Health and Wellbeing Board Tuesday 18th October 2016	Tower Hamlets Health and Wellbeing Board
Report of the London Borough of Tower Hamlets and Tower Hamlets CCG	**Classification:** Unrestricted
Transforming Care Partnership Plan	

Lead Officer	Denise Radley, Debbie Jones and Simon Hall
Contact Officers	Carrie Kilpatrick Deputy Director Mental Health and Joint Commissioning Karen Badgery Service Manager Children's Commissioning
Executive Key Decision?	No

Summary

In October 2015, LGA, ADASS and NHS England published **Building the right support**, a national plan to reduce inpatient provision and enhance community services for people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition. Building the right support sets out the ambition to mobilise commissioning collaborations of CCGs, NHS England specialised commissioners and Local Authorities to create Transforming Care Partnerships (or TCPs), tasked to deliver a specified national service model of good practice by March 2019.

Tower Hamlets CCG and Local Authority have been working as part of the Inner North East London Partnership to identify its key priority areas and develop a set of commitments able to deliver our local and collective aspirations to improve the quality of life for children, young people and adults and with a learning disability and/or autism who display behaviours that challenge; and their families.

This report provides the Board with the Inner North East London Plan as informed by a detailed analysis of our strengths and weaknesses in delivering services for this group. It sets out both our collective local aspirations to provide:

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

Recommendations:

The Health & Wellbeing Board is recommended to

1. Note and endorse the detailed commitments of the Inner North East London Transforming Care Partnership Plan.

DETAILS OF REPORT

1. Introduction and Overview

1.1 In October 2015, LGA, ADASS and NHS England published **Building the Right Support**, a national plan to reduce inpatient provision and enhance community services for people with a learning disability and/or autism who display behaviour that challenges. Building the right support set out to mobilise commissioning collaborations of CCGs, NHS England specialised commissioners and Local Authorities across England to create Transforming Care Partnerships (or TCPs), tasked to deliver a specified national service model of good practice by March 2019.

1.2 The programme aims to achieve a better community infrastructure resulting in a substantial reduction in the number of children, young people and adults with a learning disability and/or autism who display behaviour that challenges, placed in inpatient settings; and where they are admitted, a significant reduction in their length of stay. The overall aspiration being to ensure a better quality of care and a better quality of life for these often marginalised individuals and their families.

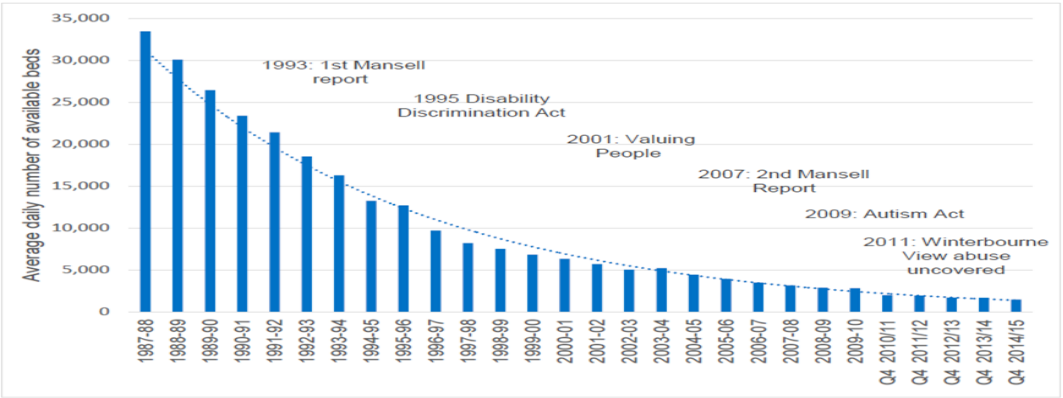
1.3 The reach of this programme is extensive; it aims to address the needs of both adults and children with a learning disability and/ or autism who:

- Have a mental health condition such as severe anxiety, depression, or a psychotic illness, and those with personality disorders.
- Display self-injurious or aggressive behaviour, not related to severe mental ill health, some of whom will have a specific neuro-developmental syndrome.
- Display risky behaviours which may put themselves or others at risk and which could lead to contact with the criminal justice system.
- Are not always known to health and social care services, who display behaviour that challenges, including behaviours which may lead to contact with the criminal justice system.

1.4 The model which has been developed with people with learning disability and/or autism, as well as families/carers, sets out how services should support people who display behaviours that challenges. At its core is the belief that we all have a basic right to live in our own home and to develop and maintain an active role in society. To achieve this aspiration local areas are challenged to mobilise innovative housing, care and support solutions within the community to enable this to happen for all, including those with the most complex support needs. The model is structured around a number of principles seen from the point of view of a person with a learning disability and/or autism.

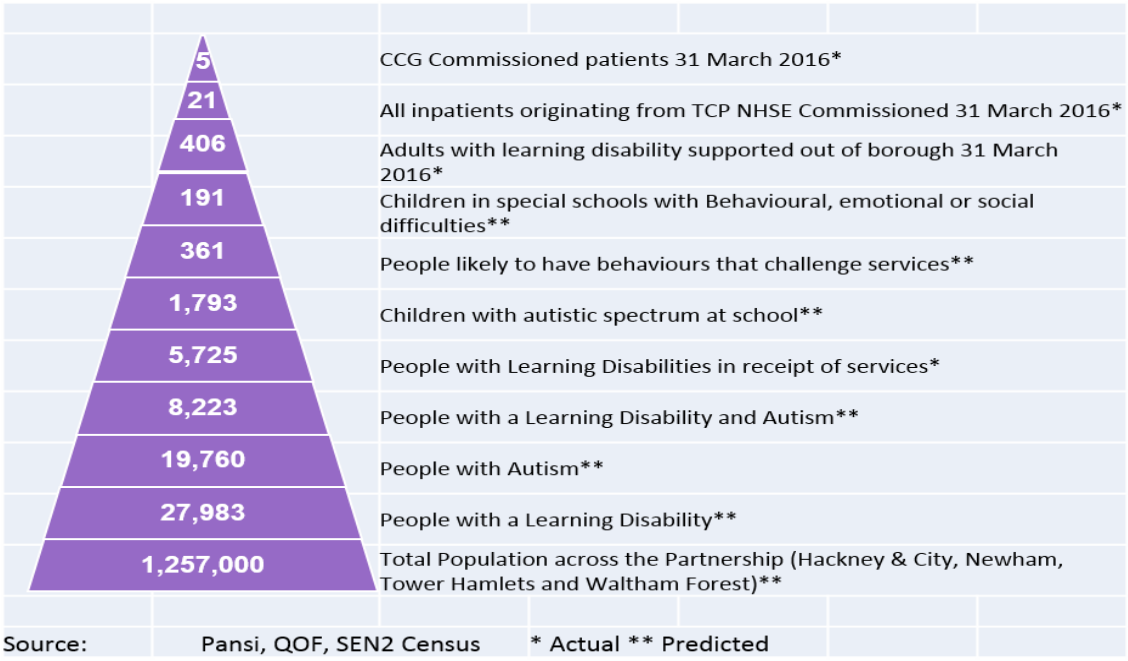
1.5 The Programme directly addresses the Winterbourne View scandal by committing to reduce over reliance on inpatient care. In February 2015 NHSE commenced a programme to close inappropriate and outmoded inpatient care, by establishing stronger support in the community. However progress nationally has been slow. As the graph below demonstrates, after an initial reduction in inpatient admissions, results have plateaued. Perhaps more stark is the disparity in the length of time people stay in an inpatient facility of this type; approximately a third of the people currently in hospital have been in inpatient settings for five years or longer.

Figure 1: NHS learning disability beds since 1987[3]



1.6 In order to secure significant and lasting change, a key requirement of Transforming Care Plans for each local area is the reduction or closure of hospital assessment and treatment units (ATUs). Each area is expected to commission no more than 10-15 CCG beds and 20-25 inpatients in NHS England-commissioned low, medium and high secure units[1].

1.7 Across the partnership our population of adults and children placed in such inpatient settings is relatively low. At an INEL level, we currently have 12 people in CCG commissioned beds, plus 18 in NHSE commissioned secure beds. Our planning target for 2019 is to reduce these numbers by 25%, which, while still a significant target, is lower than those TCP areas with high levels of in-patient bed usage.



INEL Regional picture of need

2. The Tower Hamlets Context

2.1 To fully understand the implications for Tower Hamlets and how we will seek to prioritise this programme locally, an overview of existing services and support for children, adult and families has been outlined, together with initial priority areas highlighted for further work. This has been co-produced with multi-agency professionals, providers, families and carers.

The Adult Population

[1] Per million population

2.2 In Tower Hamlets we are starting from a position of strength. We have a solid service model to build on, good local expertise within our services and a well-regarded local treatment offer. The intake teams and mental health and challenging behaviour long term team provide a pathway which includes psychological, speech and language input in addition to access to other services from the integrated team. The team also supports wider health access to mainstream health services, for example, through working with health colleagues to ensure reasonable adjustments. We are committed to providing personalised support and have been active in using mainstream mental health services, and building bespoke support for many people who challenge. The CCG is also currently implementing a pilot project to expand the use of Personal Health Budgets which will expand to comprehensively cover this whole cohort.

2.3 We have relatively low numbers of people overall in inpatient provision; In Tower Hamlets we have not made a hospital placement of this type for the last 5 years. In line with national best practice, where necessary, people with learning disabilities and/or autism who have a mental health crisis access mainstream community psychiatric services where an inpatient admission is necessary.

2.4 Tower Hamlets currently has 3 adults placed by specialist commissioning in low to medium secure units. Currently these are placed in a medium secure unit in Norfolk, the John Howard centre and one young person placed in a CAMHS hospital placement.

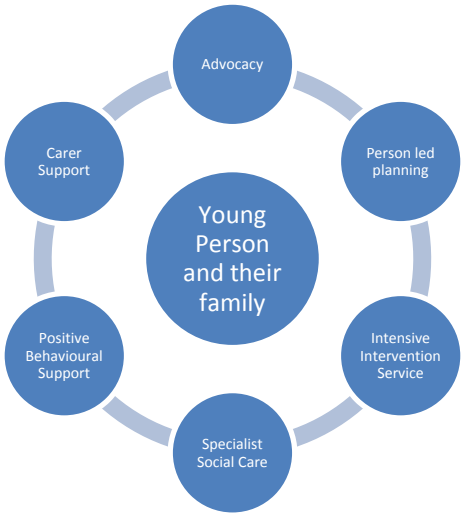
Adults in Tower Hamlets	Numbers
People with LD	4,848
People known to CLDS	850
Total number of People known to CLDS who have been categorised as meeting the criteria for this categorisation	143
Number of people categorised as a medium to high risk of admission	31
Number of out of borough LD placements	114
Number of out of borough LD placements considered to be within this cohort	45
Total number of People known to CLDS who have been categorised as within this cohort, and at potential risk of a future hospital admission, who have previously been admitted to Mile End Centre for Mental Health	43
Number of people with LD who have been admitted to Mile End Centre for Mental Health in 2015/16	7
Number of people with LD currently in secure units	3
Number of people in Assessment Treatment Units	0

2.5 In addition there are thought to be around 1,910 adults with ASD in Tower Hamlets in

2011, approximately 765 of whom do not also have a learning disability.[2]

The Children's Picture

2.6 The vision for children and young people in Tower Hamlets is consistent with the national service model, the Children and Families Plan and CAMHS Transformation Plan. Good emotional health and wellbeing is promoted from the earliest age; Children, young people and their families are supported to be emotionally resilient. Tower Hamlets has a variety of services providing behavioural support to young people and their families.



2.7 The whole children's workforce including teachers, early years providers and GPs are able to identify issues early, enable families to find solutions, provide advice and access help. Help is provided in a coordinated, easy to access way. All services in the local area work together so that children and young people get the best possible help at the right time and in the right place. The help provided takes account of the family's circumstances and the child or young person's views.

2.8 As a result fewer children and young people escalate into crisis, and fewer children and young people require in patient admission. If a child or young person's needs escalate into crisis, we want good quality care to be available quickly and delivered in a safe place. After the crisis the child or young person will be supported to recover in the least restrictive environment possible, as close to home as possible. We also aim to ensure that when young a person requires residential, secure or in patient care, this is provided as close to home as possible.

2

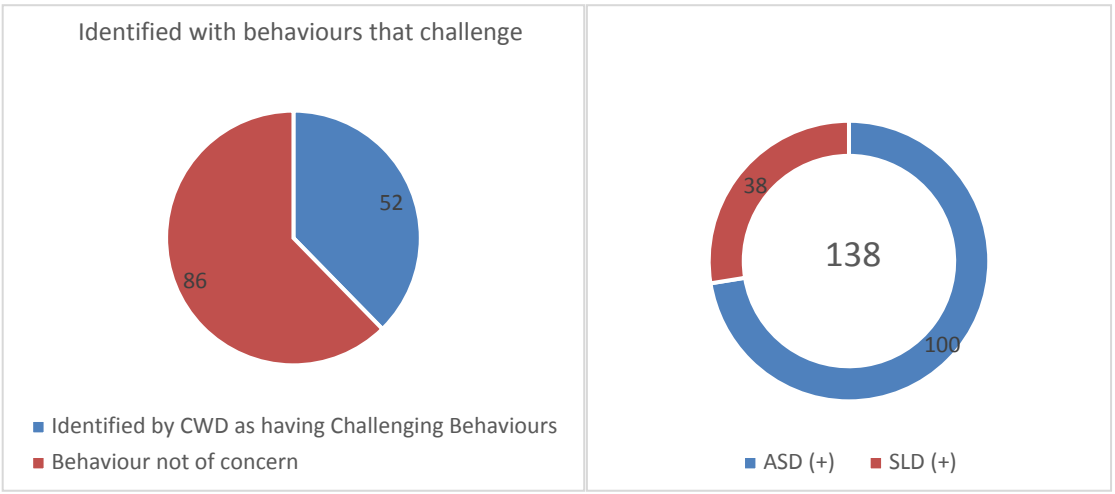
Tower Hamlets Joint Strategic Needs Assessment Autistic Spectrum Disorder: Factsheet 2010-2011

2.9 There is no one database that categorises whether a child displays 'challenging behaviour.' As such data to demonstrate the local need has been brought together from a range of key sources to build a local picture of need. As of December 2015, there were 794 children and young people aged 0-19 years with a diagnosis of Autistic Spectrum Disorder (ASD); 1.2% of the 0-19 population has a diagnosis of ASD, which is in line with national expectations. Data suggests a considerable increase in the number of children being diagnosed with ASD; 2.3% of 5-9 years have a diagnosis of ASD compared with 1.7% of 10-15 year olds. It will be important that provision and resources keep pace with this considerable increase in identification and diagnosis.

In addition it is estimated that there are less than 10 young people with autism/learning disability in touch with Youth Offending Team.

2.10 Using the special educational needs (SEN) database to ascertain SEN type and cross referencing with Children with Disabilities social care records we have a snapshot.

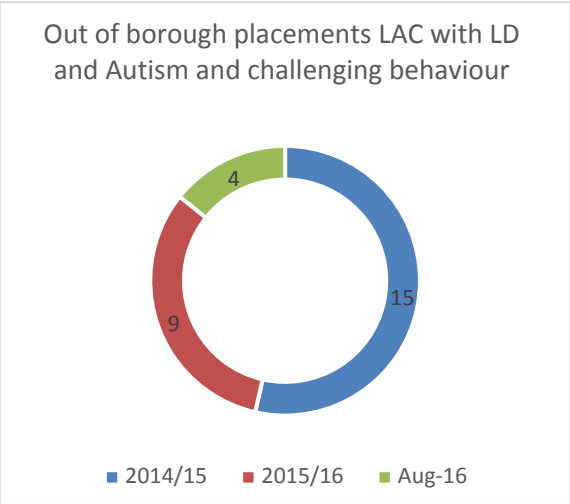
2014/15 data (SEN database and CWD client files) 13-19 years old

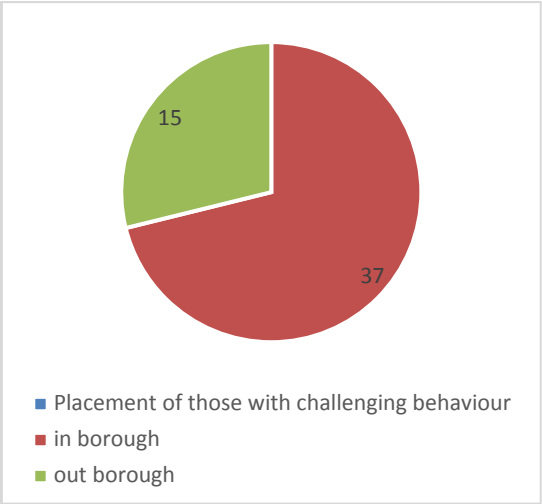


SEN Type

2.11 Scrutiny of out of borough placements data indicates a year on year reduction in these numbers, this is in line with the Borough's focus on this area as a priority. We can confidently say that there the reasons for this reduction in out of borough placements relate primarily to:

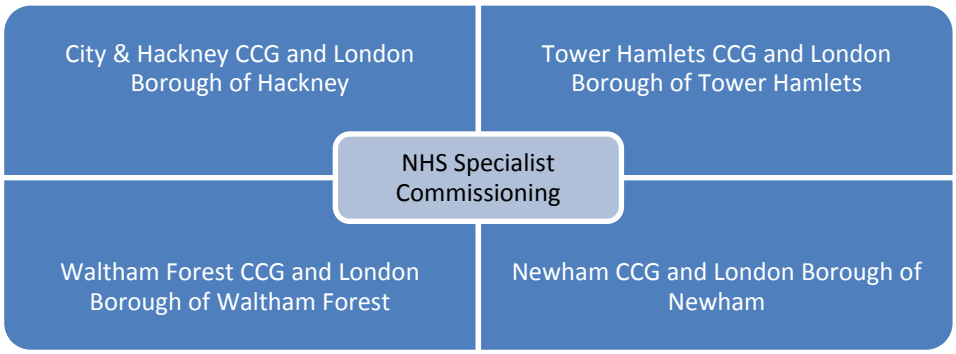
- Early identification of issues related to challenging behaviour through assessments; and early partnership working with schools, the Disabled Children's Outreach Service and the short break provisions.
- Our use of overnight respite services, including Discovery Home and House, specialist holiday provision and proactive care packages.
- Quality Assurance in relation to co-ordinating a single panel through education, social care, short break provisions and home.





3 The Inner North East London Transformation Partnership Plan and Tower Hamlets Local Priorities.

3.1 To ensure collaboration across the area and a co-produced approach we have established a Board comprising representation from each geographical area. The Board will be responsible for overseeing the development and delivery of the Programme.



3.2 In developing the plan we have also been able to gain the input of people and their families through Interviews with families who have recently experienced an inpatient admission, to understand better what might have prevented crisis and admission to hospital and what would enable successful and sustainable support in the community.

Coproduction Events	Date	
TCP Provider Workshop	3rd June	✓
TCP Carer Workshop	24th June	✓

Tower Hamlets LD sports day	19th May	✓
Carers Forum	10th May	✓
Transforming Care in Tower Hamlets	1st June	
Learning Disability Partnership Board	21st March	✓
Challenging Behaviour Sub-group	25th April	✓
LD Health Sub-group	16th March	✓
Families and Carers Event	24th June	✓
Families, Carers and stakeholders final Event	14th Sept	

3.3 Despite the solid foundation, we know that there is room for improvement and as a region we have identified common areas where we wish to collaborate to improve, and others where we can use learning from one part of the TCP to inform and improve. In particular we will design our approach around around three core components:

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

3.4 We want to provide:

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

3.5 To date, the partnership has focused on the crisis end of the challenging behaviour pathway. This is in line with the national requirements to reduce inpatient care. In order to meet the National commitment to close inpatient facilitates; preventative work and early intervention, from the beginning of the life course, is paramount. As such the partnership has produced a plan which will see years 2 and 3 of the programme, and the aligned Tower Hamlets local delivery plan, focus on prevention and early intervention, particularly in childhood, to improve outcomes. This is a broad area which spans from pre-diagnosis of autism and learning disabilities, early years support, schools provision, SEN support, Health provision, children's social care and the transition into adults services. This is not simply about specialist support but mainstream services.

3.4 Our regional plan focuses on identifying areas where there is an evidenced based case for working sub-regionally to deliver change as well as developing

and enhancing our local offer. As such the regional plan will be aligned to a local delivery plan in each Borough. This will enable us to build on the good practice within each locality to ensure that our use of more institutionalised hospital settings continues to stay low in the future.

- **Out-of-borough residential and specialist educational placements for adults, children and young people**
  Although our inpatient numbers are low, as a partnership we have many people living outside our borough boundaries because we have not been able to support them locally, so our plan will explore options to develop a more regional solution with the overall aim of placing both adults and children, where possible, closer to home. In Tower Hamlets this work will focus primarily on the development of a programme to increase local personalised accommodation options.

- **Workforce Development**
  Enabling providers to support those individuals and their families with the most complex needs builds resilience into community placements and enables people to benefit from skilled staff throughout the range of services they use, both specialist and mainstream. We will ensure a consistent level of expertise in key areas – communication, positive behaviour support and person centred planning and active support. Existing workforce partnerships and the footprint means this is an approach that could benefit from being delivered over a broader footprint.

- **Personal Health Budgets**
  Tower Hamlets will take the lead in ensuring there is an aligned approach to the development of the TCP and Integrated personal commissioning objectives. As a national demonstrator site for Integrated Personal Commissioning our IPC cohort includes both adults and children with learning disabilities. We are actively developing integrated planning and budgeting models building on existing Community Learning disability Teams' care planning processes for adults and the education healthcare planning process with children. The TCP cohort has been identified as an early point of focus for the IPC work (including identification of PHBs for these individuals). Tower Hamlets will be leading the way for our TCP and we will be seeking to learn from them to inform local plans in other boroughs.

- **Risk Register of children with challenging behaviour**
  All INEL partners, including Tower Hamlets, have yet to implement a children's risk register. Existing virtual registers within children's services, hold information on this cohort of children. All these registers are subject to statutory review processes and assessment. Schools, SEN team, CAMHS, YOT, children's social care and GP's will be involved in establishing a multi- agency register by the end of the 2016; this register will ensure that we are able to focus on those at greatest risk of admission.

- **Pathways – Transition**
  Wider transition has been identified as an area for on-going improvement in LBTH. Importance of early transition planning to deliver effective, personalised support into adulthood. There is much work going on in this area to ensure that effective, personalised, person centred planning begins at age 14 (in line with Council policy.)Processes around assessments, allocation of cases, early support planning, multi-agency working and frequency of reviews are all being looked at internally.

3.5 To align with the sur-regional governance structures we are working to establish the local governance structures responsible for delivery of the key priorities for both children and adults.

The Children's delivery plan will be embedded within the early intervention working group; Children and young people with disabilities strategy group and Children and Young People's programme board ; As well as being embedded within the reviews currently underway in SEN and Early years redesign.

The Adults delivery plan will be aligned within the governance structure of the Learning Disabilities Partnership Board as a formal subgroup of the board. The key priorities will also be embedded within the Autism and Learning Disability Strategies which are currently under development.

9. COMMENTS OF THE CHIEF FINANCE OFFICER

This report is an information report and does not contain any policy change that will lead to new financial commitments. All the services provided by Children's Services, mentioned in the report, are covered within existing budgets.

The Council spends 37% of the Adults' social care budget on learning disabilities and related services. As the following table shows the services are divided between the client cohort covered by the Council only, and the jointly provided services with Health via the Community Learning Disability Service (CLDS). A further £330k is allocated from Better Care Funding (BCF) which is dedicated to adults with autistic needs.

Services	2016-17 Forecast Spend
	£'000
Learning Disability Care Packages provided by LBTH	21,425
Joint Community Learning Disabilities Services (CLDS)	1,173
Learning Disabilities Day Centre part of CLDS	414
Grand Total	**23,012**
As % of the overall Social Care Budget	37.12%

The activity demand on the Council's learning disability care packages budget has not seen any significant increase since April 2016. However, currently the CLDS is running with a budget pressure of £486k.

There is a risk that the reduction of inpatient services will translate into additional demand on the community based services provided by the CLDS.

Demand for high learning disability needs is mostly included in the mental health care packages budget of which the Council is forecast to spend c£7.3m this year.

Given the significant budget allocated to learning disabilities and its associated needs it is expected that the recommendations contained in this report will help to meet the demand for the services mentioned within the given resources in an efficient and sustainable manner.

The Transformation Care Plan intentions are to concentrate on preventative services which in turn will reduce long term demand for care packages which should contribute to addressing the current and future budget pressures within the CLDS.

10. LEGAL COMMENTS

10.1 Building the Right Support is a national plan 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. After the publication of Building the Right Support, NHS England, the Local Government Association (LGA) and the Association of Directors of Adult Social Services (ADASS) supported the creation of 48 Transforming Care Partnerships (TCPs).

10.2 Each of those 48 TCPs have been working on their plans to change services in a way that will make a real difference to the lives of children, young people and adults with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition.

10.3 Tower Hamlets is part of the Inner North East London TCP plan and this report is advising the Health and Wellbeing Board of this Plan as well as an

informed by a detailed analysis of the strengths and weaknesses in delivering services for this group. It sets out the collective local aspirations to provide:

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

Linked Reports, Appendices and Background Documents

Linked Report

- NONE

Appendices

- NONE

Local Government Act, 1972 Section 100D (As amended)
List of "Background Papers" used in the preparation of this report
List any background documents not already in the public domain including officer contact information.

- NONE

Officer contact details for documents:
Carrie Kilpatrick, Deputy Director of Mental Health and Joint Commissioning, LBTH and TH CCG

Appendix 1:

Inner North East London

Transforming Care

Partnership Plan

Introduction

The Transforming Care Partnership (TCP) includes:

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

This plan is for

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

We want to provide

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

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

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

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

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

What is the case for change?

We have analysed our current collective position, consulting widely. We have looked at our population trends. We have assessed how we currently fit against the individual criteria set out in the National Service Model. We have considered the current provision for the wider cohort and we have concluded that, while we have a relatively low number

of people in hospitals, some are there inappropriately. We know that we send people to residential boarding schools and residential homes away from east London. We know that our current local provision is patchy in quality and insufficient in capacity and resilience.

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

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

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

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

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

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

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

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

8. We understand that our current systems and practices do not enable a ‘whole life’ approach and that timely and consistent support is often not available, contributing to

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

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

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

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

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

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

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

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

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

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

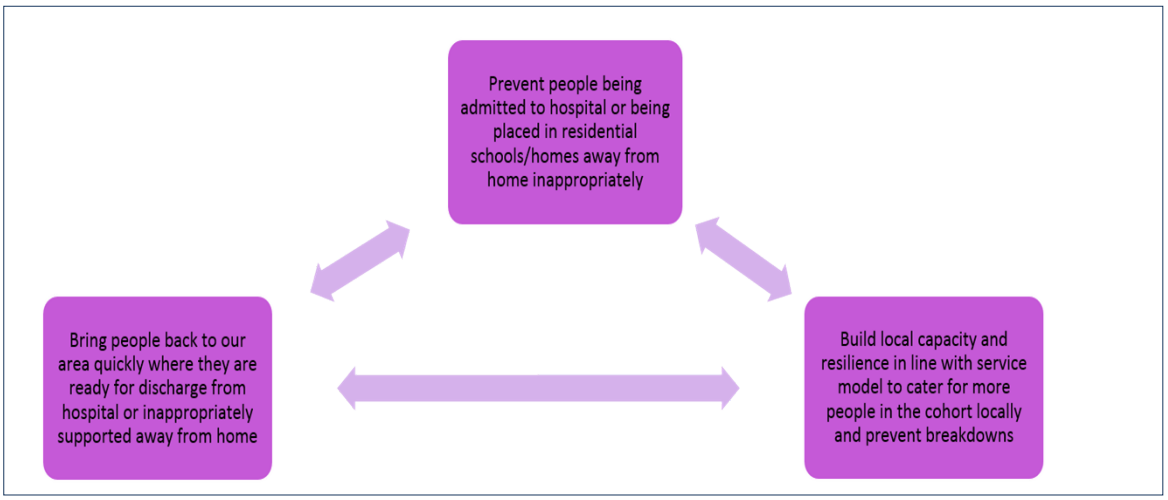
- Understanding the impact of transition periods and creating a smooth journey through starting school, transition through schools, from child to adulthood and through moving from the family home

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

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

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

What this will look like



Main Transforming Care Partnership initiatives

We have a detailed plan but our main initiatives are:

Instilling the right methodology

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

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

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

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

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

Personal Health Budgets

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

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

Housing

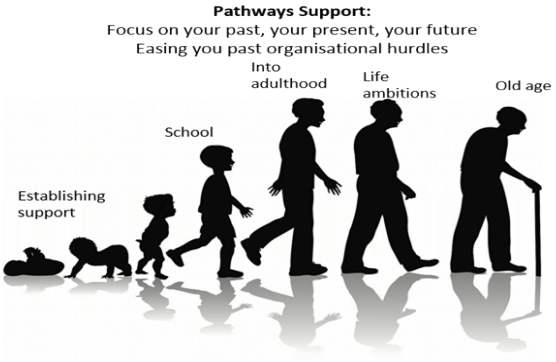
1. We will review the housing we have now and plan to ensure that people with challenging behaviour do not have to leave the area because there is nowhere for them to live locally. We will consider what people might need in their housing and seek to accommodate that. This will involve a review of NHS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

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

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

Pathways (priority area)

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



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

Providers (priority area)

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

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

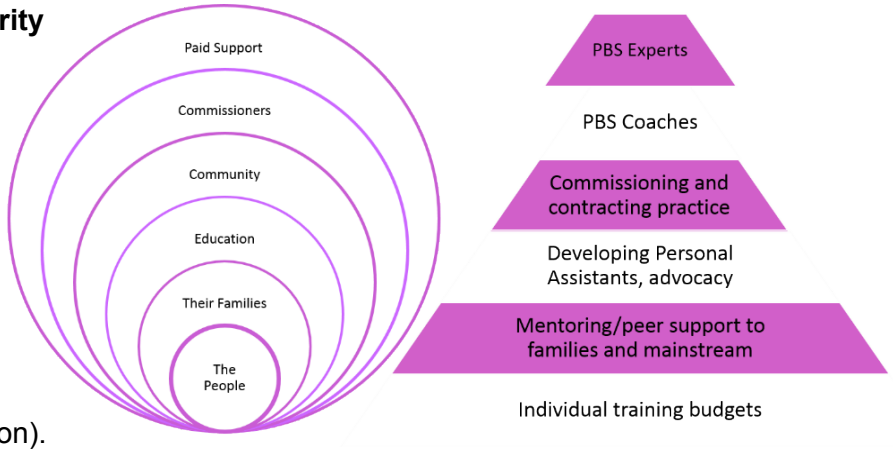
3. New guidance for reviewing officers will be developed to enable them to understand success in these services and to be able to identify risks early.

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

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

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

Workforce development (priority area)

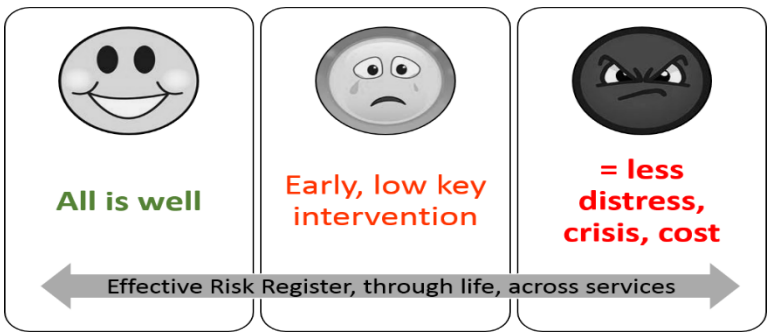


1. We will establish a full framework for competence (in staff, families, networks) throughout the person's life. Training will be accredited and where people are paid link to a professional framework (health, social care, education). This includes support to families and Personal Assistants, and an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

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

Risk register (priority area)

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



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

Contingency plans

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

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

Respite

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

Peer Support

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

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

Hospital treatment

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

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

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

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

Our partnership

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

2. We will integrate the work plan into existing roles across the partnership and recognise the need for additional capacity and expertise to ensure delivery of the

plan, including developing a specification for a strategic transforming care lead to enable the plan to be delivered.

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

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

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

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

Outcomes

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

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

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

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

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

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

6. Transition review completed and recommendations implemented.

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

8. Skilled advocacy will be in place.

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