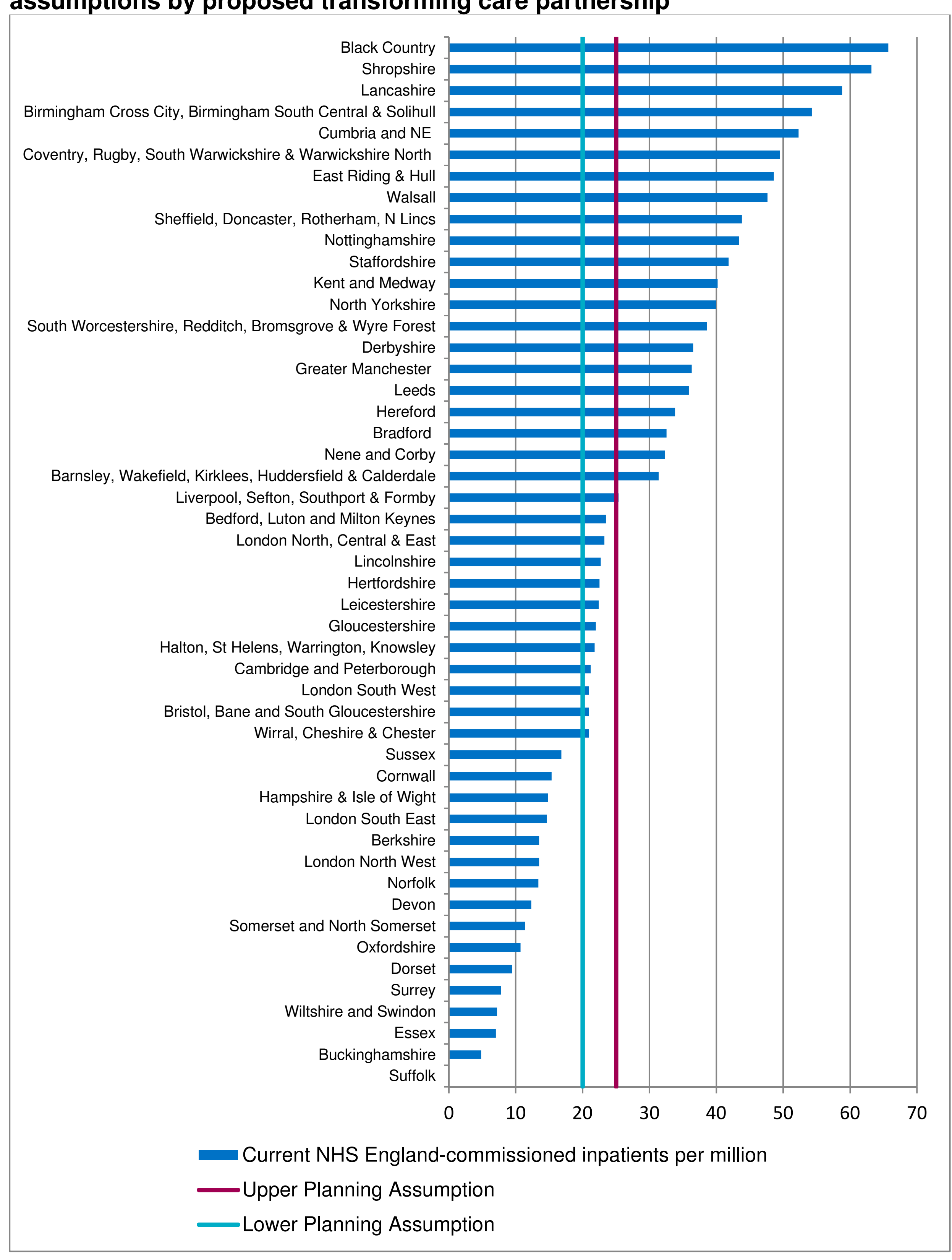
[14] Upper and lower planning assumptions have been applied to current inpatient rates at a transforming care partnership level. The map shows the % reduction in inpatient numbers represented by the midpoint between the projected upper and lower rates for each partnership. See Annex C for further notes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

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



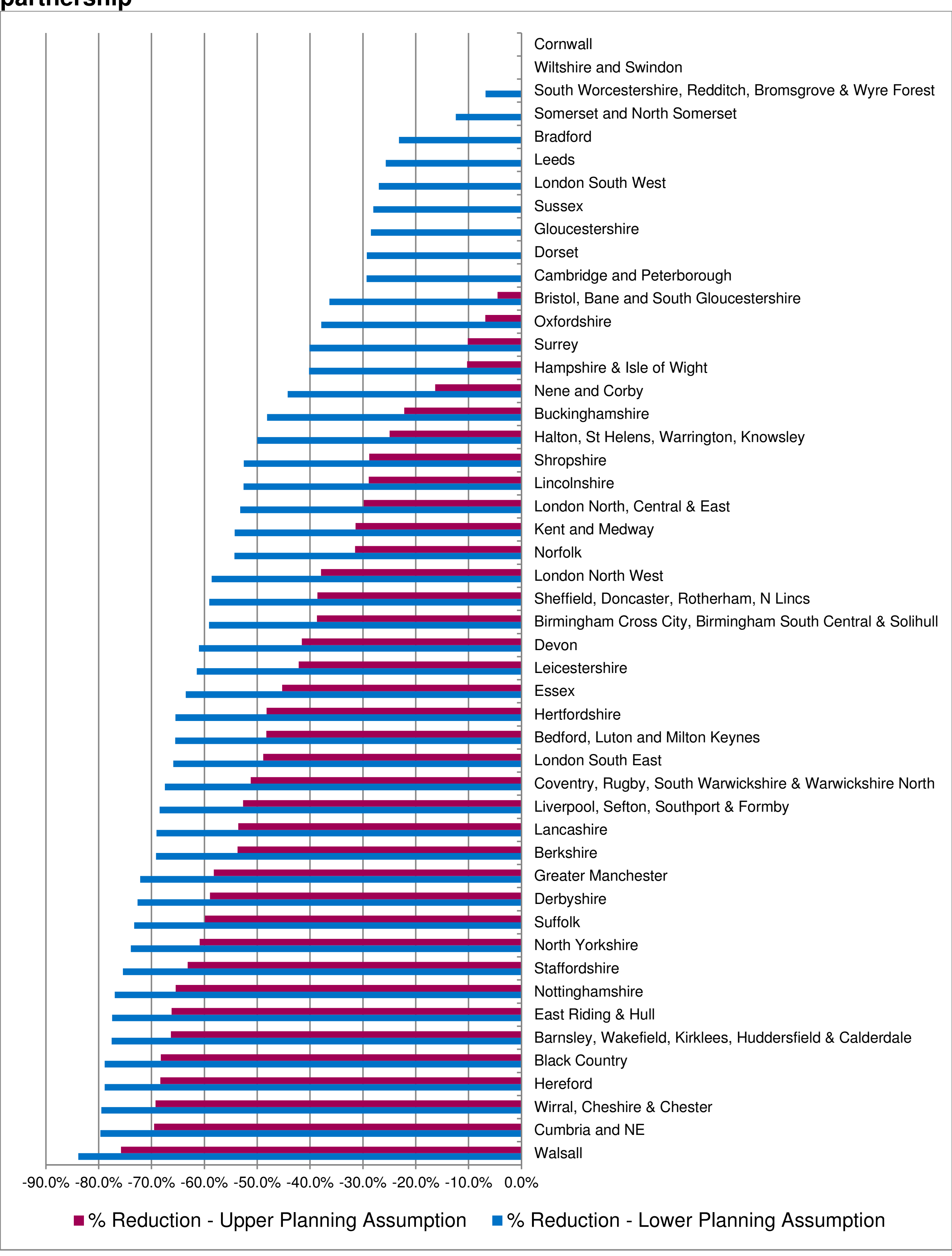
[15] See Annex C for further notes on the data used in these charts.

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



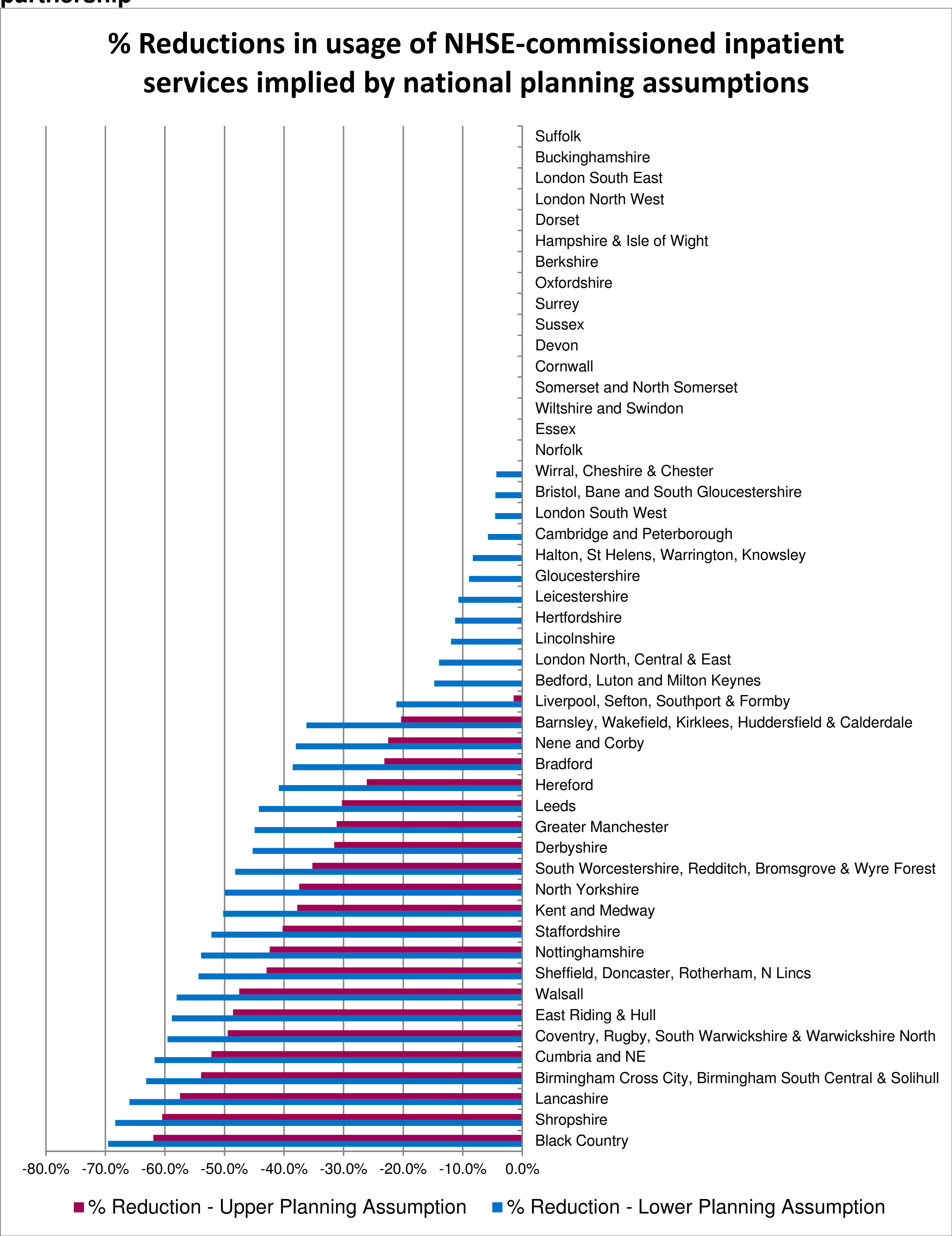
[16] See Annex C for further notes on the data used in these charts.

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



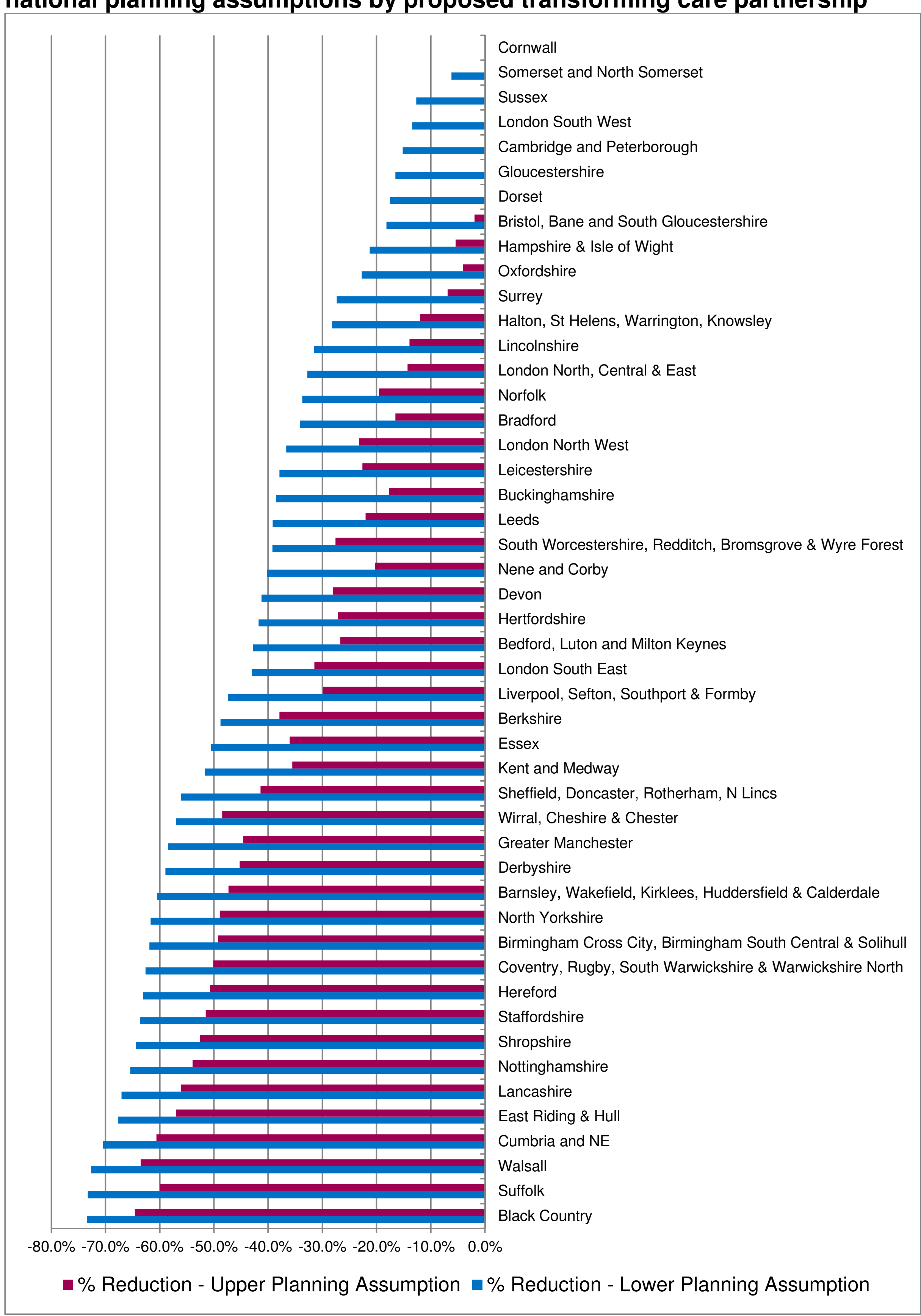
[17] See Annex C for further notes on the data used in these charts.

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



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

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



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

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

3.20 These assumptions are exactly what the term implies – assumptions for local commissioners to use as they enter into a detailed process of planning. Local planning needs to be creative and ambitious based on a strong understanding of the needs and aspirations of people with a learning disability and/or autism, their families and carers, and on expert advice from clinicians, providers and others. The starting point for service planning should be to think creatively about what support would help people to live the best possible life, as opposed to making marginal change to the set of services we have currently – and we will support people with lived experience, clinicians, providers and other experts to work with commissioners and help them think ambitiously and creatively in that way.

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

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

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

4. Working together to provide new services

Transforming care partnerships

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

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

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

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

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

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

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

The challenge

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

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

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

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

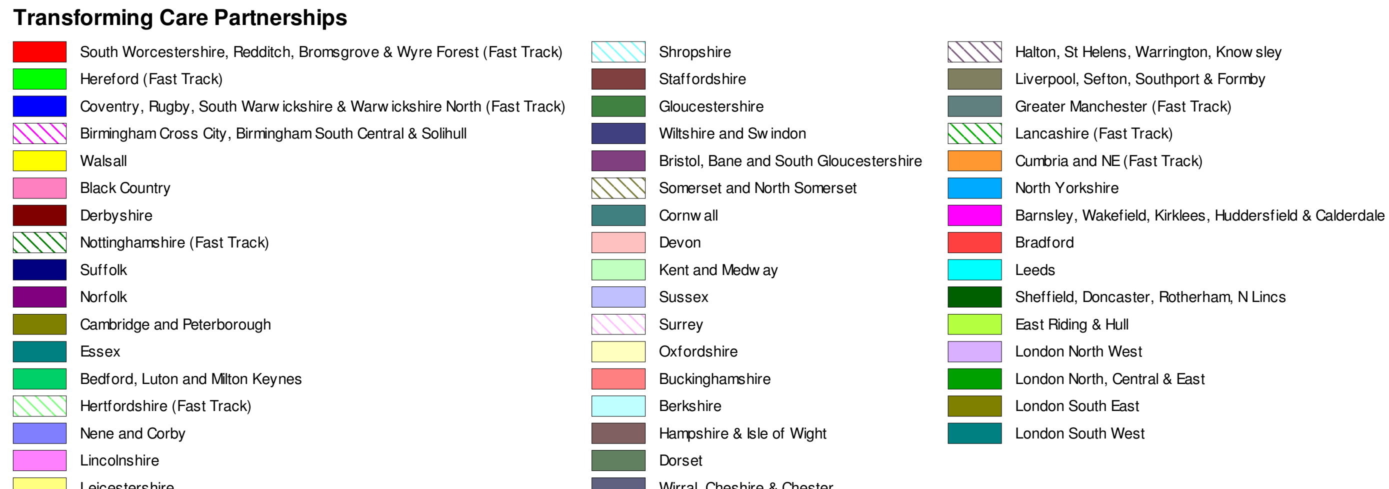
4.9 We will expect transforming care partnerships to tailor their approach based on local context, but in a way that is consistent with national parameters - in particular, the national service model and minimum planning assumptions on inpatient capacity outlined in chapter 3.

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

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

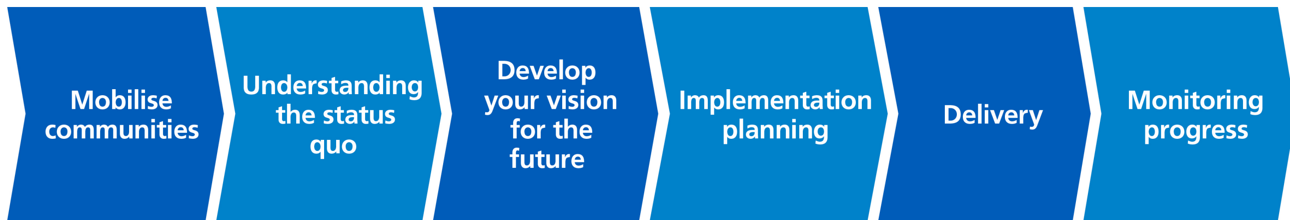
[20] K. Lowe et al, Challenging Behaviours: prevalence and topographies. Journal of Intellectual Disability Research, 51, 625–636 (2007).

Figure 16 – Proposed transforming care partnerships



Supporting local areas

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



Mobilisation

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

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

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

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

Understanding the starting point

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

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

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

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

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

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

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

Implementation planning

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

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

Delivery

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

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

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

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

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

Case study – Retail Charity Bonds

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

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

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

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

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

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

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

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

Monitoring progress

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

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

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

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

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

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

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

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

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

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

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

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

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

Financial underpinnings

4.41 A new financial framework will underpin and enable transformation.

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

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

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

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

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

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

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

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

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

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

Conclusion

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

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

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

Annex A – Proposed CCG clusters for transforming care partnerships

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

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

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

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

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

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

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

Annex B – Workforce development

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Annex C – Notes on data used in this document

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

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

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

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

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

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

Building the right support

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

October 2015

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

Health and Wellbeing Board Forward Plan

Date	Agenda	Lead
11/02/16	• Final HWBS Sign Off • Better Care Fund Section 75 Agreement Sign Off	Ceri/Ian Ceri
10/03/16	• Item in Focus – TBC • Public Health Grant • HWBB Development Session Report • Thurrock CCG Transformation Strategy • Suicide Prevention (Young People)	 Ian Wake Ceri Armstrong Mandy Ansell Malcolm Taylor

- Primary Care Estates Strategy
- Primary Care Strategy
- Early Offer of Help