NELFT NHS
NHS Foundation Trust

NHS
Barking and Dagenham, Havering and Redbridge
Clinical Commissioning Groups

London Borough of Barking & Dagenham

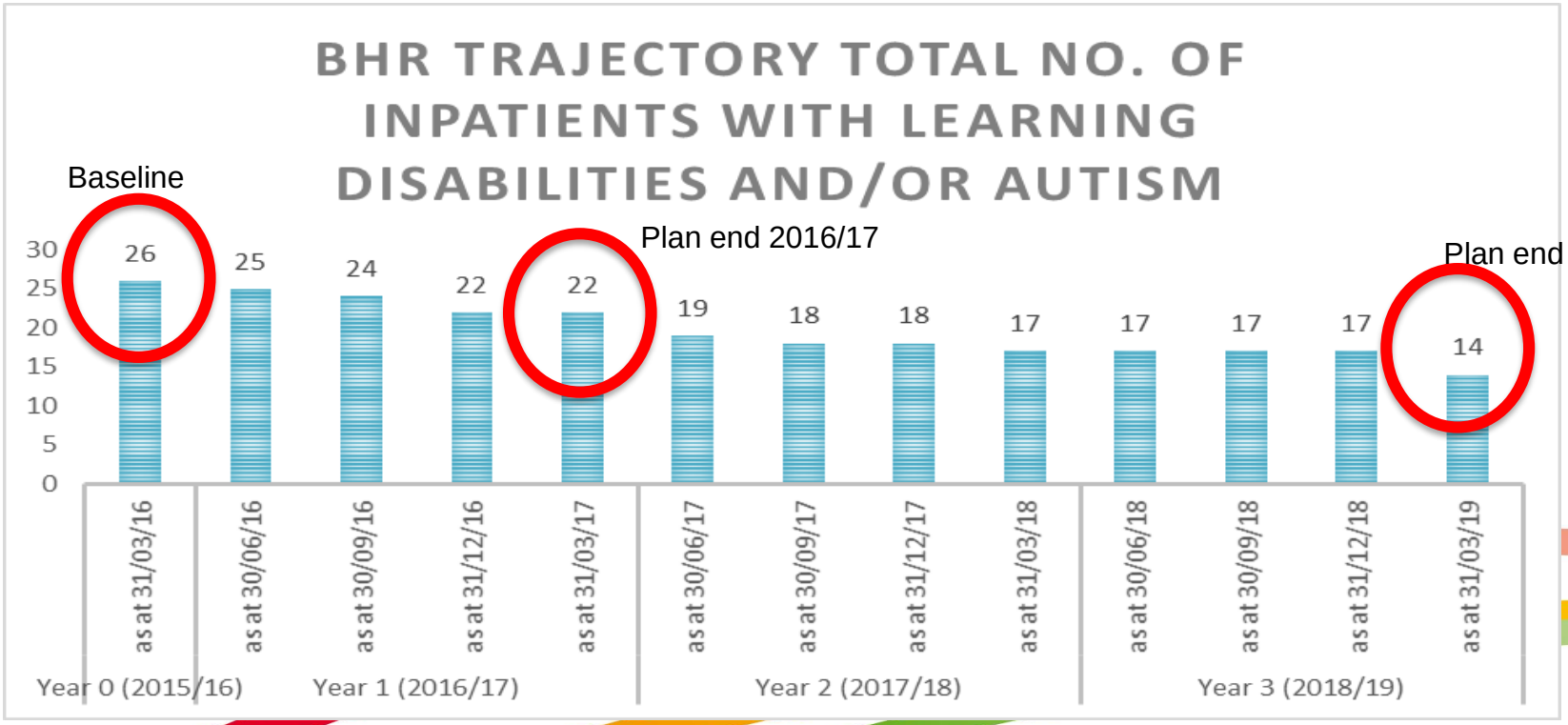
Havering London Borough

London Borough of Redbridge

Barking Havering and Redbridge Transforming Care Partnership NHSE Stocktake 12 May 2017

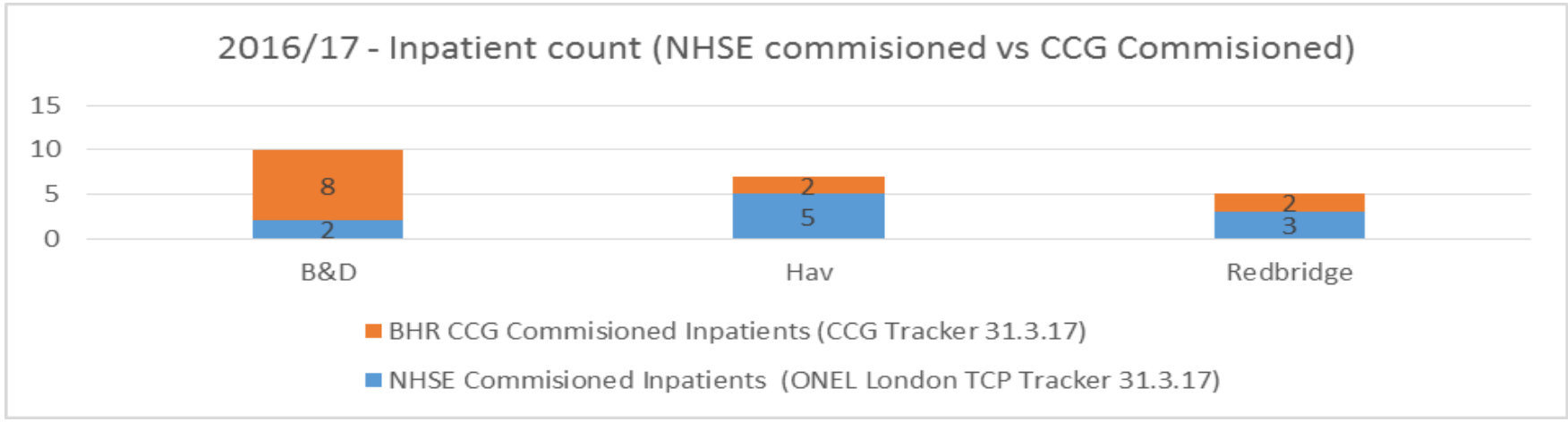
Performance trajectory

- BHR TCP plan is to reduce the number of inpatient beds commissioned from 26 in March 2016 to 14 in March 2019
- The partnership did not achieve the plan for 16/17, reducing the number of inpatients to 23 in April 2017 against a plan of 22
- Between April 16 and March 17 there were 26 discharges and 19 admissions



Current performance

- Currently on target with 22 inpatients as at 30.4.17. comprising 12 CCG and 10 Spec Comm inpatients
- Overall inpatient rate currently 37.96 inpatients per million GP registered population against baseline of 44.86 and trajectory of 24.16 end 2018/19.
- Better performance in Havering and Redbridge makes up for less good performance in B&D.
- Better performance for CCG commissioned inpatients overall makes up for slightly below plan performance for spec comm commissioned inpatients
- In April 2017 there were 11 people who have been inpatients for 5 or more years (6 CCG commissioned and 5 spec comm commissioned)
- Responsible commissioner status for S117 discharges is being queried for 3 patients



Performance

Performance management process

Discharges and admissions

- Monthly borough based CTR assurance meetings to review risk registers are tracked by CCG LD commissioner
- Quarterly surgeries have been set up between spec comm and community care coordinators to strengthen discharge planning
- Monthly tracker meetings with NHSE Strategic Programme Manager, CCG LD commissioners and spec comm to review TCP tracker and discharge dates
- Monthly escalation meetings between TCP SRO and LBBD commissioning director ASC and LD commissioners to monitor discharge processes and address barriers to discharge
- Monthly meeting with SRO, programme manager and CCG legal to address any legal issues regarding responsible commissioner status
- Root cause analysis of admissions and delayed discharges discussed at TCP Board to implement learning e.g.

Area of review	Action
Admissions into CAMHS tier 4 beds	Training of tier 3/Interact teams (June – August ‘17)
Section 117 funding apportionment	Develop BHR S117 policy (June ‘17)

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Performance

Discharges of people with long lengths of stay (> 3years)

March 2017: 11 people with LOS > 5 years (6 CCG and 5 Spec comm)
All patients are out of borough
1 Individual reviewed by "I'm out of here team" in 16/17
3 individuals where responsible commissioner for discharge is in dispute

More focus on this cohort in 17-19 plan:

- TCP Board has prioritised use of NHSE non-recurrent funding on expediting discharges of the > 5 years cohort:
  - currently exploring North West London's Placement Efficiency Project for local implementation
  - Linked into the Avenues work commissioned by NHSE on 5+inpatient needs assessments.

Our plan 17/19

The TCP Board agreed 8 workstreams to support the delivery of the TCP plan in December 2016 (Page 7) linked to the Building the Right Support principles.

The Board held a workshop on 4 May to refresh plan for 17/19 based on learning from 16/17 and in particular responding to the system challenges in delivering the planned trajectory including:

- Strengthening systems for effective engagement and discharge planning between spec comm care coordinators and local community teams/commissioners particularly for mental health
- Reducing the number of placements out of borough: In March 2017 there were 11 OOA placements – 2 above March 2016. This is primarily due to PD needs.
- Financial risks and cost pressures associated with the shift of care from inpatient to community including: higher cost of complex care packages in comparison to inpatient care
- Development of a strong business case for community investment that provides assurance on return on investment for commissioners through bed closures
- Feedback from stakeholder engagement event in January 2017 on crisis support
- Targeting of £200K non-recurrent funding from NHSE London to deliver 17/18 priorities
- Potential opportunity to deploy resource for Lumos to support pilot in one borough
- Clinical and management resource available to drive through delivery of the plan

- The work stream leads are updating actions for 17-19 in May 2018. An example of workstream 1 action plan is included on slide 8
- The refreshed plan will be signed off at 7 June TCP Board meeting.

Workstream & Objective	Proposed Plan elements 17-19
Community based care and support (BRS principle 7/8) Enable people with LD/Autism and behaviour that challenges to avoid crisis and to continue to live in community settings Support people with LD/Autism and behaviour that challenges that are in inpatient care to be discharged from hospital into community based care	• Implement effective community/blue light CTRs • Implement admission avoidance processes • Improve management of crisis • Implement effective hospital gatekeeping function • Offer community respite as alternative to hospital care • Implement effective arrangements to receive people from CCG and spec comm inpatient facilities into local community based care
Inpatient care (BRS principle 9) Support people with more complex inpatient needs to be cared for in the local ATU wherever possible and to be discharged into community based care in a timely way.	• Review Out of Borough hospital placements • Demand and capacity modelling for inpatient care across BHR and NEL • Commission service in line with need and complexity • Develop service specification for ATU • Implement effective discharge planning processes
Developing community solutions (BRS principle 5) Develop housing solutions and providers to meet the needs of local people in TCP cohort	• Business case for a respite/short breaks resource available for children and adults • intelligence/evidence gathering – gaps, voids, sites and vacant buildings across BHR • Transition plan across BHR in which to fully understand the projections. • Brokerage function across BHR for LD/Complex care and support.
Developing the right support – families, carers and workforce (BRS principle 4) Ensure that everyone working with people in the TCP cohort has the right skills, support and development	• Develop PBS strategy and implementation plan • Develop workforce strategy and plan • Provider development
Children and transition Ensure that children and young people needing TCP cohort care transition effectively into services with a focus on early intervention and community based care	• Implement appropriate identification and admission avoidance processes for children and young people • Take forward TCP children guidance (due to be issued shortly) • Work with CYPMHTP lead/children lead to ensure specific needs of children and young people likely to be in TCP cohort met
Improving health and wellbeing (BRS principle 6) Address health inequalities and mortality gap for people with learning disabilities	• LD health checks • Implement output of mortality review work • Ensure mainstream services across health and social care make reasonable adjustments for people with LD
Co-design and engagement People in TCP cohort, families and carers co-design service developments	• Co-design strategy and plan which covers all other work streams • TCP Carers Forum
Integrated & personalised commissioning Commissioning supports and enables personalised and integrated care	• Finance plan and S75 pooled budget development • Personal Health Budgets and Personal Budgets • S117 arrangements

Workstream 1 Community Based Care and Support
Aims
- **To enable people with LD/Autism & behaviour that challenges to avoid crisis and to continue to live in community settings**
- **To support people with LD/Autism & behaviour that challenges in inpatient care to be discharged from hospital into community based care**

TCP plan objective	Learning 16/17	Action 17-19	Timeline
All community patients at risk of admission have CTR	79% of TCP cohort recorded as having CTR (01/17) Children's CTR not embedded across all teams (RCA) Development and quality of support plans varies across boroughs. CTR assurance meetings mechanism for ensuring CTRs take place for relevant patients.	• Complete training programme on CTR for CLDTs and CYP services. • Establish regular monthly CTR assurance meetings to identify patients requiring community CTR – targeted on B&D	August 17 May 17
Implement robust all age admissions avoidance registers	Most admissions in B&D (B&D 9, Havering 3, Redbridge 4). Admissions avoidance registers/processes established in H and R but not in B&D. CYP RCA highlighted need to engage tier 3 and Interact CYP crisis service.	• CYP/TCP leads in place and contributing monthly to CTR assurance meetings. • Start monthly reporting on numbers on registers to TCP Board.	August 17 June 17
Improve management of crisis	Outreach/crisis model developed with NELFT adult services unaffordable and difficult to define ROI. User and carer view that PBS needed more. Some success with nurse led CYP crisis model (Interact) but needs to be integrated within wider TCP work.	• Develop and implement PBS strategy supported by clinical psychology and working with family carers and providers to prevent crisis. • Review CYP crisis offer for TCP cohort. • CTR assurance meetings to review all 52 week residential school placement transition arrangements.	December 17 Sept 17 August 17
Implement effective inpatient gatekeeping function	Lack of effective gatekeeping in children and adult inpatient care – particularly B&D.	Develop ATU specification with INEL based on NEL TCP cohort needs	Jan 18
Develop community respite offer	Limited spot purchased respite largely available as direct payments – difficult to quantify value.	Undertake options appraisal across BHR and draft service specification	August 17
Implement collaborative discharge process between inpatient care & community	Lack of process between spec comm and BHR community teams – particularly where under care of MH not CLDTs. Challenges where patients OOA.	• Establish spec comm surgeries and agree standard discharge planning processes. • Commission OOA and 5+ year patient review and placement support service	Sept 17 Dec 17
Ensure effective community services to support discharge	Gaps in community provision – autism, personality disorder, community forensic. Lack of recurrent investment funding and financial pressures where community packages are above inpatient costs.	• Complete TCP cohort needs assessment. • Develop business case for children autism support • Develop proposals to enhance for adult autism post diagnosis pathway • Develop business cases for use of CCG TCP investment – recurrent/non-recurrent - potentially with INEL for specialist services	August 17 June 17 Nov 17 July 17

Finance

How is TCP progressing its understanding of the financial implications of Transforming Care

Financial planning is being based on the following assumptions:

Discharges

- Cost of community packages will cost the same or more than a CCG inpatient bed (average £180K) – will impact on LAs (more risk for B&D LA);
- Cost of community packages will cost more than a spec com inpatient bed (proposed transfer to CCGs of £120K N/R p.a.) – will impact on CCGs/LAs (more risk for Havering CCG/LBH)
- 3 funding disputes re. S117 responsible commissioner will be resolved in BHR's favour

Admissions

- Rate of admissions in 17/18 and 18/19 will be less than 16/17 (plans targeted on B&D and CAMHS tier 4 admissions)
- ALOS will reduce as discharge processes improve
- This may have a longer term impact on the number of beds commissioned from NELFT (to be modelled)

Work is progressing to get a better analysis of the financial implications:

- Financial mapping CCG inpatients - care co-ordinators reviewing 2 years discharge plans to a) assess likely support and accommodation needs and b) discharge timeline to forecast type of package required and anticipated cost apportioned to commissioners and c) financial risk
- Early confirmation of responsible commissioner for all TCP patients on tracker

Finance

Risks

- Identified a gap in suitable local providers for some needs which is driving out of borough placements (autism, PD)
- The discharge of complex patients will present a cost pressure on local commissioners
- National guidelines not yet in place to support transfer of funding from specialist commissioning

Opportunities

- More focus on brokering best value from providers and developing the local provider market

Partnership agreement

- Current mechanism for pooled budgets is through borough based BCF Section 75s with Local Authorities as lead commissioner agreed
- Financial mapping work will inform a joint commissioning discussion on the scope and establishment of a pooled budget and risk share arrangements
- Would wish to agree the principle of an in-year transfer of resource from Spec comm whilst partnership agreements are being developed

Finance

16/17 funding

- BHR TCP received £110k one year NHSE funding in 16/17 to support crisis/outreach and to impact in particular on reducing number of inpatients.
- Some of this funding has been used to train staff across BHR in adult and children services on CTR and associated admission avoidance processes.
- Remaining funding has been used to extend the expertise and capacity of the TCP delivery team to focus on delivery of the plan and strengthen the operational arrangements with borough CLDTs and childrens services.

Community Services

- Challenges in developing community services in 16/17. In particular:
  - Inpatient cohort is relatively small in BHR and there is not scope as in other areas to reduce numbers of inpatient wards to release funding for community developments.
  - Difficulty in demonstrating ROI for new services/service enhancements given constrained financial position.
  - The financial risks to LAs and CCGs associated with increase in complex community packages to partnership as a whole from increased discharges has not been assessed in full. Partnership discussions around development of enhanced community offer to mitigate those risks have therefore been hampered.

- The work stream plan for Community Services is set out on preceding slide.

- The plan includes an action to deliver a needs assessment for the TCP cohort now and into the future. This work will inform partnership understanding of financial risk and will enable discussions around development of community services – as well as a supporting a number of other work streams including housing/accommodation, provider development and workforce needed to care for patients in community settings

- The enhancement of community services for children and young people is being progressed through the CAMHS transformation plans. Additional investment has been made to community CAMHS services to support implementation of the THRIVE model of care and single point of access to services. Through the urgent and emergency care vanguard, the provider is piloting a new crisis pathway which strengthen the gateway to tier 4 beds.

Community Services

- Workforce development has focused on two main identified gaps to date.
  - **Positive Behaviour Support:** £100k funding identified to support development of strategy and implement plan. This reflects family carer/user feedback. INEL model and models in other parts of London are being considered, with a workshop with INEL planned on 31 May for frontline staff representatives followed by local clinical input and development of specification/commissioning of training and support package. Link to Children's Mental Health THRIVE model and associated Positive Parenting support being taken forward through CAMHS plan.
  - **Management of criminality and personality disorder in community** – this has been identified as a gap in particular in respect of spec comm inpatient cohort and OOA CCG inpatient cases. This work is at an early stage but will involve review of evidence, development of a business case for funding based on reducing cost of complex care packages.
- The plan for 17/19 includes the development of a wider workforce development plan informed by cohort needs assessment, provider work and work to develop a joint specification for community and inpatient care.

Provider Development

- BHR TCP has attended 2 NHS England facilitated pan London Providers meetings aimed at sharing with providers insight into the local needs – for example autism, personality disorder

- The sessions have also developed provider understanding of CTR processes and how to engage with CLDTs to avert admissions. Providers have identified their workforce development needs, especially training in Positive Behaviour Support – a factor which will inform the development of the BHR TCP PBS strategy

- Local progress in this area to date has focused on developing the range of providers able to work with a number of complex B&D inpatients – using the CQC and NHSE provider lists. This work has identified a number of providers able to offer a community based service in B&D and a number of B&D buildings that could be developed to provide appropriate accommodation

- The BHR TCP actions for 17/19 on provider development are embedded in two work streams ***Developing Community Solutions*** *and* ***Developing the right support – families, carers and workforce***

- **Developing Community Solutions** is focused on development of providers and accommodation/ housing offer to meet needs of TCP cohort. Further information on housing accommodation slide.

- **Developing the right support** focuses on developing the workforce skills of local providers to meet local needs. For example this will include how providers working with our TCP cohort deliver PBS in line with emerging PBS strategy. Further information on the community services slide.

Housing/Accommodation

BHR is developing a housing/accommodation strategy to be considered by TCP Board September 2017. The purpose of the strategy is:

- To stimulate the housing market and ensure there is a ready market of housing providers willing and able to respond to demand to enable people to have access the right housing at the right time and provide a choice of accommodation to people with a learning disability and/or autism who display behaviour that challenges, or those at risk can choose from
- To develop a pipeline of local housing developments to meet existing and future needs
- To engage local housing departments in the housing requirements of the local partnership
- To inform capital investment plans
- Estimate the likely impact to budgets in coming years
- To provide increased clarity and certainty to providers against the backdrop of future funding for supported housing

Two developments so far that would support need identified in B&D and Havering – both bespoke builds providing up to 17 units that could be designed to meet specific needs of cohort as well as options around short term crisis support and facilities for staff to live in enabling more complex patients to be cared for in community setting in environments developed for their specific needs.

Housing/Accommodation

Further work is planned with NHSE and CCGs capital/estates leads to understand the capital requirements and to develop business cases to support this work further.

The cohort needs assessment work planned will further support the development of the strategy to reflect specific service user needs. Working with spec comm on the needs assessment will be crucial to understanding the complex needs of these patients.

This work will inform wider local authority housing strategy and will inform market shaping activities that take a whole system, lifespan approach to commissioning for people with a learning disability and/or autism, enabling them to live good lives in the community.

Dynamic Registers

- The TCP Board took stock of at risk of admission registers in the 3 boroughs in January 2017 – identifying register lead, number rated red and amber, number of children and arrangements in place to ensure monthly updates. Position as follows:

AROA Jan 17	Havering	Redbridge	B&D
Red rated adult	7	6	No response
Amber rated adult	17	15	No response
Children	0	0	No response

- This work identified that Havering and Redbridge had basic systems in place but had identified issues around engagement with children's services. This has led to identification of specific children leads in all boroughs with the responsibility to include children in the register – backed up with further training planned June-August
- The work also identified a number of issues in B&D which are being addressed through the new All Age Disability service operational from April 17
- This will continue to be closely monitored through the TCP Board. The registers will also form part of stage 3 needs assessment where the needs of patients at risk of admission are understood from a commissioning perspective in more detail

Risks

Risk/issue	Mitigation
There is a risk that specialised commissioning proposals for discharging people into the community (TCP transfers and New Models of Care) will have an adverse impact on CCG/ LA finance if not managed in a planned way with risks share arrangements in place.	- Financial mapping of spec comm caseload to assess financial risk. - Development of local partnership agreement that enables funding to transfer from Spec comm to CCG/LA - STP engagement if NHSE New Models of Care Workstream to support strategic planning.
CCG transformation funds for community services will not be secured unless the case can be made for delivery of savings across the pathway of care.	- Complete financial mapping work to establish level of financial risk and opportunities for redesign - Implement 17/18 programme to roll out PBS to workforce - Ensure related MH service developments e.g. CAMHS crisis pathway, improve pathway for TCP cohort
The cost of community packages may be more than cost of inpatient care. This is exacerbated by 2/3 average inpatient cost transfer proposed from spec comm to local partners.	- Complete financial mapping work to establish level of financial risk and opportunities for redesign
Local commissioners may not have the capability and capacity to manage complex discharges for long stay patients.	- Non-recurrent funding sourced from NHSE to commission additional support for discharge - NHSE commissioned support from Avenues to assess the needs of long stay patients.
There is limited capacity within local commissioning teams to deliver transformation plan milestones and focus on performance management of discharges/ business as usual.	- Recruitment commenced for additional commissioning post and project support
Local workforce may not be in place to cope effectively with patients discharged by specialised commissioning inpatient beds (e.g. therapies, psychology, local forensic based services).	- Further work needed to develop workforce strategy (17/19 plan)

Support

It would be helpful to be able to access NHSE support in the following areas:

- Navigating and understanding capital funding mechanisms and development of effective business case processes
- Workforce development expertise – support to scope what is needed from Skills for Care/Skills for Health
- Evidence base for community forensic service
- Expertise and hand on help with demand and capacity modelling for ATU across NEL
- Support to intercede with non-London commissioners and providers where inpatient to be discharged OOA.
- Good practice examples of inpatient needs assessments that can be undertaken rapidly to inform planning.