Inner north east London

Transforming Care

Partnership Plan

28 June 2016

Introduction

The Transforming Care Partnership (TCP) includes:

- City of London
- London Borough of Hackney
- City and Hackney Clinical Commissioning Group
- London Borough of Newham
- Newham Clinical Commissioning Group
- London Borough of Tower Hamlets
- Tower Hamlets Clinical Commissioning Group
- London Borough of Waltham Forest
- Waltham Forest Clinical Commissioning Group

This plan is for

People with a learning disability and people with an Autistic Spectrum Disorder who have challenging behaviour.

We want to provide

- the right support, in the right place and at the right time
- support from competent and confident staff
- positive local options to catch people when they fall.

While we have a lot of good things locally to offer, we know that we have much more to do before we can guarantee people and their families the right local support, consistently and through the different stages of their lives. We know that periods of transition in particular are often trigger negative consequences for this group of very vulnerable people and we are committed to improving that. Our threshold for people leaving out area to get education, care or support must be really high in the future. We believe that our plan will transform our area to deliver a much stronger, effective and resilient service across our area that will in turn reduce institutional care and enable people to get on with living good, healthy and productive lives.

By 2019 we will have developed and implemented, across the partnership, an enhanced model of care that delivers, from a positive starting point, a 20% reduction in in-patient bed usage as well as: improved quality of care and improved quality of life of ***all*** individuals with behaviour that challenges and their families/circles of support.

This improved model of care is being built around three core components:

1. Prevention and community support that minimises risk of inappropriate admission;
2. Focused and high quality assessment, treatment and care while in hospital; and
3. Effective and timely discharge supported by a plan that minimises the likelihood of readmission.

What is the case for change?

We have analysed our current collective position, consulting widely. We have looked at our population trends. We have assessed how we currently fit against the individual criteria set out in the National Service Model. We have considered the current provision for the wider cohort and we have concluded that, while we have a relatively low number of people in hospitals, some are there inappropriately. We know that we send people to residential boarding schools and residential homes away from east London. We know that our current local provision is patchy in quality and insufficient in capacity and resilience.

1. Overall, we have not had a clear sense of this cohort or of good intended outcomes for the people in it. Progress has been piecemeal. Our evidence of what works well or not is not well evidenced or shared.

2. We have identified people who are inappropriately served in inpatient provision and who need to be discharged.

3. While we currently have a lower number of people using inpatient provision than the new national target we believe that it should remain lower and so needs to reduce considerably over this period

4. Our use of out-of-area residential provision affects this cohort and therefore needs to stop being a response to people with challenging behaviour. We must find ways to prevent people moving away when it is not their choice to and we must offer ways for people who want to return to do so.

5. We have found that there is a potentially significant group of people within this cohort living on our patch (at the instigation of other local authorities) who we do not fully understand (in residential homes).

6. We have a growing population and so need to build capacity for the future for the wider cohort.

7. We do not currently meet the National Service Model requirements. We know that not all of our local services are effective for this cohort, and we know that there are areas for improvement. We have identified common areas of weakness that we wish to collaborate on to improve, and others where we can use learning from one part of the TCP to inform and improve other parts so that we all fully meet the new model by 2019. In particular we have established considerable gaps in:

    - Increasing control over services by service users and their families
    - Sufficient preventative work for children and adults who challenge
    - Understanding criminal behaviour in this cohort, especially those who are ineligible for support, or of how to support the community in accepting people returning from custodial sentences
    - Sufficient agreement and utilisation of positive methods of supporting people with challenging behaviour
    - Sufficient contract control over the quality of support people experience from all supporters – family, schools, colleges, adult services, including skills in setting up individual bespoke services
    - Sufficient support to families
    - Sufficient access to individual housing, especially when needed fast
    - Smooth navigation through education, health and support services
    - The ability of local advocacy to effectively support this group
    - Enabling this group to gain employment
    - Effective interagency working between specialist and mainstream services

8. We understand that our current systems and practices do not enable a 'whole life' approach and that timely and consistent support is often not available, contributing to the threat of crisis. Transition periods often become crises. We know there are difficulties with insufficient joint planning for adulthood (generally with adults' teams picking up responsibility too late). We see full records not always being transferred between children's and adults' services or between out-of-borough residential schools and adults' services. Roles and responsibilities are not always clear or understood. We have heard of difficulties in a change of support means that the person's support plan and positive behaviour plan effectively stop and start, with no continuity from the previous one. Our support to people during periods of change needs to change.

9. We are aware that people don't always get equal choices; some get good services, some get more restrictive support; there is no person-centred explanation for why one part of the group lives away from their home and the other is served locally.

10. Very few people in the cohort have accessed personal budgets of any sort and their control over the services offered to them is very limited. We believe that a substantial growth in this area will be a driver to people having support at the right time, in the right place.

11. We understand that the above concludes that there is a lack of sufficient capacity, skill and knowledge in supporting the wider cohort locally.

We believe that we can improve our current model of care by:

- Understanding the people in this group, where they are, their vulnerabilities, aspirations and talents. To do this we need to build on the beginnings of a proper risk register and track their journeys

- Intervening earlier in order to prevent crisis in mental health, challenging behaviour and the ability of family/carers to support the person

- Prioritising individual control through the use of personal health budgets; with their own resources, people are likely to create more local demand than commissioners have done

- Instilling better practice throughout all of our services (from health and social care providers to commissioners, mainstream services etc.) to reduce crises, through positive approaches to people who challenge, embedded locally and with knowledge and skill that supports the person as close to the person as possible through training, coaching and support to families, teachers, care staff

- Providing local options so that people never move far from home (both to hospital and to residential care) due to their behaviour or illness through access to local housing and support

- Understanding the impact of transition periods and creating a smooth journey through starting school, transition through schools, from child to adulthood and through moving from the family home

- Understanding the entire community that supports those people and collaborating to provide a positive and safe place for people to be. We believe this will reduce the impact of internal processes on peoples' behaviour (e.g. transition, access to healthcare, rebalancing health inequalities etc.)

- Prioritising opportunities to do things together to provide sufficient resilient local services accessible to the TCP as a whole in the most effective, practical and cost effective way, regardless of borough boundaries.

By 2019 we will have developed and implemented, across the partnership, an enhanced model of care that delivers, from a positive starting point, a 20% reduction in in-patient bed usage as well as improved quality of care and improved quality of life for all individuals with behaviour that challenges and their families/circles of support.

What this will look like

Main Transforming Care Partnership initiatives

We have a detailed plan but our main initiatives are:

Instilling the right methodology

1. We will employ an additional behavioural specialist to work across the area to provide additional capacity to undertake assessment, advise, train, evaluate and review.

2. We will develop a positive behaviour statement that all employees, families and the general public can see.

3. We will work with families and black and minority ethnic (BME) groups to make sure that support services are available that meet with both the National Service Model and the requirements of people from BME communities

4. We will set up a best practice forum led by the behavioural specialists across the patch, both in statutory and third sector organisations. This is to create a culture of positive and evidence based practice, to problem solve, flag up difficulties to the TCP and to collect evidence of the impact of positive behaviour support (PBS) across the patch.

5. We will review the capacity of the Community Learning Disability Teams to service more people locally in the future.

Personal Health Budgets

1. We will encourage the use of personal budgets (of all types), piloting with a group in Tower Hamlets and then spreading across the patch. We will prioritise people who are coming out of hospital. We will provide information and advice to enable people to use their money in a manner that reduces the risk of escalating behaviour or admission to secure services

2. These aim to assist people having as much control over their care and support as possible.

Housing

1. We will review the housing we have now and plan to ensure that people with challenging behaviour do not have to leave the area because there is nowhere for them to live locally. We will consider what people might need in their housing and seek to accommodate that. This will involve a review of NHS owned properties currently used for people with a learning disability.

2. While the review is underway we will rent four flats to ensure that there is accommodation if a person's current housing arrangements break down. This will be used if someone is at risk of ending up in hospital or out-of-borough, and will also be used to help people get back home quicker.

3. We will review who is living out-of-borough within our cohort to assess whether they wish to return, or should return. Where people are settled and well supported we will ensure those arrangements are recognised and that their care and quality of life is good.

Pathways (priority area)

1. We want to see each person as a whole, with a past, present and future. We know that transition can be a very difficult for people with challenging behaviour. That could be starting school, moving from children's to adults' services, losing parents or leaving home. We will employ a pathways support post to work alongside people and their families to ease these transitions. They will identify what may need to change in our systems and the way we work to improve life for the person.

2. We will conduct a full audit of the current experiences of people in transition, focussing on the move from children's to adults' services, but including other transition periods in each clinical commissioning group or local authority and draw learning from it to determine changes to be made. This will include considering whether further improvements can be made to the timeliness of diagnosis in early years. It will include checking that local policies and practices ensure that information is transferred and utilised so that the person's support is fully informed. We will also map current services available to the cohort to enable the best use of and easy access to existing services.

Providers (priority area)

1. We will identify a small group of 'targeted' providers across our area who we have identified as having the right approach and skills to support people with significant challenging behaviour. We will collaborate with them to increase local capacity and resilience to ensure a stream of available support to people when they need it.

2. We will amend our contracting and commissioning practices to ensure that people get the service that's right for them and in line with our plan.

3. New guidance for reviewing officers will be developed to enable them to understand success in these services and to be able to identify risks early.

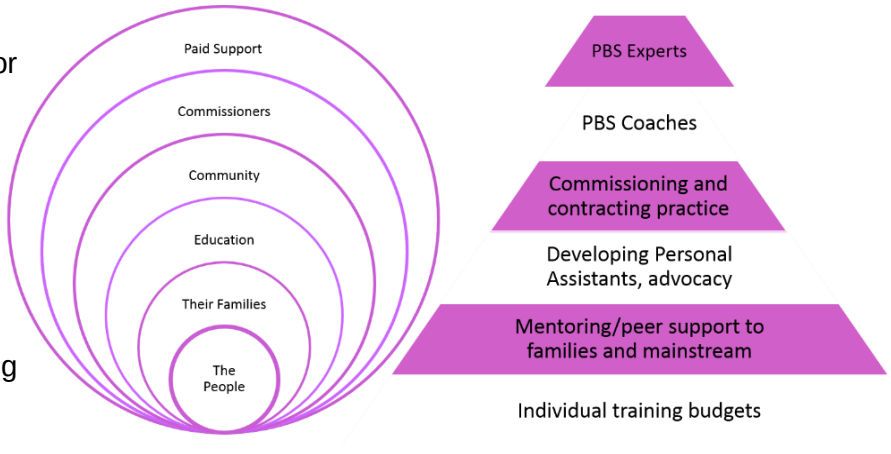
4. We will work with selected providers collaboratively to identify an appropriate and transparent costing model that secures increased local capacity.

5. We will gain active participation from schools to reduce moves to boarding schools.

6. We will review and refine the capacity of local community learning disability teams to support this group in the future as local provision is expanded

Workforce development (priority area)

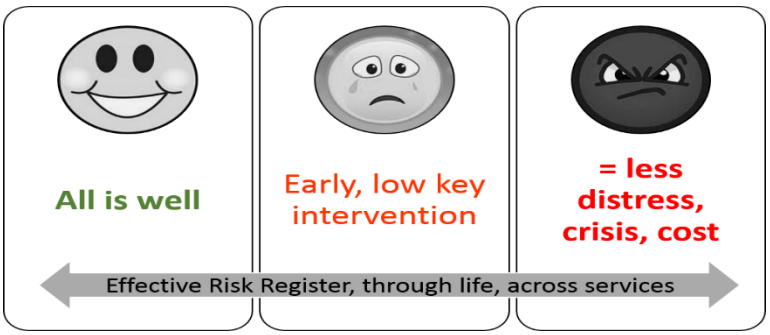
1. We will establish a full framework for competence (in staff, families, networks) throughout the person's life. Training will be accredited and where people are paid link to a professional framework (health, social care, education). This includes support to families and Personal Assistants, and an individual training budget of £2000 to people with a Personal Health Budget.



2. We will collaborate with local providers to secure the availability of a good quality local workforce

Risk register (priority area)

1. Each CCG and local authority will together hold a risk register that spans children and adults. This will be reviewed at least every four weeks and will aim to target support proactively so that people don't fall into a crisis. We aim for this to help to identify people who are at risk of getting into trouble but who do not receive services.



2. We will provide mentoring in the principles of effective support to mainstream services: colleges, police, transport staff, leisure etc. to increase community participation and to reduce incidents in the community

Contingency plans

1. For people at risk of their support breaking down (either in the family home, or somewhere they get paid support), a contingency plan will be in place so that we know ahead of time what will happen if support arrangements break down.

2. We will specifically work with the police as the majority of the people who are in hospital setting come through a criminal justice route.

Respite

1. We will increase the funding for respite for people and their families where the person is at risk of having to go into hospital or out-of-borough for the next three years. This can be used flexibly.

Peer Support

1. We will develop the competency of local advocacy to deliver to people with challenging behaviour.

2. We will pilot schemes to enable families to support each other.

Hospital treatment

1. Some people will need hospital inpatient treatment for periods when they have a significant illness. Where this is a psychiatric condition that requires hospital treatment we will aim to secure treatment locally, for their treatment to be focussed and effective, for their stay to be as short as possible and for them to return to their day-to-day life with minimal disruption.

2. Where people do need psychiatric inpatient care we will consider the use of mainstream mental health services first. These don't suit everybody, but where we are using specialist services it will be where mainstream services are not able to cater for that individual. We will collaborate with the outer north-east London TCP to secure local access to assessment and treatment within the joint area and have a clear policy regarding the appropriate use of both mainstream and specialist inpatient services for this cohort.

3. We will require a clear plan outlining the reasons for admission and intended outcomes and timescales within two weeks of admission.

4. We will use CTRs to monitor the quality and effectiveness of the service.

Our partnership

1. Our partnership will aim to create the best environment for success in delivering the plan. This will include developing co-production with people who have experience of inpatient and far from home services.

2. We will integrate the work plan into existing roles across the partnership and recognise the need for additional capacity and expertise to ensure delivery of the plan, including developing a specification for a strategic transforming care lead to enable the plan to be delivered.

3. We will agree actions across the partnership area and those that are managed within a CCG area.

4. We will use the *Transforming Care Plan* to increase collaboration including the possible pooling of budgets, adoption of shared common initiatives etc. and will be clear about what is shared activity and what remains locally steered.

5. We will Identify and facilitate opportunities collaboration in areas beyond the immediate Transforming Care programme and for the wider learning disability/autism population.

6. We will liaise with other TCP areas to identify opportunities to share practice and collaborate.

Outcomes

The main outcomes we expect to see from the programme are:

1. A reduction of 20% in the use of hospitals for this cohort by 2019. Nobody is placed in hospital away from the area or readmitted within two years.

2. An increase in the resilience and capacity of local services and consequently people moving more than 10 miles away from the TCP patch will have reduced. A costing model will be in place that is transparent to all regarding the accepted price band for services being commissioned.

3. A positive behaviour workforce development plan has been delivered to support the cohort and those supporting them such as families, staff and informal support networks, supported by the TCP wide practitioners group and 30 positive behaviour support (PBS) coaches.

4. Commissioners and providers practice will have adapted to personal health budgets and integrated personal budgets with these being offered as routine.

5. Number of people falling into the red zone on well-developed risk registers will have reduced by 10% in 2016/17 with targets for subsequent years set annually. Contingency plans for individuals at risk will be in place for those who need them and there will be fewer breakdowns within the family home.

6. Transition review completed and recommendations implemented.

7. Housing options to people in this group will increase.

8. Skilled advocacy will be in place.

9. Feedback from pilot peer support schemes to assess impact leading to longer term family support schemes will have influenced local strategy.

Inner North East London Transforming Care Partnership Plan

City & Hackney, Newham, Tower Hamlets, Waltham Forest

We serve...

People of all ages with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition

- ✓ the right support in the right place and at the right time
- ✓ with support from competent and confident staff
- ✓ and positive local options to catch people when they fall

We are succeeding when...

- ✓ KPI #1 We reduce admissions to inpatient services by 20% by 2019
- ✓ KPI #2 We reduce people leaving the area by (TBC)
- ✓ KPI #3 We increase local capacity, capability and resilience in targeted housing, education and health and care providers
- ✓ KPI #4 We increase control by people and their families through increase in personal health/integrated budgets

The journey we need to take...

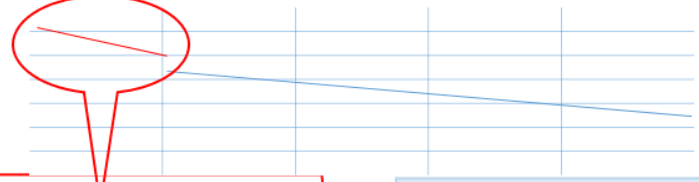
In 2015 we spent £XXm on the following service model

- Growing population and high number unengaged with current service models (BME)
  Examples of some good local services
- Low numbers of inpatients and high levels of people "placed" away from home
- Incomplete understanding of the cohort, their support needs, and future pipeline
- Insufficient local capacity and resilience in services to serve people and their families

This needs to change because...

- It doesn't produce good outcomes for all
- It's reactive, not proactive
- It doesn't use resources effectively
- It risks people's safety and wellbeing
- It contributes to health inequalities
- It places great strain on family life

Our transformational journey



Priority changes today

- Cohort and pipeline mapped
- Shift to co-production
- Risk Registers
- Practice development group with additional post
- Positive Behaviour Framework for workforce development
- Estates review
- Pathways mapped
- Provider market identified
- Personal Health Budget plan in place

Long-term enablers

- Commitment to support locally (TCP area)
- Synergetic risk registers
- Shared approach to housing the cohort
- In area or close proactive inpatient and social care provision converging to cater for this group
- Shared strategy to maintain local workforce
- Community capacity especially in criminal justice, positive behaviour support
- Openness to individually tailored support

Critical stakeholders...TCP Board, Steering Group, commissioning authorities, people and their families, health and social care workforce, criminal justice system

In 2020 we will spend £XXm on the following service model

- Local services with sufficient capacity, resilience and skill
- Direct purchasing by people and their families
- Accommodation to cater for people locally
- Streamlined pathways
- Effective risk assessment, crisis prevention and response and local inpatient provision

This is beneficial because...

- People are asking for local services. Repeated abuse scandals show risks of placing people away from home.
- Evidence shows effective approaches to challenging behaviour leads to better individual outcomes and reduced costs to the public purse