Leicestershire Partnership NHS Trust

NHS
Leicester City Clinical Commissioning Group
West Leicestershire Clinical Commissioning Group
East Leicestershire and Rutland Clinical Commissioning Group

Transforming Care in Leicester, Leicestershire and Rutland

3 Year Road Map 2021 to 2024

Leicester City Council

Leicestershire County Council

Rutland County Council

Leicestershire Partnership NHS Trust

Leicester City Clinical Commissioning Group
West Leicestershire Clinical Commissioning Group
East Leicestershire and Rutland Clinical Commissioning Group

LLR Vision

"All people with a learning disability and/or autism will have the fundamental right to live good fulfilling lives, within their communities with access to the right support from the right people at the right time".

Leicester City Council

Leicestershire County Council

Rutland County Council

A Unique Opportunity

- LLR performance has improved
- National funding in addition to local funding. NHS England has invested dedicated three year funding to transform services. This will enable long term planning for the first time
- National policy shifts Integration and innovation: working together to improve health and social care for all (White Paper 2021)
- Team LLR, we are all working together so much more than we were before, now a regional and national TCP leader of joint working

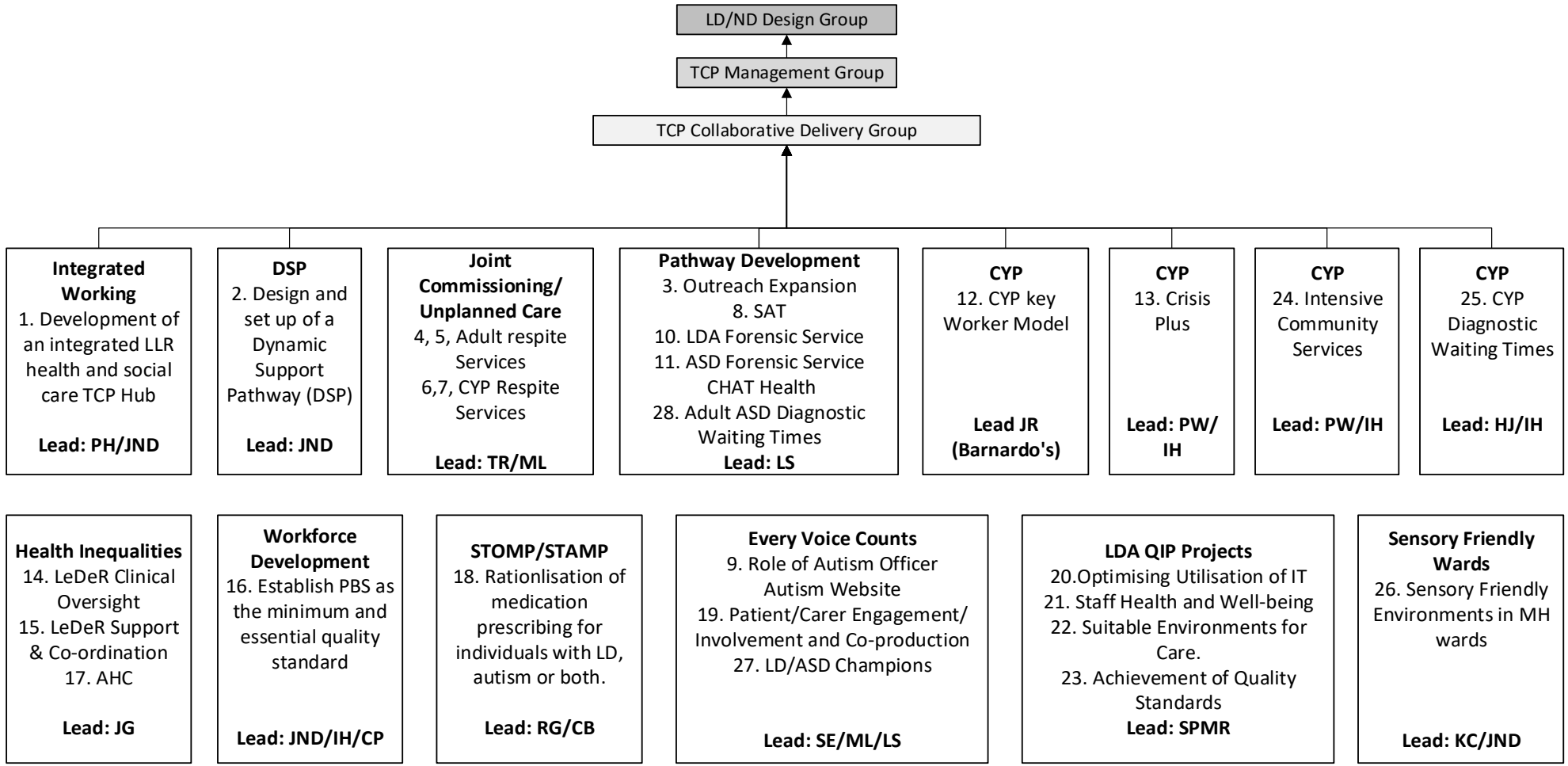
Aims and Objectives

Improve the wellbeing of people living with learning disabilities or autism or both across LLR
Person-centred, proactive and preventative approach
Reduce health inequalities
Improve quality
Increase the focus on autism especially 14+
Improve specific needs and pathways e.g. forensic, autism and transitions
Reduced admissions
Early intervention
Crisis avoidance

Key Priorities & pathways for Year 1

- Increased focus on co-production with people with LD and Autism
- Admission avoidance for CYP and adults
- Integrated team working – development of TCP Hub – joint working across LLR
- Continue to improve Annual Health Checks (AHC) completion rates – look to developing ASD AHCs
- Provide community and inpatient support for people with Autism without LD
- Learn from LeDeR (mortality review) – make service changes
- Provide better support for our LD forensic cohort

Governance Structure



Pathway Development

Specialist Autism Team (14+ community Service)

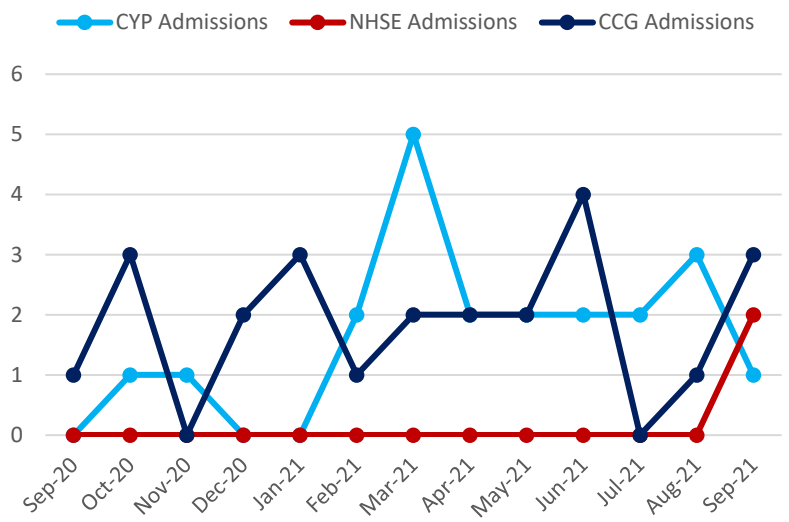
- Consultation & advice
- Positive Behaviour Support & early intervention
- Admission avoidance & support
- Inpatient discharge planning
- Post discharge support

LD & A Community Forensic service

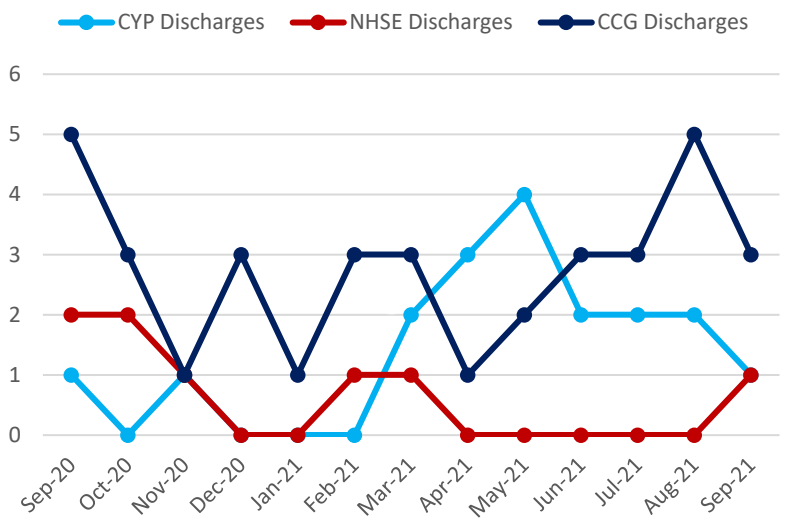
- Able to demonstrate effectiveness in reducing serious reoffending in individuals discharged from secure inpatient services.
- Dual emphasis on promoting and enabling individual recovery and independence, while also ensuring the protection of the public.

Improvements in Inpatient Data

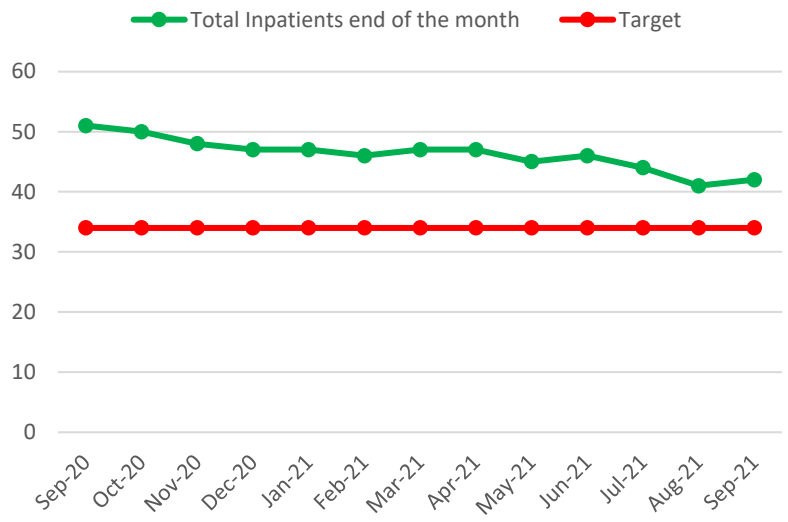
Number of Admissions each month



Number of Discharges each month



Total inpatients each month

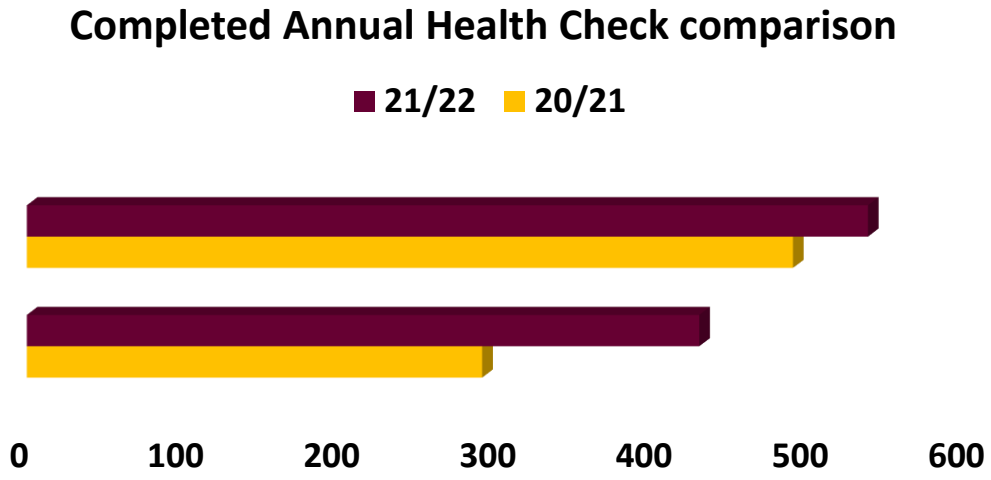


Since September 2020, there has been a total of 41 admissions, an average of 3 admissions each month across all patient types.

Since September 2020, there has been a total of 57 discharges an average of 5 discharges each month across all patient types.

Total inpatient figures have decreased but more discharges are needed to meet trajectory

Improvements in Learning Disability Annual health checks (AHCs)



Q2			
Jul-21	Aug-21	Sep-21	Total
153	119	266	538

2021/22 Total Completed	% of 14+ LD Register completed	2021/22 Not yet completed	Number yet to complete to reach 70%
968	17.98%	3712	2714

In the 1st and 2nd quarters of 2021 we have completed more health checks than the previous year. In total we have completed 968 checks, to reach the 70% target an additional 2,714 health checks need completing.

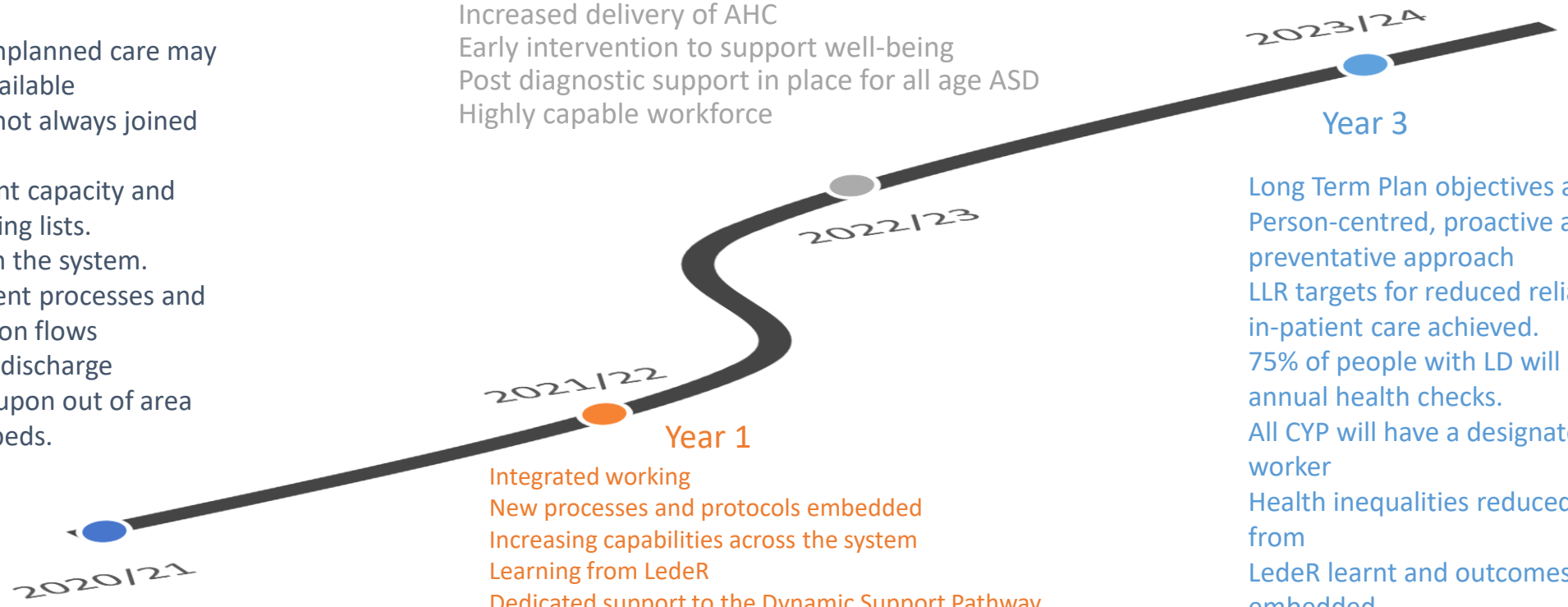
How things will look….

In year 1	Integrated working , New processes and protocols embedded, Learning from LedeR. Dedicated support to the Dynamic Support Pathway, Reduced number of admissions. New teams and new models of care for individuals with ASD and for those people with LD/ASD forensic needs.
In year 2	Timely discharges. No delays in Transfer of Care, Reduced reliance on in-patient care. Alternatives to admission available for all CYP and adults, Increased delivery of AHC. Early intervention to support well-being, Post diagnostic support in place for all age ASD Highly capable workforce.
In year 3	Person-centred, proactive and preventative approach, LLR targets for reduced reliance upon in-patient care achieved. 75% of people with LD will be having annual health checks. All CYP will have a designated key worker. Health inequalities reduced, lessons from LedeR learnt and outcomes embedded. Co-ordinated healthcare across the system. Long Term Plan objectives achieved. Interim Autism Strategy priorities embedded within the system.

Planned Outcomes

Current State

Some remaining gaps in service.
Urgent unplanned care may not be available
Services not always joined up.
Insufficient capacity and long waiting lists.
'Waste' in the system.
Inconsistent processes and information flows
Delays in discharge
Reliance upon out of area hospital beds.



Year 1

Integrated working
New processes and protocols embedded
Increasing capabilities across the system
Learning from LedeR
Dedicated support to the Dynamic Support Pathway
Reduced number of admissions
New teams and new models of care for individuals with ASD and for those people with LD/ASD forensic needs

Year 2

Timely discharges. No delays in Transfer of Care
Reduced reliance on in-patient care
Alternatives to admission available for all CYP and adults
Increased delivery of AHC
Early intervention to support well-being
Post diagnostic support in place for all age ASD
Highly capable workforce

Year 3

Long Term Plan objectives achieved
Person-centred, proactive and preventative approach
LLR targets for reduced reliance upon in-patient care achieved.
75% of people with LD will be having annual health checks.
All CYP will have a designated key worker
Health inequalities reduced, lessons from
LedeR learnt and outcomes embedded.
Co-ordinated healthcare across the system.

LOGIC MODEL – LLR Learning Disability & Autism Service

May 2021

Aim and Objectives

Aim
To improve the lives for people of all ages living with LD and/or autism (LDA) in LLR.

Objectives
Performance and Finance
NHSE/I trajectories met and surpassed. System wide savings as a result of reduced admissions and decreasing dependence on out of area independent sector hospital provision.

Systems and Processes
The LLR LDA system partners will design and deliver new processes which will result in new ways of working to increase efficiency, release capacity and improve response time and quality of care.

Patient, Family and Carer
Sustainable and on-going commitment to including the voice of the patient/carer/family in all future service development.

Service and Staffing
Teams have the capability to deliver the right interventions at the right time, in the right place and be delivered by the right person. Delivered right first time.

Estates
In-patient facilities are fit for purpose with highly capable staffing teams in place for all groups of patients with varying needs.

Inputs

Workforce
- Stakeholder capacity: Users and carers, independent sector providers (in-patient and community), adult mental health services, LD&A community services, ASD only services, CAMHS, Social care, voluntary sector providers
- Assistant Director level leadership.
- Dedicated staffing for project management.
- Deployment of dedicated existing substantive staff from both health and social care.
- Primary care
- On-going development of 'System 1' IT System to deliver required Business Intelligence.

Patient / Family / Carers
- Patient/carer involvement in all system wide workshops
- Co-production

Financial Investment:
- NHSEI Transformational funding allocation, existing staffing costs, CYP key worker funding allocation, LPT internal investment, East Midlands CAMH collaborative funding

Government Guidance
- National Guidance: Building the Right Support, NHS Long Term Plan Integrated care (2020).
- National Quality Standards
- NICE Guidance

Time.
- Meetings/workshops/task and finish groups
- Training sessions attended jointly by all system partners to facilitate a consistent approach and language.
- Completing Project Management Tools
- Evaluation support (data gathering, demand analysis, dashboard maintenance etc.)

Estates
- Allocation of required administrative and clinical space.

Activities

TCP integrated Hub
- Multiple team workshops to map all key processes within the patient journey.
- Mapping current procurement and communication processes.
- Clarification of roles and responsibilities

Dynamic Support Pathway (DSP) set up
- Liaison meetings with IT providers
- Documentation and register platform.
- DSP and Register training to all community services,

Workforce
- Focus on recruitment and retention activities
- Focus on capability. Skills gap analysis and development of training plan.
- Focus on staff well-being
- Focus on administrative support to support efficiency and capacity

Every Voice Counts
- Patients and carers involved in all workshops

Health Inequalities
- Enhance the clinical oversight of local LedeR reviews, clear action plans

Joint Commissioning
- Workshops/commissioning activities to procure components of unplanned care i.e. adult and CYP respite, 24/7 intensive support in the home

Pathway Development
- Workshops/activities to:
- Design and implement of new pathways of care, new ways of working, new roles and packages of care workshops
- Dedicated specialist team recruitment
- Agree competencies and training plans

Estates
- Detailed analysis of patient needs regarding in-patient facilities
- Current state mapping of current facilities

Outputs

TCP integrated Hub
- New processes and protocols in place for key functions of the team e.g. for crisis avoidance, crisis management, admission, discharge planning, transition and post discharge follow up.

Dynamic Support Pathway (DSP)
- Register and process for requesting and delivering more robust multi agency meetings completed.
- Dedicated project support officer to maintain register and support pathway in place.
- SOP completed and rolled out.

Workforce
- Training plan in place
- Staff well-being forums on-going.
- Successful recruitment
- Retention activities

Every Voice Counts
- Forums, focus groups, surveys, co-production of pathways and models of care

Health Inequalities
- LedeR - clear understanding of cause and effect, Clear understanding of lessons learnt
- Increased number and quality of AHC for all

Joint Commissioning
- Contracts as required
- Rapid response intensive home support available – Adults and CYP
- Short term respite beds available Adults and CYP

Pathway Development
- New care pathways for individuals with ASD and for individuals with LD/ASD with forensic service needs
- CYP key worker model of care in place

Outcomes

Integrated Hub Working
- Duplication of work removed. Gaps in processes causing delay identified and reduced. Role and task clarity
- Obstacles to discharge anticipated and proactive measures in place to reduce
- Process timelines reduced leading to faster admission to appropriate hospital, faster access to required treatment and more rapid and streamlined discharge.

Dynamic Support Pathway (DSP)
- Individuals in the community (all age) have their needs identified early and interventions provided quickly to reduce the risk of further deterioration in well-being.
- Reduced number of admissions for CYP and adults.

Workforce
- Highly capable workforce – capacity and competencies as required to deliver the right care when required

Every Voice Counts
- Sustainable and on-going commitment to including the voice of the patient/carer/family in all future service development.

Health Inequalities
- Improved quality of care for all individuals at all stages of their care and support

Joint Commissioning
- Alternatives to hospital admission during times of crisis are available.
- Prevention of carer breakdown.

Pathway Development
- Dedicated specialist teams in place and with the capability of meeting the needs of the individuals within their pathway.
- Reduced admissions, reduced LOS

Impacts

Identified aims and objectives are achieved.

LLR will have in place an inclusive, person-centred, proactive and preventative approach that supports the individual's needs and preferences.

When support is required all individuals will have access to the right support at the right time, in the right place and be delivered by the right person.

Adults, children and young people with a learning disability, autism or both are able to thrive in the community in their own homes in the least restrictive environment possible, develop independence, make their own choices, be able to integrate into society, maintain family and friend relationships, take part in hobbies and activities and lead a life of 'beautiful ordinariness'.
Families remain together.

Individuals are able to contribute to society through vocational activities and paid employment.
Individuals physical, emotional and mental well-being is maintained.