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HEALTH & WELLBEING BOARD

Subject Heading:	Transforming Care Partnership
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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

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

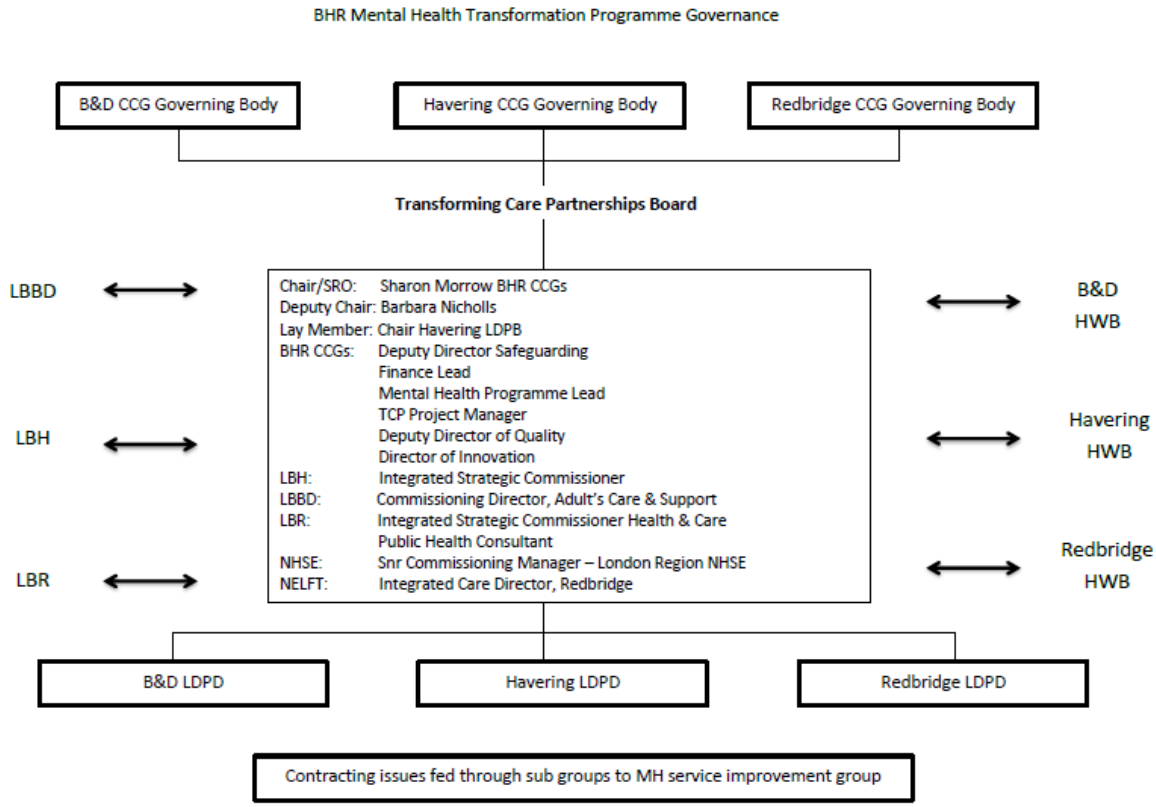
Totals across all three boroughs	Year 0 (2015/16)	Year 1 (2016/17)	Year 2 (2017/18)	Year 3 (2018/19)
NHS England commissioned inpatients	9	7	6	6
Inpatient Rate per Million GP Registered Population NHS England commissioned	15.53	12.08	10.35	10.35
CCG commissioned inpatients	17	15	11	8
Inpatient Rate per 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.

Havering
LONDON BOROUGH

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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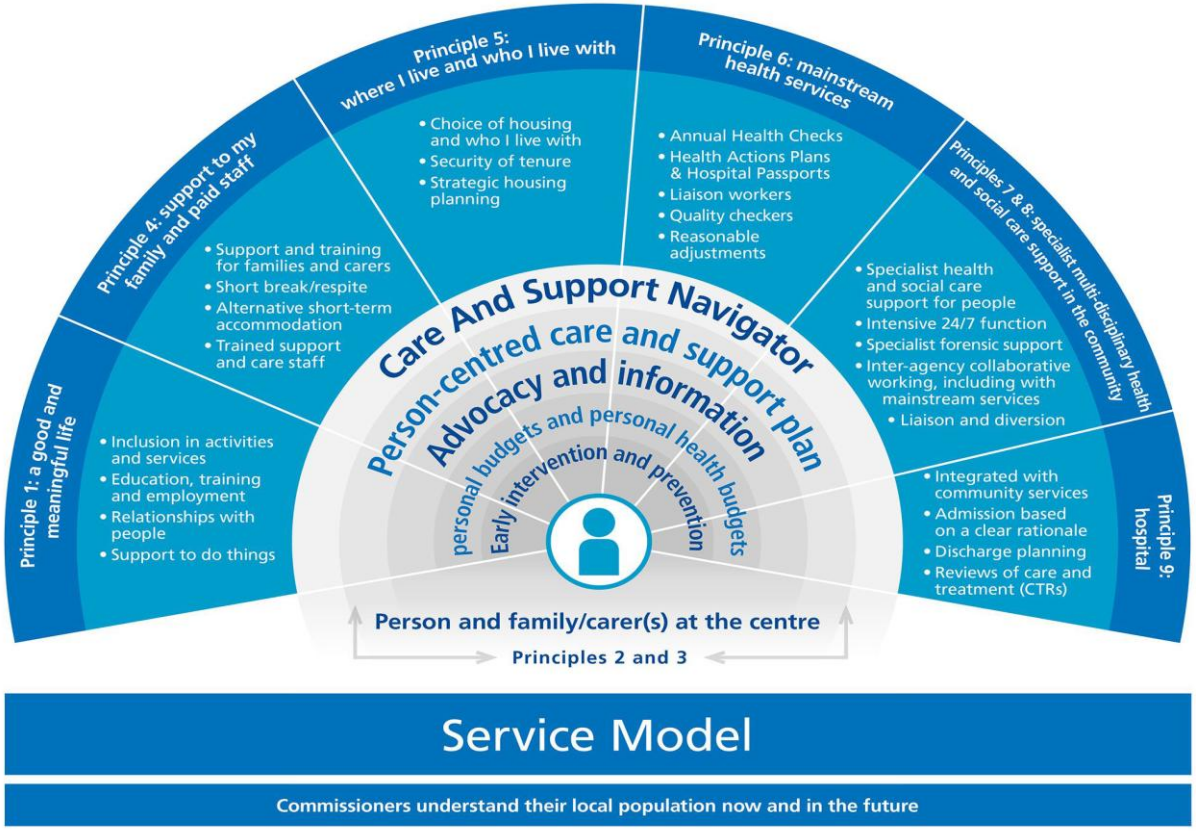
Appendix 1 – National Service model



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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	

Havering
LONDON BOROUGH

	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	

Havering
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	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	

Havering
LONDON BOROUGH

	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	

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		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	