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Havering
LONDON BOROUGH

HEALTH & WELLBEING BOARD
AGENDA

1.00 pm	Wednesday, 21 September 2016	Committee Room 3B - Town Hall

Members: 16, Quorum: 9

BOARD MEMBERS:

Elected Members:	Cllr Wendy Brice-Thompson (Chairman) Cllr Gillian Ford Cllr Roger Ramsey Cllr Robert Benham
Officers of the Council:	Dr Susan Milner, Interim Director of Public Health Andrew Blake-Herbert, Chief Executive Tim Aldridge, Director of Children's Services Barbara Nicholls, Director of Adult Services
Havering Clinical Commissioning Group:	Dr Atul Aggarwal, Chair, Havering Clinical Commissioning Group (CCG) Dr Gurdev Saini, Board Member Havering CCG Conor Burke, Accountable Officer,Barking & Dagenham, Havering and Redbridge CCGs Alan Steward, Chief Operating Officer, Havering CCG
Other Organisations:	Anne-Marie Dean, Healthwatch Havering Matthew Hopkins, BHRUT Ceri Jacobs, NHS England Jacqui Van Rossum, NELFT

For information about the meeting please contact:
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What is the Health and Wellbeing Board?

Havering's Health and Wellbeing Board (HWB) is a Committee of the Council on which both the Council and local NHS and other bodies are represented. The Board works towards ensuring people in Havering have services of the highest quality which promote their health and wellbeing and to narrow inequalities and improve outcomes for local residents. It will achieve this by coordinating the local NHS, social care, children's services and public health to develop greater integrated working to make the best use of resources collectively available.

What does the Health and Wellbeing Board do?

As of April 2013, Havering's HWB is responsible for the following key functions:

- Championing the local vision for health improvement, prevention / early intervention, integration and system reform
- Tackling health inequalities
- Using the Joint Strategic Needs Assessment (JSNA)and other evidence to determine priorities
- Developing a Joint Health and Wellbeing Strategy (JHWS)
- Ensuring patients, service users and the public are engaged in improving health and wellbeing
- Monitoring the impact of its work on the local community by considering annual reports and performance information

1. WELCOME AND INTRODUCTIONS

   The Chairman will announce details of the arrangements in case of fire or other events that might require the meeting room or building's evacuation.

   Councillor Brice-Thompson

   Start time: 13:00

2. APOLOGIES FOR ABSENCE

   (If any) – receive.

   Apologies have been received from Tim Aldridge, Director of Children's

Services.

3. DISCLOSURE OF INTERESTS

Members are invited to disclose any interest in any of the items on the agenda at this point of the meeting.

Members may still disclose any interest in any item at any time prior to the consideration of the matter.

4. MINUTES (Pages 1 - 8)

To approve as a correct record the minutes of the Committee held on 20 July 2016 (attached) and to authorise the Chairman to sign them. To also consider any matters arising not on the action log or agenda.

Councillor Brice-Thompson

Start time: 13:05

5. ACTION LOG (Pages 9 - 10)

To consider the Board's action log (attached).

Councillor Brice-Thompson.

Start time: 13.10

6. COMBINED UPDATE ON ACO/STP (Pages 11 - 20)

Report attached.

Conor Burke/Alan Steward/Andrew Blake-Herbert

Start time: 13.15

7. SEND INSPECTION AND NEEDS ASSESSMENT (Pages 21 - 54)

Report attached.

Mary Phillips/Sue Elliott

Start time: 13.40

8. TRANSFORMING CARE PARTNERSHIP - FOR SIGN OFF (Pages 55 - 138)

Report attached.

Barbara Nicholls

Start time: 14.05

9. CCG ASSURANCE FRAMEWORK AND RATING (Pages 139 - 144)

Report attached.

Conor Burke/Alan Steward

Start time: 14.25

10. FORWARD PLAN (TO BE TABLED)

Elaine Greenway on behalf of Susan Milner

Start time: 14:45

11. DATE OF NEXT HEALTH AND WELLBEING BOARD MEETING

16 November 2016

12. EXCLUSION OF THE PUBLIC

To consider whether the public should now be excluded from the remainder of the meeting on the grounds that it is likely that, in view of the nature of the business to be transacted or the nature of the proceedings, if members of the public were present during those items there would be disclosure to them of exempt information within the meaning of paragraph 3 of Schedule 12A to the Local Government Act 1972; and, if it is decided to exclude the public on those grounds, the Committee to resolve accordingly on the motion of the Chairman.

(Meeting close time – 15.00).

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MINUTES OF A MEETING OF THE HEALTH & WELLBEING BOARD
Committee Room 3B - Town Hall
20 July 2016 (1.00 – 2.50 pm)

Board Members present:

Councillor Wendy Brice-Thompson (Chairman), Gillian Ford, Roger Ramsey and Robert Benham
Andrew Blake-Herbert, Chief Executive **(ABH)**
Dr Susan Milner (Interim Director of Public Health), **Andrew Blake-Herbert** (Chief Executive), Tim Aldridge (Director of Children's Services) and Barbara Nicholls (Director of Adult Services) **(BN)**
Dr Atul Aggarwal (Chair, Havering Clinical Commissioning Group (CCG)) **and Conor** Burke (Accountable Officer,Barking & Dagenham, Havering and Redbridge CCGs) **(CB)**
Matthew Hopkins (BHRUT) **(MH)**
Carol White, NELFT **(CW)**

Also Present:

Ade Abitoye, Interim Head of Public Health Intelligence **(AA)**
John Green, Strategic Commissioning Lead **(JG)**
Dave Tapsell, Head of Systemic Practice **(DT)**

One member of the public was also present.

All decisions were taken with no votes against.

1 **WELCOME AND INTRODUCTIONS**

The Chairman announced details of the arrangements in case of fire or other event that might require evacuation of the meeting room or building.

2 **APOLOGIES FOR ABSENCE**

Apologies were received from Alan Steward, Havering CCG, Anne-Marie Dean, Healthwatch Havering and Jacqui van Rossum, NELFT (Carol White substituting).

3 **DISCLOSURE OF INTERESTS**

There were no disclosures of interest.

4 MINUTES OF LAST MEETING AND MATTERS ARISING (NOT ON ACTION LOG OR AGENDA)

The minutes of the meeting held on 11 May 2016 were agreed as a correct record and signed by the Chairman. There were no matters arising not covered elsewhere on the agenda.

5 ACTION LOG

Electronic copies of the CCG's commissioning intentions for children's services had now been distributed. Joint commissioning arrangements for children would be brought to the Board as a separate item.

BN was now leading on the Transforming Care Partnership and this would come to the next meeting of the Board for sign off. An event had been held the previous day for commissioners, providers and operational staff and there would be engagement with Learning and Achievement as part of this work.

The sexual health services reconfiguration consultation had been extended by one week due to technical problems with the survey form and would now close on 22 July. This would be followed by the preparation of a non-key Executive Decision paper for agreement by Councillor Brice-Thompson. SM confirmed the survey was available on-line and had been sent to key stakeholders. SM also emphasised that the service was no longer viable in its current form.

CCG and NELFT health assessments for Looked After Children and pre-adoption – no update available.

The revised Board Terms of Reference were now complete and SM would recirculate the final version for information.

It was noted that there was no longer any statutory requirement to have a Children's Trust and that other mechanisms such as the Local Safeguarding Children's Board and Multi-Agency Safeguarding Hub now fulfilled the role of the Children's Trust. The Board therefore **AGREED** that the Children's Trust was no longer needed in Havering.

SM had agreed with Councillor Brice-Thompson to wait to refresh the Joint Health and Wellbeing Strategy until after the Sustainability and Transformation Plan (STP) and Accountable Care Organisation (ACO) business case had been published. SM would bring a final draft of the Joint Health and Wellbeing Strategy to the September meeting of the Board.

BN confirmed that comments by the Board on Place of Safety Guidance had been included in the response to the consultation.

6 **DELIVERING THE NHS FIVE YEAR FORWARD VIEW: DEVELOPMENT OF THE NORTH EAST LONDON SUSTAINABILITY AND TRANSFORMATION PLAN AND STRATEGIC OUTLINE CASE FOR THE ACO**

CB explained that the NHS five-year forward view encourages the development of sub-regional devolution pilots. In addition the NHS had also introduced Sustainability and Transformation Plans (STPs) for providers and commissioners. It was noted that the STP for Havering also covered the whole of North East London. The North East London STP had been put forward in December 2015 and sought to achieve a financially sustainable health system by 2021. It was accepted that this would be challenging, particularly given the deficits at BHRUT and Barts Health.

Given the financial challenges, there had been a lot of focus on finding different ways of delivering care. Many savings were targeted around the acute hospital pathway although it was accepted that not all interventions required to close the financial gap had been identified at this stage.

CB and MH had met with the national STP team the previous week and felt that the meeting had been quite successful with the primary focus being on delivery in the current year – both financial factors and outcomes.

The STP sought to address a number of key priorities including managing the demand for health services from a rising population and transforming the way care was provided. Other priorities included ensuring providers remained sustainable and transforming specialist services, the commissioning of which was likely to be devolved from NHS England to a local level. The development of a system-wide decision making model and the maximisation of the use of estates were also priorities under the STP.

There was work underway with housing re the STP although this was in its early stages. It was accepted that people's environment was critical to their health. All partners were required to be transparent about costs involved in the STP and it was hoped that any issues involving costs sharing etc could be resolved quite quickly. The Local Authority's financial gap was not included in the STP but would be picked up by the ACO work.

It was hoped there would be more buy-in from other councils in the STP area as political support was required from Councils in order to make the changes work. CB felt that if a strong case was made for the value of the STP then the business case would succeed but this again needed buy-in from all the Councils involved.

The Board **AGREED** that it should record its displeasure that NHS England would not allow the contents of STPs to be shared. CB would communicate this to NHS England.

The business case for the ACO set out to answer similar questions for the Barking & Dagenham, Havering and Redbridge area. The business case addressed how the financial challenge would be met and proposed a direction of travel for how this work could be delivered in partnership.

Work on localities was fundamental as this was considered the best way to transform health outcomes. The business case proposed how localities could be created and trialled. The aim of the programme was to put the person at the centre and focus on preventative care and the impact of areas such as housing, leisure and work.

A lot of progress had been made but it was accepted that this work remained a big challenge. It was planned to agree the business case for the ACO in September 2016 and a lot of engagement would be needed between the parties involved in the work.

The ACO was an overall vision but it would not be possible to cover care at all stages of life within the 18 month pilot period.

The Board **NOTED** the position with the ACO and STP.

7 JSNA PROGRAMME UPDATE

SM explained that the previous version of the JSNA had not been fit for purpose. The JSNA now consisted of a suite of web-based products including 'This is Havering' which showed facts and figures about Havering's population and was updated quarterly. The JSNA also included the Statement of Health and Social Care Needs of the Local Population which covered these issues at a high level and is updated annually.

Interactive ward health profiles have also been developed. These are web-based tool which allow comparisons of wards within Havering and with the national average for issues such as demography and health. The system was very simple to use and it was felt could also assist in place-based commissioning. The public were able to locate their ward by entering their postcode and then find information on any of 66 indicators on the system.

The age of the data used varied by indicator but was not more than 5 years old. Admissions indicators were based on yearly data and pooled overall. The use of nationally pooled data allowed standardisation and quality control. There were not currently any mental health indicators on the system although other data collection tools were also used as required. The ward health profiles were demonstrated to the board.

It was confirmed that more use would be made of infographics to put over information. The ward data was also fed into the ACO business case. For work on the ACIO and STP and the associated place based commissioning, the system may need to be reformulated in order to profile localities but the

framework to support this was already in place. Variations between different wards would also be taken into account.

An annual report of the Public Health Outcomes Framework for Havering was also provided to the Board.

8 DEMAND MANAGEMENT STRATEGY: CASE STUDY - SOCIAL ISOLATION

This project had been focussing on social isolation as the driver of increased demand for health and care services. JG explained that community navigators had been recruited to engage with people identified as being socially isolated and that a total of 275 cases had been identified within Havering.

Individuals responded in different ways to contact from the team and JG felt that some people used care workers as a proxy for social interaction and it was often very difficult to alter this. Nonetheless, a lot of successful outcomes had been seen from getting people to attend social or activity groups etc.

JG felt that more activities could be commissioned for people who were socially isolated. Personal assistants could perhaps be trained to assist people to get out of their homes more and transport options may need to offer more of a chaperone role in order to assist with this. JG also felt that facilities for groups needed improving and that people with similar interests could be brought together more than at present.

The work would now also seek to look at socially isolated people outside of the social care system. The emphasis was on social and physical rehabilitation which would also lead to a cost saving for the Council. Community navigators were persistent and contacted people several times but it was accepted that some people simply did not want any social interaction.

A digital solution – Vizbuzz had been taken on as part of the project which offered a Tablet with Facetime installed. This had been delayed due to technical problems although most users had responded positively.

The community navigators were linked to the NELFT Talking Therapies service and would refer people who they thought needed mental health services. A person's frailty index was also considered.

It was **AGREED** that the Board should receive a further update on this work in early 2017.

9 LAUNCH OF FACE TO FACE INTERVENTION (WORKING WITH CHILDREN IN SOCIAL CARE)

TA explained that there had been a large rise in demand for children's services and, in common with other areas, there was also difficulty in recruiting and retaining children's social workers. There was therefore a wish to transform services in order to work more directly with children and families.

Over the course of 2-3 years, it was planned to train all children's social care staff in systemic family therapy, establish a small team to model new ways of working and to pilot new working methods. This was with the aim of reducing the numbers of families requiring intervention.

DT explained that the systemic or family therapy approach moved the locus of intervention from individuals to relationships. Social care staff would look to help families change how they did things although it could be difficult to alter established family behaviour. All front line social workers and managers would therefore be trained in systemic therapy.

It was hoped this approach would also achieve better outcomes for staff, making then feel more valued and hence improve recruitment and retention. It was hoped the new programme would also lead to better retention of agency social workers. This would also allow the management of a rising population with more complex needs and a clinical team was currently being recruited to work with social workers.

The 15 day course for staff in systemic therapy would allow staff to view interaction with families in different ways and hence improve the quality of social work undertaken. Support and supervision for staff would also be altered with more use made of techniques such as peer supervision and discussion groups.

The Board **NOTED** the update and **AGREED** that details of the Open Dialogue technique used by NELFT should be brought to a future meeting.

10 FORWARD PLAN

It was **AGREED** that the following items would be added to the forward plan:

0-5s (TA)
Rainham and Romford Housing Zones (Neil Stubbings)
Open Dialogue update at next meeting (CW/Jacqui van Rossum).

11 DATE OF NEXT HEALTH AND WELLBEING BOARD MEETING

The next meeting of the Board would be held on 21 September 2016 at 1 pm in Havering Town Hall.

Chairman

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Health and Wellbeing Board Action Log (following July 16 Board meeting)

No.	Date Raised	Board Member Action Owner	Non-Board Member Action Owner	Action	Date for completion	RAG rating	Comments
16.11	20 July 16	Sue Milner		Recirculate finalised ToR to board members	By 21 Sept 16		
16.12	20 July 16	Sue Milner		Bring draft of refreshed Joint Health and Wellbeing Strategy to next Board meeting	By 21 September 16		

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Havering
LONDON BOROUGH

HEALTH & WELLBEING BOARD 21 Sept 2016

Subject Heading:	**Update on North East London Sustainability and Transformation Plan**
Board Lead:	**Conor Burke, Accountable Officer, Barking & Dagenham, Havering and Redbridge CCGs**
Report Author and contact details:	**Helena Pugh,** Local Authority Engagement Lead, NEL STP 020 3816 3813 nel.stp@towerhamletsccg.nhs.uk

The subject matter of this report deals with the following priorities of the Health and Wellbeing Strategy

- ☒ Priority 1: Early help for vulnerable people
- ☐ Priority 2: Improved identification and support for people with dementia
- ☐ Priority 3: Earlier detection of cancer
- ☐ Priority 4: Tackling obesity
- ☒ Priority 5: Better integrated care for the 'frail elderly' population
- ☒ Priority 6: Better integrated care for vulnerable children
- ☒ Priority 7: Reducing avoidable hospital admissions
- ☒ Priority 8: Improve the quality of services to ensure that patient experience and long-term health outcomes are the best they can be

SUMMARY

This report provides a further update to the Board on the development of the north east London Sustainability and Transformation Plan (known as the NEL STP). A draft 'checkpoint' STP was submitted to NHS England on 30 June 2016. A summary of progress to date (see Appendix 1) will be used to facilitate meaningful engagement on the NEL STP over the coming months, enabling us to gather feedback, test our ideas and strengthen our STP.

The STP Board is establishing a working group of senior representatives from partner organisations to develop the STP governance. This includes Local Authority representation.

Further work is continuing to develop the plan in more detail; the next iteration of the plan will be submitted to NHS England in October. Additional updates will be presented to the Board as they become available.

For more information go to http://www.nelstp.org.uk or email nel.stp@towerhamletsccg.nhs.uk

RECOMMENDATIONS

The Havering Health and Wellbeing Board is recommended to note the:

- summary of progress to date in Appendix A
- proposed approach to developing governance arrangements for the STP

No formal decisions are required arising from this report.

REPORT DETAIL

1. Background

1.1 In December 2015 NHS England planning guidance required health and care systems across the country to work together to develop sustainability and transformation plans (STPs). An STP is a new planning framework for NHS services which is intended to be a local blueprint for delivering the ambitions NHS bodies have for a transformed health service, which is set out in a document called Five Year Forward View (5YFV). England has been divided into 44 areas (known as footprints); Redbridge is part of the NEL footprint.

1.2 STPs are five year plans built around the needs of local populations and are:

- based on a 'place' footprint rather than single organisations, covering the whole population in this footprint, which is agreed locally
- multi-year, covering October 2016 to March 2021
- umbrella strategies, which span multiple delivery plans, ranging from specialised services at regional levels, to health and wellbeing boards' local commissioning arrangements, as well as transformational programmes, such as those redesigning services for people with learning disabilities, or urgent care
- required to cover the full range of health services in the footprint, from primary care to specialist services, with an expectation that they also cover local government provision
- to address a number of national challenges, such as around seven day services, investment in prevention, or improving cancer outcomes

1.3 These plans will become increasingly important in health service planning because they are the gateway to funding. In 2016/17 they are the basis for accessing a transformation pot of £2.1bn. This will encompass the funding streams for all transformational programmes from April 2017 onwards, and will rise to £3.4bn by 2021. It is envisaged that this approach will have significant benefits over the earlier approach to transformation funding.

Where there had previously been fragmented approaches, both in terms of schemes and locality-based working as a result of emerging programmes and new funding arrangements (such as the Prime Ministers Challenge Fund, Urgent & Emergency Care Vanguard etc.), there will now be a single unified approach across the STP footprint. This will prove extremely valuable in assisting providers and commissioners to work in a more collaborative and co-ordinated way enabling transformation and efficiencies to be delivered that would not otherwise be achievable.

1.4 As well as implementing the Better Care Fund, many local areas are developing more ambitious integrated health and care provision. The Spending Review committed the government to build on these innovations – it will require all areas to fully integrate health and care by 2020, and to develop a plan to achieve this by 2017. The Spending Review offered a range of models to achieve this ambition, including integrated provider models or devolved accountabilities as well as joint commissioning arrangements. The STP guidance requires STPs to be aligned with these local integration programmes and ambitions.

1.5 The NEL STP describes how locally we will meet the 'triple challenge' set out in the NHS Five Year Forward View, to:

- meet the health and wellbeing needs of our population
- improve and maintain the consistency and quality of care for our population
- close the financial gap

1.6 It builds on existing local transformation programmes and supports their implementation. These are:

- Barking and Dagenham, Havering and Redbridge: devolution pilot (accountable care organisation)
- City and Hackney: Hackney devolution in part
- Newham, Tower Hamlets and Waltham Forest: Transforming Services Together programme

1.7 In addition, it will support the improvement programmes of our local hospitals, which aim to support Barts Health NHS Trust and Barking, Havering and Redbridge University Hospitals NHS Trust out of special measures.

1.8 For Havering, the work to develop the detail underpinning the STP is being taken forward jointly with Barking & Dagenham and Redbridge through the development of the business case for an Accountable Care Organisation. The issues that any ACO would need to address in order to achieve improved outcomes from health and social care, in the context of a financially sustainable health economy, will be reflected in the contributions from Barking & Dagenham, Havering and Redbridge to the NEL STP.

1.9 Further guidance was issued on 19 May which set out details of the requirements for 30 June. This guidance stated that the draft STP will be seen as a 'checkpoint' and did not have to be formally signed off prior to

submission; it formed the basis of a local conversation with NHS England on 14 July.

1.10 Formal feedback on the submission was received at the end of August; it asked that the next draft of our STP, due to be submitted to NHS England on 21 October:

- Clearly articulates the impact the STP proposals would have on the quality of care
- Provides more detail, with clear and realistic actions, timelines, benefits (financial and non-financial outcomes), resources and owners
- Includes plans for primary care and wider community services that reflect the General Practice Forward View
- Contains robust financial plans that detail the financial impact and affordability of what is proposed
- Sets out plans for engagement with local communities, clinicians and staff

2. Proposal

2.1 Appendix 1 provides a summary of progress to date: Better health and care: developing a sustainability and transformation plan for north east London; it is also available at: http://www.nelstp.org.uk/downloads/Publications/NEL-STP-summary-2016.pdf

Governance and leadership arrangements

2.2 The STP Board has agreed to take an inclusive and engaging approach to developing the governance arrangements required, recognising the need to ensure all partners are thoroughly engaged in the process and the governance implications across the system are understood and aligned to the existing organisational governance and regulatory regime. The STP Board is establishing a working group of senior representatives from partner organisations to develop the STP governance. This includes Local Authority representation. The group is chaired by Marie Gabriel, Chair, East London NHS Foundation Trust. The group aims to have a proposal for the governance arrangements developed for testing and implementation in October. This initial set of arrangements will operate in shadow and be reviewed in January 2017 to check its effectiveness, with the aim of full implementation rom April 2017. Best practice and exert advice will be sought to support the development of the governance. It is also anticipated that NHSE will release guidance at the end of September 2016.

Transformation planning

2.3 Since the submission on 30th June discussions have been held to agree how we will work together to carry out the more detailed transformation planning that is required for the next submission in October. This process began with a series of workshops in July in each of the following areas in the NEL STP footprint: Barking & Dagenham, Havering and Redbridge; City

& Hackney; and Waltham Forest, Newham and Tower Hamlets. Following these meetings the NEL Clinical Senate met and ratified a proposal to progress a range of transformation initiatives at three delivery levels (locally led / locally led with NEL coordination / NEL led with local delivery).

2.4 To implement this model 10 core workstreams have been established with SROs and Delivery Leads identified. Each workstream is developing their own governance and working group arrangements to support the process with more detailed planning ahead of the next submission in October, engaging with local lead across the system. The workstreams are:

- Prevention (locally led with NEL coordination)
- Local Integration plans (locally led)
- Primary Care (locally led with NEL coordination)
- Planned Care (NEL led with local delivery)
- Maternity (NEL led with local delivery)
- Cancer (NEL led with local delivery)
- Unscheduled Care (NEL led with local delivery)
- Mental Health (locally led with NEL coordination)
- Medicines Optimisation (locally led with NEL coordination)
- Learning Disabilities, including the Transforming Care Partnership programme (locally led with NEL coordination)

2.5 As an example, a workshop was held with CCG and Local Authority representatives on 23 August to discuss the priority prevention programmes where joint working across NEL may enable greater benefits than are achievable through local working alone. This resulted in the recommendation to coordinate our efforts across NEL in three priority areas initially:

- Smoking cessation and tobacco control
- National Diabetes Prevention Programme rollout
- Workplace health

2.6 Nominations are being sought to take part in working groups to further progress our plans in these areas, once they are confirmed by Directors of Public Health.

Considerations

2.7 Whist we recognise that aspects of the STP process are challenging in particular where the NEL STP footprint cuts across existing local government and partnership planning arrangements, the importance of developing a shared purpose and vision for the NEL population and the need to build understanding and trust across the local health and care system is paramount. Much work within BHR and NEL more generally (including having a local authority chief executive on the STP board), has helped to address this. There is a need to consider how:

- **resources are allocated between different organisations and the way that risks and rewards are shared** (this will require detailed technical knowledge, and a less transactional and more relationship-centred approach).
- **local leaders use their authority to design structures and processes that support more collaborative working** – both within and across organisations.
- **lessons from Vanguards and the Better Care Fund can be shared**.

2.8 We know the key role local authorities can play in supporting the aim of seven day working by helping to prevent people seeking emergency admissions and assisting them to be supported in the community as soon as possible following admission to hospital. This includes improving mental health and dementia services as well as care for those with learning disabilities.

2.9 In addition, the STP footprint does not align easily with other London Devolution Programmes, all of which are looking at the wider cross borough opportunities for devolution broader than health and social care. All three BHR local authorities are part of the Local London Partnership as three of eight London boroughs and we have joined together to develop and implement a coordinated programme to both seek meaningful devolution deals with regional and national government, and effectively deliver on any responsibilities transferred to the sub-region. (The other five boroughs are Bexley, Enfield, Greenwich, Newham and Waltham Forest.) Leaders and Mayors for the boroughs that form part of 'Local London' have received a report and presentation on 15 July about the health devolution work in Barking & Dagenham, Havering and Redbridge, and began to consider how the footprint of the STP can be reconciled with the differing Local London geography, as well as what the BHR ACO work can bring to devolution work in Local London.

2.10 Other NEL STP local authorities such as Hackney and City of London are partners in other London devolution programmes. Therefore careful management will be required within the STP footprint if the objectives of the STP are in conflict with emerging priorities of devolution programmes with which NEL local authorities are also engaged.

Next steps

2.11 To help us with the process of **developing and implementing our STP** we have engaged the Local Government Association (LGA) to provide the following support:

- *Stage one:* individual HWB or cluster workshops to explore self-assessment for readiness for the journey of integration - with the use of a toolkit launched at the recent LGA conference and being piloted until early October (Havering's workshop will take place on 28 September).

- *Stage two:* NEL strategic leadership workshop to consolidate outputs from individual HWB / cluster workshops and to explore potential strategies and ways to strengthen the role of local authorities.

2.12 **Further work will continue** beyond this to develop the plan in more detail. For **more information** go to http://www.nelstp.org.uk or email nel.stp@towerhamletsccg.nhs.uk

3. Engagement

3.1 The involvement of patients, staff and communities is crucial to the development of the STP. We want it to be based on the needs of local patients and communities and command the support of clinicians, staff and wider partners. Where possible, we will build on existing relationships, particularly through health and wellbeing boards and patient panels and forums.

3.2 We are meeting with local public and voluntary stakeholders to discuss the plan. We held a successful meeting where partners, lay members and voluntary groups considered the challenges and opportunities of the STP. We have developed a website, http://www.nelstp.org.uk which shares some key points, links and background information about the STP and draws attention to the newly developed summary of progress to date. We are also seeking to work with the voluntary sector to commission local organisations to engage with local people.

4. Financial considerations

4.1 The NEL STP will include activities to address current financial challenges across the health and social care economy. The ambition is to ensure that all NHS organisations are able to achieve financial balance by the end of the five year period of the plan.

5. Legal considerations

5.1 The NEL STP Board is developing a plan as stipulated by the NHS England guidance.

6. Equalities considerations

6.1 The NHS guidance states that the STP is required to meet the meet the health and wellbeing needs of its population. To ensure this a detailed public health profile for north east London population was carried out in March 2016 to identify the local health and wellbeing challenges. The profile shows that:

- There is significant deprivation (five of the eight STP boroughs are in the worst IMD quintile); estimates suggest differentially high growth in ethnic groups at increased risk of some priority health conditions.
- There is a significant projected increase in population with projections of 6.1% (120,000) in five years and 17.7% (345,000) over 15 years. Estimates suggest differentially high growth in ethnic groups at increased risk of some priority health conditions.
- There is an increased risk of mortality among people with diabetes in NEL and an increasing 'at risk' population. The percentage of people with Type 1 and Type 2 diabetes who receive NICE-recommended care processes is poor. Primary care prescribing costs are high for endocrine conditions (which includes diabetes).
- NEL has higher rates of obesity among children starting primary school than the averages for England and London. All areas have cited this as a priority requiring system wide change across the NHS as well as local government.
- NEL has generally higher rates of physically inactive adults, and slightly lower than average proportions of the population eating 5-a-day.
- Cancer survival rates at year one are poorer than the England average and screening uptake rates below England average.
- Acute mental health indicators identify good average performance however concerns identified with levels of new psychosis presentation.
- With a rising older population continuing work towards early diagnosis of dementia and social management will remain a priority. Right Care analysis identified that for NEL rates of admission for people age 65+ with dementia are poor.

6.2 All of these challenges are linked to poverty, social exclusion, and vary by gender, age, ethnicity and sexuality. Equality impact assessment screenings will be conducted to identify where work needs to take place and where resources need to be targeted to ensure all protected groups gain maximum benefit from any changes proposed as part of the STP.

Appendices

Appendix 1: Better health and care: developing a sustainability and transformation plan for north east London (A summary of progress to date), Summer 2016
http://www.nelstp.org.uk/downloads/Publications/NEL-STP-summary-2016.pdf

NEL-STP-summary-2016.pdf

BACKGROUND PAPERS

- NHS Five Year Forward View https://www.england.nhs.uk/ourwork/futurenhs/
- Guidance on submission of Sustainability and Transformation Plans https://www.england.nhs.uk/wp-content/uploads/2016/05/stp-submission-guidance-june.pdf

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Havering
LONDON BOROUGH

HEALTH & WELLBEING BOARD

Subject Heading:	CQC/OFSTED Area Inspection of services to support those with SEND
Board Lead:	Mary Phillips Assistant Director, Learning and Achievement London Borough of Havering
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The subject matter of this report deals with the following priorities of the Health and Wellbeing Strategy

- ☐ Priority 1: Early help for vulnerable people
- ☐ Priority 2: Improved identification and support for people with dementia
- ☐ Priority 3: Earlier detection of cancer
- ☐ Priority 4: Tackling obesity
- ☐ Priority 5: Better integrated care for the 'frail elderly' population
- ☒ Priority 6: Better integrated care for vulnerable children
- ☐ Priority 7: Reducing avoidable hospital admissions
- ☐ Priority 8: Improve the quality of services to ensure that patient experience and long-term health outcomes are the best they can be

SUMMARY

The attached presentation updates the Health and Wellbeing Board about: -

- the form and purpose of the joint CQC/OFSTED Area Inspection of services to support children and young people aged 0-25 with special educational needs and disabilities (SEND)
- work undertaken to date by Council and CCG officers in preparation for a future inspection
- work underway to address known risks
- priorities for further action

The executive summary of the JSNA chapter for children and young people with SEND is provided and describes:-

- What we know about children with SEND and their needs
- The services (education, health and social care) available locally to ensure that children with SEND make good progress in being prepared for adulthood and independence, participating in society and being as healthy as possible
- The outcomes achieved by children with SEND
- Recommendations for further action by statutory partners

RECOMMENDATIONS

The Health and Wellbeing Board is asked to note the preparations for a future inspection and comment on the work underway and/or planned to further improve the local offer to children with SEND and their families.

REPORT DETAIL

See Presentation and JSNA Executive Summary provided as background papers.

BACKGROUND PAPERS

Update
CQC/OFSTED Area Inspection of services to support those with SEND

Mary Phillips (LA) and Sue Elliott(CCG)

Inspection summary

How is the **area** working together to

- improve the **outcomes** for children and young people with SEND (0-25) through ensuring they make good progress in being prepared for **adulthood** and **independence, participating in society and** being as **healthy** as possible
- **Children and Families Act Compliance**

Main strands

- know and **understand fully the needs** in the area so they can be met
- create a Local Offer which sets out the **support available by all** organisations to meet this need
- undertake **joint assessments** to produce, and convert , Education , Health and Care plans (replacing statements)
- **commission jointly**, with the CCG to meet the needs identified and improve outcomes
- through out all these processes **involve Children and Young People** and **Parents/Carers**

Practical arrangements

- **All areas** will be inspected over 5 year cycle – 8 already
- **Random sample**, geographically spread but also using "soft intelligence" to target
- **Team of 3-** CQC, OFSTED, plus "LA based" inspector
- Based on a robust **self evaluation**
- **5** days long
- Phone call to Chief Executive of CCG and Director of Children's Services **five days before**
- **Narrative** judgement

Scope

- Children and Young people
  - Those with **SEND needs including but not only those with EHC plan** or statement including those with mental health needs
- Organisations
  - LA including those in youth justice system and those not attending school
  - CCG
  - NHS England
  - Health Providers
  - Early Years settings
  - Schools
  - FE colleges
- Age range
  - **0-25**

Evidence base -Information

- **Complaints** to CQC/OFSTED re LA and Health
- Data about
  - area wide **analysis of needs** from birth of all C and YP with special/additional needs,
  - **shared process** to jointly commission services
  - delivery of **health child programme**, other commissioned services such as national screening programmes
  - use of **disagreement resolution services**, mediation, appeals to Tribunals
  - meeting **statutory timescales** for assessment
  - **outcomes for C and YP** as set out in SEND 1 and 2 DFE data eg national assessments, destinations on leaving school

Evidence base -Meetings and Visits

- Meet with
  - Key managers in education , health and social care- (providers and commissioners)
  - Children and young people and parents and carers
- Visit
  - Sample of EY settings, Schools and FE colleges including meeting with SENCOs, HTs, governors, parents,children
  - Health settings
  - Look at sample files in all settings to assess how all professionals contribute to integrated assessments (less case based)

What has happened so far

- SEND Area Inspection Group with representation from CCG/PH, health providers and LA teams to oversee the work
- Joint CCG/LA Commissioning Group in place
- Additional P/T resource to support LA prep
- Priorities agreed across CCG/LA and actioned*
- JSNA Deep Dive on SEND competed*
- Development of self evaluation- outline attached*
- Information sharing with all partners drafted e.g. LA teams, EY settings, schools, colleges, governors

What has happened so far

- “Reviewed and refreshed” joint assessment processes with CCG
- Preparation for Adulthood (inc. refreshed transition protocol) and new integrated 16-25 provision, creating new employment opportunities
- Developing joint children's commissioning strategy inc. joint commissioning reviews, joint equipment and respite commissioning, exploring pooled budgets
- Review and updating of Local offer with parents/carers, etc
- New School SEND Transport Policy reviewed and co –produced with wide parent group
- Inspection organisational planning processes agreed across CCG/LA

Risks being mitigated

- Low Personal Budget numbers, LA and health
- Smooth transition processes
- Evidence of joint commissioning taking place
- Tracking of children through health identification from pre-birth onwards not yet live
- Integrated EY checks - HV and EY settings

Next

- Consideration and implementation of SEND JSNA recommendations*
- Enhance PH contribution and analysis

  Eg School nurses contribution to early identification and intervention of SEND
- Develop joint specialist pathways
  - Autism
  - Mental health
  - Speech and language
- Review data and documentation already available-SEF summaries on key aspects?

SEND JSNA Deep Dive

- Contributions from a range of stakeholders
- Data challenges -availability & understanding
- Useful process to undertake
- To be updated regularly
- Recommendations agreed by all parties
- Actions to be embedded in all team plans

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Children and Young People from birth to age 25 with Special Educational Needs or Disability Needs Assessment

Executive Summary

1 Context

This needs assessment about children and young people from birth to age 25 with Special Educational Needs or a Disability (SEND)[1] is part of the Havering Joint Strategic Needs Assessment (JSNA).

It reflects the new obligations contained within the Children and Families Act 2014. The Act seeks to ensure that all children and young people, irrespective of disability, are better prepared to lead a full, active and productive life. The JSNA is a crucial element in the ensuring that this happens.

Health and Wellbeing Boards are required to capture the needs of vulnerable children and young people, including those with SEND, in the JSNA and reflect them in the local Health and Wellbeing Strategy (HWBS).

Local partners must use the insight captured within the JSNA and the priorities identified in the HWBS to shape their commissioning for children and young people with SEND.

Their coordinated commissioning will form the 'Local Offer' which sets out the range of facilities, activities and support available for children and young people with SEND, and their parents and carers.

Education, Health and Care (EHC) plans will set out the outcomes that are important to the individual child and any services from the 'Local Offer' necessary to meet their needs.

Overtime, the needs of all children with an EHC plan will be collated to refresh the JSNA and thereby improve the fit between the Local Offer and the needs of local children.

The Act makes clear that: -

- children and young people, together with their parents and carers must be at the centre of the process;
- education, health and social care services must work together, if that helps them do better for children and young people with SEND.

[1] We use the Department for Education's definition of SEND which encompasses all children (or young people up to the age of 25) who have significantly greater difficulty of learning than the majority of others of the same age or… a disability which prevents or hinders him or her from making use of facilities of a kind generally provided for others of the same age in mainstream schools or mainstream post-16 institutions …. Including those with mental health needs.

This needs assessment seeks to describe:-

- what we know about children and young people with SEND, including risk factors for SEND and vulnerable groups
- key services within the local offer and how they work together
- outcomes for children with SEND in terms of their education attainment

Recommendations are made about:-

- how key partners work together to develop and implement relevant strategy
- the local offer in terms of services, how they work together and the further development of staff
- the future development of the JSNA to improve our understanding of the needs of children and young people with SEND

2 What do we know about CYP with SEND

2.1 Children aged 0-5

Our best measure of the prevalence of SEND amongst younger children is the number of children known to the 0-5 CAD team (see section 2.3.1); 372 children in 2015, up from 164 in 2014 and 138 in 2013.

Table 1: Number of referrals to CAD 0-5 team in 2015 by primary need of child

	number	%
communication and interaction	263	71
cognition and learning	29	8
social, mental and emotional health	19	5
sensory and / or physical	57	15
category not known	4	1
total	372	

The great majority of referrals and most of the growth in referrals relate to communication and interaction issues.

2.2 School aged children

Currently, there are more than 3400 children with SEND in Havering schools.

Very few children with SEND are formally recorded as such before they enter school. About 120 boys and 50 girls are identified with SEND in Yr R. The number of children with SEND in each year group then increases to around 230 boys and 100 girls in Yr 2 to Yr 6 and thereafter slowly decreases to 160 boys and 70 girls in Yr 11. Small numbers of children with SEN attend alternative provision[2] (n = 13) or are home schooled (n=8).

The proportion of school age children and young people in Havering recorded as having SEND (≈10%) is low compared with London and national averages (> 15%). This may reflect

[2] Alternative provision is for pupils who can't attend mainstream school for a variety of reasons, such as school exclusion, behaviour issues etc,

the success Havering previously achieved in implementing a 'statementless' schools policy. If so, and given national policy has changed, the % of children recorded with SEND may increase overtime closer to the national average.

Either way, the number of children and young people in the borough, including those with SEND, will increase as a result of an increasing birth rate and the steady influx of families from elsewhere, particularly other London boroughs.

In line with national trends more than 2/3rds of children with SEND are male. The evidence suggests that boys are more susceptible to harm e.g. from trauma and infection, both pre and post birth. However, there is also evidence the girls' needs may go unrecognised as they tend to exhibit less typical and intrusive behaviours in response to their difficulties.

The number of Asian/Black or Black British children receiving SEN support is increasing but the proportion is still low in comparison to pupils in mixed or white British ethnic groups. This may be a cultural artefact whereby Asian/ Black families are less willing to have their children 'labelled' as having special educational needs.

The prevalence of SEND varies with disadvantage – rates are around twice as high in Harold Hill and South Hornchurch as they are in Cranham and Upminster.

Havering schools attract significant numbers of children from adjacent authorities. Flows of children with SEND in and out of the borough are more balanced such that the net inflow is only 24 children. 240 children with SEND are placed out of the borough because their specific needs can be better met elsewhere and / or a desire to maintain an existing placement for young people who have moved into the borough.

The primary need of statemented children (a sub-set of all children with SEND likely to have the greatest need) varies with age and care setting (see Table 2).

Table 2: Statemented children in Havering by setting and primary need, 2014/15

Primary need	Havering			Out of borough
	primary (n=310)	secondary (n=353)	special (n=294)	special (n = 77)
Speech & Language & Communication Needs (SLCN)	28.1%	17.3%	11.6%	
Moderate Learning Disabilities (MLD)	16.8%	22.9%	19.7%	
Autistic Spectrum Disorder (ASD)	26.5%	21.8%	27.6%	24.7%
Severe Learning Disability (SLD)			21.1%	
Behavioural, Emotional & Social Difficulties (BESD)				36.4%

The needs of a cohort of children, who were more likely to have behavioural, emotional and social difficulties or autistic spectrum disorder could not be met locally and attended out of borough special schools.

2.3 Children and young people with mental health problems

The new definition of SEND makes specific mention of children and young people with mental health problems. Improved mental health is associated with better outcomes in all aspects of life for people of all ages and backgrounds. This includes better educational achievement, increased skills, improved employment rates and productivity, reduced anti-social behaviour and criminality, and higher levels of social interaction and participation.

Based on national predictive models, it's likely that around 1 in 10 children in Havering aged five to 16 years (3,093 children) currently have a mental health disorder.

This figure can be broken down as follows:

- 3.5% (1,194) have emotional disorders such as phobias, anxiety, OCD
- 5.5% (1,862) have conduct disorders such as aggression and vandalism
- 1.5% (505) have hyperkinetic disorders including hyperactivity and ADHD

The recently agreed Havering CAMHS Transformation plan provides detailed information about the:

- mental health needs of local children and young people;
- action to strengthen levels of mental wellbeing and prevent mental illness;
- current treatment services and how they will be improved.

3 Risk factors for SEND

What happens in pregnancy and early childhood impacts on physical and emotional health throughout life, including the risk of having SEND.

3.1 Pre-natal and birth factors affecting the risk of SEND

The majority of permanent disabilities have their origin in neonatal disease or trauma. Exposure in-utero to infection; poor maternal nutrition and maternal obesity; maternal smoking, alcohol and substance misuse increase the risk of premature birth, traumatic birth, low birth weight and congenital anomalies; all of which carry an increased risk of developmental delay or permanent disability.

One in ten women in Havering smoke during pregnancy. Midwifery services at BHRUHT have adopted the 'babyclear' programme to maximise the impact of advice given to women who continue to smoke during pregnancy. The Council has decommissioned smoking cessation services but has committed to reinstate support for pregnant women.

Teenage pregnancy is associated with a range of negative health and social outcomes for both mother and baby. Teenage pregnancy rates in Havering have declined and are similar to the national average but higher than the average for London.

The risk of problems during pregnancy and at delivery; and congenital anomalies rises with maternal age. The risks are more marked for women aged 40 and over. Nonetheless the

majority of pregnancies will be unaffected and the trend towards later maternal age is driven by a range of personal, cultural and social factors that are unlikely to change soon.

Fertility treatment is also associated with an increased risk of poor outcomes, in part due to the increased risk of multiple pregnancy. Twins and triplets are more likely to suffer congenital anomalies, and are also at increased risk of growth restriction and preterm birth, which in turn are associated with disability including cerebral palsy and learning difficulties.

Participation in the complete programme of personalised maternity care affords the opportunity to:-

- Support the adoption of healthier lifestyle choices.
- Offer screening for serious genetic and developmental abnormalities
- Effectively monitor and manage difficulties should they occur during pregnancy

Targeted outreach to vulnerable and socially excluded groups can reduce the proportion of women who access maternity services late.

Premature birth can have long term effects on motor development, behaviour and later educational achievement. The prevalence of premature birth in Havering (7.6%) is similar to that in comparable London boroughs.

Premature birth is associated with visual impairment. Retinopathy of prematurity (ROP) affects 65% of babies weighing less than 1250g at birth to some degree, but only 6% will have advanced ROP requiring treatment. All low birth weight babies or babies born at or before 32 weeks gestation will have regular eye screening examination until the risk is passed. Treatment can limit the harm caused but a small proportion of babies will nonetheless have significant vision loss.

The risk of hearing impairment is also increased for premature babies because of prior oxygen starvation or as a side effect of the treatment they may require e.g. the use of antibiotics or noise induced deafness as a result of being in intensive care.

Once sensory impairment is identified, early support is key to development of age appropriate skills, again this has implications for early support services and sensory specialist advisory teachers.

3.2 Post-natal factors affecting the risk of SEND

The mother-child attachment bond shapes baby's brain, with effects on self-esteem, their expectations of others, and their ability to develop and maintain successful relationships in later life which in turn influence a range of outcomes including educational achievement. A number of factors influence parental attachment including: -

Breastfeeding - is good for babies in so many ways; reducing the risk of infection and childhood obesity as well as promoting attachment between mother and baby. Only 1/3rd of women in Havering breastfeed beyond 6-8 weeks of birth; significantly below both the London and England average.

Maternal mental illness has adverse effects on the woman herself, but also on the future development of her infant. A handful of new mothers in Havering each year will experience acute and severe mental illness (e.g. post-partum psychosis); many hundreds will have less severe problems that may impair attachment between mother and child. Screening for perinatal mental illness, primarily by health visitors and the provision of appropriate support and treatment where necessary is effective and cost effective.

Child abuse and neglect can impair brain development with long-term consequences for cognition, language skills and education attainment, and pre-dispose to mental illness.

The proportion of children who come into local authority care in Havering has increased in recent years but is still relatively low compared with rates elsewhere in London and the country as a whole. Nonetheless, the Council is 'parent' to nearly 250 **Looked After Children** who are at high risk of having SEND as a result of their experiences in earlier life.

In addition, in 2014/15, an average of 173 children were on a **child protection plan**[3] at any one time; the average for 2013/14 of 124. Proportionally more children (49 / 100,000) were on a child protection plan in Havering than London (47) as a whole; but fewer than the national average (54).

Havering has a low rate of **children in need**[4] (500/10,000) compared to the London (818) and national (674) rates. Disability was identified as the primary need for relatively few children and parents when compared to our statistical neighbours.

Child poverty is both a cause and an effect of SEND. About 1 in 5 children in Havering live in poverty. The prevalence of SEND is highest in those areas with the highest levels of disadvantage i.e. Harold Hill and South Hornchurch.

[3] If, following a child protection conference, the local authority decides that a child is suffering, or is likely to suffer, significant harm, it will draw up a child protection plan setting out how the child can be kept safe, how things can be made better for the family and what support they will need from the Council and other partners.

[4] Children in need are defined in law as children who are aged under 18 need local authority services to achieve or maintain a reasonable standard of health or development and / or prevent significant or further harm to health or development.

4 Pupil and Parent Voice

The Children and Families Act and the SEND code of practice are clear that children and their families should be at the centre of everything we do – at the level of the individual child but also in strategic planning to meet the needs of all children.

Locally, children are involved in a variety of ways:-

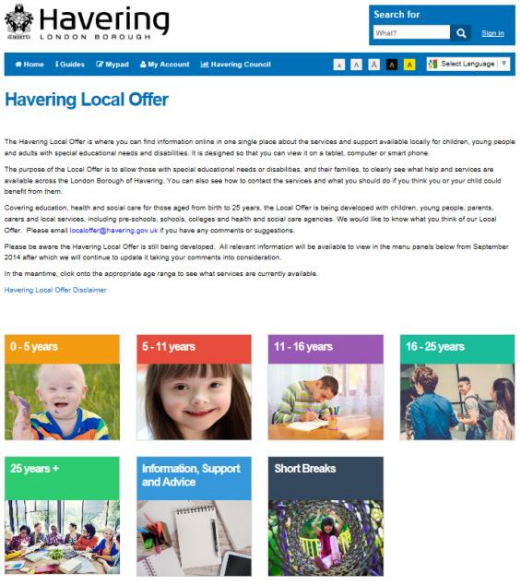
- The child's voice is strong in each individual Assessment and EHC planning process.
- ViewPoint, the Council's tool for gaining feedback from all children, including those with SEND, involved in children's social care statutory processes is used and consideration given to feedback in service delivery and development.
- Pupil forums are being developed through the *Advocacy for All* contract and work is underway to establish the School Council Pupil network.
- POET, a nationally developed tool for capturing the views of children, young people, their parents and carers was used successfully last year and will be used each year going forward.

Similarly, parents are involved in a variety of ways at different levels:

- Parents are central to the development of individual EHC plans for their children.
- Havering has an established Parent Forum. The Council also uses wider events and targeted consultations to reach as broad an audience as possible
- Parents were involved to the development of the process employed to develop EHCs generally; the Local Offer web site and reviews of existing commissioned services e.g. Transport.
- A task and finish group, comprising officers and parents, was established to create and then implement a new vision for children and young people's preparation for adulthood. The new vision is now in place, new provision opens in September 2016 and work is underway to create a CAD Preparation for Adult team.
- A similar approach will be employed to progress the agreed future work programme including the continued development of our personal budget offer and the re-commissioning of short break provision.

5 Key services within the local offer

The Havering Local offer is accessible to local residents on-line and provides information, including contact details, about the help and services available for children, young people and adults with SEND. The JSNA focuses on key statutory sector services and how they work together.



5.1 Children and Adults with Disabilities (CAD) Service

The 0-25 Children and Adults with Disabilities Service (CAD) brings together the key functions and responsibilities of the Local Authority regarding Education and Social Care for those age 0-25 with SEND, into a single management arrangement. The multi-disciplinary teams within CAD are focussed on delivering joined up social care and education involvement for our SEND children, putting them and their families at the centre of what we do. The teams together with health partners and schools work to identify outcomes for children and, using available resources, help children to meet them.

CAD Assessment and Placement

The Assessment and Placement team within CAD works collaboratively, across the 0-25 age range, with schools, parents and support services including those from the voluntary sector. The main function of the team is to collate a range of information relating to individual children and young people and distil it into Education, Health and Care plans (EHCP) in an accessible format. The team prepares and presents information to a panel which determines the outcome of requests for statutory assessment and the placement of children and young people following assessment. The team works closely with providers to ensure that all children and young people are in education or training. The team works alongside schools, health and social care to determine, review and disseminate information about processes involved in requesting an EHCP, holding Annual Reviews and converting existing statements into EHCPs.

CAD Educational Psychology

The educational psychology service is delivered as part of the multi-disciplinary CAD teams offering a collaborative service to children and families. Educational Psychologists primarily work in schools and settings where they plan and carry out assessments of individual children and young people and deliver training for school staff. Educational psychologists support children with academic development, emotional wellbeing and ability to lead

independent lives into adulthood through school staff and in collaboration with health and social care colleagues.

CAD 0-5

The CAD 0-5 Support team works with agencies across education, health, social care, the voluntary sector and with early years settings, schools and parent/carers to provide appropriate support packages and early intervention.

The team includes Area SEND Coordinators, keyworkers, specialist teachers, an educational psychologist and social worker.

The CAD 0-5 Support Team provides access to:-

- **Home-based support** – working with parents / carers to:-
  - Carry out an in-depth, on-going assessment of their child's needs and set targets to gauge progress.
  - Jointly plan and model appropriate learning opportunities
  - Provide information and guidance on the best approach to help their child.
  - Specific support provided may include : -
    - **Home Learning Support –** for children aged 1–3 years with additional needs; to develop their existing and emerging skills through play.
    - **Social Communication Support** - keyworkers work with parent/carers to support children with social communication needs.
    - **Early Support –** for children with complex needs requiring significant multi-agency support from birth to five; help with coordination of services, keyworker support and multi-agency meetings.
- **Setting-based support**:-
  - Area SEND Coordinators - advise and support early years care providers
  - Specialist Teachers - support teaching staff in maintained nurseries and schools
- **Sleep service** – offering weekly sleep advice drop-in sessions and a helpline. A full sleep assessment and individual sleep programme is devised for children with significant sleep issues.
- **Groups** - to help parents understand their child's needs and how to support them to achieve best outcomes. The range of activities offered include; swimming, baby massage, a developmental group, baby signing, messy play and stay and play sessions.

More than 70% of all referrals to CAD 0-5 are for support with communication and interaction problems. Area SENDCos support the greatest number of children, working with early years care providers. The early support and home learning support teams work with smaller numbers of children with more complex problems.

The CAD 0-5 Early Support Team receives referrals from the community paediatricians, therapy services and health visitors. Early years settings make referrals for Area SENDCo input for children with SEND.

The CAD 0-5 team chairs a monthly multi-agency planning meeting to discuss children with complex medical needs with the Early Help Service and relevant health professionals including community paediatricians, therapy services, health visiting. The neonatal team at Queens Hospital send a discharge summary to the Community Paediatrician Service regarding premature births and babies with health care needs. The paediatricians then present these cases at the monthly planning meeting. Thereafter, children with complex needs are reviewed biannually by a joint education, health and social care panel.

Transition into school

161 children with SEND were transitioned to primary school in 2015; 2/3rd with communication and interaction problems.

A child centred planning meeting is held involving parent/carers, school and early years setting staff, and any other agencies working with the family to put in place an action plan for the child's transition.

Children with high needs are tracked from pre-nursery and identified on the Early Years Transition list. The child centred approach used ensures that schools are fully prepared for these children and a dedicated team of key workers from the 0-5 and 5-19 CAD teams is allocated to the highest need children to further liaise and work with settings and schools in the Summer Term prior to transition into Reception and Year 7.

A local nursery offers up to sixteen places for children in the year prior to Reception with social communication difficulties and /or another diagnosis needing highly specialist support.

Not all children transitioning need continuing help from the CAD team or the help needed may change significantly. Some children progress as a result of early intervention such that a differentiated approach isn't required when entering mainstream schooling. Some parents want to develop the expertise to act as their own key worker. Child centred planning facilitates the agreement of an appropriate, bespoke plan for each child.

CAD 5-19

The 5 -19 CAD Support Team offers support to children and young people with a range of difficulties, their schools, settings and families. The areas covered are sensory (visual, hearing and multi- sensory difficulties); medical and physical; speech, language and social communication needs; complex needs; learning difficulties and transition into Key stage 4 and Key Stage 5. The team includes educational psychologists, social workers, family support workers, specialist advisory teachers, specialist assistants and a 'mobility and habilitation' officer. The team will support children and families wherever they are; at home, out of borough, in school, nursery or clinic.

In addition to the increasing numbers of children with social communication difficulties, ASD, and complex or challenging behaviour; the CAD 5 – 19 team continues to support significant numbers of children with sensory, medical or physical impairments (> 300 children on the caseload of 3 key workers).

Transition to adult services

Havering has developed a multi-agency protocol to ensure effective transition from child to adult support. The protocol improves the coordination of support so that every young person with SEND aged of 13-25 years and their parents/carers have a smooth and positive transition. This should mean:

For young people that they…..	For their parents/carers that they …….	That during / after transition …….
make decisions and take the lead or are supported by people that can advocate for them.	see agencies working together and pursuing agreed plans but remaining flexible to accommodate change.	young people and their families are well informed and fully involved in the process to make their own choices.
are supported so they can plan for what they want to achieve.	are listened to and fully involved.	the process is coordinated, systematic and consistent with close partnership working between all professionals and agencies
are able to access the same opportunities as other young people.	have a single point of contact.	every young person receives services and support according to need and eligibility
have access to services.	feel supported.	at the level of the individual young person, the need for services is identified early and planned for in good time
can try things out beforehand.	receive consistent messages.	post 16 services and opportunities are commissioned effectively, based on an accurate assessment of collective needs for young people in the borough as a whole.
can change their mind.	have easy access to understandable information.	

Work is underway to embed the protocol more fully into operation and a Preparation for Adulthood Team within CAD is being established.

Child protection and social care

Disabled children present additional challenges when fulfilling the statutory functions of child protection and care proceedings. Specialist workers within CAD lead this work and provisions such as foster care both long and short term are difficult to source but work is underway to increase provision in this area.

The provision of short breaks can prevent families reaching crisis point. Commissioned services include a range of activities: holiday clubs, pre-school sessions, buddy and befriending services and youth clubs. Nearly 250 young people currently access commissioned short breaks from 6 providers. Approximately 150 families are in receipt of Direct Payments.

5.2 Health services for children and young people with SEND

Historically, data systems within the NHS locally have not recorded the SEND status of children and young people. Hence it is currently not possible to identify and describe the health services used by this specific cohort. The new iteration of RIO (the local child health information system) has the facility to identify children with an EHC plan but EHC plans will not be in place for all children until 2018. Until then and or until a bespoke SEND database capturing the health, social care and education support provided for all children with SEND in the borough is established, we must make use of the available proxies for SEND status e.g. relevant medical diagnosis and / or look at the activity and performance of health services likely to be accessed by children with SEND.

General Practice

People with learning disabilities are known to have higher levels of obesity and physical inactivity and a greater risk of developing chronic illness including diabetes and heart disease. To address this risk, GP practices are funded to provide enhanced care to people with learning disabilities aged 14 and over. As at June 2016, 43% of patients on practices' learning disability registers had had an annual health check and 33% were recorded as having had a health action plan completed.

Community health services

North East London Foundation Trust (NELFT) provides community health services to children aged 0-19 registered with a Havering GP in a variety of settings including home, community clinics and early years and educational settings.

NELFT operates a **Single Point of Access (SPA)**, so children are referred in once and can then be referred internally to multiple services. This is often needed for children with complex, life-long limiting illnesses; with both physical and mental health needs. Individual children may be engaged with multiple community health services for extended periods of time. Services include:

- **Community Paediatrics** - Almost 1700 children were under the care of community paediatric services in 2014/15, up by 22% from 2012/13. Just under 60% were aged 0-5 and a further 30% aged 6 – 10. The service received nearly 1100 new referrals in 2014/15. The interval between referral and first appointment is 18 weeks. 14% of first appointments are not attended. 80% of looked after children are seen within 4 weeks of referral.
- **Occupational Therapy** - Almost 500 children were under the care of occupation therapy in 2014/15; up by 2/3rd since 2012/13. About 40% were aged 0 – 5 years and similar proportion were aged 6 – 10 years. The service received 232 new referrals in 2014/15. The interval between referral and first appointment is 27 weeks. 19% of first

appointments are not attended. 14% of looked after children are seen within 4 weeks of referral.

- **Physiotherapy -** Paediatric physiotherapy services as a whole received 694 new referrals in 2014/15. The interval between referral and first appointment is 9 weeks. 15% of appointments of first appointments are not attended. 14% of looked after children are seen within 4 weeks of referral.
- **Child and Adolescent Mental Health Service (CAMHS)** - More than 2400 children were under the care of CAMHS in 2014/15; up by a third from 2012/13; 60% were aged 11 to 16. See Havering CAMHS transformation plan for more information about current services and priorities for development.
- **Speech and Language Services** – Over 1800 children were under the care of NELFT speech and language therapy services in 2014/15, up by 10% from 2012/13. More than 60% were aged 0-5 years and a further 30% 6 – 10 years. The service received more than 1000 new referrals in 2014/15. The interval between referral and first appointment is 14 weeks. 12% of first appointments are not attended. 18% of looked after children are seen within 4 weeks of referral.

  NB. Speech and language therapists (SLT) operate as part of a joint health and education service with specialist advisory teachers and specialist teaching assistants. Assessments and care are largely provided in the school setting. Children are assessed and prioritised based on severity to receive support from an SLT; a specialist teacher /assistant or from within the school's own resources which include access to Language Link and Speech Link, a commercial package which identifies difficulties and provides a programme of intervention. This approach supports over 3000 children each year.

Palliative care

90% of support and care provided by Haven House is to children living with life limiting conditions. End of life care per se is provided to very small numbers of children but this is necessarily intensive and often at very high cost. BHR CCGs intend to review all forms of hospice support in 2016 with the aim of developing new models of care with providers.

5.3 Schools and engagement in education

School provision for children with SEND

Havering seeks to meet the needs of pupils with special needs in their local mainstream schools. For children whose needs cannot be met in their local school there are four primary and three secondary schools with Additional Resourced Provisions (ARPs) or targeted additional funding; each with a particular specialism - hearing impairment (x2),language difficulties (x2), ASD (x2) and social, emotional and mental health.

Capital money has increased and improved the provision at 2 of the above ARPs and has been used to develop a new Primary ARP due to come online in January 2017.

Rather than being taught in a single school as was previously the case, pupils with visual impairment are now supported in their local school by an Advisory Teacher for VI and the 'Habilitation Officer'. Training for individual schools is given and borough-wide training is also offered regularly.

For children with more complex needs, Havering has three special schools. One designated for children with severe learning disability (71 places from ages 2 – 16, and an additional 23 places for post-16 students) and two for moderate learning disability (198 places in total). However, about half of pupils attending the latter have ASD with complex or challenging behaviour, and the schools have adjusted their curricula to reflect this change.

A similar change is evident amongst Havering's mainstream schools where the pupil population is becoming more complex as, in line with the new SEND Code of Practice, mainstream inclusion is considered as the first line response in most instances. A range of training is offered to grow expertise and confidence about supporting pupils with additional, complex needs.

Permanent exclusion

National data show that children with SEND are far more likely to be excluded. In Havering, there were in total 22 permanent exclusions from Maintained, Academies and Free Schools during the academic year 2013/14 of which 9 related to children with SEND.

Havering employs two vulnerable children's officers to support pupils and parents where there is the threat of a permanent exclusion. Parents of pupils with SEND can also receive impartial information and advice from Havering's Parents in Partnership (PIPs) service. Where necessary, officers will challenge schools to employ alternative strategies such as managed moves or alternative provision. There is also a team of behaviour support specialists that can advise and support schools where they experience challenging behaviour from pupils, including those with special educational needs.

A secondary school 'exclusions concordat' is being developed which includes the following:

'Before considering fixed term or permanent exclusion, schools should consider whether continuing disruptive behaviour might be the result of unmet educational or other needs. At this point, the school should consider a multi-agency assessment and the possible use of alternative provision'

A Fair Access Panel (IYFAP) meets monthly to consider cases of pupils at risk of exclusion. In the case of pupils/young people with a statement of SEN/EHC plan, the Panel will seek advice and support from the CAD team.

Fixed term exclusions

There were 1053 fixed term exclusions days from Academies and Free schools in Havering during the academic year 2013/14; 300 related to pupils with SEND.

The rate of exclusion of children with SEND in Havering is lower than that in comparator areas but still much higher than the average for all children in Havering.

Work continues to assist schools to develop strategies to maintain pupils successfully; challenging behaviours linked to with ASD and ADHD is a particular priority.

Persistent absenteeism

Persistent absenteeism is defined as being absent for more than 15% of sessions at school. 12% of children with a statement or EHC plan (likely to have the greatest needs) were persistently absent in 2013/14 which was higher than in comparator areas and nearly four times the rate recorded for all children in Havering.

5.4 Equipment

Equipment can promote independence, assist carers and facilitate access to education. Many agencies have a responsibility to provide equipment but this has led to a level of confusion around who provides what and in what circumstances. Work is underway on guidance and eligibility criteria covering provision across health, social care, education and schools. The intention is then to explore the possibility of centralised equipment purchase and recycling to achieve more timely provision and greater efficiency across partners.

At present, equipment used in nursery settings and mainstream schools is purchased by the Council. Total spend has doubled since 2012 to £59K in 2016. In addition, a further £8K spend was avoided through recycling. This reflects the changing population in mainstream schools.

Special schools have historically purchased their own equipment out of delegated funds. They have purchased more and more equipment as the complexity of their pupils has increased and a joint mainstream/special school equipment stock is being considered.

Children's hearing aids demonstrate some of the complexities of current arrangements. Pupils with a hearing impairment in mainstream provision often have a hearing aid rather than Teaching Assistant support and so provision and maintenance of equipment is crucial for access to the curriculum. The upgrading of hearing aids by Paediatric Audiology has necessitated upgrading the type of Radio Aid provided – by Education. Education and health colleagues work closely together to co-ordinate these upgrades and changes.

5.5 Transport and assistance with traveling

402 young people were provided with travel assistance in the 2015/16 academic year, 80% by bus, the remainder taxis. Following a refresh of our transport policy, the Council is working with parents/carers to develop a range of flexible travel options.

5.6 Youth Justice

The Youth Offending Service (YOS) is designed to address the offending of all entrants into the Criminal Justice System. It is a multi-agency team (CAMHS, Prospects, Police, Social Work, Drugs and Alcohol, Probation) to address the varied drivers for offending.

The YOS is hosted within Early Help facilitating intervention with young people likely to offend in the future via Targeted Youth Support (TYS).

The number of first time entrants into the criminal justice system in Havering has fallen almost five fold from nearly 150 in 2010/11 to just over 30 in 2014/15. Only 3 of the 440 cases over this period were recorded by the YOS as having SEND. Just over 50 young people received a custodial sentence in the 5 years 2010/11 – 2014/15. None were recorded as having SEND. The YOS acknowledges that it hasn't consistently recorded SEND in the past.

Nonetheless, the service recognises that a significant proportion of clients have speech, language and communication needs and it is currently seeking to increase speech therapy input.

5.7 Leisure Services

London Borough of Havering is committed to providing leisure services that are appealing and accessible to everyone including children and young people with SEND. Central Park Leisure Centre, Hornchurch Sports Centre and Chafford Sports Centre have disabled parking bays, full access into the facility, accessible toilets and changing areas and pool hoist into the swimming pool. The former two sites have accessible equipment in the gym area. Further improvements will be made once the new leisure contract is awarded.

A Havering Disability Group has recently been established to liaise with relevant stakeholders about the activities children and families with SEND want. Subsequently, a first Para Active Open Session Event was held in February 2016 Half Term and attended by 13 children. Further sessions have been held during subsequent holidays and have attracted greater numbers – up to 26 (10 returners and 16 new) during May Half Term. Feedback showed that 100% of the participants enjoyed the event. Coaches from local clubs have contributed to Para Active Sessions. Other local clubs who deliver all inclusive sessions have been invited to come along to future events and promote their sessions via the dedicated webpage www.havering.gov.uk/paraactive

6 Educational attainment of children with SEND

6.1 Monitoring and quality assurance of educational outcomes

Over the last two years, there have been no adverse references to SEND provision or achievement within any Ofsted report.

A quality assurance review of every school is undertaken annually looking at a wide range of areas including provision, policy, curriculum and compliance with regards to SEN. Where significant issues are identified, support is brokered through the Havering Education

Providers Monitoring Group, as set out in the Havering Education Providers Quality Assurance Framework, and progress is monitored regularly.

The Education Providers Monitoring Group meets monthly and comprises representatives from all relevant council services including the SEND team. Any concerns regarding schools are discussed and relayed back to the provider; actions are agreed and implementation monitored. Detailed SEND reviews have been commissioned in response to concerns about provision for SEND pupils resulting in recommendations to the school's leadership team and governors. Where whole school reviews are undertaken, a SEND specialist is included within the reviewing team where the data suggests possible underachievement or poor provision. Support can then be brokered through a school to school support partnership and/or from Council officers.

Strategic Leads regularly review school websites for compliance, quality and ease of access. Where there are issues, for example with published SEN information, this is brought to the attention of the school's leadership team.

Governor services support the development of governors, including training and advice on SEND issues for governors generally and those with specific responsibility.

Head teachers and leaders are regularly briefed and offered training sessions including regular input from the specialist SEND team. Additionally, we hold school-led network meetings for inclusion leads and a SENDCos development network which aim to keep practice current and compliant and to share ideas and strategies. We have invested in the NAHT "Aspire" programme for the past three years for a substantial cohort of schools, and a key driver of this programme is focused on systematic development of inclusion and support for SEND and vulnerable pupils, placing this at the centre of school improvement.

6.2 Educational attainment of children with SEN

Various measures of development and educational attainment are reported at the end of each key stage for children with no identified SEN, children in receipt of SEN support and statemented children enabling comparisons to be made between the different pupil cohorts as they progress through school in Havering and elsewhere in the country: -

- Unsurprisingly, the attainment for children with statements or identified SEN is lower than that for children with no identified SEN in Havering and elsewhere.
- Nonetheless a significant proportion of children with identified SEN support achieve the expected minimum level of attainment at the end of each key stage and that proportion tends to increase over the primary school period demonstrating the effectiveness of the support provided within local schools. However:-
    - the attainment of children with identified SEN support locally tends to be lower than that reported for relevant comparators. But fewer children are identified as having SEN support in Havering and as such they are thought likely to represent a different, more complex cohort than in other areas

- the proportion of children with SEN support meeting the benchmark attainment drops back in secondary schools – most likely reflecting the complexity of those pupils who still require SEN support in Secondary school.

- A lower proportion of children with statements achieve the expected level of attainment at the end of each key stage than children with SEN report or no identified SEN but performance is similar to that reported for relevant comparators, possibly because 'statemented children' represent a more consistent cohort of children across areas.

6.3 SEND Transition post-16

The Young People's Education & Skills team commissions *Prospects* to fulfil the Council's statutory duty to ensure young people participate in education, employment or training and to provide Targeted Information Advice & Guidance for all learners.

The Not in Education, Employment or Training (NEET) cohort receive specific targeted interventions from a range of local and neighbouring education and training providers making use of bespoke programmes tailored to the specific needs of this cohort and funded using European Structural & Investment Funds (ESIF).

Advisors support learners and their families with transition e.g. assisting with the completion of applications, attending interviews at potential placements and arranging taster sessions.

The Prospects team work with the 16-25 resident SEND cohort in Havering and robustly track their participating in compliant education, training, apprenticeships and volunteering.

Achievement in Havering is similar if not better than that in comparable areas with a higher proportion in learning and a lower proportion NEET, unknown or in non-compliant destinations.

Table 3: Participation of 16-25 resident SEND cohort in RPA compliant learning, Havering and Bexley, June 2016.

	Havering	Bexley
In learning	280 (88.0%)	281 (81.4%)
NEET	18 (5.7%)	31 (9%)
Unknown	5 (1.6%)	12 (3.5%)
Other destinations non RPA compliant	15 (4.8%)	21 (6.1%)
Total	318 (100%)	345 (100%)

7 Recommendations

The SEND Needs Assessment Steering Group made a series of recommendations under 3 broad headings:-

- Strategic – about how key partners work together to develop and implement relevant strategy
- Services - in terms of what is available and how services work together to better meet the needs of children and their families
- Technical – to assist service delivery and improve our understanding of the needs of children and young people as presented in future iterations of the JSNA

Strategic recommendations	
1	Undertake a review of the groups responsible for local strategy, commissioning and planning of education, health and social care services relevant to children and young people (0-25) with SEND to eliminate duplication; reaffirm terms of reference and membership and confirm governance with the Health and Wellbeing Board
2	Use the SEND JSNA to develop strategic commissioning intentions and service development priorities across education, health and social care
3	Give greater transparency regarding the eligibility criteria for health, education and social care services to aid partnership working and give clarity to children and families.
4	Ensure key services e.g. community health services are commissioned for outcomes and reports on these outcomes are shared via the refreshed governance structure.
5	Fully implement the personal budget policy in conjunction with health, where appropriate
6	Ensure a continued focus on prevention and early intervention (universal services and targeted support) to address the risk factors for SEND
7	… including healthy lifestyle support for pregnant women / women considering pregnancy to address maternal obesity, smoking in pregnancy etc

Service recommendations	
8	Review the joint EHC planning and resource allocation meetings to ensure the process and membership enables timely sign off of plans
9	Implement the findings of the review of equipment services across education, health and social care to further improve user experience and outcomes
10	Ensure the planned re-commissioning of short breaks includes input from health so that a joint approach can be developed and implemented.
11	Ensure the data presented in the JSNA regarding community health services informs the on-going review(s) of therapy services
12	The resulting improvement plans for therapy services should reflect recent / predicted increases in demand and rapid implementation should be a priority
13	Continue to provide appropriate challenge to any educational provision not achieving good outcomes for children and young people with SEND and other vulnerable groups including LAC and children in need.
14	Monitor the delivery of the recently implemented Transitions Plan
15	Establish a framework to collate and analyse service user and family feedback to better inform policy, practice and commissioning across health, education and social care services
16	Work with local GPs to improve uptake of health checks for (young) people with learning disabilities and the subsequent agreement of health action plans to address lifestyle issues and lower the risk of long term conditions
Technical recommendations	
16	Create a single database of children and young people with disabilities and /or complex health needs (0-25) across health, social care and education beginning with those with EHC plans
17	Ensure the new child health information system (CHIS) records children and young people with a EHC plan
18	The Youth Offending Service should review its processes to identify and record children and young people with SEND so they can better target support as required
20	Formalise a systematic approach whereby midwives, health visitors and school nurses alert CAD of new born babies and / or children newly resident in the borough likely to have SEND.

Havering
LONDON BOROUGH

HEALTH & WELLBEING BOARD

Subject Heading:	Transforming Care Partnership
Board Lead:	Conor Burke, BHR CCG's Barbara Nicholls, Havering Council
Report Author and contact details:	Barbara Nicholls Acting Director Adult Social Care barbara.nicholls@havering.gov.uk

The subject matter of this report deals with the following priorities of the Health and Wellbeing Strategy

- ☒ Priority 1: Early help for vulnerable people
- ☐ Priority 2: Improved identification and support for people with dementia
- ☐ Priority 3: Earlier detection of cancer
- ☐ Priority 4: Tackling obesity
- ☐ Priority 5: Better integrated care for the 'frail elderly' population
- ☒ Priority 6: Better integrated care for vulnerable children
- ☒ Priority 7: Reducing avoidable hospital admissions
- ☒ Priority 8: Improve the quality of services to ensure that patient experience and long-term health outcomes are the best they can be

SUMMARY

This report provides an update to the Health & Wellbeing Board regarding the Transforming Care Partnership work underway, following the plan submission in April 2016, and further to the report to Health & Wellbeing Board on 23rd March 2016

The Barking and Dagenham, Havering and Redbridge Transforming Care Partnership (BHR TCP) is a partnership with membership from the three Local Authorities, Clinical Commissioning Groups (CCG's), NHS England Specialist Commissioning and North East London NHS Foundation Trust (NELFT).

The Transforming Care Partnership was formed in February 2016 in response to the 'Building the Right Support' national plan, published in October 2015, setting out a new framework to develop more community services and close inpatient units, called Assessment & Treatment Units (ATU's), for people with learning disabilities and/or autism who display behaviour that challenges, including those with a mental health

condition. The national plan was launched by NHS England (NHSE), the Association of Directors of Social Services (ADASS), and the Local Government Association (LGA). The programme is an extension of the Winterbourne View programme, with local TCP areas asked to accelerate plans to support the transfer of people in ATU's to community settings. Plans have been developed setting out commissioning intentions over the next four years, through to the end of 2019/20 financial year.

The TCP plan was submitted on 11th April 2016, and has received assurance from NHS England on 28th July 2016. BHR CCG's are the lead organisation locally in managing the TCP, with a programme now established and work underway, to begin the process of transformational change in services for this vulnerable cohort of patients.

This report includes the final TCP plan, now assured by NHS England, and sets out the programme plan for delivery of our ambitions.

RECOMMENDATIONS

- Receive the final TCP Plan submitted to NHS England on 11th April 2016 (now assured by NHS England)
- Note the programme plan now underway to deliver the TCP plan.
- Receive at least annual updates to the Havering Health & Wellbeing Board, or more often should circumstances require, to be updated on ongoing progress against the delivery of the programme.

REPORT DETAIL

1. Background

1.1 In October 2015, NHS England, the Association of Directors of Adult Social Services (ADASS) and the Local Government Association announced a national plan called "*Building the Right Support*". The plan, agreed by all national partners, aims 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. The programme is expected to achieve a closure of 40-65 % of inpatient facilities nationally within the next 4 years. *Building the Right Support* is the next step in the vision set down in the Winterbourne View Concordat which seeks to ensure that people with learning disabilities are given the support that they need close to home. The national service model is shown at Appendix 1.

1.2 Transforming Care Partnerships have been set up to achieve the aims set out in the national plan. Locally, our Transforming Care Partnership includes Barking and Dagenham, Havering and Redbridge and includes the three local authorities, CCGs and North East London NHS Foundation Trust. Each TCP is expected to produce a transformation plan by 11 April 2016 setting out how it will work together to reduce the usage of institutional settings, namely Assessment and Treatment Units (ATUs), and provide more services in the community.

1.3 Transforming Care Partnerships will work alongside people who have experience of using services, as well as their families/carers, clinicians, providers and other stakeholders to formulate and implement these joint transformation plans.

1.4 It is intended that TCPs will bring commissioners together at a scale larger than most CCGs and many local authorities. It is envisaged that these wider partnerships will enable TCPs to:

- Build where possible on existing collaborative commissioning arrangements in place in the area (e.g. joint purchasing arrangements amongst CCGs, joint commissioning arrangements between CCGs and local authorities).
- Develop 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 it makes sense for those CCGs to implement change collaboratively.
- Commission 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.

2. Our local vision

2.1 Locally across BHR our vision is consistent with the national service model and is currently (subject to further stakeholder engagement to confirm exact wording):

"People with a learning disability and/or autism, including people with complex and challenging behaviour, can lead fulfilling and rewarding lives while being part of a community that is able to support them with dignity and respect and ensure that people's individual wellbeing is at the heart of decisions."

2.2 The Partnership have stated that they are committed to achieve the vision by designing and implementing care and support services that:

- Provide support and interventions in the least restrictive manner and for the shortest time possible;
- Provide respite for families and carers that enables at home placements to be maintained with positive family relationships;

- Ensure that people who need inpatient care do not have to travel long distances to access it;
- Strengthen multi-disciplinary and multi-agency working to reduce health inequalities;
- Make better use of community provision across the three boroughs;
- Ensure that people have choice and control over their own health and care services;
- Ensure that early identification and early support is commissioned and provided;
- Enable people with learning disabilities and or autism and their family and carers to have access to the right level of information, advice and advocacy.

The full plan is available at Appendix 3

3. Understanding the local picture

3.1 Overall we do not have a high number of people in receipt of inpatient care compared nationally, however we are over the national upper limit with 29 inpatients per a million population. The national target is 10-15 inpatients per million population by year 3.

3.2 As of 31st March 2016 we had the following number of people in each borough in receipt of inpatient services:

Table 1

	Barking & Dagenham	**Havering**	**Redbridge**	**Total**
In borough	4	3	1	**8**
Out of borough	4	3	2	**9**
In secure setting (Specialised commissioning)	1	2	6	**9**
Total	**9**	**8**	**9**	**26**

3.3 As per national requirements, the BHR local TCP plan sets out the planned projections of people in inpatient settings, and this is set out below. Analysis of patient level information, both people currently in inpatient settings, as well as

people at risk of admission (including young people who are or will be in transition to adult services), have informed the projections.

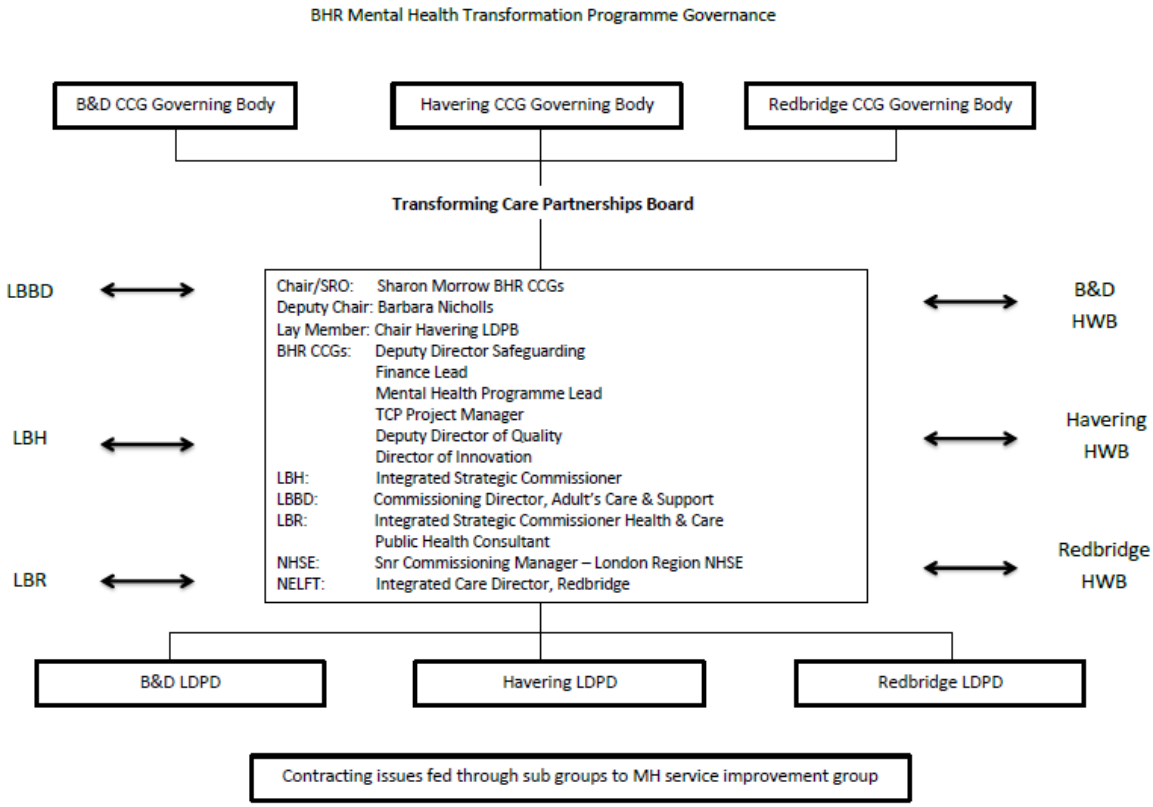
Table 2

Totals across all three boroughs	Year 0 (2015/16)	Year 1 (2016/17)	Year 2 (2017/18)	Year 3 (2018/19)
NHS England commissioned inpatients	9	7	6	6
Inpatient Rate per Million GP Registered Population NHS England commissioned	15.53	12.08	10.35	10.35
CCG commissioned inpatients	17	15	11	8
Inpatient Rate per Million GP Registered Population CCG commissioned	29.33	25.88	18.98	13.80
Total No. of Inpatients with learning disabilities and/or autism	26	22	17	14
Total Inpatient Rate per Million GP Registered Population	44.86	37.96	29.33	24.16

4. Governance and engagement

4.1 The BHR Transforming Care Partnership provides the leadership on the delivery of the TCP plan and is accountable for the delivery of the programme. The Transforming Care Programme has now established a Partnership Board, which consists of representatives from all Boroughs, CCGs, NHS Provider services and NHS England, which is described in the diagram below.

Figure 1 – TCP governance



4.2 People with lived experiences of services, their carers and providers (including the community and voluntary sector) as stakeholders remain key to the successful delivery of the TCP programme. The Partnership Board has a service user representative (from Havering), with existing borough partnership boards critical to ensuring the programme delivers locally, including the borough Learning Disabilities Partnership Boards, as well as boards and forums for Mental Health, Autism and Carers.

4.3 Quality Assurance and Safeguarding (both adults and children) is recognised by the BHR partnership as critical to the successful delivery of our TCP plan, and there will be engagement with Local Safeguarding Children's Boards and Safeguarding Adults Boards from time to time. The BHR CCG's Deputy Director Safeguarding and Deputy Director Quality are key members of the Partnership Board.

4.4 The Transforming Care Programme Partnership Board was established in December 2015, with revised governance, membership and terms of reference in place since June 2016. Key reporting lines are through to the CCG Governing Bodies and borough Learning Disabilities Partnership Boards and borough Health & Wellbeing Boards. Each partner organisation is responsible for reporting to their respective organisations, including obtaining executive decisions through their usual procedures.

4.5 The local partnership is also accountable to the national programme with governance arrangements established to monitor progress against key milestones and KPI's, including monthly performance reporting projected discharges within each TCP footprint.

4.6 At a national level, key workstreams include:

- Empowering Local people and families (LGA lead)
- Getting the right care in the right place (NHS England lead)
- Regulation and Inspection (CQC lead)
- Workforce (HEE lead)
- Data and information (NHS England lead)

Each of these workstreams are intended to act as enablers to local TCP footprints and support the delivery of plans locally.

4.7 Transforming care for people with learning disabilities has been identified as one of the 10 London priorities to be delivered through the STPs. The North East London STP has described this as one of the 23 transformation programmes and a Senior Responsible Officer and Delivery Lead have been identified for this workstream. Work is progressing to develop the NEL STP delivery plan, building on the TCP plans that have been already been agreed at the BHR and INEL partnership boards. Preliminary discussions across the two partnerships suggest that there are some common areas in the plans that would benefit from joint working.

5. TCP Programme Plan

5.1 The Programme Plan has been designed around delivery against four key domains or work areas. These are:

- Co-production
- Bed closure
- Developing a new service model
- Funding Arrangements

The domains cover the key four areas of focus for the programme, with clear objectives and key milestones agree these. There is also a programme risk register, setting out issues and risks that are in the system, including financial sustainability.

5.2 Co-production

The primary focus of this domain is ensure that people with lived experience of services, and their families and advocates are 'plugged in' in the right places and in the right way to help drive the TCP plan at both a strategic and operational level. Given the vulnerabilities of the cohort of services users /

patients the TCP covers, this means planning more than workshops and meetings. To that end the Partnership is currently working with the National Development Team for Inclusion with a view to commissioning them to supporting people with lived experience of services, to be able to contribute to the TCP programme, in ways that suit them, including participation in strategic meetings, in planning ahead, particular in regards to transition from children to adult services, and in developing the service model of the future, including housing solutions.

5.3 Bed Closure

Critical to the success of the programme is the release of funding from acute and specialist ATU settings, to support the development of better community based provision. However this also means supporting the redesign of the local ATU (run by NELFT), so that where admission to an inpatient bed is unavoidable and is clinically justified, the local unit is able to manage a wider range of need, negating the need for expensive out of borough placements.

5.4 Developing a new service model

As previously noted, new ways of working are required, so that people in need of specialist services in the community can be supported more effectively, reducing the need for inpatient admissions, and improving their health and social care outcomes. This includes developing a crisis response service for the three local areas, that is available to community providers (such as supported living schemes), statutory services and families to step up wrap around support for people using services, to keep them in their community setting rather than being at risk of admission to an inpatient bed.

It is also about health and social care commissioners understanding the current and future needs of service users (including those young people who are or will be transitioning into adult services, to plan for the appropriate provision that will be needed, both in terms of bricks and mortar, but also the specialist support services that will be needed.

In Havering, the Great Charter Close supported living scheme that opened in late 2014, is an example of the kind of schemes commissioners will be working with Housing and Planning colleagues (including capital requirements) to develop, with the potential for some efficiencies / economies of scale in planning for this across the BHR footprint and sharing resources to deliver what is needed.

5.5 Funding arrangements

A particular requirement of all transforming care partnerships is the scaling up of use of personal health budgets, personal budgets and integrated personal budgets as well as education, health and care plans, as the means for people who use services (often managed on their behalf by families) to plan for how their care and support needs will be met.

There is also a need for a full review of partnership arrangements across the three areas, including refreshing section 75 arrangements, and looking at pooled budgets where appropriate.

The programme plan milestones are available at Appendix 2.

6. Finance

6.1 Local TCP's (including NHS England Specialist Commissioning) are being asked to review the total sum of money we spend (across the BHR areas) as a whole system on people who fall into the TCP cohort, with a view to disinvesting in inpatient care and investing in community based solutions to deliver care in a different way and achieve better outcomes for the people who use services. The costs of future models of care are therefore to be met from the total current envelope of spend on health and social care services. NHS England estimates that nationally through the closure of inpatient services, this will 'release hundreds of millions of pounds for investment in better support in the community'.

6.2 For people who have been an inpatient for five years of more (as at 31st March 2016), there has been a commitment that money will 'follow the individual' through dowries, payable from by the NHS to local authorities for people leaving hospital on discharge, where the local authority arranges and is responsible for paying for the care and support package. Dowries will be recurrent, will be linked to specific individuals, and will cease on the death of the individual. Dowries will not be increased over the course of the individual's life – i.e. will be fixed as at the point of discharge for the individual.

6.3 NHS England has recognised that such a large transformation programme is likely to involve significant transition costs, including managing double running costs for a period of time as inpatient beds close, with new services coming on stream before funding can be released from the inpatient bed(s). To that end £30 million over three years has been made available nationally to support the transformation. As already noted, the BHR TCP has been successful in bidding for £625K over three years and has secured £110k non-recurrently for year 1 from the transformation funding available, which is to be match funded by BHR CCG's within the NELFT contract.

6.4 In addition there is also £15 million capital funding over three years made available, with NHS England committing to exploring making more capital available following the next Spending Review. The BHR TCP has an indicative proposal.

6.6 There is concern, particularly from local authorities, about the financial risk associated with delivering the national requirements. Care and support packages for the cohort of service users / patients that the TCP covers generally require high levels of support when in the community with packages of support costing usually between £2.5 and £3.5k per week. Where dowries

do not apply (i.e. the individual has or had been in an inpatient setting for less than five years as at 31st March 2016) the care package cost is a new burden for local authorities. Equally as the amount paid by dowry remains as a fixed contribution as at the date of discharge to a community setting, over a period of years, this contribution as a proportion of the total cost of the care package, will reduce in real terms. Financial sustainability across the system, is a key feature of the programme plan and concerns about sustainability are reflected in the programme risk register.

BACKGROUND PAPERS

- Building the Right Support – national plan and guidance
- Local TCP plan – submitted 11th April 2016
- TCP programme plan and risk register

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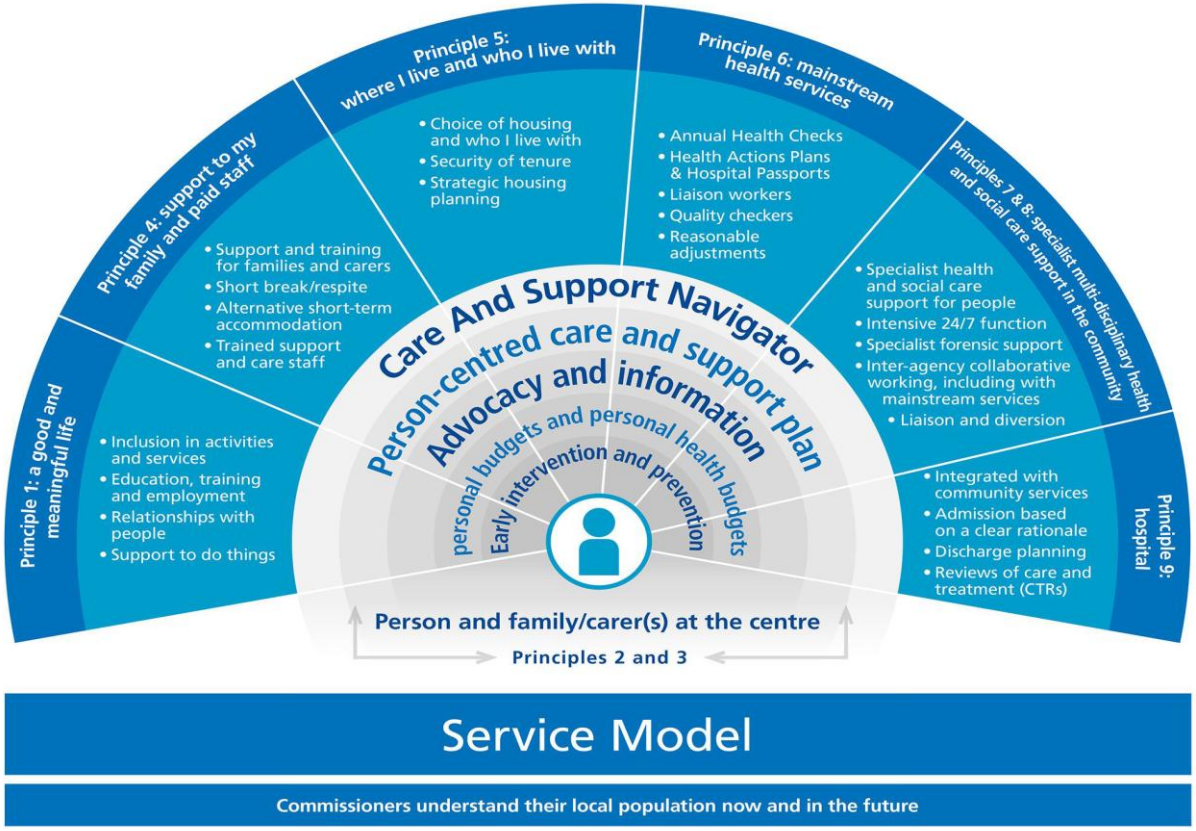
Appendix 1 – National Service model



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Appendix 2 - TCP programme milestone plan as at August 2016

Domain *Work area*	**Objectives** K*ey objectives*	**Key Milestones** *Key milestones for delivery against TCP delivery plan*	**Date Complete**	**RAG Status**
Co-Production	Embed people with lived experience into the design, delivery and implementation processes associated with TCP plans at both strategic and operational levels	Transforming care partnership board will have representation from people with direct experience of LD/A services feeding into TCP strategic decisions. The boards will meet on a monthly basis. To start in June 2016 and be ongoing.	31/03/2019	
		CCG local Learning Disability Partnership Boards to have representation from people with direct experience of LD/A services to provide strategic input at a local level. These meetings will take place on a quarterly basis from April 2016 and will form feedback as part of the partnership board	31/03/2019	
		CCG's to carry out survey of LD/A service users to understand patient experience and to inform program change and how we need to improve services across the system. An initial survey was done in March 2016 and will be continued on a 6 monthly basis. However adhoc sessions will be commissioned when service user input is needed into specific elements of design and redesign.	31/03/2019	
	Engage with a number of borough based children focused user groups and carers of children within the 5 cohorts	Co-produce early help and behaviour support as part of TCP and CAMHS Transformation	30/06/2016	
		Listening event to discuss SEND assessments and transition process post 14 for both health and social	31/08/2016	

	Co-produce community based housing solutions - Give people choice and control on where they live	As part of the professionals event in July 2016 a group discussion will be focused on community housing and care provider provision to identify the professionals view point on our provider and housing gaps which will be used to identify further areas of engagement	31/07/2016	
		Engage with stakeholders and general public to co-produce community based housing solutions this will start in December 2016 onwards	31/03/2019	
		Engage with people with lived in experiences on 1:1 basis around housing solutions as part of communication with this cohort	31/03/2019	
Bed Closure	Redesign of the local ATU based on current and future needs of this cohort to introduce new model of care. This will then allow BHR not to commissioning any new out-of-borough placements unless clinically necessary	Professionals workshop involving both inpatient and community services to develop a new service model across LD services for both ATU, community care and outreach crisis response	31/07/2016	
		New model of ATU care to be introduced which will start the process of reducing out of borough placements and result in out of borough bed closures as patients are discharged into the community	31/10/2016	
		Facilitate discharge of 15 patients across BHR which will have a net impact of 2 OOB beds being reduced in year 1 due to specialist commissioning step downs and CCG admissions. Q1 – 3, Q2 – 6, Q3 – 4, Q4 – 2	31/03/2017	
	Strengthen CTR process to ensure that all current cohort of patients are discharged on discharge	To ensure that borough CTR processes comply with national framework	31/03/2016	

	dates set either within CTR's or as part of discharge planning.	Strengthen CTRs to include education, LAC and CYP to ensure with children cases that they are not receiving inpatient treatment for any longer than clinically necessary and ensure a smoother transition back into the community. Process to prevent admissions in the first instance	30/06/2016	
		Root cause analysis of admissions to inform pathway development as part of the professionals workshop in July 2016	15/07/2016	
		Ensure that all new patients entering into this cohort have CTR's arranged in line with national standards to ensure that treatment pathway is not longer than clinically necessary	31/03/2019	
	Strengthen blue light CTR process and crisis response to reduce the number of admissions per the cohort	Standardise risk stratification process across 3 boroughs and refresh the 'at risk' registers across all cohorts	30/06/2016	
		Standardised CTR Process - Blue light/Community/Inpatient	30/06/2016	
		Mandatory training to be provided to teams on process of blue light and community CTR's to ensure correct use and implementation	30/09/2016	
		At present all inpatients have person centred care plans and crisis plans or if not in place are a core recommendation. This practice needs to be replicated in the community for all patients on the risk registers. Process to start in August 2016 and to be completed by December 2016 for all current at risk patients. Continue going forward as part of best practice for future 'at risk' patients	31/12/2016	
		Review current crisis pathway for LD/autism under Mental Health services	31/07/2016	

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	Improving transition of individuals from Specialist commissioning to CCG	CYP - Redesign model of care for CYP with challenging behaviour to reduce inpatient beds at Brookside	31/07/2016	
		CYP - Closure of 5 beds at Brookside and implement new service model for children which is more community based.	15/08/2016	
		Design Pathway across BHR for adults stepping down from specialist commissioning	30/09/2016	
Developing a new service model	Increase the capacity and capability of community services by introducing new models of care to manage people with more complex conditions to ensure that admission to hospital is an exception.	Professionals workshop involving both inpatient and community services to develop a new service model across LD services for both ATU, community care and outreach crisis response and scope current services and functions of each area of care	31/07/2016	
		Undertake gap analysis of needs against existing service provision/borough provider map. Measure against the national service model to inform commissioning intentions.	30/09/2016	
		Investment plan to be approved by TCP Board for an integrated model of care for inpatient, outreach and community support to ensure a joint way of working to ensure a smoother care pathway for patients	17/10/2016	
		New model introduced for intensive community support for crisis and outreach.	31/10/2016	
		New model of care to be introduced to CLDT's	31/10/2016	
		BHR CLDT's to undertake forensic training to manage more complex and challenging individuals in the community	30/11/2016	
		Develop commissioning assurance framework that addresses quality assurance post discharge	31/12/2016	
		Develop a zoning system across BHR to support early identification of CYP needing additional support.	31/03/2017	

		PBS training to be offered to all BHR providers	31/03/2017	
		Start to Commission specialist challenging behaviour providers in-borough (for year 2)	31/03/2018	
	Improving quality of life in both health and social aspects for all 5 cohorts	Increased number and quality of LD Health Checks	31/03/2017	
		Set KPI's for improving Health & Social care to decrease any local health inequalities	31/12/2016	
		Review of safeguarding's and adverse events recorded (Annually)	31/03/2017	
	Review of Children placements and redesign Transition pathways.	Review of children OOB placements in residential schools	31/10/2016	
		Identify children who could be cared for closer to home	31/03/2017	
		Following listening event look to strengthen transition planning and remodel pathways	31/12/2016	
	Workforce Transformation	New TCP Workforce Model focused on personalised care support	30/09/2016	
		Workforce Transition Plan developed	31/12/2016	
		Workforce Transformation Implementation Planning	31/12/2016	
Funding Arrangements	Increase in uptake of personal health budgets and personal budgets	Agree PHB roll out plan	31/07/2016	
		Monitor uptake of Personal Health Budgets across BHR CCG's	31/03/2017	
		Monitor uptake of Personal Budgets across BHR LA's	31/03/2017	
	Review at Borough level at pooled budget arrangements under Section 75	Havering to pool budgets as part of S75 renewal	31/03/2017	
		Review Redbridge	31/10/2016	
		Review B&D	31/03/2017	
	Development of local shared budgets and pooled funding arrangements	Proposals to be discussed at Transformation Care Partnership Board for 17/18 contracts.	31/03/2017	

Barking & Dagenham, Havering and Redbridge Transforming Care Partnership Plan 2016/17 to 2019/20

Executive Summary

This three year plan sets out our vision and confirms the commitment of the Barking and Dagenham, Havering and Redbridge (BHR) Transforming Care Partnership (TCP) for improving the care and support available for 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]. This plan addresses the needs amongst the diversity and complexity of the population for people with:

- A learning disability and/or autism who have a mental health condition such as severe anxiety, depression. Or a psychotic illness, and those with personality disorders, which may result in them displaying behaviour that challenges.
- An (often severe) learning disability and/or autism who display self-injurious or aggressive behaviour, not related to sever mental ill health, some of whom will have a specific neuro-developmental syndrome and where there may be an increased likelihood of developing behaviour that challenges.
- A learning disability and/or autism who display risky behaviours which may put themselves or others at risk and which could lead to contact with the criminal justice system.
- A learning disability and/or autism, often with lower level support need and who may not traditionally be known to health and social care services, from disadvantaged backgrounds, who display behaviour that challenges, including behaviours which may lead to contact with the criminal justice system.
- Adults with a learning disability and/or autism who have a mental health condition or display behaviour that challenges who have been in hospital settings for a very long period of time, having not been discharged when NHS campuses or long-stay hospitals were closed.

This plan, which we acknowledge is iterative, describes:

- Our TCP governance and programme arrangements for how we intend to deliver on our commitment
- The demographics of the outer north east London area covered by BHR
- The services that are currently commissioned and provided for people with a learning disability and/or autism
- Our ambition and shared vision to improve the quality of care and services over the next three years by implementing the national service model
- Our engagement plan and our high level plans describing how we intend to deliver our ambitious vision.

This plan, which builds on and further develops the good work already in place in each individual

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

borough, has been developed through collaboration across our partnership and through engagement with people who have a lived experience of using the services, community and inpatient clinicians, social care staff, housing departments, health and social care commissioners and primary care providers.

Across BHR we have already made excellent progress in moving away from inpatient care and developing supportive community provision, however we will not stand still as we recognise there is much more to do. The work to be taken forward through this programme will be wide-ranging. Over the coming months we will continue to co-design and co-produce in partnership with people with a learning disability and/or autism, the BHR Learning Disability Partnership Boards, local third sector organisations, national organisations in the health and care system (such as Health Education England) and all members of the partnership.

Introduction and Context

The national vision described in Building the Right Support is that 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 the same dignity and respect. They should have a home within the community, be able to develop and maintain relationships and get the support they need to live a healthy, safe and fulfilling life.

Locally across BHR our vision is consistent with the national service model and is that (subject to further stakeholder engagement to confirm exact wording):

"People with a learning disability and/or autism, with complex and challenging behaviour including those with a mental health condition, can lead fulfilling and rewarding lives while being part of a community that is able to support them with dignity and respect, ensuring their individual wellbeing is at the heart of decision-making"

We will achieve our vision by designing and implementing care and support services that:

- Provide support and interventions in the least restrictive manner and for the shortest time possible
- Provide respite for families and carers that enables at home placements to be maintained with positive family relationships
- Ensure that people who need inpatient care do not have to travel long distances to access it, unless this is necessary due to clinical need
- Strengthen multi-disciplinary and multi-agency working to reduce health inequalities
- Make the best possible use of community provision across the three boroughs
- Ensure that people have choice and control over their own health and care services
- Ensure that early identification and early support is commissioned and provided
- Enable people with learning disabilities and/or autism and their family and carers to have

access to the right level of information, advice and advocacy.

Through this transformation programme we will put in place:

- A shared value base which places individuals and their quality of life at the heart of all we do
- Care and support that is delivered with the aim of improving quality of life for people with a learning disability and/or autism and their family/carers
- A service model across our entire geographical area that delivers the nine principles of the national service model (see below).

As a group of organisations, we recognise the scale of change required, and we are committed to working together to ensure that we succeed in transforming care for people with learning disabilities and/or autism. To enable that, we have established a strong partnership board and programme governance structure, with defined workstreams. As organisations we have different legal structures and accountabilities. However we have agreed to develop collaborative solutions bringing together resources, capabilities and expertise. A Business Case to form an Accountable Care Organisation (ACO), and based on collaborative and integrated working across the BHR health and care economy, is being developed for submission in June/July 2016. If the bid is successful we will move to implementation phase quickly - if we are unsuccessful we will develop a model based on the ACO for implementation over the next 3 years. In the meantime the TCP Plan will form the basis for closer working across the Partnership.

We intend to progress the transformation of services for people with a learning disability and/or autism through our Integrated Care Coalition (ICC). This was formally established in 2012 to bring together the lead organisations in our health and social care economy to support the commissioning of integrated care. As a result there is a strong history of successful collaborative working across BHR, with an emerging track record of true partnership, leading to real improvements for our local populations. The ICC is a leadership group which makes recommendations to and works closely with the local health and wellbeing boards in developing our longer term strategic plan and driving improvements at pace across the BHR system. The ICCs purpose is to improve outcomes for local people through best value health and social care in partnership within the community. Through the ICC all commissioners have mature and strong relationships with the main providers across the geographical area – notably Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT) and North East London Foundation Trust (NELFT) – and these well-developed relationships mean that we are confident we can deliver on our commitment in this plan.

This plan is developed to cover the full range of commissioning and encompasses strategic, operational and individual/micro commissioning and is aligned to the development and implementation of our Local Transformation Plans for Children and Young People's Health and Wellbeing, local plans for delivering the Mental Health Crisis Concordat and the 'local offer' for Personal Health Budgets (PHBs). It also incorporates our Winterbourne View Concordat plans, actions from the Francis Report Implementation plan and Learning Disability and Autism Self Assessments. When developing this plan the partnership also took into account our legal duties under the Equality Act 2010 and had regard to reducing health inequalities and our duties under the Health and Social Care Act 2012, Care Act 2014 and Children & Families Act 2014.

Planning template

1. Mobilise communities

Describe the health and care economy covered by the plan

This plan covers the Transforming Care Partnership formed by the London Boroughs of Barking and Dagenham, Havering and Redbridge, the Clinical Commissioning Groups of Barking and Dagenham, Havering and Redbridge and North East London NHS Foundation Trust (NELFT). Already the three borough-level CCGs have formed a coalition and have shared executive and back office services.

Overview of BHR health system boundaries

There is currently no joint Local Authority commissioning across BHR, though commissioners cooperate and share information through the East London Leads Network and East London Solutions. There are a range of commissioning practices including frameworks and spot commissioning (the latter particularly for this cohort) currently in place.

We have a combination of NHS, independent and voluntary sector contracts to provide care for people with learning disabilities and their families and carers. While some providers are common across the boroughs, each of the three Local Authorities has slightly different formal governance arrangements. There are different integrated models of care across the boroughs in which

Community Learning Disability Teams (CLDT) offer speech and language services, psychiatry, psychology, specialist nursing and care management. Community provision includes a range of residential, supported living, shared lives and respite.

Inpatient care for people with learning disabilities is predominantly provided by NELFT from the shared Assessment and Treatment Unit (ATU) at Goodmayes Hospital. NHS England London, specialist commissioning, commission placements both in and out of area.

The BHR CCGs commission from the independent sector some hospital placements for patients with learning disabilities who do not require a secure hospital setting (which would come under the remit of specialist commissioning); but are not able to be treated and cared for by the local NELFT ATU. The placements are not all in-borough, but some of these are local (e.g. Newham) and the most distant is less than 2 hours' drive and most of the others 1 hour or less.

For a few such patients (currently two), the CCG makes a financial contribution to the patient's independent sector provided care package jointly with the responsible local authority. Each CCG has a Section 75 arrangement with their respective coterminous Local Authority. Through these arrangements, the Local Authorities lead the commissioning and performance management of Community Learning Disability Teams.

In **Barking and Dagenham** a Section 75 agreement has been in place since 2015 with London Borough of Barking and Dagenham as the lead organisation and commissioner and NELFT as provider. Provider staff from the Council and NELFT are co-located at the Civic Centre. The CCG and the Local Borough of Barking and Dagenham have been working towards the development of collaborative commissioning arrangements under a Section 75 arrangement. Whilst a formal agreement has not yet been signed off, a joint commissioning manager has been appointed and progress has been made towards the development of a joint commissioning strategy. The Health and Wellbeing Board has received a consolidated action plan for the delivery of improved services for people with learning disability and autism, bringing a coherent single response to the delivery against a number of policy requirements, which has been shaped by the Learning Disability Partnership Board (LDPB). NELFT is a key partner and provides health services for people with a learning disability, funded by the CCG. The CCG also commissions Assessment and Treatment beds through a block contract arrangement at Goodmayes Hospital. In October 2015 B&D signed a new Section 75 agreement bringing greater formality to the long-standing integrated Community Learning Disability Team (CLDT), combining Local Authority and NHS services for people with learning disabilities. This comprises social work, nursing, psychiatry, psychology and therapy services, is co-located and is led by the Council. The Section 75 is governed by an Executive Steering Group that oversees operational issues relating to the performance of CLDT.

In **Redbridge** an Executive Board has monitored the delivery of the Section 75 agreement across the London borough of Redbridge, Redbridge CCG and NELFT. This expires in October 2016. NELFT is the provider, LBR is the lead organisation. LBR and NELFT staff work side-by-side in care management. The current arrangements have been developed and strengthened to build on our successful partnership working over the past ten years. LBR has a pooled budget with the CCG which funds the joint Learning Disabilities Commissioning Service. A revised broader Section 75 agreement has been developed that fully integrates health and social care staff in Redbridge; and from 1 April 2016 there will be a fully integrated health and social care partnership with many more services included in the

new agreement. Care delivery will be split from a central location to four areas or hubs of excellence aligned with the CCG's four localities. This will make care deliverable on a more local level and allow closer working with GPs and partners, and ensure the individual, their family and/or carers are at the centre of their care. It is also important to recognise that individuals using services are not aware of the boundaries drawn by the health systems. For example, a lot of patients who live in the west of Redbridge travel to Whipps Cross hospital which is located in Waltham Forest.

In **Havering**, commissioning for adults is undertaken jointly across adult social care and the CCG, with the Local Authority being the lead organisation for the delivery of services for people with learning disabilities, and the CCG leading on mental health. Frontline staff are co-located and have strong collaborative working arrangements. Havering CCG and Local Authority commission the Community Learning Disability Partnership. The current Section 75 agreement is under review. Havering Combined Learning Disability Team currently commissions from a number of providers both in and out of the borough, through a mix of block contracts and individual purchase. NELFT provide mental health services on behalf of the Local Authority and CCG and case manage a small number of this cohort of patients. The main provider of acute care is BHRUT, operating across two sites – Queens and King Georges Hospitals. The local authority also has a discrete Brokerage and Quality Assurance Team that source and quality monitor commissioned services.

The TCP will further develop joint commissioning arrangements so we are working to a common framework across the BHR partnership.

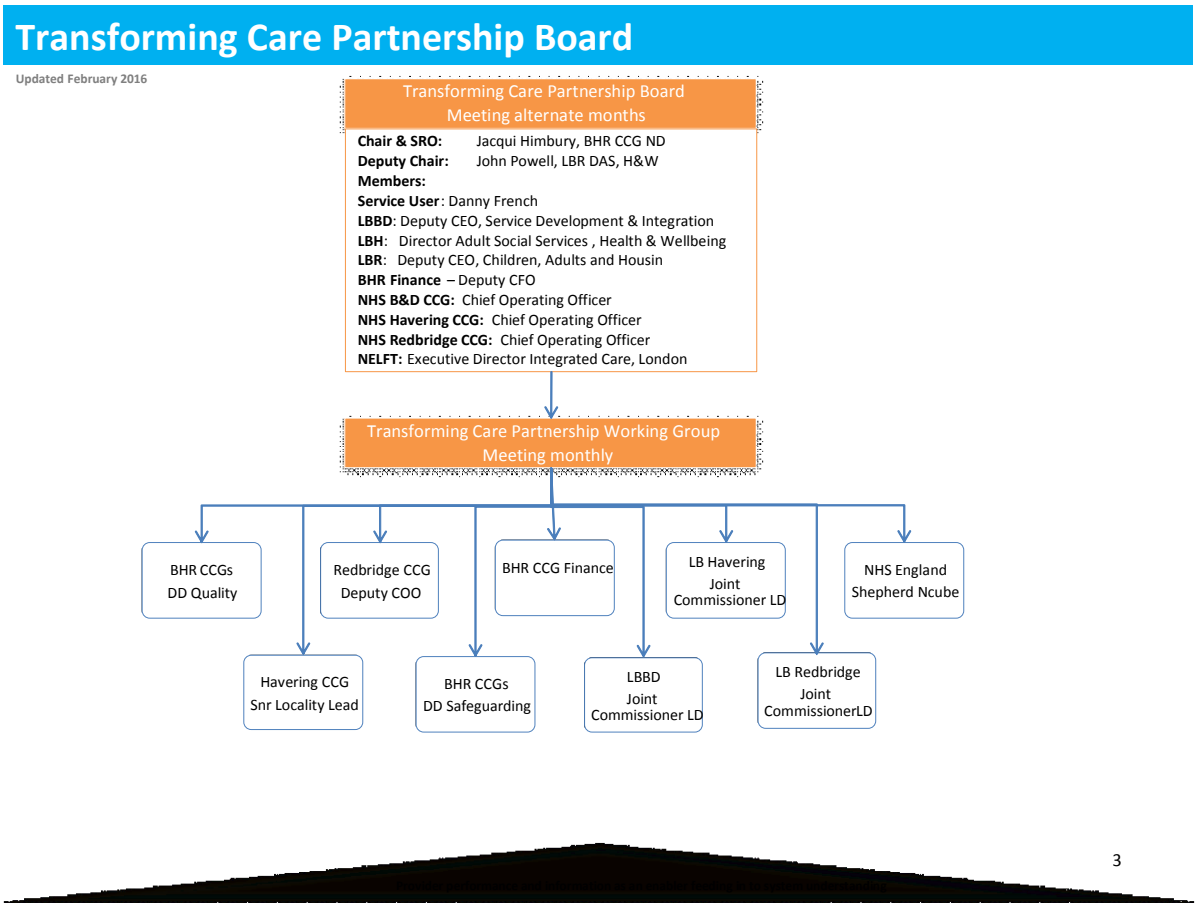
Describe governance arrangements for this transformation programme

The BHR TCP was established to provide leadership and governance on the delivery of the Transforming Care Partnership Plan, and is accountable for the delivery of the programme. The Transforming Care Programme has a Working Group and Shadow Board (an interim arrangement while the terms of reference and governance arrangements are finalised) which consists of representatives from the respective Local Authorities and Clinical Commissioning Groups (CCGs), and NHS England. At the time of submitting this plan the Transforming Care Partnership Shadow Board has met four times (as has the Working Group, and there have been two facilitated sessions).

The members of the Shadow Board are:

- BHR CCG Nurse Director (Chair)
- LBR Director of Adult Social Services, Health and Wellbeing (Deputy Chair)
- LBH Deputy Chief Executive of Children, Adults and Housing
- LBBD Deputy Chief Executive & Strategic Director for Service Development and Integration
- BHR CCGs Chief Operating Officers
- NELFT Executive Director Integrated Care (London) & Corporate Communications
- NHSE Specialist Commissioning
- BHRUT Chief Operating Officer

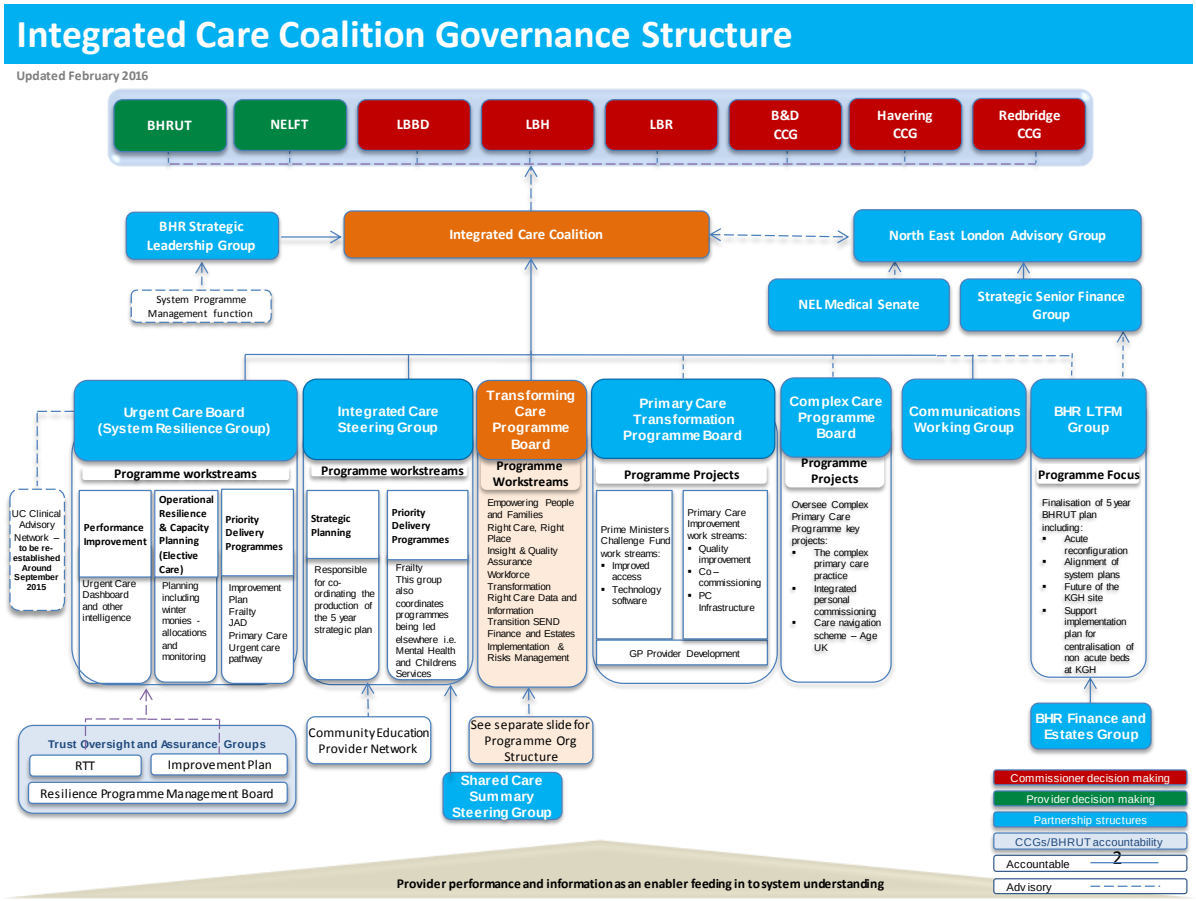
While there has been good representation from children's commissioning from across the Partnership on the Working Group; we have yet to appoint a children and young people's services representative to the TCP Board. We are currently identifying the appropriate representative.



The Transforming Care Programme has a senior responsible officer – Jacqui Himbury, Nurse Director of BHR CCGs. The deputy senior responsible officer is John Powell, Director of Adult Social Care at London Borough of Redbridge. We are seeking to appoint the Co-Chair of a Learning Disability Partnership Board, who has a mild learning disability, to become a member. In addition we are engaging with inpatient services, housing, Healthwatch, the Youth Offending Service, and community safety and safeguarding, in the respective boroughs, with a view to widening the membership. There is also intent, as the Board develops, to engage third sector organisations, the criminal justice system, Local Education and Training Boards and the Liaison and Diversion service. An Interim Programme Manager and Project Support Officer have been appointed and are supporting the delivery of the programme.

As we already have robust governance arrangements with all partners across the system for delivery of all our transformation programmes, the proposal is that the TCP Board accounts to the Integrated Care Collation (ICC). This is yet to be finalised as system wide governance arrangements across the BHR economy are being reviewed. The relationship of the TCP Board to each of the Learning Disability Partnership Boards (LDPBs) is yet to be finalised, as each has established its own governance arrangements and strategic plans for improving services. It is therefore vital that the Partnership incorporates the excellent work of the LDPBs, and that this plan reflects the local variations of need and governance arrangements. Each of the LDPBs has representation from people

with learning disabilities and carers; and when developing and implementing this plan we will build on these engagement approaches that are already working well.



Redbridge has an LDPB, which is a sub group of the Health and Wellbeing Board. It is co-chaired by a parent-carer and a person with a learning disability, and has a membership including providers, councillors, people with a learning disability and family carers. Regular reports on Transforming Care go to the Board and an Annual Report is submitted to the Health & Wellbeing Board.

Havering Health and Wellbeing Board meets monthly. Meetings alternate between formal business meetings and development sessions - the latter provide Board members with the opportunity to undertake an in-depth review of priority areas linked to the Havering Health & Wellbeing Strategy. The following report to the Health and Wellbeing Board:

- Havering LDPB meets quarterly with membership including people with Learning Disabilities and their carers, commissioners from the Local Authority and CCG, and providers from the health, social care and voluntary sector. It is co-chaired by an elected service user and the Assistant Director of Adult Social Care.
- Havering Mental Health Programme Board meets bi-monthly with membership as per the Learning Disability Partnership Board, except the co-chairing arrangements are between the CCG and Local Authority.
- Havering Autism Partnership Board was established in 2015 to drive improvements in access

to services, specifically for people with Autism and Aspergers Syndrome.

- Havering Joint Management and Commissioning Forum, made up of commissioners from the CCG and Local Authority (across public health, children services and adult services) meets monthly.

Barking and Dagenham Health & Wellbeing Board meets every 6 weeks. Its membership includes representatives from the Local Authority, CCG, NELFT, BHRUT, police, Healthwatch, with a place offered to NHS England, and the regular opportunity for attendance as an observer for both the chair of the Health & Adult Services Select Committee and the independent chair of both safeguarding boards. The Board regularly seeks assurance through subgroup reporting to ensure it is delivering the objectives of its programmes. The LDPB, a subgroup of the Health and Wellbeing Board, oversees the delivery of the Winterbourne View Concordat and the development of the commissioning and service delivery of Section 75 agreements for people with learning disabilities. It also oversees the delivery of the Autism Strategy, the Learning Disability Self-Assessment Framework (LDSAF) action plan; the Borough's Challenging Behaviour Plan, and relevant aspects of the Carers' Strategy. These and other pieces of work delegated to it by the Health and Wellbeing Board are monitored through a Delivery Plan. Barking and Dagenham's Group Manager for Intensive Support has been appointed to the Shadow TCP Board to ensure CLDT representation.

Describe stakeholder engagement arrangements

Guidance notes; who has been involved to date and how? Who will be involved in future and how? It is important to explain how people with lived experience of services, including their families/carers, are being engaged.

The BHR TCP Board is clear that stakeholder engagement is about more than informing stakeholders of our plans and goals. It is about having a close dialogue with them (e.g. as we have with the chairs of the Learning Disabilities Partnership Boards), and developing with them the vision upon which this Transforming Care Plan is based. All three CCGs, Local Authorities and Learning Disability Partnership Boards within the BHR footprint have played an active role in the drafting of this plan. Stakeholder engagement in the development of the Transforming Care Partnership Plan includes:

- Presentations to Redbridge, Havering and Barking and Dagenham Learning Disabilities Partnership Boards, Autism Partnership Boards, Mental Health Partnership Boards, Health and Wellbeing Boards, and both the Safeguarding Adults and Safeguarding Children Boards. This has included discussion of DH Winterbourne View Review – Concordat: Programme for Action. There will be quarterly updates on progress to each Board.

- A stakeholder event across the three boroughs on 30 March 2016 with attendees from the Local Authorities, CCGs, Learning Disabilities Partnership Boards, Mental Health Partnership Boards, Voluntary and Community Sector, representatives from Children and Young People, carers groups and from people with lived experience of services. A summary of the discussions can be found in Appendix 5.

We actively and widely engage with people with learning disabilities and autism, and carers and families, to improve our services. We are always keen to know what our users feel we do well, do not so well and where they feel we can improve. All Boroughs have stakeholder forums where we

seek feedback on strategies and service delivery. Each CCG has a Patient Engagement Forum (PEF) with people from different backgrounds, representatives of young people, people with learning disabilities, parents and carers, and community groups with an interest in learning disabilities and Autism. The CCGs and Local Authorities engage directly with parent and carer groups that focus specifically on the needs of people with learning disabilities and autism; and will continue to do so as we develop this plan. We know that not all people with learning disabilities or autism, or their families and carers, are part of groups or networks. So we look for other ways to involve them. For the purposes of this Transforming Care Plan, we will conduct surveys (including online), continue to utilise the CCGs' lively social media channels and commission easy read versions of key documents to ensure all children, young people and adults are able to take part in its development.

There is good practice in engagement across the partnership. As part of the implementation of our CAMHS Transformation Plan we have established a BHR 'Participation and Outcomes Group' which is specifically focussed upon engaging with children and young people with learning disabilities, Autism and mental health problems. This will enable us to harness their views and inform the further development and implementation of both our CAMHS and Transforming Care Plans. In **Redbridge**, for instance, an Adult's with Autism Working Group, Children's ASD Planning Group and Parent/Carer Focus Group meet to consider key strategies and plans including the Autism SAF. There is also a Respite Carers Forum and Day Services Forum; and the Borough uses a locally co-produced Quality Checker System for Day Services, and involves service users in staff recruitment. In **Havering**, in March 2014, Healthwatch (a member of the Health and Wellbeing Board) conducted a review of Services for People who have Dementia or a Learning Disability based on a series of workshops including service users and carers, volunteers and professionals from across health, social care and the voluntary sector. In **Barking and Dagenham**, the Learning Disability Partnership Board has a Service User Forum, Carer Forum and Provider Forum. These groups discuss and comment upon items that go to the Board, and escalate issues facing people with learning disabilities and Autism. A representative from each forum, two of them service users, sits on the Board. The Board also oversees engagement events, particularly over Learning Disability Week, with carers and service users on a variety of topics including community safety and transport. All providers of learning disability services are encouraged to attend the Provider Forum. It is an opportunity to engage on national and local priorities. Over the past 6 months they has been asked to develop a more resilient workforce; and to ensure Positive Behaviour Support (PBS) is core mandatory training for all staff working with people with a learning disability .

Our ongoing planning will build on the existing Barking and Dagenham, Redbridge and Havering wide partnership structures and stakeholder engagement arrangements; and make sure this continued engagement results in a coordinated approach to addressing the needs of individuals, carers and families, and any challenges or barriers that we meet. As we begin to implement the TCP Plan and develop new community-based housing solutions we will engage stakeholders in the process of putting together detailed design plans. This will include ensuring that the locations, environment and the aesthetics are fully disability compliant, robust, sound resilient, and designed with appropriate colour co-ordinated features; to assist service users with sensory support needs alongside their learning disability.

Our Communications and Engagement Plan aimed to inform and involve all stakeholders in the development and implementation of this plan can be found in Section 5.

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

We fully recognise the importance to the success of our plan in engaging extensively with people with learning disabilities and autism, their families and carers. In addition to meetings, workshops and events with all stakeholders, we will continue to engage these individuals in particular, and in a variety of ways, as appropriate to their needs and circumstances. We are seeking their advice on:

- Which aspects of our services are working well?
- Which aspects of our services are not working well and why?
- How can we improve on these services?
- Which additional services we do need to expand upon and commission more of?
- Which new services do we need to look to start commissioning?

Indeed, it is fundamental to our approach that those stakeholders with lived experience are central to our Transforming Care Plan:

- On 30 March we invited health and social care professionals, former users of inpatient care and current users of community care and their families, to a Transforming Care Workshop at Redbridge Central Library to discuss services and how they could be improved. It took place in the middle of the day at the suggestion of our Learning and Disability Partnership chair. This ensured parents and carers of children and young people with learning disabilities and Autism, who need to meet school buses in the morning and in the afternoon, were able to attend. A summary can be found in Appendix 1.

- Commissioning of National Development Team for Inclusion undertook 10 days of engagement work across BHR. Through March the facilitator arranged 1-1 sessions and small focus groups with people with lived experience of being in inpatient settings and now living in the community. A summary of this work can be found in Appendix 2.

- Borough-based Community Teams for People with Learning Disabilities (and Mental Health Services) met with current inpatients in March to discuss the Transforming Care Partnership Plan and how it affects them as individuals. This will form a part of their discharge planning and moving back into the community.

We will build on good practice across the Transforming Care Partnership engaging people with lived experience in the coproduction of both their own care and support, and wider provision, in the development of this Plan.

In **LBR**, children with Special Educational Needs Support or an Education, Health and Care Plan are encouraged to share their views about their needs, outcomes and future aspirations; and they participate in the process to determine needs and shape the provision and support they receive. There is the Supporting those with Aspergers or Autism in Redbridge (STAAR) group for parents of children with an Autistic Spectrum Disorder, and a Social, Emotional and Mental Health (SEMH) group for parents of schoolchildren with social and emotional difficulties. The CCG Engagement Officer routinely meets with these groups and engages the families, including children and young people, with particular areas of service development. These groups are engaged with the Child and

Adolescent Mental Health Service (CAMHS) Transformation work; and will co-produce with professionals the workstream for extra and early help focussing on behaviour support pathways; and will contribute to the development and implementation of this plan.

LBH has successfully involved people in the coproduction of their own care, discharging them into accommodation with services that are bespoke in meeting their care and support needs. At Care and Treatment Reviews the Community Learning Disability Team (CLDT) ensures that inpatients are active participants in planning for their future accommodation and support needs in community settings. LBH has recent experience of successfully engaging those with lived experience, and co-designing new specialist housing provision for people with complex learning disabilities and mental health issues. For instance with those admitted or at risk of admission into hospital settings and in the opening of Great Charter Close – 6 independent living flats with onsite 24 hour support – last year. Service users, including future residents and one person discharged into the new provision from an inpatient setting after 8 years in an ATU, were actively involved in the commissioning process. A workshop organised by the health sub-group of the LDPB in March 2015 included people who had lived in ATUs, and families and carers. They were able to tell us what worked and didn't work including support on moving back into the community or in times of crisis. We also worked with user groups that support and inform the delivery of services from two key providers of services in Havering.

B&D engage an active group of Carers and Experts by Experience on initiatives including e.g. working with Community safety to develop the Safe Place Scheme across the borough for vulnerable people. Commissioners have engaged with stakeholders on the development of the Challenging Behaviour Strategy, the implementation of the Winterbourne View Concordat, the Adult Autism Strategy and the development of collaborative commissioning arrangements between the CCG and the Council. Service users and carers were also involved in the evaluation process of the borough's Supported Living tender in late 2014, leading a 'speed dating' event in which they formulated and asked 'quick-fire' questions to prospective bidders. This formed part of the quality score for the tender.

To inform the development of our CAMHS Plans we have already met across the boroughs with a wide variety of user/carer and community-based groups. These include Youth Councils, Young Cabinet and Children In Care Council, parent / carer forums, learning disability and Autism support groups, CCG Patient Engagement Forums, provider/patient participation groups and other groups such as Ab Phab youth club, STAAR, True Colours and Fun4all. We've set-up thematic engagement groups, and are currently planning on how we will engage with harder to reach groups (including those with learning and communication difficulties). Other work has also commenced to engage with children and young people as part of a meaningful and ongoing dialogue on the theme of mental health. We will further develop these mechanisms including incorporating feedback from engagement on our local Children's Autism Strategies; and learning from the Education, Health and Care planning process which includes meetings with children, young people and families. Also the 'Participation and Outcomes Group' which includes children and young people with learning disabilities, Autism and mental health problems, will report back to the Children's Services Lead TCP Board Member once appointed. We will accelerate this work in Year 1 to ensure that young people are able to shape this plan from the very start; and work with us to ensure it transforms services, and transforms their experience of services and the quality and nature of support that is available.

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

by your Transforming Care Partnership

2.Understanding the status quo

Provide detail of the population / demographics

Total population aged 18-64 predicted to have autistic spectrum disorders

	2014	2015	2020	2025	2030
REDBRIDGE	1834	1866	2006	2135	2258
B&D	1177	1205	1318	1418	1511
HAVERING	1433	1443	1494	1540	1599
TOTAL	**4444**	**4514**	**4818**	**5093**	**5368**

People aged 18-64 predicted to have a learning disability

	2014	2015	2020	2025	2030
Redbridge	4518	4607	4970	5280	5577
Barking and Dagenham	2955	3013	3296	3546	3774
Havering	3553	3587	3721	3846	3999
Total	**11026**	**11207**	**11987**	**12672**	**13350**

People aged 18-64 with a learning disability, predicted to display challenging behaviour, projected to 2030

	2015	2030
Redbridge	85	102
Barking and Dagenham	55	69
Havering	66	74
Total	**206**	**245**

Source: Projecting Adult Needs and Service Information (PANSI), February 2016.

There are, according to PANSI, 11,207 adults with learning disabilities in Barking and Dagenham, Havering and Redridge. This is projected to increase to 13,350 by 2030. There are 206 people aged between 18 and 64 with a learning disability and challenging behaviour. This is projected to increase to 245. There are 4514 recorded on the autistic spectrum, and this is projected to increase to 5368 over the same period.

Children with Disabilities Teams across BHR have identified approximately 150 young people currently in the TCP cohort who are likely to need adult social care support. This number shows increases year on year: from 28 in 2013/14 to nearly 50 per borough in 2016/17.

	B & D	Havering	Redbridge	Total BHR

0-4	19,661	15,563	22,863	58,087
5-9	17,984	14,812	21,099	53,895
10-14	13,352	13,735	18,912	45,999
15-19	12,971	15,045	18,164	46,180
Total 0-19	63,968	59,155	81,038	204,161
Total with SEN Statement/EHC Plan	1096		1347	
Prevalence				
Autism (prevalence 1% 0-19)	694	591	810	2,095
Moderate Learning Difficulties (2% prevalence)	2,097	1,182	1,620	4,899
Severe Learning Difficulties (0.4% prevalence)	312	236	324	872
Profound and Multiple Learning Difficulties (0.1%)	51	59	81	191
Specific Learning Difficulty	223	591	810	1,624
Local Authority SEND Database				
Number CYP with Autism (incl Aspergers)			171	
Number of children in Special Schools		261	493	
CAMHS				
Number with Autism known to CAMHS		169	79	
Child Disability Team Data				
Total population 16+ known to CLDT	812	810	740	

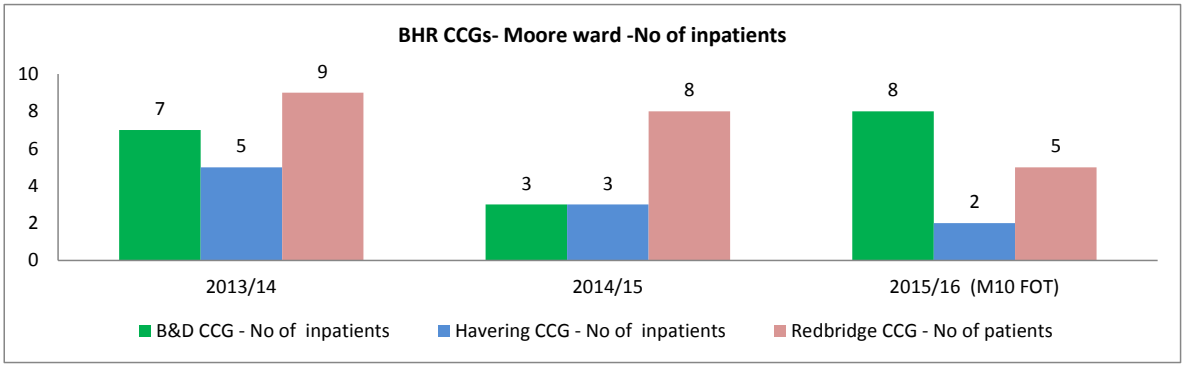
The data for children and young people (above) need to be considered with a little caution as the variation in projected numbers may reflect better recording in some boroughs than others. This is something we will address as part of the Right Care Programme Data and Information workstream. The data held locally on children in this cohort and the wider population is in some places incomplete and in others contradictory. For instance, the SEND databases record only the primary special educational need in most cases and not co-morbidities. Local SEND data indicates numbers of children with particular needs as significantly lower than national prevalence rates. We expect that the majority of the young people in the TCP cohorts will be known to existing services and receiving support.

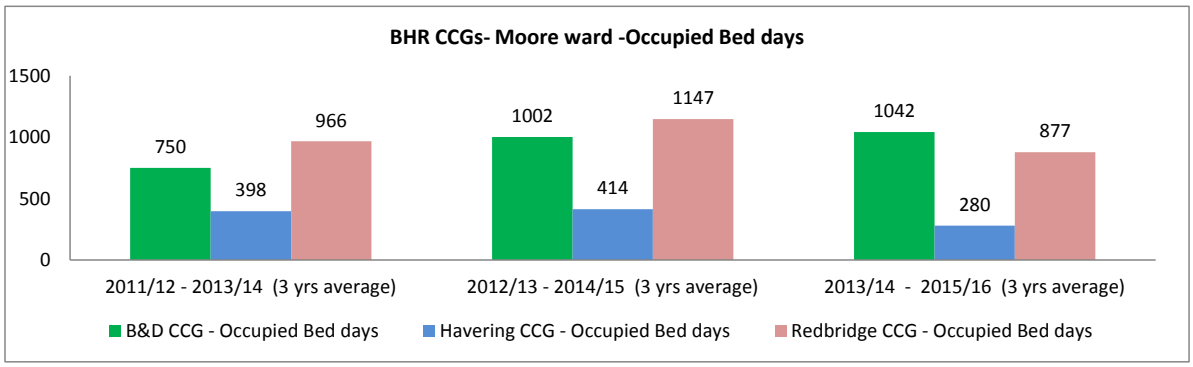
Across the BHR area there are 204,161 0-19 year olds – a small minority of whom will come into contact with Local Authorities as part of their SEND work, with their Children with Disabilities Teams, Transition Teams, Youth Offending Teams or alternatively with Community Health or Mental Health Services. Those young people with SEND but without social care input, and care leavers or those being supported by Youth Offending Teams are not necessarily picked up for transition planning. Others in this cohort may not be known to services at all. This presents a challenge for how we work across the Partnership and with schools to identify those at risk and to support them at the earliest opportunity. Some we do not know because they don't meet the eligibility criteria for adult services and may, consequently, be at greater risk of admission or contact with the Criminal Justice System.

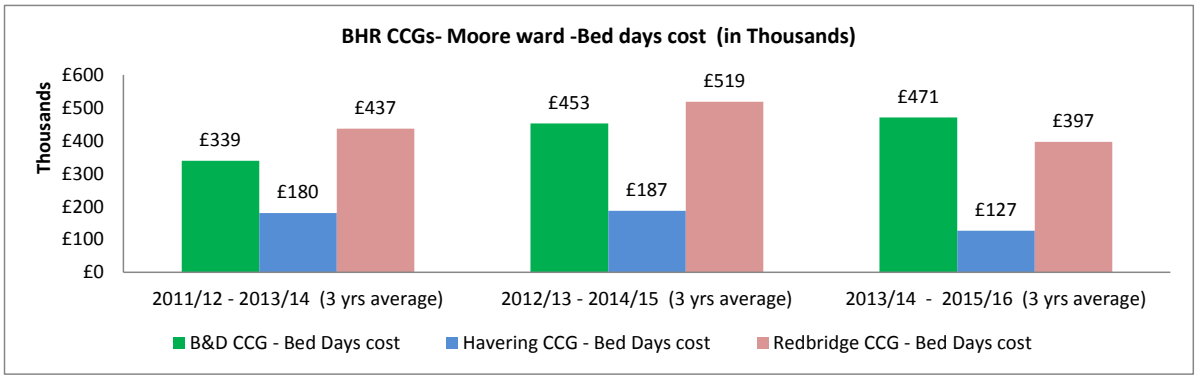
Across the agencies working with children, cohorts differ, reporting protocols are not aligned and data is collected in different ways. The population and demographic details we have collated from our partners indicates the need for better data recording and definitions, particularly for children and young people.

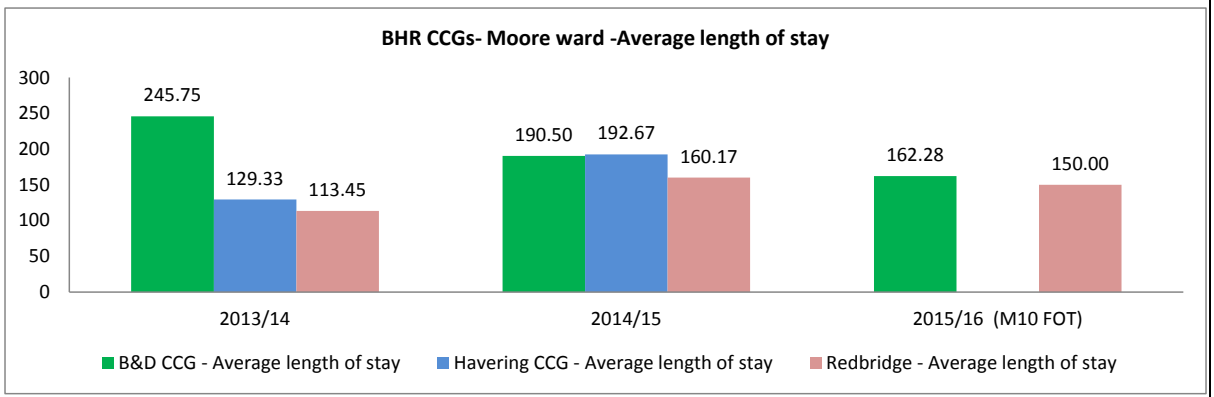
Analysis of inpatient usage by people from Transforming Care Partnership

The trend in recent years has been towards a reduction in the number of inpatients at our principal ATU in Goodmayes Hospital.


BHR CCGs- Moore ward -No of inpatients
10
8
6
4
2
0
7
5
9
3
3
8
8
2
5
2013/14
2014/15
2015/16 (M10 FOT)
B&D CCG - No of inpatients
Havering CCG - No of inpatients
Redbridge CCG - No of patients


BHR CCGs- Moore ward -Occupied Bed days
1500
1000
500
0
750
398
966
1002
414
1147
1042
280
877
2011/12 - 2013/14 (3 yrs average)
2012/13 - 2014/15 (3 yrs average)
2013/14 - 2015/16 (3 yrs average)
B&D CCG - Occupied Bed days
Havering CCG - Occupied Bed days
Redbridge CCG - Occupied Bed days


BHR CCGs- Moore ward -Bed days cost (in Thousands)
Thousands
£600
£500
£400
£300
£200
£100
£0
£339
£180
£437
£453
£187
£519
£471
£127
£397
2011/12 - 2013/14 (3 yrs average)
2012/13 - 2014/15 (3 yrs average)
2013/14 - 2015/16 (3 yrs average)
B&D CCG - Bed Days cost
Havering CCG - Bed Days cost
Redbridge CCG - Bed Days cost


BHR CCGs- Moore ward -Average length of stay
300
250
200
150
100
50
0
245.75
129.33
113.45
190.50
192.67
160.17
162.28
150.00
2013/14
2014/15
2015/16 (M10 FOT)
B&D CCG - Average length of stay
Havering CCG - Average length of stay
Redbridge - Average length of stay

There are 17 inpatients across BHR. This figure consists of 8 at Goodmayes Hospital, 7 of which are in Moore Ward and 1 in Picasso Ward. The remaining 9 patients are currently being treated out-of-borough. We are treating one further inpatient at Moore Ward on behalf of Barnet CCG.

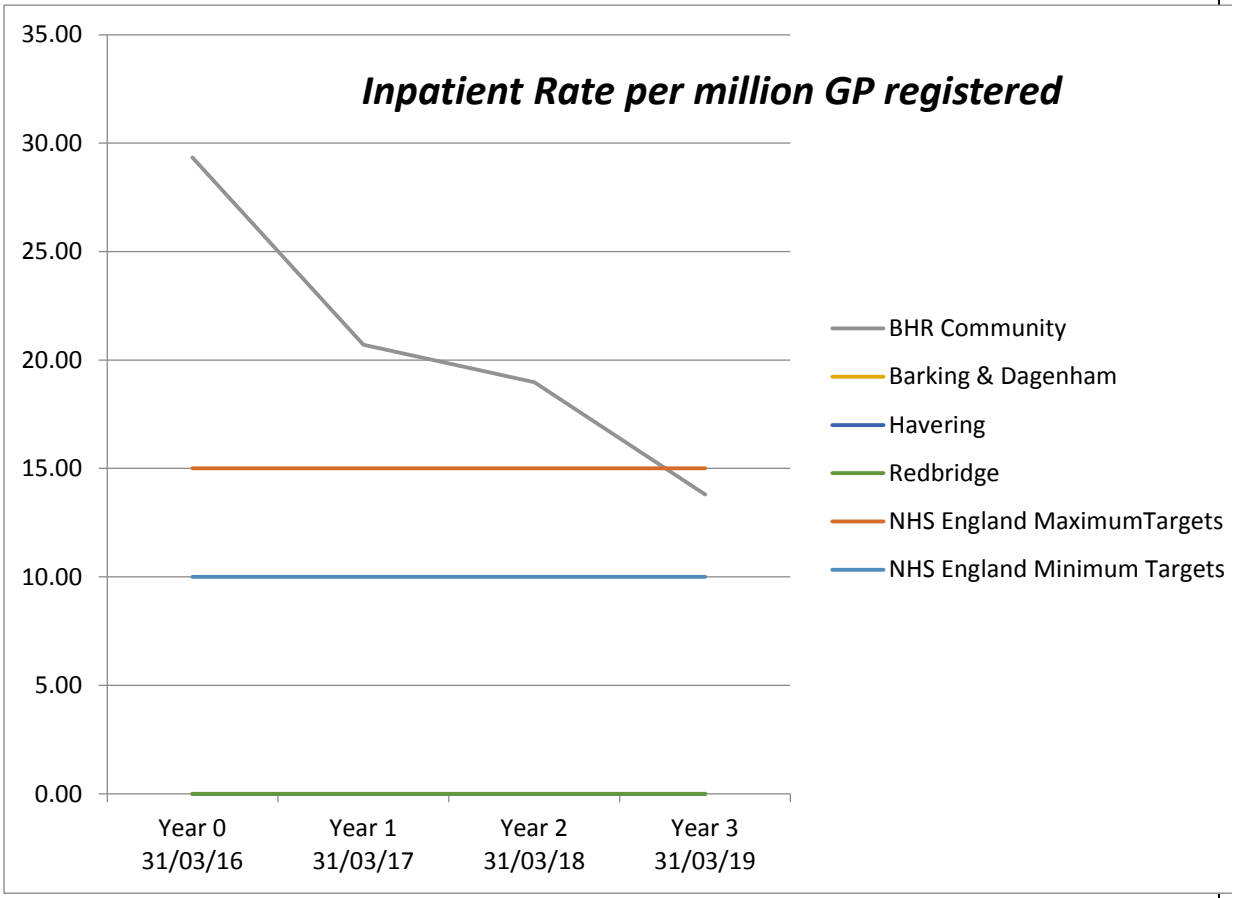
	Barking and Dagenham	Havering	Redbridge	Total
Total inpatients by borough	**8**	**6**	**3**	**17**
Inpatients in Moore Ward – Discharge Dates (DD) below	4	2	1	7
Inpatients in Picasso ward (DD May 2016)		1		1
Inpatients in Maidstone (DD June 2016)	1			1
Inpatients in Glencare, Bexhill B&D (DD September 2016) LBH (DD July 2016 and 'early' 2017)	1	2		3
Inpatients in Bedford (DD December 2016)	1			1
Inpatients in Cygnet House, Beckton (DD July 2016)			1	1
Inpatients in Jeesal , Norfolk (DD November 2016) Inpatients in Colchester (DD June 16) Cygnet Lewisham (DD December 2016)	1	1	1	1 1 1

The discharge dates for the 7 inpatients in Moore ward are:

B&D		**Havering**		**Redbridge**	
Patient 1	30/06/16	Patient 1	May 2016	Patient 1	30/04/16
Patient 2	30/06/16	Patient 2	October 2016		
Patient 3	30/09/16				
Patient 4	30/09/16				

A planned reduction of 50% for our CCG-commissioned patients over the next 3 years will bring our

current inpatient number down from 17 to 8.



This will bring us from our current figure of 29 inpatients per million (based on a BHR population of 579k) to a figure of 14 per million which would be by more than half; and inside the NHSE guidelines of 10-15 inpatients per million. The current number of 9 patients commissioned by NHS England across BHR represent a figure of 16 inpatients per million of population (well within the current guidelines of 20-25 per million of population). This is projected to reduce further to 10 per million of population. The number of inpatients, both CCG and NHSE-commissioned, is projected to fall from 45 to 24 per million of population.

As of 1 April 2016, 15 of the CCG-commissioned inpatients had a length of stay of less than 5 years; with 2 more than 5 years. Of the former, 7 were placed in Moore Ward and 1 in Picasso Ward (a mental health ward); 3 were placed out-of-borough by Barking & Dagenham, 2 by Havering and 2 by Redbridge; the latter were placed out-of-borough by Barking & Dagenham and Havering.

We are aware that due to their length of stay some of these patients have developed connections to these areas and have expressed a wish to be discharged there. Admissions into the local Assessment and Treatment Unit have resulted in discharge placements mostly within the community or close to the location of relatives. One current inpatient at Moore ward is being treated on behalf of Barnet CCG.

CCG Length of stay	0-1 years in placement	1-5 years in placement	5-10 years in placement	Over 10 years in placement	Total OOB placements
B&D CCG OOB	1	2		1	4
Havering CCG OOB	2		1		3
Redbridge CCG OOB	2				2
B&D CCG NELFT in BOROUGH	4				
Havering CCG NELFT in Borough	3				
Redbridge CCG NELF in Borough	1				
Totals	13	2	1	1	

All the Assessment and Treatment units we commission include a Multi-Disciplinary Team (MDT) of health professionals. The MDT is overseen by a Responsible Clinician. All patients receive 6 monthly Care Plan Approach meetings (CPA) and Mental Health Tribunal hearings (usually annually). On being recommended for discharge patients are supported with a discharge plan. Issues relating to funding, provider identification, and the current and future responsible authorities, are covered to ensure the discharge plan is successful. For all people who require inpatient care, both the Community Teams for People with Learning Disabilities and Mental Health Services remain involved in the patients care whilst in a bed, and work with the inpatient clinical teams around discharge planning from the point of admission.

CLDTs and Mental Health services across BHR use inpatient settings as a last resort, and have protocols in place to ensure all community based interventions have been exhausted before an inpatient setting is considered. Out of area placements are also avoided where possible. If an out of area placement/inpatient stay is considered necessary this is only where the move is clinically justified and all other options have been exhausted.

As part of the aspiration to keep people cared for in their own home or as close to home as possible it is necessary to avert crises and support partner services to deliver this aim. Havering Community Learning Disability Team (CLDT) has a local protocol in place that no placement should take place out of area. This is something that we would like to roll out across BHR. The CLDT works proactively to avoid crises occurring by planning effectively and ensuring that robust contingency arrangements are put in place. The CLDT refer to this admission avoidance arrangement as the 'blue light' protocol. All 3 boroughs undertake regular CTR analysis of service users in inpatient settings as well as community or blue light CTRs for people believed to be at risk.

The **Havering** CLDT local protocol describes when this "Blue Light" response is needed. The protocol is referred to and determines the preference of support arrangements:

- 1st preference - Support the person at home with the relevant help taking place there. Additional support packages will be considered favourably by commissioners.
- 2nd preference - the person is supported in a local non inpatient unit, using residential

nursing, or short breaks services.

- 3rd preference - a local inpatient service in the Goodmayes area

In Mental Health Services, again, referral to a specialist inpatient setting is considered as a last resort. An individual is supported to remain in the community with a range of services, including being supported by care coordination, home treatment team, inpatient stay in one of the specialist NELFT inpatient beds and so on. Where this is exhausted, there are two avenues for referral into an inpatient setting outside of the :

- Tertiary referral process, where the case is referred for agreement of funding from the CCG or NHS specialist commissioning. Referral via this pathway will usually be for people who require an initial period of assessment to support diagnosis and treatment.
- Individual Service Agreement (ISA) process, where a referral is triggered for people who may need a period of ongoing treatment and where this cannot be managed in the community. The ISA process is a risk share agreement between NELFT and the 4 CCG's where funding for specialist treatment has been passported to NELFT to manage.

In Havering, patients who are currently in ATU / inpatient settings are monitored monthly by the CLDT and CCG, with all current inpatients having an allocated case manager (social worker) who proactively works with the inpatient clinical team around discharge planning, including attending 6 monthly Community Treatment Reviews, working with commissioning and housing around ensuring appropriate community provision is sourced as part of the discharge planning process. Patients are reviewed monthly by the CLTD worker and as above are visited at least 6 monthly (including attending CTR's and/or CPA meetings) or more often as required particularly when the patient is nearing discharge.

The challenge is to develop discharge plans with patients with severe and enduring needs that require a high level of support, and with the relatives and providers, over the long term in the community rather than as inpatients. There are lessons the boroughs and CCGs can learn from each other. For B&D, this year's usage is higher than last year, but not as high as the year before. Havering's use is very much lower. But the overall BHR profile shows a distinct downward trend since 2012-2013. B&D inpatients amount to about half the BHR total. However, Redbridge has a consistently lower intake of inpatients – despite having a larger population – and Havering have a shorter average inpatient length of stay than their neighbouring areas. So we will be working together to see exactly why these differences exist and share best practice we find across BHR.

Beyond these figures, it should be acknowledged that we are now working with inpatients with much more complex needs and we expect this to continue. We are constantly reviewing our provision at MooreWard accordingly, and are currently discussing how we can develop our relationship to support alternatives to inpatient admissions too (see briefing in Appendix 3). We anticipate an increase in forensic bed needs. Currently, there are 9 patients in these NHSE-commissioned beds - 1 from B&D, 2 from LBH and 6 from LBR; 3 of them occupying medium secure beds, 4 in low secure beds and 2 in CAMHS beds.

Also, whilst there are only a small number of in-patient beds for children and young people locally (at the Brookside Unit), a number of those of school age are likely to reflect the TCP cohort. LBH place 169 young people, and Barking and Dagenham, 63 young people in OOB residential

educational units to support their complex social, emotional and behavioural, and mental health difficulties. This is another reason for ensuring we develop good quality alternative all-age provision.

Describe the current system

Across BHR, we have developed registers of all people with a learning disability or autism. We are currently aligning our approach to reviews of placements. We are ensuring that, across the BHR area, they are carried out every six months through a comprehensive Care and Treatment Review (CTR) following the national guidance. It is likely that practice will differ but this should ensure that a range of stakeholders are involved: including individuals, their carers and families, commissioners, specialist clinical experts, experts by experience, and advocates. Each CTR assesses the quality of care and treatment an individual is receiving, their level of progress and outcomes and options for providing support within the community. CTRs enable us to ensure that the right patient care is being provided at the right time, based on an individual response. We conduct community CTRs (pre-admission), urgent blue light CTRs (where a patient is in "crisis" and there is not time to pull together the community CTR) and inpatient CTRs.

Two years ago, in response to the Mencap's *Death by Indifference* report and *Six Lives*, BHRUT and Barts Health created a specific Learning Disability Liaison Nurse role for adults – a senior post aimed at working with the hospital staff, raising awareness and ensuring that reasonable adjustments are made for people who are inpatients or visiting the hospital. The role provides an essential link between the hospital and the community learning disability team staff, to ensure that discharges are planned properly, that hospital passports are being used and health inequalities are addressed. It has proven to be extremely successful and BHRUT have also appointed a paediatric Learning Disability Liaison nurse. BHRUT are committed to improving the inpatient experience for people with learning disabilities and have also signed up to the Mencap Getting it Right Charter.

NELFT runs a number of clinical groups as part of its own governance structures. For instance, Challenging Behaviour Pathway Group: All heads of learning disability clinical disciplines meet monthly to ensure Positive Behaviour Support (PBS) approaches are used in relevant settings. NELFT-led Learning Disability Task Group: Senior clinical leads and CLDT Managers meet monthly at strategic group which feeds into NELFT Community Practice Board.

Children and young people who are covered by this TCP plan are managed by the Children and Adults Disabilities Team (CAD). This consists of social workers (key workers), education advisors, educational psychologists, commissioners and brokerage. There are a range of partners working with children and young people who make up the TCP cohorts. Some children will be known to multiple services. Others will not, and others may not be known to services at all. Some, with mental health needs, may be managed by local Tier 2 or 3 mental health services. Many of those within the TCP cohort are also likely to have a special educational need. They may receive SEN support in schools or have an Education, Health and Care (EHC) Plan. A number of children with learning disabilities and/or autism who display particularly Challenging Behaviour can be placed in OOB residential educational placements. Children known to children with disabilities social work teams will be offered care and support packages to meet their needs; and will be referred to the Adults Transition Team as they prepare for adulthood. This process starts from at least age 14 to provide an alert to adult services and planning and preparing for adulthood. The partners, across BHR, are also part of the North East London Liaison and Diversion pilot, designed to reduce the risk of offending.

Across BHR OOB placements are only agreed where there is no alternative or where someone wishes to live elsewhere. This recognises that keeping people closer to their families and social networks is critical to their wellbeing and the sustainability of placements. An OOB placement may be required in certain circumstances, including service user choice, or where there are clinical or legal reasons for a placement out-of-borough.

While there are differences across BHR, in **LBH**, the cohorts of adult patients covered by this TCP plan are looked after primarily by the CLDT with a small number known to Mental Health Services. The decision as to which service is best placed to work with this cohort of patients is based on primary presentation. In terms of the five needs groupings in the Transforming Care cohort. The two primary areas of need for LBH, are

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 with personality disorders, which may result in them displaying behaviour that challenges.

and

Children, young people or adults with a learning disability and/or autism who display risky behaviours which may put themselves or others at risk and which could lead to contact with the criminal justice system (this could include things like fire-setting, abusive or aggressive or sexually inappropriate behaviour).

For the cohort of individuals who are not currently in an inpatient setting, services commissioned include a mixture of residential care (currently six placements) and supported living placements (also currently six), with one individual living with their family and in receipt of a direct payment. Services are commissioned as a mixture of block and spot purchase care.

LBH's Community Learning Disabilities Team is multidisciplinary, consisting of social workers, nurses, SALT, psychiatrists and psychologists. It also includes a Challenging Behaviour specialist. The CLDT commissions:

- Local Authority or joint funded residential and nursing placements for around 146 people (78 in borough and 68 out-of-borough). In the Borough we utilise approximately 20 providers for residential and nursing care.
- Local Authority or joint funded supported living placements for around a further 94 people (75 in borough and 19 out of borough). In the borough we commission from approximately 15 providers.

Mental Health services, run by NELFT and with social care seconded into the service, are similarly multidisciplinary. They commission:

- Local Authority or jointly funded residential and nursing placements for around 40 people both in and out-of-borough.
- Local Authority or joint funded supported living placements for a small number of people both in and out-of-borough.

Havering Mental Health Services operate in-house Group Homes: catering for a number of residents with a step-down model to transition them from high levels of support (residential care or supported

living) to independent living. People who are diagnosed with autism and meet eligibility criteria are supported primarily through the learning disability service, with some in our mental health service. Other services include the Autism Hub, which offers information, advice and signposting, as well as other tailored support to individuals, families and other organisations, to raise awareness of the services available.

The borough has four block respite beds for people with learning disabilities. These are provided by Outlook at Neave Crescent. If it requires anything over and above this it has to spot purchase it. It has no nursing respite and spot purchases where necessary. There is a lack of housing availability and a need for providers to enhance their offer on Positive Behaviour Support (PBS). However, housing services are very engaged in supporting the development of appropriate accommodation options for people with care and support needs, and is able to provide access to social housing properties when required. There are 57 people living in their own home (generally with a family member) and receiving a care and support service; and a cohort of 68 regularly accessing planned and unplanned respite services (usually in a residential setting). The borough has more supported living provision than is needed for its own residents and as such is a net importer of people who need care services. The excess provision tends to be supporting living that caters for lower level need, with insufficient provision available for people who have high or complex needs – such as people with a learning disability who also have mental health issues and/or complex physical disabilities. LBH operates a day opportunities resources directly (Avelon Resource Centre) and commissions a number of places from small private and voluntary sector providers. Approximately 121 people with a learning disability attend a day opportunities centre – of which 95 are registered to attend the Council's in-house service for anything between 1-5 days.

LBH seeks to meet the needs of pupils with special needs in their local mainstream schools. For children whose needs cannot be met in their local school there are eight schools who are specially resourced to meet particular needs. As well as local provision, Havering commissions specialist education provision out of borough: 169 pupils across 95 providers in maintained and non-maintained provision, pre- and post-16. For children with mental health issues, Havering CAMHS service is provided by North East London Foundation NHS Trust.

In LBR the CLDT is multidisciplinary, consisting of social workers, nurses, SALT, psychiatrists and psychologists. Respite provision includes residential. There are two accommodation options with a total of 15 bed spaces, 9 of which can provide nursing care. The borough has developed an at risk register which covers all people from age 14. The list is RAG rated. All priority cases have a community CTR carried out. While there are differences across BHR, the following tiered approach adopted in this Borough is typical:

Tier 1 services are focused on the health of the whole of our population with learning disabilities. This includes adequate housing provision, transport and leisure facilities, education, and employment and volunteering schemes for people with a learning disability and/or autism (e.g. Ellingham, Jackson's Lane and Cherry Tree café).

Tier 2 is about making sure people with learning disabilities have regular checks in mainstream health services, and advice and support on lifestyle decisions. For instance, Redbridge is introducing GP hubs aligned with expertise in learning disability and mental health, so as to ensure patients receive the right care at the right time.

Tier 3 consists of specialist ongoing support from the community teams for people with learning disabilities or autism and a moderate degree of mental ill-health. These symptoms could manifest themselves as anxiety, depression or psychotic traits about which individuals would be referred to one of a number of community healthcare providers.

Tier 4 addresses the needs of individuals who pose a severe risk to themselves and the wider community, with chronic treatment resistant mental illness which often results in challenging and offending behaviour. Inpatient services are often required with a 24/7 assessment and treatment package to enable them to make a safe return into a community-based treatment programme. Services include assessments and treatment using a combination of behaviour support services, forensic teams and a combination of crisis and home treatment teams.

B&D has a combination of established providers alongside a number of small and new providers covering a range of activities. The Council provides **supported living** to 64 people with learning disabilities via a block contract. The contract was retendered in 2014. The Council is currently working with the provider to roll out a new personalised model, which incorporates core support but with the majority of services paid for with PBs. The Council contracts over 12 supported living places from external providers. The Council and CCG commission a number of **care and nursing home beds** from the private and voluntary sector. New placements are rare. The Council also directly provides a home for 12 people with moderately challenging needs at 80 Gascoigne Road. Health-related care (or Continuing Healthcare) and support is being provided to people with learning disabilities in a range of settings that are community-based and allow for maximum independence. In 2015 **day services** were modernised following a consultation with, and the involvement of, people with learning disabilities. Fifty services users were moved from centre-based provision onto Personal Budgets and services for 60 people with Autism and other complex needs were consolidated at the Heathlands Day Centre. The CCG commissions a local **Enhanced Optometry** Service for people with a learning disability. This forms part of the Bridge to Vision Service ensuring support by specially trained clinicians to access extended appointments. This is regarded by See Ability as being one of the most successful services of its kind in the country. Commissioners from Children, Adult and Carers services meet to ensure the commissioning intentions are aligned, at the Special Education Needs and Disability (SEND) Board. For instance, the recent re-tendering of the Carers Support Hub and the Advocacy service. The relationship between the commissioners ensures service specifications are designed to meet future need. The contract monitoring process includes engagement with families on the quality of the service and comments for improvements. This is fed back to the provider to implement. The borough has limited housing stock available to meet the needs of those of vulnerable adults; but a growing population of small providers offering shared accommodation of 3-4 bedrooms.

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

We have a BHR CCGs (Draft) Estates Plan, but more work is being undertaken to identify and understand the BHR Estate for this cohort as a whole across the health, social care, housing and education sectors, and across and out-of-boroughs, however funded.

An Assessment and Treatment Unit is situated in Moore Ward at Goodmayes Hospital in LBR. We (and Waltham Forest) have access to 12 beds, provided by NELFT, as part of the contract with BHR

CCGs, with beds allocated using a three-year rolling average. We have additional facilities such as Picasso Ward (principally a mental health ward, also at Goodmayes Hospital) with care beds for up to 10 male patients and 5 female patients. We are in discussion with NELFT regarding our use of Moore Ward across BHR; with a view to reducing inpatient usage, aligning practice and process, and building a new care model. There is also Brookside Child and Adolescent Inpatient Unit with 18 in-patient beds covering the Barking, Havering, Redbridge and Waltham Forest area – 14 beds in Reeds Ward with and 4 high dependency beds in Willow Ward.

Patients are supported after discharge (e.g. from Moore Ward or Brookside Inpatient Unit) in a variety of settings including living at home, supported living, residential homes and 'Shared Lives':

- Our residential providers are Airthrie Homes, Alpam, Ashbrook Nursing Home, Care Link, Care Tech, Care UK, Clearwater Care, CMG, Fari Care, 80 Gascoigne Road, Leyton Lodge, MCCH, Mencap, Norwood, Outward, Russell Lodge, Saffron Care Homes, Sahara House, Tealk Services, Tomswood Lodge, Venus Healthcare, Vibrance and Voyage Care.

- Our providers of Supported Living are Access Living, Care Tech, Cogni Care, Divine Lodge, East Living, Footsteps, King's Lodge, Look Ahead Care and Support, Mencap, Norwood, Outlook, Outward, PICAS, Spencer and Arlington and Three Cs.

Residential and special schools also form an important part of the support we offer our children and young people. There are 10 Special Schools across the three Boroughs: 4 in LBR (Newbridge, Hatton, Roding, Little Heath) 3 in LBH (Ravensbourne, Corbets Tey, Dycorts) and 3 in B&D (Trinity, Hopewell, Riverside Bridge). There are also a number of mainstream schools with a special educational needs specialism.

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

The case for change is very clear across BHR. We believe that the majority of people with learning disabilities and/or autism are not best treated in an inpatient setting. A number of admissions, including individuals placed OOB (including children placed in residential schools), could have been prevented had there been an appropriate community-based or respite provision, with trained staff and quick access to community clinical support.

We need to ensure that no person is admitted to any inpatient facility unless a CTR finds this to be clinically necessary, and to be the only course of treatment that meets the person's current needs. We also need to ensure that no one remains in an inpatient facility any longer than necessary, through continual monitoring, CTRs, and putting in place community provision that can meet their needs at the point of discharge. Close assessment of current inpatients and enhanced community programmes will allow for as early as possible discharges.

We need to strengthen community assessment by better identifying at risk individuals, closely monitoring them with community of, if necessary, 'blue light' CTRs. In this way we can pick up on any crisis moments in their lives at the very earliest opportunity, before their situation escalates further and they need admittance to an inpatient facility. By identifying potentially at risk individuals, and enhancing our community clinical and social care programmes, we can reduce the number of admissions in the first place.

We believe that more can be done to ensure individuals are at the centre of their own packages of care and support and those systems and processes need to be made more person-centred. Enhanced community provision, and complex needs schooling provision, needs to take into account the different demands and complexity of needs for different individuals. It also needs to be tailored to the needs of children, young people and adults, including the transition from one to the other.

The current approach to supporting children and young people is embedded across a number of services e.g. social care, education and health with different routes in to support. There has been limited focus on these children as a single cohort. They are supported on an individual basis but without a strategic plan for how we manage risk for them as a group overall. The TCP provides an opportunity for joining up commissioning, decision-making and care (e.g. across the SEND team, social care and health) and provide a more integrated and seamless care package.

We need to ensure that people with learning disabilities or autism have the same rights that any other resident of our boroughs enjoys. We need to build the right community-based services to support them to lead active lives in the community and to reduce the current inpatient provision. To do this we need to implement plans that give people more choice and control over their own care. An important part of this is the expansion of PBs, PHBs and integrated budgets.

Please complete the 2015/16 (current state) section of the 'Finance and Activity' tab of the Transforming Care Activity and Finance Template (document 5 in the delivery pack)

Any additional information

	Barking and Dagenham	Havering	Redbridge	BHR Total
NELFT cost of Moore Ward by CCG	£623,192	£267,082	£445,137	£1,335,411
Cost of all OOB inpatients by CCG	£611,375	£256,692	£337,622	£1,205,689
Total cost of inpatient care by CCG Y/E 30/03/16	£1,234,567	£523,774	£782,759	£2,541,100

Havering has the lowest cost of inpatients at Moore Ward and Out of Borough, perhaps due to the high investment in resources (~£901/-) to support LD Patients in the community.

Table: Tier 4 activity and costs (NHS England)

CCG Name	Cost 2014/15	Activity 2014/15
NHS Havering CCG	990,738	1,884
NHS Barking and Dagenham CCG	1,185,520	1,979
NHS Redbridge CCG	897,750	1,413

3.Develop your vision for the future

Describe your aspirations for 2018/19.

While there is not likely to be a reduction in ATU capacity in the short term, we plan to reduce the number of admissions and average length of each stay by enhancing current ATU procedures and improving our community provisions. We are planning, for instance, to more than halve CCG-commissioned inpatient bed usage by 2018/19 (see above).

No person should be newly admitted to an OOB inpatient facility unless it is not possible for them to be treated in Moore Ward, our ATU in Goodmayes Hospital. Circumstances have arisen in the past where two patients cannot be treated in the same facility at the same time due to a personality clash and risk of violence. However, only in such exceptional circumstances or where it is clinically necessary will we in future use an OOB inpatient facility.

It is important that the community provision is robust, substantial and adequate and there are other alternatives for people with learning disabilities and/or autism to be fully supported in the community. We are determined that no patient will be admitted to an inpatient facility due to a lack of the community provision needed to treat them at the point of need.

Where appropriate we will always treat people in a community setting as opposed to an inpatient facility and will make sure that the community provision available always matches the needs of the person however complex their demands may be.

We aspire for children, young people and adults with a learning disability and/or autism, and their families, to be able to say:

- I have choice and control
- I manage my health with the level and quality of support I need
- I am part of a community
- I have a home I can call my own
- I direct my care

We will achieve this aspiration by developing pathways and services with them that:

- Are community-based where possible, with a reduced reliance on inpatient facilities
- Have staff with the right skills and experiences to manage complex needs
- Provide respite for families and carers to maintain at home placements
- Accommodate people with a learning disability and/or autism locally wherever possible

These services and pathways will help us to achieve:

- Timely access to assessment and treatment for learning disabilities and/or autism
- Reduced numbers of admissions to hospital settings (both secure and non-secure) and shorter stays if admitted
- Improved health and educational outcomes
- Improved quality of life

In BHR our aspirations are aligned with the NHSE vision of empowering children, young people and

adults with learning disabilities and / or autism. This means enabling them to lead active lives in the community and to live in their own homes as opposed to being treated as inpatients. In addition to reducing their and our dependence on the ATUs, we are actively seeking to improve the quality of care we offer. We will give genuine choices to individuals, and their carers and families, so they have both an improved quality of care and, in turn, can enjoy a better life.

How will improvement against each of these domains be measured?

We are reviewing our data infrastructure and reporting protocols across BHR. This will ensure that the Transforming Care Partnership Programme has a standardised register of every patient at risk, a risk stratification process for identifying those most at risk of inappropriate admissions; a step-down from the specialist commissioning pathway, a standardised CTR process across the area; a reporting mechanism to HSCIC, and establishment of KPIs for the NHS England Standard Contract and quality measures. Existing tracking systems will continue for inpatient use e.g. HSCIC portal, fortnightly returns and monthly tracking meetings.

The Insight Programme and Quality Assurance workstream has begun to identify Key Performance Indicators to ensure a measurable improvement in life chances for this cohort. KPIs will be fully developed during May 2016, but initial measures are:

- An increased number of individuals in employment
- An increased number of individuals maintaining their tenancies
- An increased number of individuals accessing educational opportunities
- Increased confidence in patients leading their own life measured by pre and post questionnaires, and the number of patients accessing leisure activities
- An increased number of patients enjoying high standards of physical health and making informed choices concerning their lifestyle.
- A reduction in the number of hospital admissions for health related issues and a reduction in the number of patients admitted via emergency services.
- An increase in the number of timely and effective interventions due to improved quality of CRT and care plans. This would be measured by audit processes.

We will also monitor **reduced reliance on inpatient services** with measures including:

- Number of CTRs (including inpatient, pre-/post-admission and blue light) undertaken
- Number of new admissions to inpatient care
- Average length of stay in inpatient care
- Number of forensic beds used and complexity of inpatients' needs
- Numbers of patients discharged from inpatient care
- Number of re-admissions
- Number of patients with a planned discharge date
- Number of patients whose discharge dates change
- Numbers of people on the at risk register
- Numbers of patients admitted to inpatient care who were not on the risk register
- Number of hospital admissions for health or emergency reasons
- Numbers of in-borough and OOB placements

We will monitor the **quality of care** experienced by this cohort. In part we will do this by adopting the basket of indicators recommended for local use by the panel of experts who conducted the Department of Health review. They looked at indicators to monitor the quality of care and progress in implementing the national service model. These are:

- Proportion of inpatient population with learning a disability or autism who have a person-centred care plan, updated in the last 12 months, and local care co-ordinator
- Proportion of people receiving social care primarily because of a learning disability who receive direct payments (fully or in part) or a personal managed budget
- Proportion of people with a learning disability or autism readmitted within a specified period of discharge from hospital
- Proportion of people with a learning disability receiving an annual health check
- Waiting times for new psychiatric referral for people with a learning disability or autism
- Proportion of looked after people with learning disability or autism for whom there is a crisis plan

Beyond this, we also want to ensure that individuals in this cohort and their carers, have received an assessment. Beyond the health and social care elements of each package we will monitor:

- Access to a range of options for housing that meet individuals' needs
- That we increase supported living options vs. residential placements
- The numbers of safeguarding issues and adverse events recorded in all settings

Across BHR we have developed sets of 'I statements'. For instance, as part of the development of the Integrated Health and Adult Social care Service (HASS) LBR has used them for a snapshot survey in a range of locations. This will be followed up to compare experience of contact with health and social care services since implementation.

We will also build a picture of people's **quality of life** and that of their carers/families:

- Social care related quality of life (via adult social care surveys)
- Individuals who have control over their daily life (via adult social care surveys)
- Individuals who reported that they have as much social contact as they would like(via adult social care surveys)
- Their participation in volunteering
- Whether they are able to use transport that meets their needs
- Whether they are able to access community facilities e.g. respite or leisure

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

We are adopting and localising the *Building the Right Support* principles:

1. People should be supported to have a good and meaningful life (see our 'aspirations')

2. Care and support should be person-centred, planned, proactive and coordinated (see our

'model of care')

3. People should have choice and control e.g. by co-producing services with people who have lived experience of inpatient stays (see our 'personalised support packages').

4. People should have support to live in the community from and for their families and carers as well as paid support and care staff (see our 'model of care').

5. People should have choice about where and with whom they live e.g. with the development of the market to ensure specialist and high quality providers are able to work in-borough (see our 'personalised support packages').

6. People should get good care and support from mainstream NHS services e.g. with a more integrated and co-ordinated approach to planning and commissioning, and better cross-organisational working (see our 'model of care').

7. People should be able to access specialist health and social care support in the community e.g. with specialist staff working in our community support teams able to manage more complex cases (see our 'model of care').

8. People should, where needed, be able to get support to stay out of trouble e.g. with early access to the right clinical support when behaviour triggers are reached and closer working relationships with other sectors such as criminal justice (see our 'model of care').

9. People should be able to access high quality assessment and treatment in a hospital, staying no long than they need to, and with discharge planned on admission e.g. with a reduced reliance on inpatient admissions and usage (see our 'model of care').

Please complete the Year 1, Year 2 and Year 3 sections of the 'Finance and Activity' tab and the 'LD Patient Projections' tab of the Transforming Care Activity and Finance Template (document 5 in the delivery pack)

4.Implementation planning

Overview of your new model of care

Across BHR we have three different health and care delivery models of services for people with learning disabilities and/or autism. However the same principles are used by all partner organisations with the overriding ambition of reducing the use of inpatient facilities including OOB ATUs. To reduce inpatient care at the Goodmayes ATU by 50% over the next 3 years, BHR and NELFT are redesigning the service specification to meet the current and future needs of people with a learning disability and/or autism. We will conduct an in-depth review of respite services, especially for those with complex needs. We will further discuss with providers how they support people with behaviours that challenge.

Our model of care will be inclusive, apply to people of all ages, and be tailored to each individual's needs and desired outcomes. We will be working closely with our stakeholders beyond health and social care e.g. public protection unit, probation, diversion service, community safety, education,

leisure and housing. Our model of care will be totally inclusive and tailored to each individual patients with PBs , PHBs and integrated budgets that gives the individual the ability to make choices regarding their own care and treatment. We will review the current advocacy and brokerage offers across BHR to support this. There will be a greater emphasis of joint funding from health and social care. We will create bespoke packages of care; and we will work with individuals, carers and families to develop 'I statements' that better reflect the outcomes they would like to see, and to ensure care planning is genuinely person centred for all ages.

For children and young people the model of care will include:

- Early identification of learning disabilities, autism, including with mental health and/or challenging behaviours
- Risk register for those at risk of admission or CJS contact (including those not in receipt of services)
- Developing mainstream community provision so that it is accessible to and supportive of this cohort with inclusive policies and practices
- The use of PBs to increase their, and their families, independence, choice and control over their care
- Identifying and supporting this cohort throughout the SEND assessment and planning process including post-16
- Reducing OOB placements in residential schools
- Joint commissioning and partnership working across health, social care and criminal justice, to build a local offer that meets the needs of the cohort in-borough

Currently transition planning and assessment for adult services tends to start just prior to a young person leaving school. We will put in place a process across health and social care to identify these young people as early as possible and start to plan their transition towards adulthood from Year 9. A young person becomes an Adult at 18 but will start the transitioning process in year 9 aged 14-15 across BHR. We will strengthen transition planning and arrangements, and support for those who do not meet adult services criteria but still may be at risk of in -patient admissions or contact with the criminal justice system. We will remodel pathways for accessing activities, including education, training and employment. We will learn from the 'Preparation for Adulthood' service developed by B&D to improve the transition pathways for children into adulthood; with greater emphasis on life skills and raising the ambitions of young people with disabilities, and building on their strengths as individuals and increasing resilience. There will be a greater focus on building the aspirations and resilience of young people starting from their mid-teens around living as independently as possible once they reach adulthood, and preparing them for life as an adult, including moving into education and work where possible, including volunteering.

By building on the successes of the current integrated partnerships agreements, the new model will look to establish:

- **An enhanced front door** with experienced Wellbeing Co-ordinators, a greater focus on early intervention and prevention through appropriate signposting and a proportionate response.
- **Cluster-based provision** to reduce the likelihood that people move around the system.
- **Integrated Multi- Disciplinary Team Approach** to reduce the number of assessments a person needs to go through.

We will not simply close acute beds on Moore Ward but do so in order to accommodate crisis beds, explore the use of expertise from this, our main ATU, to support community services; and seek to develop an outreach service that utilises the skills of the current inpatient hospital staff to work in the community with individuals in crisis. Moore Ward's inpatient management staff and specialist psychiatrists and psychologists have been meeting to develop crisis team pathways. The focus is on reducing the cross-borough beds on the ward from 12 to 10 by September 2016. The two beds that will be released will be used differently to facilitate a 24/7 response to crisis which will be supplemented by outreach support.

This will be at the core of our enhanced community offer to accommodate crisis (both social care and health-related) in the community. We will create a centre of excellence across the BHR region with a single pathway offering access to the best local care, prevention of admission, fast track rehabilitation (where Inpatient care is needed) and a comprehensive clinical, social care and community support system. This will include reinvesting funds currently included in our block contract into the up-skilling of staff as part of an active outreach service able to support individuals entering crisis in a number of community settings; and in a 24/7 combine learning disability / mental health community support service that will support people in their own homes. It will also allow us to reduce the use of OOB placements, and contribute to an overall reduction in both the number if inpatient spells and the average length of stay.

If this model is to be effective, and if we are to manage more complex patients in the community, we will need to remodel the services that will enable us to support crisis at an earlier stage, working to mitigate the need for admission to inpatient settings. We will reflect on CTRs to inform a review of current provision including contributions of individuals, carers and families; and providers will be held to account to deliver on the outcomes of support or treatment plans. There will be a lower usage of beds but at a higher intensity, achieved by 'topping up' our contract with NELFT. These beds will come with acute, mental health, social care and emergency support as required. We will develop the market to ensure a greater range of services that support choice and control – personal assistants, more flexible use of personal budgets for people living in supported living schemes etc. Having the right skill mix of clinical and non-clinical staff (both in statutory services and within the provider market) to support this cohort of people, including managing crisis, will be vital.

We will need to have a respite (and short breaks) resource available for children and adults from across the BHR area to support individuals that develop increased short-term need but do not, necessarily, require assessment or treatment; or who are at risk of placement breakdown. The lack of respite/in-borough residential units is largely responsible for avoidable admissions to Moore Ward. So there will also need to be an increase in the provision of the right mix of accommodation and support options for looking after this cohort. We will, for instance, build on our success in co-developing new-build and service provision with individuals e.g. Greater Charter Close development in Havering. We will work with providers to develop flexible support packages to manage crises when the needs arise, in particular when individuals first come out of hospital and are at highest risk of crisis or readmission.

The service will also deliver a range of interventions and support including:

- Diagnostic assessment
- Behavioural Support
- Psychological Therapies

- Risk assessment and management
- Crisis and emergency planning
- Medication management
- Improving physical and mental health, and wellbeing
- Skills development
- Promotion of social inclusion

We will:

- Improve facilitating of 'blue light' CTRs and ensure we have options to support people in the community. Upon completion of a planned CTR we will ensure the recommendations identified are resourced to meet the timescale
- Review the service specification of the current ATU to include the offer of support to individuals in crisis in the community. We will also work with providers to develop ways of supporting individuals in crisis in the community: using a range of legal options such as DoLs or Community Treatment Orders
- Consider ways of developing accredited PBS support training and development of an NVQ in conjunction with local universities; and facilitate workshops to offer training to family carers
- Develop respite care options locally that prevent the need for an ATU admission where assessment and treatments are not required.

As part of the service redesign we will:

- Improve clarity for individuals, carers and families, as well as external partners, regarding the services and outcomes that are provided by specialist learning disability services.
- Assist individuals to make informed choices about the outcomes they would like to work towards, with input from specialist health staff.
- Help develop skills and capacity in the wider care system to effectively meet the needs of people with learning disabilities.

Taking effect from April 2016, this will build on two new operating models that have been developed in Redbridge jointly across Adult Social Services, Public Health, NELFT and the CCG. This will comprise an **Integrated Health and Adult Social Care Service** (HASS) and the **HUB**. The latter will provide the statutory and business delivery functions of the Directors of Adult Social Services and Public Health; and comprise: commissioning, public health, safeguarding, strategic planning, performance, systems and resources functions. The HASS will draw together staff and services from both the Local Authority and NELFT and will build on the existing Learning Disabilities and Mental Health Partnerships. It will include social workers, occupational therapists and support staff; services including day opportunities and extra care, memory clinic, palliative care, tissue viability, continence and nursing services.

We will improve tracking, risk management and admission avoidance:

- Close assessment of current inpatients to allow for as early as possible release
- Monitoring of potentially at risk individuals in the community with an all-age register – i including post-14 age group, those coming via health, social care, children and young

people's services and education; and those not eligible for transfer to adult services.

- An embedded community awareness programme of supporting people "at risk" with all commissioned services and providers
- Specialist support to reduce the risk of inappropriate hospital admission, breakdown of home support arrangements, contact with CJS or difficulty accessing mainstream services
- To have trained and supported individuals and carers on the "at risk register" to self-support to recognise their own triggers to crisis and coping mechanisms and reduce the immediate reliance of support from the authority.
- Creating a wider community awareness of support to people "at risk" and ensuring all commissioned services and providers support the copying and alerting strategies of service users.
- Develop an 'action alliance', building on the success of the Dementia Action Alliance and 'Safer Places' (autism) in Havering as a model for working with community leaders, communities businesses and so on, to increase awareness of people with learning disabilities including those with complex needs such as with this cohort.
- Strengthen and standardise the risk stratification process we use to identify people with LD and/or autism who are potentially at risk of admission to hospital; and ensure that if people are becoming unwell further community support is put in place.
- We will standardise intake assessments into ATUs across BHR
- We will develop an all-ages strategy on behavioural support (PBS) to – get people out of ATUs, prevent them going in, advise families to prevent escalation, and support providers to avoid placement breakdown.
- A strategic oversight group appointed from across BHR TCP will review packages of care, identify patterns, tensions, resource issues, be a critical friend and challenge care and placement decisions where appropriate for this cohort.

To support the working of the Transforming Care Partnership we will recruit a specialist case manager, supported by a social worker, and a specialist team for crisis response/prevention as part of the new model described above. These changes will ensure that by year 2 we are able to manage Moore Ward inpatients in the community; and by year 3 provide intensive care packages with re-skilling, CLDT and respite provision in place.

What new services will you commission?

There will be more joined-up commissioning of services, particularly specialist services, across the BHR footprint. There will be a scoping review of services to determine what new services we need to commission to meet the needs of this cohort and reduce reliance on inpatient and out-of-borough provision. Where the current provider base does not present a viable or sustainable option we will commission services in collaboration across the BHR area. We will aim to commission services from a range of specialist providers. New services will have a more defined service specification. This will mean:

- Redirecting investment towards supporting local community provision and enabling local schools to manage challenging behaviour; putting in place respite and short breaks, parenting support programmes, resilience building in schools and supporting them to retain children in local schools.

- LBH has a commissioning strategy in place to address the need for additional school places including for children and young people in this cohort. The strategy is also about supporting schools to develop improved capacity to deal with complex needs, including complex behaviours. For example, developing with schools Additionally Resourced Provision such as buildings for specialist provision which, in the longer term, will support a reduction in OOB placements. LBH is also developing new post-16 provision locally, which will open in September 2016 with a small number of students, but with plans to grow to supporting approximately 50 students within the first two years; and with integrated health and social care support on-site.

- In the first year, an additional nurse will be recruited to work closely with young inpatients helping develop care pathways and liaise with other agencies including Specialist Commissioning and CJS. They will ensure no discharges are delayed due to lack of adequate provision or because CTRs or reviews are not undertaken on time. They will monitor at risk patients and prevent unwarranted admissions by making sure the care needed is in place. We will also take on a social worker and administrator to support this work, build a new 7 unit scheme based on the model of the current flagship scheme at Great Charter Close, in LBH, which opened last year; and build a 4-bed scheme in B&D. In the second year we will also recruit a quality assurance officer, extend CLDT team hours to cover week days 5-9pm and weekends 9am-9pm, and an 'on call' doctor 40 hours a week for an initial 6 month trial period.

- We will develop an outreach service that utilises the skills of the current inpatient hospital staff to work in the community with service users in crisis.

- There will be a particular focus as part of our scoping review on the development of respite options across BHR as an alternative to inpatient admission.

- We will commission more services through PBs, PHBs and DPs. We will also review the support (i.e. advocacy and brokerage) available for people in this cohort to help them make the best choices for themselves.

- We have identified a need to develop a service specification that meets the need of people that display challenging behaviour. It is recognised that there is a national and regional lack of providers with the expertise to develop bespoke packages of care, and to sustain support to people with challenging and complex needs. We are collaborating with neighbouring boroughs across North East London on preliminary work to develop a framework of expert providers to be in operation by April 2017. We will also support local providers to achieve PBS accreditation.

- We would like to micro-commission more complex, bespoke packages of care but the lack of appropriate tenancies has been an inhibiting factor. In many cases individuals with complex needs require their own bespoke living space. We are reviewing our current housing stock which, as with most London boroughs, is in short supply; and will develop new housing solutions that meet the needs of individuals without isolating them from the community. There will be a range of independent self-contained flats within close proximity of each other to ensure the level of support required can be utilised flexibly according to need. We will support and

encourage services that provide imaginative supported living schemes with 'life skills' that allow clients to move on. We will also improve the accommodation offer, working with Mental Health Services, to support clients with learning disabilities and co-morbid personality disorder and forensic needs.

B&D are developing an Independent Living Strategy with Housing Services for people with learning disabilities and Autism. Commissioners have met with a number of developers willing to invest in housing specific to meeting the needs of people with a learning disability and/or autism. One such scheme would see a new build of 6-8 flats on church land. Havering too are working with Housing Services and the market to commission specialist supported living schemes (such as Great Charter Close) that are able to address more complex needs than is currently available in the borough over the next 3-5 years. As it is expensive to increase the provision and in order to develop a joint resource, we are exploring the option of pooling resources to create new provision on a number of sites which can be shared across the three Boroughs.

- We are also planning to increase awareness among the community of the needs of this cohort, including employment opportunities and access to key services. A recent initiative in Havering has established a shop in the Mercury Shopping Centre designed for people with autism, which will provide a safe space as well as information and advice. This is something we will build on across BHR.

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

We are already actively reducing the number of inpatient usage days in our ATU. We have discharged the remaining 3 April 2013 cohort of patients into alternative long term provision that meets their on-going needs. There will be a reduction of ATU bed usage (in Goodmayes Hospital and NHSE inpatients via Specialist Commissioning) over the next 3 years as we develop more community-based support. We will commission less assessment and treatment within the hospital based ATU and offer assertive outreach support where appropriate. We will reduce the commissioning of OOB ATU, residential and supported living placements, and will repatriate individuals placed outside BHR unless they choose to remain or a clinical or legal decision makes it necessary that they stay. In order to allow for this shift in the way we provide care to this cohort, there will be changes to existing services, different commissioning arrangements will be put in place, and we will develop new services where there remain gaps in provision (see below).

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

The commitment of the TCP is to develop services that support people to be as independent as possible, and to actively discourage long term provision that does not enable full realisation of potential for those receiving services. These changes will help to avoid unnecessary inpatient admissions and reduce length of stay. They will also allow us to scale back bed usage and numbers at the ATU in Goodmayes Hospital. We are currently looking at wide ranging changes across BHR to enhance and improve our community support and care experience, and provide the basis for a greater quality of life for individuals and families.

We are conscious of our reliance on family carers to provide vital support to people with learning disabilities, so we will be closely looking at the crisis and respite support we currently provide. This will entail a remodelling of current statutory services (including CLDTs and Mental Health Services) to ensure an improved response to crises and expanding the 'blue light' protocol. We will ensure that CLDTs are equipped to respond within the community by having learning disability nurses and social workers skilled in forensic work. We will also review as part of our workforce development plan our training offer across care settings, including to carers and families e.g. on Deprivation of Liberty Safeguards (DoLS) and PBS. We will seek to develop an outreach service that utilises the skills of the current inpatient hospital staff to work in the community with individuals in crisis.

We will engage stakeholders in the process of reviewing existing respite provision and extending access to it, as necessary, to meet people's needs across BHR. Our ambition is to work with local providers to remodel their service offer to be able to work with those with higher and complex needs, enabling people to return to the borough where they wish to do so. In Havering, despite provision being used by other funding authorities, making the area a net importer of people with learning disabilities; it has a number of supported living schemes that do not provide the level of support needed for this cohort of patients, and that are often not of sufficient quality. Across the BHR area there is insufficient local accommodation for people in this cohort who have complex and specialist needs (including those with dual diagnosis of mental health/autism). Consequently some individuals are placed out-of-borough away from family and local networks (other than through making a choice that they wish to live in another area). So the approach will be the same: to increase the availability of appropriate accommodation and support for this cohort of patients.

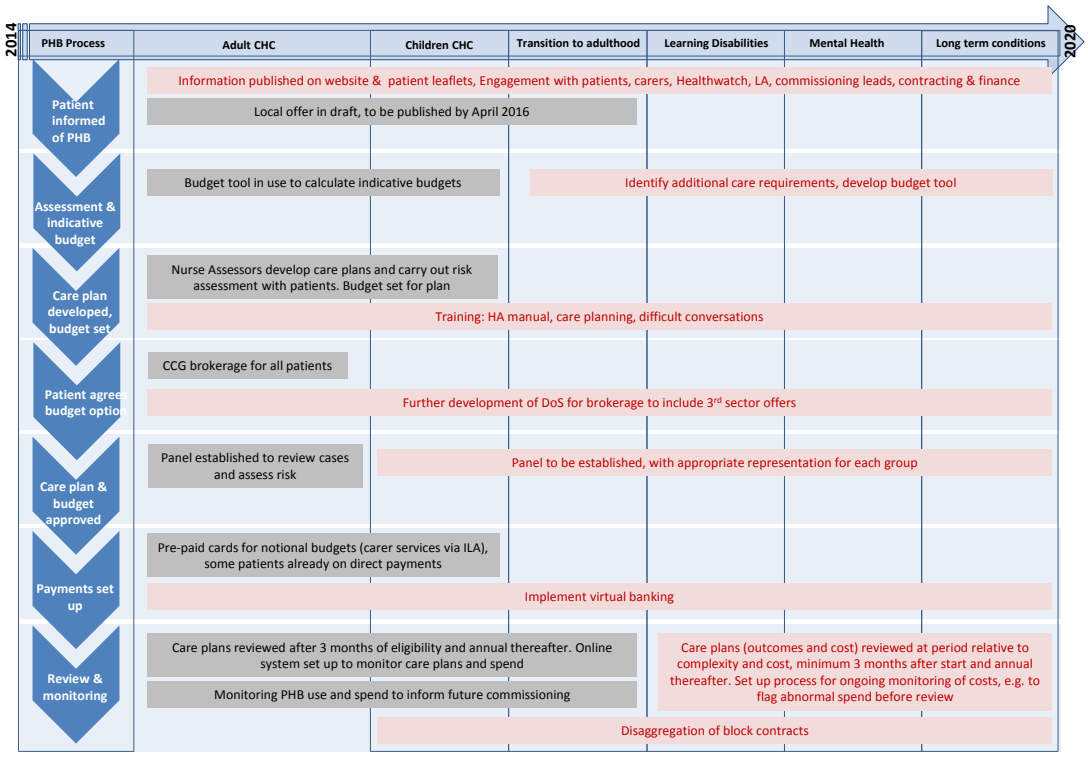
Describe how areas will encourage the uptake of more personalised support packages

Individuals have been using PBs and DPs for several years across BHR. Around 750 people currently use them. However PHBs are a newer addition with less than 20 people currently receiving them. Beyond personalisation of budgets and care planning, BHR is improving person centred care in a number of other ways. For instance, with the successful introduction of a hospital liaison nurse for people with learning disabilities and Autism, the participation of BHR in the Liaison and Diversion Scheme; and creation of HASS in Redbridge with the potential for development, with the ACO, across BHR. We will also make sure that all service provision, including housing and crisis care, are in place to meet people with learning disabilities' and their families' needs. There will, therefore, be an increasingly person-centred approach to both assessment and the delivery of care over the coming three years.

We will, nevertheless, greatly increase the uptake of PBs, PHBs and DPs across BHR too. Where PHBs are used we will make sure the right level of support and advice is given to accompany the payments; so the individual is always in the best position to make the right choices regarding the right care for themselves. We are currently developing a package of support for case managers to ensure each patient in receipt of a PHB gets a detailed care plan. The quality of care plans will be regularly reviewed by the PHB Panel. We will also develop formal mechanisms for delivering integrated personal budgets; and ensure there is sufficient advocacy and respite care available for

this service user group across the BHR area.

CLDTs consist of a team of integrated professionals that carry out a range of assessments, reviews and support planning. At each stage individuals and their carers are encouraged to consider a model of support that is personalised and keeps them in control of their support plan. The CLDT works with providers to ensure that as individuals' needs increase, all efforts are still to maintain, reduce or delay increased dependency. The CLDTs also work closely with commissioners to ensure tailor-made solutions are identified that are personalised to the individual.



The Continuing Healthcare Team (CHT) has undergone significant changes over the last few years and therefore the progress with PHBs has been affected. Nevertheless, the CCGs are committed to developing the take up of personal health budgets as well as the options to increase joint PHBs alongside PBs. The current local offer is clear and the CHC Team offer PHBs to all patients when they are notified of their eligibility for NHS Continuing Healthcare. Once an individual requests a PHB and are assessed as being eligible, a care plan is then developed (in partnership with the patient) and their budget is set. Individuals are informed of the ways in which they can manage their budget, e.g. direct payments, third party or notional payments, after which time their care plans are agreed and payments are set up. Risk assessments are carried out at a very early stage and potential risks are monitored throughout the process. Care Plans and budgets are regularly reviewed and individuals are able to contact their care-coordinator at any point. To date, uptake has been slow. However, over the last year the number of patients with PHBs across BHR has increased by 130%, and we expect there to be an increase across all cohorts over the next two to five years. The table below shows the number of individuals with personal health budgets as of January 2016.

Borough	No. PHBs	Cohorts
Redbridge	1	CHC Adults
Barking & Dagenham	8	CHC Adults & transition from CHC Children
Havering	7	CHC Adults

The draft plans for development and expansion of PHBs set out the CCG's improvement priorities over the upcoming years:

1. Further engagement with service users, partners and third sector organisations to identify where improvements can be made. This will be an ongoing process through development of the PHBs
2. Development of literature for service users, carers, etc. to ensure individuals eligible for PHBs are well informed and empowered to take control of their care
3. Supporting young people with complex health needs transitioning to adulthood – offering personal health budgets to enable young people to develop packages of care to meet their needs
4. Expansion of the budget tool to include non-traditional care, or requirements not currently captured
5. Develop governance arrangements for PHBs for additional cohorts, ensuring appropriate representation on any panels/groups
6. Streamlined payment mechanisms ensuring that patients have a clearer understanding of their budgets and spend
7. Development of a support package for both staff and patients:
    a. Expansion of the brokerage team's Directory of Services to include third sector offers, increasing support available to individuals
    b. Training programme for staff to include, for example, care planning, having difficult conversations and enabling self-care. Care co-ordinators will be able to successfully build collaborative partnerships with individuals and develop care plans through a person-centred approach
    c. PHB information pack for patients that have decided to take up the offer, ensuring they are able to make informed decisions
8. Development of capitated budgets to allow patients with long term conditions to take greater control over their care
9. Working with commissioning leads, contracting and finance colleagues and providers to identify mechanisms to increase flexibility and allow for a more personalised approach to care, e.g. the disaggregation of certain block contracts.

A small number of children are in receipt of a PHB in respect of a continuing healthcare package, and some children across the BHR local authorities are in receipt of either direct payments or personal budgets. Care packages for young people transferring from children to adult social services are allocated based on their needs as assessed through a transition assessment. Young people are offered the opportunity to receive their packages of support through commissioned services, personal budgets and / or a mix of both. However, no Resource Allocation System (RAS) is used to allocate an Indicative Budget. PBs are allocated based on costs of care packages agreed at panel. Take up of PBs is quite high, especially for school leavers. This is because they offer the opportunity to use services that are not commissioned by the local authority.

Discussions routinely take place with Housing Service to develop personalised housing solutions to meet assessed needs of individuals. The need for further work to be undertaken across BHR to review respite options available for younger people and those with complex needs has been identified. In **B&D** personalisation of services starts at an early stage in life. Their Parenting for Adults pathway (PfA) begins to address some of the expectations around personalisation. The PfA explains at which points key decisions need to be made and lists the stages various services become available, such as:

- Careers advice at the ages of 14, 16 and 18
- The Department of Work and Pensions Benefits advice from the age of 16.
- The availability of Adult Social Care Assessments from the age of 18.
- The transfer to Adult Health Services at 18.

The PfA aims to raise aspirations and expectations for young people as they move into adulthood; and to increase their independence between the ages of 14 and 25. As young people move along the PfA their needs are increasingly seen as independent of their family. It ensures that everybody knows how to support young people to achieve positive life outcomes in the areas of, employment, maximising independent living, good health, friends, relationships and community participation. In some instances, it is explained, it is possible for elements of a PB to be paid directly to a family or young person as a DP, enabling them to directly purchase some of the services that are stipulated in their EHC plan. This could include transport, respite care, domiciliary care, and equipment. In many cases a young person's view on how to spend DPs may differ from the views of their parents or carers. It is essential that wherever possible, young people between the ages of 14 and 18 are involved in the negotiation and management of PBs and DPs. From the age of 16 young people can apply for a PB and be in receipt of a DP independently of parents or carers.

The Council was an early adopter of PBs and a large proportion of adults arrange their own support packages using a direct payment. This includes some people with very complex needs who require support 24/7. The Council provides detailed information to people on what a PB is and how to manage it. The Borough's Care & Support Hub encourages and supports individuals to take up, and where possible manage, their own personalised package of support. It includes a Personal Assistant (PA) finder. This allows individuals (and their carers) to have more independent access to support without the need for Council intervention. As at February 2016, Barking & Dagenham Council expects to spend £2.6m on daycare, homecare and direct payments for people with needs related to their learning disability, with 190 service users receiving a total of £2.46m in Direct Payments. (Figures gross, with expected £100k income from client contributions.)

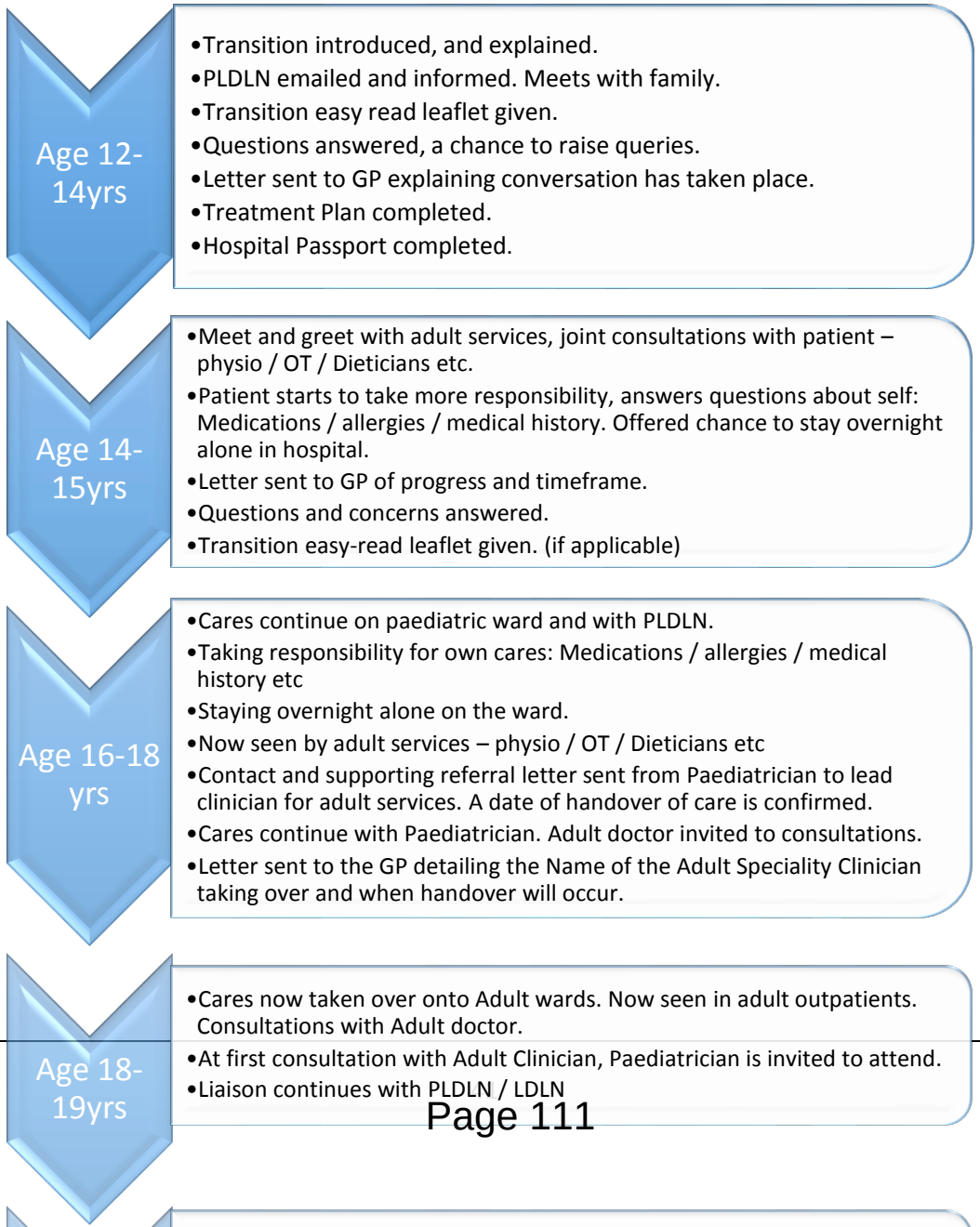
In **LBR** the number of people with a PB or DP, as of January, 2016 was 237. The proportion of people with a learning disability receiving a funded service who were on a DP was 35%. In 2016/17 this is projected to increase to 276 and 36%, and by 2017/18, to 317 and 39%.

LBH is developing the market and increasing the number of personal assistants that enables people to buy in their support workers directly as this is currently underdeveloped. There are currently 202 people with learning disabilities who have taken up DPs, and 57 people for whom the Council

manages their budget on their behalf and commission's community based services for them. In addition a number of people with learning disabilities in receipt of DPs buy their day opportunities from both our internal service and local external providers. There are also 12 people known to mental health services in receipt of DPs; with a further 25 people for whom the Council manages their budget on their behalf and commissions community based services for them.

What will care pathways look like?

Some of the children and young people's pathways are already in place e.g. transition from children's to adult's social care (below), and for EHC and CHC assessment and planning. These are not, though, currently integrated. The CAMHS Plans include the development of a care pathway for vulnerable children and young people, including those in this cohort. This will be developed with NEFLT to ensure that these children receive prioritised access to services (within 4 weeks); and that the service or treatment is delivered by a professional with expertise in working with this group e.g. learning disability or CSA trained therapist.



There is ongoing work on the development and alignment of existing pathways across the BHR area. LBH, for instance, as part of its review of the S75 for Learning Disabilities (currently underway) is reviewing care pathways, including those specific to this cohort of patients e.g. response to crisis. The new 'Preparation for Adulthood' services will be reviewing transition pathways to ensure this is as seamless as possible for children moving into adulthood. A learning disability admission care pathway is currently being updated (estimated completion April 2016). Dedicated therapy resources have been identified as part of the redesign to ensure appropriate clinical input is available to people who need admission to an ATU.

We will work with providers and other partners to design and develop robust, 'Right care, Right place' pathways – from discharge to community support, and also from the point of identification to preventative support. NELFT have developed a number of policies and pathways that boroughs use e.g. a transition policy (see below) and a learning disability assessment and management of Challenging Behaviour Pathway, and an Autism Diagnostic Pathway. A learning disability mainstreaming care pathway is under development. NELFT, the CLDTs and CCGs have arranged a TCP Joint Away Day on May 9th to discuss Challenging Behaviour Pathways.

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

In LBR between 28-48 of this cohort are transitioning to adulthood in each of the next three years. B&D have 48 children and young people with a learning disability and/or on the Autistic Spectrum Disorder and/or with Challenging Behaviour, on their transition list. In 2015/16, across the BHR area, seven young people (at least half of whom were previously 'looked after') aged 17/18 were transferred from children's services to adult services. In 2016/17, eleven young people (of whom 7 were 'looked after') aged 16/17, were transferred. Thirteen of these young people were living in Barking and Dagenham, and one in Havering; the others out-of-borough. Twelve are recorded as having Aspergers Syndrome Disorder, three as having a learning disability and two as having Behavioural, Emotional or Social Difficulties (BESD).

There is good practice across BHR on supporting young people making the transition to adult services.

- We have a transition pathway in place for children using our hospital services (see above) and

BHRUT has put in place a Treatment Plan for children with learning disabilities who are in transition from child to adult services.

- As part of the service development work undertaken to implement the Children and Families Act, B&D has launched a new, integrated team serving young people from 0 – 25 requiring Education, Health and Social Care Plans. In developing the service the borough has worked closely with Trinity School (for children with learning disabilities). In order to support the transition of young people to adulthood, this team incorporates two dedicated social workers. In an effort to further integrate services and eliminate the 'cliff edge' between services for children and adults, the Council is currently scoping a disability service for people aged 0 – 55.

- LBH is setting up a 'Preparation for Adulthood' service to improve the way they support children moving into adulthood. The key focus of this service is to support young people with complex disabilities to access a range of services to assist with moving towards independent living and adulthood, including accessing further education and employment. Existing arrangements include a monthly Transition Monitoring Group, reviewing the health, social care and education plans of those aged 14 to 25. This is led by Learning and Achievement within the Council, and Adult Social Care and CCG colleagues participate in the discussions; with providers including B&D College, Havering College and Prospects (who are commissioned to provide advice, information and support to young people and their families). Through this Group young people's progress against their outcomes is tracked and informs planning for future care and support once they transition to adult services. Adult Social Care attends support planning reviews from the age of 17½. LBH also facilitates an EHCP Panel, which includes discussing CAMHS support where this is an assessed need within the EHC Plan. The 5-19 support team will work with schools if there is an indication of the need to refer to CAMHS and to support the sharing of information during, for example, review meetings. Information from the Panel is provided to the monthly Transition Monitoring Group, including costs and placements details, to support the planning of the future service provision as young people get closer to adulthood.

- In LBR the Transition Team is a joint children and adult's team working across social care, education and health services. The work of the Transition Team is based on processes and practices defined in the Disabled Young People Transition Protocol. The protocol is a living document and any change to it is agreed and signed off by the Transition Steering Group. The Transition Team supports young people to plan for their transition from Children's into Adult Services; from school into further education; and any care and support need they might have. Transition Assessments are carried out prior to an individuals' 18th birthday. For those eligible for Adult Social Care, Transition Assessments and Care Plans are also presented to the relevant Adult Panel or decision-maker. The funding transfers to the appropriate adult team the week following a young person's 18th birthday. The Transition Team continues to case manage, review and monitor young people's needs and support until they are 'settled' and ready to be transferred to the relevant adult team. A package is considered settled when a clear transition plan is identified and implemented after young people have left school (usually when they are aged 18 – 19).Support with transition planning for school leavers is available from Outward Brokerage Service (commissioned by LBR Children's Services).

However, despite support for young people transitioning from one set of services to another being well developed in each borough, it is not integrated across BHR to ensure there is seamless provision

for those in this cohort wherever they live, or whichever services they use, across the geographical area. This is something we will address over the coming period with a view to sharing best practice and aligning processes across BHR.

How will you commission services differently?

In order to encourage a more person-centred approach we will ensure all contracting has provision for a core and flexible model. This way, individuals will experience more tailored provision, and will be able to commission their own choice of provider and service if they choose. This will mean developing micro-providers and capacity-building to ensure a wide range of quality services are available to choose from. The TCP will also identify the needs of this cohort and plan population and service level commissioning, rather than relying on individual purchasing of more expensive and often inappropriate residential provision. In order to minimise the number of OOB placements we will work as a partnership (including non-health and social care partners) to jointly fund placements, working with providers and landlords to develop services in our locality.

In B&D, for instance, meeting the housing needs of people with learning disabilities is a priority for the LDPB and a part of its commissioning intentions. The borough is on a working group led by the Tizard Centre at Kent University, one of the world's leading research and study centres on learning disability. The completion of a service specification, resulting from this joint work, will assist with commissioning providers to design services for people with challenging behaviour and achieve good outcomes for people with learning disabilities and autism. Sahara Homes, currently a residential facility, needs up-skilling and development, to provide the necessary support for this cohort and flexible options for potential residents. LBH will have a Joint Commissioning Plan agreed by the end of September 2016 (across adult's and children's services). Plans are currently being reviewed and will include a market development piece around expansion of the personal assistant market (currently underdeveloped); and increasing the number of people who have greater choice and control through integrated PBs and DPs. Increased in-borough specialist education provision to reduce reliance on out-of-borough education placements will also feature in the plan.

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

We have a developing proposition around devolution and ACO. Until we have completed that work, it will be unclear what options there are for specifically linking future estates plans to the LD strategy and BHR TCP. However, the three CCGs across BHR do have an initial draft local Strategic Estates Plan in place that describes the health estate across the boroughs:

- articulates the commissioner's vision for the estate, based on the Five Year Forward View (5YFV) and commissioning plans;
- assimilates core information about the current estate in the area;
- identifies the current and planned broad locations for the delivery of services in the area;
- outlines the opportunities that exist within the properties in the area to meet the requirement for the delivery of services; and

This will support new models of care planned for the system, including the new care model being

developed for this cohort, using infrastructure as an enabler. More specifically plans for the NELFT estate include:

- A hub and spoke model of service delivery will be developed in each locality, the first one being the central hub development on the current Thorpe Coombe Hospital site (in Waltham Forest).
- There will be a programme of estates rationalisation working in partnership with other organisations to maximise the use of local health economy fixed assets
- There will be a maximum utilisation of freehold estate and less reliance on leased property- this will link in with the development of hubs in each locality, which, where possible will be developed on freehold estate, taking the opportunity to reduce reliance on expensive leased accommodation.

The provision of housing, rather than the health estate as such, though is critical to meeting the needs of people with learning disabilities and/or autism in the community, and avoiding OOB and inpatient admissions. B&D has committed to develop a vulnerable people's housing strategy to shape future provision. There is considerable difficulty in finding suitable stock to provide supported living or step-down into independence. The borough will be transformed over the years to come, with very significant new housing developments, but in the meantime will continue to source options for small supported living developments particularly by working with local community sector organisations who wish to develop their sites. Across the TCP, there is very limited social housing stock for this cohort; so we will work with providers to identify innovative solutions and suitable housing options e.g. utilising social housing bonds as LBR has with Golden Lane. It is anticipated that wider engagement with stakeholders and providers will help identify any further housing needs and can ensure these needs are included in housing strategies and commissioning plans.

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

We recognise, first of all, the need to develop and/or commission provision that can meet the needs of clients with complex needs and who have been an inpatient for a long period. We have used a number of approaches to reintroduce people back into the community. A common challenge is encouraging people to go out unsupported. We put in place support to increase their confidence going out, we provide travel training and help them with their budgeting skills. We will continue to do this, encouraging peer support and working closely with families, to increase their independence. LBR has only one person who has been an inpatient for a long period of time – on a Section for over 12 years. The specialist broker has been working with CLDT, the provider and family to assess the individual's needs and has identified a suitable move-on service. In B&D there is a rolling programme of exploring repatriating people back to the borough through service user reviews. The borough works with patients in long stay hospitals with a view to discharging them nearer home, or family and friends, where appropriate. Some have actively chosen to remain in the community where they were placed having established new social networks and support. The borough's approach to resettling people who have been in hospital for a many years has been to allow sufficient time for individuals to re-adjust and regain their confidence. In LBH, placements are reviewed annually, and

options for repatriation are considered wherever possible; including where the individual has been an inpatient in an ATU for a significant length of time. Of the current cohort one has been an inpatient for more than 5 years, another for over 10 years. Through CTRs and regular monthly review visits, discussion is ongoing with each of the patients and their clinical team, as to the kind of accommodation and wrap around service they will require as their discharge is planned.

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

Links are already in place between BHR, and being built on as part of the proposed creation of the ACO across the three boroughs. This new model will include:

- Community service and primary care teams, hospital specialists and local authority services will work together in a multi-disciplinary team serving populations of approximately 50,000 patients.
- Local General Practice will be the provider and coordinator of services for patients.
- Local general practice will focus on the proactive management of patients with complex care needs. They will be supported by the wider health care system to achieve this.
- Where patients with urgent but minor illness are unable to get an appointment with their GP, they will be treated on the same day at a local urgent care hub.
- In-hours same day access to ACP level hub arrangements, General Practice will be supported to have longer, higher quality consultations with the most complex patients.

BHR System Resilience Group (SRG) also aims to create a simplified, streamlined urgent care system delivering intelligent, responsive urgent care for 750,000 residents in the most challenged health economy in the country. The SRG believes there is a need to do things differently and that patients are confused by the many and various urgent and emergency care services available to them – A&E, walk-in centre, urgent care centre, GPs, pharmacists, out of hours services.

Each borough has agreed a **Crisis Care Concordat Action Plan** and is progressing work to:

- Extend the hospital- based and CAMHS-based support for children and young people at high risk
- Review CAMHS outreach services to ensure children and young people identified as high risk are supported to remain out of ED

The CCGs actions, to be carried out by CLDTs, include:

- The development of registers of all people with a learning disability or autism in NHS funded care
- Maintenance of the register
- A comprehensive review of all placements for individuals identified as being resident within Assessment and Treatment units (ATU)

B&D will be the lead partner taking forwards **the pathway and protocols of implementing the CTR process**. This will include agreeing how 'blue light' and community CTR are facilitated. The work steam will be the vehicle for sharing outcomes of the CTR and ensuring that the BHR Partnership is able to plan and develop potential services for this cohort that are identified in the process. Over the next 4 months we will agree a protocol for sharing the "at risk register". We will raise awareness of being "at risk" via the LDPB Provider, Carer and Service User Forums and Groups. The Challenging

Behaviour, Crisis Concordat and Carers Strategy will each frame the implementation of supporting the "at risk" register.

Each borough has agreed a **Children and Young People's Mental Health and Wellbeing Transformation Plan**. Our vision is that children and young people are empowered to be resilient and able to cope with the challenges of everyday life; with services that are flexible and integrated, responding to varying levels of need and responding well to the additional needs of vulnerable children and young people. We have committed to:

1. The development of a local model for Children and Young People (CYP) mental health services that meet the needs of all CYP in the three boroughs
2. Better support for CYP and their families who have emerging behaviour difficulties through the development of a local pre-specialist behaviour pathway
3. The development of an integrated health and justice pathway for young people to access the youth offending services

Each borough has agreed a Crisis Care Concordat action plan and is progressing work to:

4. extend the hospital based and CAMHS based support for children and young people at high risk
5. Review CAMHS outreach services to ensure Children and Young People identified as high risk are supported to remain out of ED

The **CAMHS Transformation Plans** comprise one core offer across the BHR area. All three have themes on building resilience, early and extra help focussed on supporting behavioural challenges, improving access to evidence based treatments for diagnosable mental health conditions, improved access to crisis support, supporting vulnerable children and young people and improving outcomes and participation. All of this will be delivered through Wellbeing Hubs (one in each CCG area). They include a range of workstreams and care pathways to be developed that will support children and young people in the cohorts of CYP defined in the Transforming Care Programme:

- Resilience building for all children and young people including those with learning disabilities and Autism and with Challenging Behaviour, supported by specific training for professionals.
- A specific work-stream and delivery group focussed on early and extra help with a focus on early intervention and effective support for behavioural difficulties, including support for children with learning disabilities and/or autism and their families (including parental support programmes).
- Vulnerable children and young people have been prioritised as a specific cohort and a work stream has been established to ensure they receive prioritised access to services; and are supported by trained professionals with expertise in that area of vulnerability. That includes children in this cohort. This is being led and progressed by a multi-disciplinary group and includes representatives from youth offending service, social care, education and adult services.
- Developing an Outcomes Framework including specific outcomes for vulnerable children, including those with learning disabilities and/or Autism and Challenging Behaviour.
- One of the key objectives of our plan is to focus upon strengthening services and support in the community and a commitment to explore new ways of delivering services working with the voluntary and community sector.

The TCP dovetails with the strategic direction of travel for **LBH** including:

- Health and Well-being Strategy – priorities include integrated support for people most at risk and improving the quality of services to ensure that long term health (and social care) outcomes are the best they can be.
- Havering's market position statement – setting out our intentions around how we want to change our relationship with our market including prevention and managing demand, commissioning differently to facilitate better outcomes for residents, and improving working in partnership with a range of stakeholders, including residents and providers, including co-production as a default.
- Havering Better Care Fund plan – including a joint scheme specific to learning disabilities, with the key outcomes of people with learning disabilities and autism have access to safe appropriate services, are encouraged to lead healthy lifestyles (that reduce health inequalities), service promote wellbeing through encouraging citizen engagement, and that we review and design services via co-production
- Havering Children and Young People's Mental Health Transformation Plan – with 5 key themes for specific development and investment – including building resilience and promoting prevention, establishing a Wellbeing Hub, maximising use of digital resources and promoting self-support, and importantly, reviewing and improving support for children, young people and their families with mild and emerging behaviour difficulties.

In **LBR** the Autism Plan has recently been refreshed and is out for consultation. Its priorities include:

- Improved involvement and engagement of people with ASD
- Addressing low hate crime reporting
- Helping adults/older people living unsupported in the community to access mainstream services including employment support
- Review take-up and impact of Autism Training in terms of making reasonable adjustments; and providing Care Act compliant needs assessments and reaching BAME Communities;
- Exploring transition, preventative and carers support needs
- Meeting information, advice and advocacy needs, including for people with complex needs
- End of life issues

B&D is implementing the strategic commitments made **in Addressing Behaviour that Challenges Services**, its Challenging Behaviour Plan. The key actions relating to this plan are:

- Developing local services that have the expertise to support behaviour that challenges.
- Developing services that offer service users and carers a respite during short term crisis.
- Working regionally to develop provisions that are feasible and sustainable across the neighbouring borough boundaries.
- Sharing good practice across the region and nationally.

The following actions have been achieved in the first phase of the Challenging Behaviour Plan:

- Improved integration with health and social care. Many service users that display behaviour that challenges often have a combination of health and social care support needs, joint

assessments and joint funding solutions have been a successful outcome to meeting the needs of the service user.

- Raising awareness understanding, and knowledge of good practice in supporting service users that have challenging needs. This has included encouraging Providers through the Providers Forum to implement Positive Behaviour Support as a core training element of their induction programme for staff.
- Supporting Providers to implement the Safeguarding reporting and DoLS in a transparent, non-risk aversive approach that leads to service improvements.
- Reshaping the CLDT to include specialists in behaviour that challenges and ensure these specialists offer training and crisis intervention.
- Working with existing providers/specify in the supported living tender the need to move people who have attended day services for a long time and who wish to move on to find mainstream opportunities.

The next phase of the Challenging Behaviour Plan will take place over the next 5 years and has been captured in the LDPB delivery plan.

B&D are also implementing their Prevention and Independent Living Strategies. An ongoing challenge is the availability of housing which can be tailored to ensure that services for individuals with challenging behaviour can be delivered. This will include developing links with landlords and the Housing department. This will be incorporated into the Independent Living Strategy and monitored through the LDPB meetings.

The B&D Prevention Strategy is all about enabling social responsibility and encouraging residents to do as much as they can for themselves. This means that individuals, with support where necessary from communities and local networks, will be primarily responsible for making their own decisions about their personal life choices; and for seeking the advice and information they need to achieve the outcomes they desire. Individuals with the highest levels of need will continue to receive support from statutory agencies such as the NHS and, for those who meet the national eligibility criteria, from the local authority. Improved social responsibility relies on good community and individual resilience, supported by an effective infrastructure and access to a range of appropriate, high quality local services. This work has started with the development of community hubs and empowerment of local people through better use of local assets such as children's centres, libraries, leisure centres and neighbourhood networks.

This Prevention Framework – prompted by the Care Act 2014, with its emphasis on local authorities and the NHS, and other agencies, promoting people's wellbeing and independence – acknowledges that wellbeing is essentially personal and by no means the same for everyone. The impact of life events may impact very differently on each individual and may influence their wellbeing. Some communities and individuals may have greater or lesser resilience for sustaining wellbeing. Our approach to prevention is therefore flexible, diverse, and responsive to individual need. The prevention framework has three guiding principles - prevention is only effective when individuals (**Me**), communities (**Us**) and public services (**You**) work together. This promotes the strengths-based approach to assessing needs and supporting people that BHR will build on in Transforming Care.

LBR have a multi-agency Autism Working Group for Children which is developing a Child Autism Strategy. **LBH**'s Market Position Statement sets out its commissioning approach and intentions. It will deliver appropriate community based services at scale, including joint work between social care providers and providers of clinical service and develop a robust local response to any emergencies. Havering will access the investment needed to expand and improve at pace including potentially through social investors. In addition it will explore the option of securing capital to deliver high quality housing in community settings, including social investment solutions such as charity bond issues. It will work alongside providers to mobilise new services and housing in the community and with HEE, Skills for Health and Skills for Care; and support current inpatient staff to develop skills to work in our community care programme. Inpatient provision will only be reduced when people are supported to move in an appropriate and timely way to high quality services that meet their needs.

5.Delivery

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

We have drawn up a programme of work (see below) for implementation, and a cross-sector alliance of organisations is already committed to support BHR TCP to deliver on our ambitious agenda. We need to fully identify the team but the Working Group and Shadow Board are in place, and we have a framework of workstreams (see below) upon which the operational delivery of the local programme can proceed. Our workforce development plan is underway and we are currently conducting workforce analysis (see below). We are also developing our Estates Plan to be finalised in 2016/17 – as discussed above.

Communications and Engagement Plan

It is our aim to transform care and develop community services for people of all ages with learning disabilities and/or autism across BHR, by involving stakeholders in developing the local TCP Plan, and shaping, commissioning and implementing new service provision. To achieve this we have been engaging a range of stakeholders to ensure it includes insight from individuals, family carers as well as organisations and our partners who work to support individuals. Engagement with these groups will continue as we begin implementing the three year plan from April 2016.

Aims and objectives

- To engage key stakeholders in the development of the TCP Plan
- To raise awareness among key stakeholders of our ambitions and plans to improve the service
- To engage stakeholders in developing and coproducing the new service provision
- To raise awareness of the new service provision and how it is improving the lives of those with learning disabilities and/or autism.

Stakeholders

A number of key stakeholder groups have been identified who we will engage and communicate with throughout the development and implementation of the TCP Plan.

Stakeholder group	Key stakeholders	Communications and engagement methods

Individuals, family carers, patient/carer groups	Individuals with experience of lived-in care (experts by experience) Individuals who live in the community Families of individuals	One-to-one sessions Small focus groups Easy read materials Workshops Attend group sessions
Interest groups and voluntary sector	Learning Disabilities Partnership Boards (LDPB) Borough Forums Patient Engagement Forums Healthwatch Community and Voluntary Sector (CVS)	Presentations at meetings Email briefings / communications Workshop Social media
NHS and Local Authorities	Local Authority Health and Wellbeing boards Mental Health Partnership boards Autism Partnership Boards Local Safeguarding Boards GPs and clinicians CCG and Local Authority staff Police	Presentations and updates at meetings Email briefings Workshops Intranet Newsletters
Councillors and MPs	Health Scrutiny Committee members Cabinet Member for Health, Adults and Children Local MPs	Presentations and updates at meetings Face-to-face briefing (MPs) Email briefing Workshop Social media
General public	Media Local residents Parents Carers	Using Council and CCG communications channels: Websites Newsletters / publications Media releases Social media

Strategy

Engagement and communications will be delivered in two phases. The first phase involved engaging stakeholders in shaping the TCP Plan. Once the plan is finalised the second phase of engagement will begin and we will continue to work with our stakeholders to shape the new service provision, and raise awareness of our ambition and plan to improve services. As the new services provision is implemented we will also raise awareness of the impact it is having on those with learning disabilities and/or autism in BHR.

Phase one

To involve individuals in the development of our plan we commissioned the National Development Team for Inclusion (NDTI) to deliver targeted engagement. One-to-one sessions were held with inpatients and former inpatients now living in the community.

We also worked with a number of pre-existing boards and groups formed by the local authority, NHS and voluntary sector, as the basis of our engagement with our providers and partners; to gain feedback and to provide strategic insight to ensure our plan fits with the wider social care and health economy across the area.

Our engagement in this phase culminated with an all-stakeholder workshop where we discussed our TCP vision and gained feedback from attendees, which we used to finalise the strategy.

Phase two

Having established networks and relationships with our target stakeholders we will continue to engage with them as we implement the plan and develop the service specifications. Through regular communications and meaningful engagement we will continue to build positive relationships, and work with them throughout the course of the strategy to ensure it meets local need. As well as engagement, we will use existing Council, CCG and provider communications channels, as well as those of our partners, to raise awareness amongst our stakeholders and the public of the TCP Plan and new service provision as it is implemented across BHR.

Key messages

- Help us shape services for people with learning disabilities and/or autism in BHR
- We are improving services for people with learning disabilities and/or autism in BHR
- We are improving care and helping people live more independent lives

Implementation

Audience	Action	Key message
Councillors, Local Authority officers	Presentation to each borough: • Health & Wellbeing Board • Safeguarding Adults Board • Local Safeguarding Children's Board • Stakeholder event • Workshops/meetings with Cabinet Member and Local Authority Directors • Health Scrutiny Committee	We are improving services Help us shape our services Tell us how we can improve

Partners	Presentation and regular updates to each borough: • Learning Disabilities Partnership Board • Autism Partnership Board • Mental Health Partnership Board Stakeholder event	We are improving services Help us shape our services Tell us how we can improve	
Individuals (inpatient and community-based) and family/carers	1-1 sessions with individuals Small focus groups Stakeholder event		
Voluntary and Community Groups	Stakeholder event		
Carers' groups	Stakeholder event		

A detailed engagement and communications plan will be developed to deliver targeted communications with our stakeholders as the new model of care is developed and new service provision is implemented. This plan will focus on communicating and engaging on the detail of the service improvements, showcasing the new model of care, good news stories, and clear, concise information on the impact of the new service provision on individuals.

Monitoring and evaluation

We will measure the engagement and communications through:

- Number of stakeholders engaged with
- Attendance at stakeholder workshops
- Feedback from partners and councillors
- Number of visits to webpages about the plan
- Social media engagement

When we move into phase two and deliver communications to the public, we will also monitor media coverage.

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

The BHR TCP workstreams (and leads) are as follows:

- Empowering People and Families (Barbara Nicholls, LBR)
- Right Care, Right Place (Karel Stevens-Lee, LBB&D)
- Insight Programme and Quality Assurance (Sue Elliott, BHR CCGs)
- Workforce Transformation (CEPN)
- Right Care Programme Data and Information (LBR / RCCG)

- Transition Special Educational Needs and Development (Sue Elliott, BHR CCGs)
- Finance and Estates (Rob Adcock, B&D CCG)
- Implementation and Risks Management (Christine Kane, BHR CCGs)

We will continue develop the Transforming Care Partnership Project Team and governance processes. This will include signed-up Terms of Reference, secondment of resources to the Transforming Care Partnership, and robust governance and reporting to the Programme Board. There will be a full time Programme Manager and Project Leads from each of the organisations are already identified above. Each organisation will delegate responsibilities to other members of staff to report up through the governance process. In this way we will ensure a smooth transition from existing services to the Transforming Care Programme and full integration across the Barking and Dagenham, Havering and Redbridge area.

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

The plan includes tasks and activities to define each workstream going forward:

TCP Project Plan vs 4 290316.pdf

Empowering People and Families

TCP has held stakeholder workshops and will continue to conduct sessions with people with lived-experience (see above).

Right Care, Right Place

Workshops were held across the BHR economy to map out local Borough CTR processes to support patients with LD/Autism in the community, and to understand trigger points for patients being admitted to ATU. This included a workshop at Moore Ward (NELFT) which was attended by NHS England, Moore Ward Manager and NELFT Psychiatrist. The step-down process from Specialised Commissioning is currently being mapped. The next steps are to strengthen CTR processes to include education, LAC and CYP. The mapping process has identified a number of different data sources across Health and Social Care which identify patients at risk. This includes include GP patient lists, data uploaded to HSCIC and local spreadsheets. A key task in the delivery plan is to identify a mechanism to consolidate and share this information across BHR, to ensure that all parties know exactly who is at risk, and that there is one mechanism to ensure that these patients are monitored using a standardised Risk Stratification Process.

Insight Programme and Quality Assurance

The Insight Programme and Quality Assurance workstream has begun to identify Key Performance Indicators to ensure a measurable improvement in life chances for individuals with learning disabilities and/or autism. KPIs will be fully developed during May 2016. Initial measures are described above. The plan includes tasks to develop a pathway for learning from incidents to

embedding practice change, by defining a reporting system to report and investigate incidents. Root Cause Analysis will be carried out on all admissions to ATU.

Workforce Transformation Workstream

The case for change will mean reviewing the skill sets and numbers of our workforce who support people with a learning disability and/or autism: including those, currently working in an inpatient facility in need of retraining prior to being relocated to a community setting. Detailed workforce data has been received from all three boroughs, identifying the existing skill mix and costs for Local Authority and NELFT management of this cohort and resources specifically assigned to CLDTs. Initial analysis of the make-up of the CLDT Teams shows, for instance, that Havering (NELFT) CLDT team has a high number of clinicians across different specialities:

- Challenging Behaviour (1 WTE)
- Psychology (1.5 WTE)
- Speech and Language (1.5 WTE)
- Psychiatry (1 WTE)
- Physiotherapy (1 WTE)
- LD Nurse (4 WTE)
- Community Therapy (2.1 WTE) – includes an Art Therapist

Havering has the lowest cost of inpatients at Moore Ward and out-of-borough, which may be due to this high investment in resources to support individuals with learning disabilities and/or autism in the community. By comparison, Redbridge (NELFT) has :

- 5.7 WTE Nurses
- Occupational Therapists
- 2.5 Physiotherapists
- 1.2 Speech Therapists

Redbridge does not currently employ a challenging behaviour specialist, or provide psychology or psychiatric services. Barking and Dagenham has:

- 2 Occupational Therapists
- 1 Physiotherapist
- 2 Community Nurses
- 1 LD Practitioner
- Speech and Language Therapist

The TCP is collating a complete list of services, and the next steps will be to devise a new workforce model starting in June 2016. Workforce transformation tasks will include the development of personalised care support and treatment approaches through holistic assessments and non-aversive treatment strategies.

Right Care Programme Data and Information

The Right Care Programme Data and Information workstream will define the data required to inform TCP; and will devise a Standard Operating Procedure for reporting patient status. This work is due to commence in April/May 2016.

Transition Special Educational Needs and Development

The Transition SEND workstream tasks will map local care pathways by TCP cohort and need, and develop multi-agency assessments linked to CHC and Annual Reviews. This workstream will develop a universal & preventative local offer on building and preparing for adulthood, and review services for crisis support and respite. Further development of the capacity of CAMHS will be linked to the workforce transformation plan.

Finance and Estates

We are currently developing our Estates Plan and it will be finalised in 2016/17 (see above).

What are the risks, assumptions, issues and dependencies?

There are currently 23 risks on the register. These, and the mitigations we have in place, are detailed in the TCP Issues and Risk Report:

TCP Issues and Risk Report 290316.pdf

What risk mitigations do you have in place

See above

6.Finances

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

End of planning template

Appendix 1: Transforming Care Workshop, Redbridge Central Library on 30 March 2016

VISION

Individuals, their carers and families, service providers and others were invited to take part in a Transforming Care Workshop to help us develop the vision underpinning our plan. John Powell Vice-chair of the BHR TCP Partnership explained to those present that 'the dialogue will continue'.

1. **Provide support in least restrictive way**
   - Additional package arranged by hospital that can be accessed by family and friends

- Communication to be strengthened regarding any key workers, health action plans that can be accessed for example by schools and HE
- Staff training/expertise in BTC will support services/care to be delivered in least restrictive way – supporting them at their worst is where we should focus.
- De-escalation techniques
- Techniques and de-escalation techniques for parents/carers – training
- Admission avoidance
- Strengthened out of hours crisis care
- How we support transient population eg students and re-registering
- Staff trained in how to communication effectively to elicit response
- Include voice of child especially transition

2. **Have good respite that supports families**
   - Continued investment especially in children's services respite/short breaks
   - Links to commissioning intentions from 14
   - 2 types of respite: a) for child/YP/adult
     b) for carer/parents
   - Means testing under Care Act is limiting access to respite for carers/parents
   - How do we consider effect of means testing to access respite/short breaks?
   - Expediency of getting respite package in place
   - Strengthen inclusivity in mainstream rather than just acute respite
   - Shared lives
   - Living 'ordinary lives' like that of any other family eg holidays
   - Why does it need to separate families to 'achieve respite'? most families will come together
   - How does system 'enable' not 'disable'?

3. **Have inpatient care as near to home as possible**
   - SPG Level Tier 4 commissioning – BHRCCGs & LAs
   - Support for BTC in supported living – limited/no local provision/support
   - Awareness raising – eg GPs, school nurse, teachers re MH/autism/BTC
   - Too much focus on parenting; makes it more difficult to get issues identified correctly.
   - Better training/expertise to recognise/identify indicators underlying BTC and underlying conditions
   - Transient staff is an issue in identifying needs
   - Transition tracking needs to start at 14 years of age
   - Develop 'long list' of those not meeting criteria for adult services who are actually likely to be more at risk
   - Life course approach from Early Bird programmes potentially – how does all of this translate into commissioning intentions?
   - Additional services required (Darren Q)

- Befriending parents
- Parent support group (currently not resourced)
- Build on what support is already in place (funded and unfunded)
- See plan before 8th April
- Meaningful input
- Further detailed input/engagement
- Action plan to consult on; How we do IT
- Publish on websites – LA/CCG/BHRuT/NELFT/Vol organisation; have feedback button
- Survey monkey out to ALLS; Link to plan (accessible); suitable to audience – pictures not words
- Reasonable adjustments: example of waiting 35 mins to see GP

4. **Keep trying to reduce health inequalities**

5. **Make good use of community provision**
   - **Respite:**
     - weekend provision more
     - Booked so far in advance
     - Share facilities BHR wide
     - Provider facility
     - Accessible community
     - Audits for individuals
     - Training
     - Use resources that want to be involved
   - **Capacity**
     - services
     - space
     - suitability
   - **Ensure quality of services**
     - PBS training
     - Meet individual needs
   - Current services expected to do more in same provision. Impacts on quality outcomes
   - Better 1:1 care when needed
     - Hard to source
     - Quality
     - Funds

6. **Ensure people have choice and control over their health services**

   Choice and control:
   - Checks – money used for that individual
   - Clear outlines for what it is for

- Menu of services to guide and support: expertise, quality
- Direct Access Methods: Accounting, support JLA (B&D)
- Access to more mainstream services
- Availability
- Cost of services – budget has to be realistic to private costs, not to our budgets
- Facilitate the process; brokerage, advice and guidance
- Q: could register with LD expert GPs rather than current postcode lottery

7. **Early Identification of needs and support**

Children needs – transition

- Treatment plans (BHRuT)

- **Raising awareness in schools**
  - Mainstream
  - Special needs
  - Support for individuals
  - Diagnosis earlier
  - Transition Team in Redbridge working well (E&H Care Plan)
  - Schools to support – What does adult services need to offer individual
  - Some doing well/others not so well
  - PBS at a Young Age – prevention
  - Guidance/support/process for those with complex needs/challenging behaviour/family and staff training
- **MAP process**
  - communication tools
  - Full Access to history

8. **People have access to information, advice and advocacy**
   - Autism HUB (Romford) – successful : satellite to other areas
   - Advocacy
   - HUB/groups
   - Health Drop Ins
   - Website/Leaflets
  - **Council to produce list of individuals**
    - A4 sheet – issue with updating
    - Social Services to distribute
    - Website – guided by A4 sheet
    - Cover all needs/LD/autism/MH/physical disabilities
    - Equipment and support in various locations

  - **Support to research**
    - Find services

- **Information to GPs on health pathways**
  - Autism
  - Easy read/accessible – BHRuT example
  - Alerts to clinical staff to give them info and support (BHRuT)

There was ongoing and broad discussion about the challenges this cohort face and how we might work better together to address them – e.g. we should share facilities BHR-wide to meet individuals needs such as with Challenging Behaviour. We should promote better access to supermarkets and cinemas and provide training. We need to improve capacity and have the right services in right places, supported by brokerage able to choose from a menu of services including access to mainstream services. We need more 1-to-1 support, for instance, and there needs to be resourcing of community providers to do more specialist work. The Havering Autism Hub, based in Romford and run by the Sycamore Trust, should be built on with satellite sites in different areas (with information, equipment and support).

Respite

- There are two types of respite: for the child and for the carer. Respite is being shifted to the Carer Assessment. It's a double whammy. Parent/carers are being means tested [in B&D, not in Havering] and refusing to be financially assessed. Many are not entitled to any provision. Services won't cope with carers.
- It's taken nearly 3 months to get just 5 hours of respite per week. No respite holidays are available. Why is respite only used to separate a family and not to enable them to spend quality time together?
- Why am I being means tested for respite for myself as a parent and carer of a child with learning disabilities? It means I will not accept the service and have to struggle on without it.
- We'd like to be a family unit again. I don't think it will happen again until we have some separation from her.
- Respite doesn't include family holidays – we could use funds for activities etc. Family cruises are brilliant. They're totally safe and they can't get away. Surely you want an integrated family?
- There is not enough respite provision at weekends and key dates such as Easter or holiday periods.

Staff Training and Mainstream Services

- A representative from NDTI talked about the importance of building expertise and confidence in young people in using mainstream services (especially schools) so that they are able to manage Challenging Behaviour.
- Commissioners [says a carer / volunteer] need to build resilience and confidence-building, and an approach that reduces individuals' isolation, into services.
- It is too black and white. They're either disabled in a disabled system or in a mainstream system without support. There doesn't seem to be any grey area.
- Diagnosis needs to be earlier – educate clinical staff.

- People are still not getting diagnosed until their teens or beyond.
- Raise awareness in schools.
- Schools hold a lot of history on children – this is important for transition.
- GPs and other health professionals need more training on identifying and dealing with learning disabilities.
- The school nurse told her [his mother] that she was not a bad parent as the GP had told her [he has Autism]. It is important to raise awareness particularly with GPs.
- There needs to be better understanding and training for key professionals across all local services in particular health and education.
- Health and care plans need to link more closely with schools and teachers need PBS training as do staff in non-secure residential placement settings
- Provision needs to be in place to support my child at her worst as carers are not trained properly to deal with her abusive and violent behaviour.
- She doesn't see herself as disabled and yet she can't function in mainstream without support.
- My son doesn't want to mix with disabled kids – he wants mainstream.
- We're told 'you'll benefit from parenting classes'. We are the first to be blamed for everything.
- It shouldn't be us providing support [another carer/volunteer] ... but there needs to be funding for parents groups like Face 2 Face who have the experience to support parents in similar situations . Additional funding of such groups would allow more support to other parents. It would also allow them to spend more time talking to health professionals and schools to educate them on dealing with people with learning disabilities from people with real life experience.
- Often parents with a child with a learning disability feel like they are bad parents and they are doing something wrong, but they are not. It is the system that needs to adapt to their needs and not the other way around. They would benefit from help and support of others with this lived experience.
- There needs to be constant support e.g. university following a Section [of her daughter's friend] gave her no support. Friends cleaned up the blood of her suicide attempt. Her daughter knew what ward she had been on. Students have to re-register and go back on waiting lists when they're at home. There is no continuity of care.
- It is about communicating appropriately – we [people with Autism] can have difficulty with communicating. I remember at school meeting to assess my needs I was asked can I use the bus. I said yes. What I didn't say was that I was not travel trained. I am glad my mum was there. As we become adults they say 'shut up parent'. But they are almost like our lawyer, fighting our corner since we were a little kid. Empowerment is great but if my mum hadn't been in that meeting that would have really screwed up my support.

Case study

My daughter has Asperger's Syndrome and we are currently falling between gaps in service provision. The CLDT team say she is brighter than average and hasn't got a learning disability. But the mental health team tell us it's not a mental health issue as she has a form of Autism. So she doesn't get the psychological or befriending support that she needs. We are fighting against her ending up in prison or a mortuary. That other stuff about our hopes and dreams for her and all of

that amazing potential she has is irrelevant without that support. There is nothing in the area that will support people with Challenging Behaviour in a Supported Living setting. We see a new person every 6 months to carry out an assessment. Support is not about numbers [3 or 4 to 1] but about being consistently and appropriately robust and effective. Getting staff to do, asking relatively inexperienced staff to deal with frightening behaviour, is really complex. It is about staff training and management, and keeping them motivated. Her Supported Living placement crumbled to nothing. It couldn't support her at her worst. She sits at home on the sofa all day doing nothing. My eldest daughter has moved out. Everything can become catastrophic if she's not supported at her worst. Challenging Behaviour makes everything fall apart. She can be verbally abusive including using racist words. Train your staff not to take offence. Teach them de-escalation techniques and how to do an emergency drill with her. What part of her Care Plan is ringing the police? It's about knowing what her triggers are. They don't know us and all they do is fill out some forms and tick some boxes and we never see them again. There is no continuity of care personnel. My daughter wasn't diagnosed until she was 13.

Appendix 2: NDTI-facilitated engagement with in-patients, those now living in the community and their families

This piece of work involved speaking to a number of providers over the phone and in person to learn from their experiences of supporting individuals in community placements, both successfully and

otherwise. It involved meeting several people with learning disabilities being supported in the community, as well as people who are currently in-patient on Moore Ward in Goodmayes Hospital. The work also included speaking to several carers in order to gain family perspective. We asked them - What has worked well? What didn't work out? What would improve matters for the individuals concerned? How the various agencies involved can work together more effectively?

The report included a number of observations:

- The community support package for people who are a danger to themselves and others needs to be carefully planned for the person to feel secure and confident in their staff, and also to get the backing of families who often have a history of disappointments (and worse) in regard to the services provided. Good clear communication across the board is essential.
- Make the best use of the specialist knowledge that Moore Ward can contribute to the Discharge Plans i.e. regarding what the support package consists of.
- The Commissioners should draw on the expertise of those local organisations that have successfully taken on potentially difficult people when looking to widen the pool of provider sources.
- Look closely at how each person processes information and events, understands what is happening, and how they respond. If you can talk with the person, make sure that you go at their pace and use simple, clear words and instructions. Don't overload people with too much information.
- Make sure that when you present a potential option for community support it has been properly thought through, so that you don't then turn round to the person and their family and say that it isn't going to be suitable or affordable.
- Sometimes, the person's mental ill health dominates their life and they do need specialist care and treatment. At other times, their learning disability is the bigger factor which may impact on their ability to keep themselves safe and well.
- This group of people is totally varied in terms of how they live their lives day to day. They are different in regard to what sort of routines are of benefit or interest, and in how they respond to anything new and different. So the type of support that they each need must vary according to their personalities and needs in order to continue to be successful.
- There are good examples of where services have been developed around and with the person (sometimes with the full participation of their family). A strong staff team has been established that connects well to the individual (sometimes after initial "teething troubles"). The provider shows that they can adapt their support approach, learning from actual experience with the service user, rather than relying on historical reports.
- When they are well, it is important for individuals to do local activities (including work opportunities) that enable them to access the wider community, and build up their self confidence.
- Some people find it hard to take responsibility for their own situations. Support services then have to focus on keeping these service users and others around them safe.
- BHR need to identify local providers with a proven track record.

It also included recommendations for action to support the continued contribution of people with learning disabilities and family members to put the TCP plan into practice during 2016/2017:

- The BHR Transforming Care Plan needs to fully reflect the information collated on the care and support of people it currently provides services for (an approximate number of 16 adults has been given) with short term and longer term goals.
- This information needs to be regularly updated at a known reference point. (Some of the contact information I was given was not clearly defined).
- It also needs to take account of the number of children and young people coming up through transition who will expand the local risk of admission.
- A useful resource in this area with examples of effective local services is: http://pavingtheway.works/ "Early intervention for children with learning disabilities whose behaviours challenge"
- Measures need to be put in place to ensure that there is good, clear communication between all the local organisations involved in providing specialist care and support, and crisis intervention to the individuals concerned.
- It is important that the results of their mutual exchanges are made available and are accessible to the individual and their families wherever possible.
- The contacts made during this piece of work underline the view that when the support provider's approach is geared to the individual (e.g. in a single service package) there is a better chance of success.
- With this approach the person receives a consistency of staffing, a daily structure that means they know what to expect and a stimulating range of activities that offers progression on their own individual terms.
- The BHR Transforming Care Partnership (TCP) should continue to work on sharing the learning from the experiences of local providers (in-patient and Supported Living in the community).
- It should explore the further involvement of the Shared Lives approach for individuals within this group of people who are at risk of re-hospitalisation.
- Drawing on the positive examples in other localities, the TCP should ensure that the voices of people with learning disabilities and family carers continue to be heard during the work of the Transforming Care Board so that the Board's Plan can be scrutinised and publicly held to account.

Appendix 3: Moore Ward Briefing 22 March 2016

Attendees: FinolaSyron (NHSE), Amelia Howard (NHSE), Gordon Mutuvi (NELFT), Ian Milne (NELFT Moore Ward Manager), Sean Gravestock (NELFT Psychiatrist), Christine Kane (BHR CCGs)

Routine Admission Process:

Admission to Moore Ward requires the following:

1. CLDT Care Coordinator who sponsors the admission sends a pre-admission request to Moore Ward.
2. NELFT perform an eligibility step back to the CLDT
3. NELFT has a threshold for admission, which includes needs assessment, legal framework, mental capacity and whether funding is in place
4. A routine admission typically takes up to 2 weeks.
5. A pre-admission CTR is not standard practice at Moore Ward, ie not an established process across the patch, and is dependent on local variations/appetite for CLDT involvement/Psychiatrist on duty.
6. A pre-admission assessment proforma is completed from the following steps/sources of information:
    i. Meeting with the patient and family/carers
    ii. Clinical assessment
    iii. Requires a health action plan
    iv. Hospital passport
    v. GP history
7. Admission is only agreed if the CLDT provides an outcome of admission – what treatment is expected for this patient and an anticipated timeline of length of stay, based on CTR.

Emergency Admission

1. Sean and Ian said that emergency admissions typically occur when a patient is not optimally managed in the community.
2. An emergency admission may bypass the steps above, with patients sectioned and then admitted without following the routine admission steps.
3. An example was a patient living at home had to be moved to residential care as the mother had a TIA. The patient had been taken in by the grandparents, but proved too challenging for them, and, following several attendances at A&E over a couple of days was sectioned and taken to Moore Ward by the Grandparents.

Reasons for not admitting to Moore Ward:

1. The Sponsoring CLDT has not provided a clear pathway to discharge from Moore Ward – Moore Ward will not accept a patient who does not have a clear treatment need and an anticipated timeline for length of stay
2. Where there is no need for treatment
3. Where a patient does not want to be admitted

4. Where a patient's challenging behaviours would risk other patients. In these cases, some alternatives are:
    i. St Andrews, which is a private specialist Autism unit
    ii. John Howard, which is a locked rehabilitation unit
    iii. Cambian
5. Approximately 25% of admission requests are declined by Moore Ward.

Discharge Planning

1. There is currently no formal pre-discharge CPN or CTR (GAP)
2. The discharge steps are:
    i. Outcome of admission is achieved
    ii. There is a vision of where the patient belongs after Moore Ward and local authorities and/or healthcare have provisioned for this
    iii. An OT placement profile is performed to assess the patient's needs. This is mapped to the Environment, the patient's care needs and clinical risks
3. It was noted at the meeting that CPA reviews are performed every 6 weeks, but the CLDTs do not always attend.
4. For short admissions, a CPA is carried out within 6 weeks
5. For longer admissions, the CPA is carried out at 3 months.
6. It is noted that patients often remain in Moore Ward beyond their planned discharge dates due to lack of involvement/engagement from CLDTs and lack of planning for placement following discharge.
7. Sean stated that there would be additional capacity (2-3 months/long stay patient) if discharge planning was started pre-admission, and CLDTs remained engaged with the process.

Gaps:

- Patients with mild LD (MLD) (categorised as IQ 50-70) and social vulnerable may not be known to CLDT.
- High functioning Asperger's patients with challenging behaviours may also not be known to CLDT.
- CLDT Risk Registers are not available to Moore Ward and/or not integrated between the 3 CCGs.
- There is a lack of capacity for SALT for Moore Ward patients
- There is no agreed pathway for patients with challenging behaviours. NELFT has a draft pathway and this is reviewed at monthly meetings, but has not been agreed.

Good Practice:

- LB Waltham Forest has a very good challenging behaviours model
- LB Havering has a good triage model for challenging behaviours
- LBBD has a good CPA

Suggestions for TCP

- NELFT offers outreach services from external providers, such as Spencer and Arlington, which is not often taken up
- Moore Ward can take patients from Tower Hamlets, Waltham Forest, City and Hackney and Newham. Makes sense to contact them to see what their good practices are.
- More training on dealing with challenging behaviours is needed for families of LD patients at home – positive behavioural support
- The meeting highlighted that there are many assessment tools and that different aspects of assessment are done at different times and are challenged by capacity in these services (for example, psychiatric assessment at NELFT Moore Ward is done within days, whereas SALT assessments can take up to 6 months). TCP must look into this.
- CLDT workforce is not consistent across the three Boroughs – some boroughs have high forensic and psychiatric resources, others have high LD nurse contingent. This is the focus of the workforce transformation workstream.
- NELFT is having a Challenging Behaviours workshop on 9th May, and suggestion is that this is extended to CLDT/CCG under the TCP umbrella.
- New providers are emerging: Lilly Close in Rainham, owned by 'Partners in Care, which consists of three bungalows with shared occupancy.

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Havering
LONDON BOROUGH

HEALTH & WELLBEING BOARD

Subject Heading:	CCG Assurance, Improvement and Assessment Framework
Board Lead:	***Conor Burke/Alan Steward, NHS Havering CCG***
Report Author and contact details:	***Marie Price, Director of Corporate Services, BHR CCGs*** ***Marie.price9@nhs,net***

The subject matter of this report deals with the following priorities of the Health and Wellbeing Strategy

- ☐ Priority 1: Early help for vulnerable people
- ☐ Priority 2: Improved identification and support for people with dementia
- ☐ Priority 3: Earlier detection of cancer
- ☐ Priority 4: Tackling obesity
- ☐ Priority 5: Better integrated care for the 'frail elderly' population
- ☐ Priority 6: Better integrated care for vulnerable children
- ☐ Priority 7: Reducing avoidable hospital admissions
- ☒ Priority 8: Improve the quality of services to ensure that patient experience and long-term health outcomes are the best they can be

SUMMARY

Clinical commissioning groups (CCGs) are rated annually by their regulator NHS England (NHSE). Havering CCG had generally been receiving 'good' ratings, but due to the referral to treatment (RTT) delays at Barking Havering and Redbridge University Hospitals Trust (BHRUT), Directions were applied against the CCG, which led to an 'Inadequate' rating and the downgrading of previous scores for 2015/16. The process for rating CCGs in 2016/17 is changing this financial year, with indicative ratings due in the next few months.

RECOMMENDATIONS

To note the contents of the report

REPORT DETAIL

1.0 Introduction

1.1 This paper explains the process by which CCGs are assessed, the current rating and planned approach for 2016/17.

1.2 CCGs) are regulated by NHSE and are assessed annually. NHSE consider the CCG's progress and performance within a number of domains and rate accordingly. Havering and the fellow CCGs in the Barking and Dagenham, Havering and Redbridge (BHR) collaborative have generally secured 'good' ratings. However, the most recent rating has been negatively impacted by the RTT issue.

2.0 2015/16 Assurance Framework and rating.

2.1 Havering CCG was recently issued with Directions in respect of elective care performance at BHRUT. The imposition of Directions impacts on a CCG's rating, and in this case has led to a rating of 'Inadequate'. There were positive areas cited within the assessment, including: 'significant improvements' in urgent and emergency care, excellent understanding of local health priorities, delegated primary care commissioning, patient engagement and good management of our finances.

2.2 The CCG had on balance been receiving good ratings throughout the year. However once the extent of the referral to treatment (RTT) delays to patients became clearer, further action was required to ensure that the CCG as a responsible commissioner focussed on ensuring that BHRUT, as well as the CCG, deliver their respective elements of a joint CCG/Trust recovery plan – due in September 2016. NHSE decided to apply for Directions and this also led to some elements of the previous assessments being downgraded.

2.3 The CCG is working closely with regulators and the Trust to address the serious issue of the unacceptably long waits that patients have experienced. Havering CCG is making good progress and will work to provide NHS England with the necessary assurance leading to the ultimate lifting of the Directions. A briefing is attached at Appendix 1 summarising the issue and positive progress to date.

2.4 The CCG is working closely with NHS England and is clear about what needs to be done to improve the assurance rating. The CCG will work hard over the coming year to make the necessary improvements, in the interests of all people who use health services in Havering.

3.0 New assessment framework 2016/17

3.1 In March 2016 NHSE introduced a new CCG Improvement and Assessment Framework[1] (IAF) to replace both the existing CCG assurance framework and CCG performance dashboard. The approach aims to reach beyond CCGs, enabling local health systems and communities to assess their own progress from ratings published online.

3.2 The *Five Year Forward View*, *NHS Planning Guidance*, and the Sustainability and Transformation Plans (STPs) for each area, are all driven by the pursuit of the "triple aim": (i) improving the health and wellbeing of the whole population; (ii) better quality for all patients, through care redesign; and (iii) better value for taxpayers in a financially sustainable system. The new framework aligns key objectives and priorities, including the way that CCGs are assessed.

3.3 The IAF makes clear that the NHS can only deliver the *Forward View* through place-based partnerships spanning across NHS commissioners, local government, providers, patients, communities, the voluntary and independent sectors. In the IAF guidance NHSE gives primacy to tasks-in-common over formal organisational boundaries and expects CCGs to act as local system leaders, rather than focus solely on what resides exclusively within their own organisational locus.

3.4 There are some delays from NHSE for the initial ratings, which are expected to provide an indicative view (but not formal assessment) on CCG performance for 2016/17, however a limited number of scores for three areas have been issued. These cover dementia, learning difficulties and diabetes, with initial assessments of 'performing well, needs improvement and greatest need' for improvement respectively. Progress has been made in a number of areas which we expect to see reflected in the final end of year assessment ratings. The Committee will be updated once there is further detail.

IMPLICATIONS AND RISKS

[1] https://www.england.nhs.uk/commissioning/ccg-auth/

Financial implications and risks: Not applicable. Item is for information only.

Legal implications and risks: Not applicable. Item is for information only.

Human Resources implications and risks: Not applicable. Item is for information only.

Equalities implications and risks: Not applicable. Item is for information only.

Appendix 1

Referral to treatment (RTT) and directions

The NHS Constitution gives patients the right to access services within 18 weeks following a GP referral. BHRUT suspended formal reporting of its Referral to Treatment (RTT) performance in February 2014 due to a lack of confidence in its ability to reliably report the numbers of patients waiting.

BHR CCGs and BHRUT were subsequently tasked by NHS England (NHSE) and the Trust Development Agency (TDA), now NHS Improvement (NHSI), to develop and deliver an RTT recovery and improvement plan.

In March the Trust revealed it had more than 1,000 patients waiting over 52 weeks. Since April, the main focus of the CCGs has been the RTT issue and the efforts to tackle these significant and unacceptable delays for local patients.

In June, Havering CCG received specific Directions from NHS England (NHSE) in relation to RTT. Directions are a way of formally highlighting areas where regulators feel they need more assurance that CCGs are able to effectively deliver their plans – including those developed with local partners. The Directions were issued against Havering CCG only, because it leads on the BHRUT contract for all three BHR CCGs.

We are, of course, disappointed that NHS England has applied legal Directions to the CCG but it wasn't a surprise and we welcome the extra support that this gives to the system to continue our focus on resolving the issue.

BHRUT does not have sufficient capacity to address all of the issues currently, so commissioners and the Trust have agreed a joint response that includes:

- Redirection of waiting patients to alternative providers by GPs
- Demand management including use of alternative providers, (including additional community provider clinics)
- Clinically led Pathway review across 10 specialty areas by CCG and BHRUT clinicians
- Improving patient pathways to reduce delays and duplication
- Trust looking to increase capacity through staff recruitment
- Trust looking to increase activity through its operating theatres.

As of 12 September, GPs across BHR had managed to redirect 6,747 patients to alternative providers with a 40% reduction in referrals overall, thus reducing the pressure on BHRUT and helping patients get the treatment they need more quickly. For their part, the Trust had cut the 52 week waits list to 319.

The CCG is clear that addressing the RTT challenge remains our absolute priority. Pathway redesign is progressing well and additional provision from current and new providers is being sourced. The aim of this is to help ease the pressure on

BHRUT and enable them to focus in particular on those who have been waiting for over 52 weeks.

Clinicians from BHRUT and the CCGs continue to meet on a monthly basis through our joint clinical reference group to agree new pathways, while the CCGs have a weekly internal RTT programme meeting – attended by the Havering CCG Chair - to monitor progress on delivering against our demand management plan.

Our GP members receive weekly updates from their CCG Chair outlining developments with new providers and referral routes, as well as the latest in terms of patient numbers.

Our recovery plan must be finalised for September 2016 and draft plans have already been produced. Progress on this is monitored through the joint RTT Programme Board.

Patient safety is of paramount importance and the Trust has agreed a clinical harm process drawing on good practice developed elsewhere. This is being implemented with both an internal and external harm review panel meeting to review progress and outcomes.

It is anticipated that the earliest recovery of the 18 week standard will be March 2017; however there remains substantial risk to achieving this due to the volume of patients who have already breached their 18 week wait. Priority is given to any patient that has waited over 52 weeks to make sure that they are treated as soon as possible. Focus is also being given to patients waiting above 18, but below 52, weeks to ensure that the over 52 week waiting list does not increase.

We expect our demand management schemes, hospital outsourcing arrangements and pathway redesign work to deliver even better results in the coming months and for our patients to be getting the safe, high quality care that they are entitled to.

We will work to provide NHS England with the necessary assurance of these improvements, leading to the ultimate lifting of the Directions against Havering CCG as soon as possible.