# North West London Transforming Care Partnership

## Memorandum of Information

### 1. Background

Following the publication of Building the Right Support in October (2015), the North West London Transforming Care Partnership (NW London TCP) was established to improve the care and support available for the people of NW London with a learning disability (LD) and/or autism who also have a mental health condition and/or challenging or offending behaviour.

The Partnership includes representation from the eight NW London boroughs and CCGs, NHS England and Specialised Commissioning. It aims to avoid unnecessary admissions, reduce the reliance on out-of-area inpatient care, and reduce lengths of stay by ensuring a range of community and inpatient services and support is available locally. Achieving an effective model of integrated community and inpatient services and support is key to delivering the TCP's strategic aims. This includes maximising the use of local mainstream mental health services where it is safe and appropriate to do so.

### 2. The needs of the Transforming Care cohort

People with LD and/or autism who are placed in or are at risk of admission to an inpatient setting are a highly heterogeneous group and the integrated model of care and support needs to reflect that diversity. The profile of the inpatient cohort from NW London broadly falls into these categories:

- Mild LD with a diagnosed mental health need
- Moderate or severe LD and autism with challenging behaviour including self-injurious behaviour
- Mild LD and / or autism with a forensic history, with /without a mental health diagnosis
- Autism without co-occurring LD with a mental health need, including eating disorders
- Autism without a co-occurring LD who display challenging behaviour

People may also have needs relating to drugs and alcohol, complex health conditions, physical needs disabilities, and live with families who are difficult to engage or where the dynamics are complex.

### 3. Inpatient population

As at 31st July 2019, there were 71 people with LD and/or autism from NW London placed in inpatient settings; seven of these patients were children and young people (CYP). Since the TCP was established in 2016, the partnership has successfully achieved a 27% reduction in the overall number of inpatients. The needs and circumstances of the remaining patients are highly complex, and often individual. NHS England has set renewed targets for 2019/20 and there is an increased focus on the quality of inpatient provision.

| Commissioner | No of patients as at 1st July 2019 | Target for 19/20 |
|---|---|---|
| CCG (Adults) | 36 | 29 |
| NHSE Specialised Commissioning (Adults) | 28 | 29 |
| NHSE Specialised Commissioning (CYP) | 7 | 6 |
| **Total** | **71** | **64** |

## 4. Progress

Over the past two years, the TCP has:

- Agreed an integrated model of care and support
- Developed an overarching service specification for the provision of Community LD Teams (CLDTs)
- Commissioned a peer-led review of the autism diagnostic pathways in three of the boroughs (Westminster, Brent and Harrow)
- Produced guidance on establishing risk of admission registers
- Secured funding from NHS England to support the eight boroughs to develop their local community infrastructure
- Commissioned training courses including autism awareness training for staff working in mental health services, LD and autism awareness training for frontline staff working in acute services, carer-led training on challenging behaviour for families, Positive Behaviour Support
- Produced a housing plan
- Contributed to the development of a proof of concept pan-London community forensic service which is being commissioned by NHSE Specialised Commissioning
- Worked with colleagues in NHSE Specialised Commissioning to repatriate patients in out-of-area low- and medium-secure settings back to London

## 5. The proposed model for North West London

The NW London TCP has developed an integrated model of care and support for the Transforming Care cohort across the eight boroughs to support people close to home and in the least restrictive setting. The proposed model emphasises the principles of Building the Right Support and the need for early intervention, proactive and reactive support to avoid admissions (including the use of dynamic risk registers), and Care (Education) and Treatment Reviews (C(E)TRs). ***See Appendix 1***

## 6. The current gaps

NHS England has set challenging targets in relation to achieving a further net reduction in the number of inpatients, and the delivery of community and inpatient C(E)TRs for 2019/20 and 20/21. There is a risk that the NW London TCP will not meet these targets as the needs and circumstances of the remaining patients are complex, and there are currently gaps in local provision.

Just over half of the current CCG-funded patient cohort are placed out-of-area. This presents a challenge for commissioners in developing positive relationships with providers, chairing Care and Treatment Reviews and monitoring the quality of provision. Similarly, it presents an issue for inpatient providers in developing an understanding of the local community infrastructure which is essential in supporting the smooth transition of patients back to the community. The development of local inpatient services could potentially support a shorter length of stay as it is easier to maintain essential links with family, friends, clinicians, support networks and commissioners.

The TCP has reviewed the relevant services commissioned by the CCGs, Local Authorities and NHS England across the eight boroughs and identified the following gaps in provision:

- Insufficient capacity within local LD assessment and treatment services resulting in a reliance on out-of-area placements
- A lack of local step-down beds to facilitate move on from secure settings for patients with LD
- An opportunity to improve access to services at all stages of the local mental health care pathway for people with LD and/or autism, including out-of-hours crisis care
- A lack of NICE-compliant autism diagnostic services and specialist multi-disciplinary post-diagnostic support for autistic adults who don't have LD
- The systematic use of dynamic risk registers by commissioners and Community LD Teams (CLDTs) as a tool for proactive crisis and contingency planning is not fully embedded in all localities
- A lack of specialist community support services for people with LD, autism and challenging behaviour (e.g. housing, day opportunities, respite)
- Supported housing for people with LD and/or autism who have forensic histories
- Crisis accommodation as an alternative to a hospital admission

## 7. Priorities for NWL TCP

The TCP has agreed a portfolio of initiatives to support the development of a whole systems community offer with improved access to specialist evidence-based support and universal services. Some initiatives will need to be implemented locally, whilst others will be led by the TCP, largely influenced by the commissioning landscape, locally defined needs and the specialist nature and volume of the services to be provided. These priorities are currently being reviewed in light of the recently published NHS Long Term Plan.

### 7.1 Local delivery

Commissioners have committed to ensuring that local strategies, market position statements and commissioning intentions all articulate the plans to develop the market in order to provide a wide range of specialist community based services (e.g. supported living, respite, crisis accommodation and day opportunities) for the Transforming Care cohort. These plans will promote access to universal services and provide more opportunities for choice, independence, employment, and education. Technology-based support which contributes to increased independence will be considered as an addition or alternative to traditional support models.

In order to promote consistency in quality across the eight boroughs, the TCP has produced an overarching specification which describes the specialist integrated services to be delivered by the CLDTs in NWL. It is recommended that this specification is adopted by CCGs where contracts are under review or due to expire, and consideration is given to the arrangements for monitoring contracts against both the requirements and the quality and performance indicators. There is provision to append a local specification to reflect the specific requirements in response to locally defined needs and priorities.

CCG Commissioners will continue to work collaboratively with CLDTs and CMHTs to embed the systematic use of dynamic registers and community CTRs as crisis and contingency planning tools in business as usual operations, and strengthen the links between the registers for children and young people and adults to aid transition.

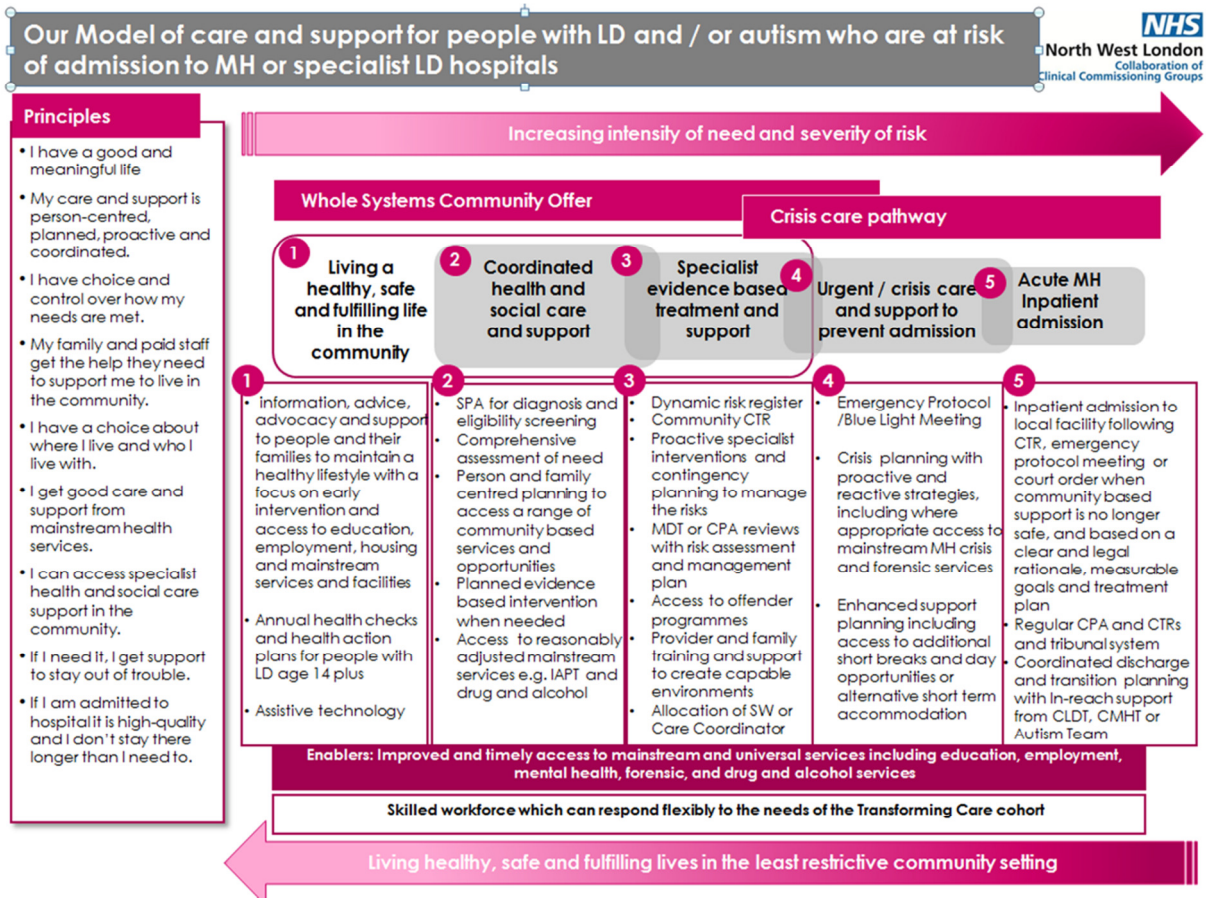
### 7.2 Delivery across NWL

The following key initiatives will be delivered at a regional level:

- Implement a market engagement strategy to develop and shape local specialist inpatient services and explore alternative contracting options to reduce reliance on out-of-area placements
- Make explicit the need to make reasonable adjustments for people with LD and/or autism in the Transformation Plan for Crisis Care and the contracts with the trusts
- Use the findings from the autism pathway review to recommend improvements to current provision and, if applicable, to inform an options appraisal exploring the benefits of developing a regional/sub-regional autism diagnostic service
- Input further clinical and commissioning views into the development of the pan-London community forensic service ensuring that any gaps are addressed, to evidence the need for this service, and shape provision post-pilot stage
- Carry out a deep dive into the admissions of children and young people to develop a shared understanding across the TCP of the needs and circumstances of the inpatient cohort, common themes, risk factors and gaps and what action is needed to reduce admissions and length of stay
- Develop a workforce plan
- Work with local authorities, CCGs and providers to introduce risk registers for autistic adults who don’t have LD

# *Appendix 1*

## Integrated Model of Care and Support




**Steps 1 and 2** of the model rely on a whole systems community offer which includes improved and timely access to mainstream and universal services as well as specialist evidence based treatment and support provided by the CLDT or CMHT when needed. The starting point should always be for mainstream services to support people with LD and/or autism, making reasonable adjustments where necessary and with access to specialist multi-disciplinary support from the community teams as appropriate to ensure people experience the same health outcomes in line with the general population. For the Transforming Care cohort, access to annual health checks, health passports, drug and alcohol services, and mainstream mental health services including IAPT are particularly relevant.

Another key to the success of the model is person-/family-centred support planning with access to advocacy services and skilled and experienced social care providers that deliver supported living, residential care, respite, and day opportunities in community settings. These all support opportunities for choice, independence, employment, and education. As mentioned previously, technology-based support which contributes to increased independence should be considered as an addition or alternative to traditional support models.

The model recognises the importance of good support to families, ensuring they have access to support well before they reach crisis point. Information, advice, training and support should be available for families to support them in their caring role, including access to peer support.

**Step 3** of the model describes the additional specialist clinical and social care support that should be made available to people with complex sensory, emotional, behavioural and / or mental health needs who are presenting some level of risk to themselves or others which can't be safely managed by universal services or within their current care package. Interventions would be dependent on individual need but could include functional assessments, positive behaviour support plans, communications passports, medication reviews, restriction reduction plans, offender programmes and sensory integration plans, and subject to regular reviews coordinated by an allocated care coordinator or social worker. Clinicians would provide specialist training and consultancy to the community providers and / or the families to support them to create capable environments at home and in other community settings. Family therapy should be made available, especially during the transition phase.

Access to reasonably adjusted offender programmes and interagency treatment and support should be made available to adults with offending behaviour who are presenting an increased level of risk to themselves or others which can't be safely managed by the CLDT on their own. The CLDT would continue to hold the case but would seek support from the forensic team to undertake a joint risk assessment and formulate proactive strategies to reduce risks.

Dynamic risk/admission avoidance registers should be used systematically to identify people who may be at risk of admission, with regular MDT discussions with local commissioners to formulate contingency plans and specialist early interventions. There should be a link between the children and adult registers, where young people are approaching transition. Where it is felt that the risks are likely to continue to escalate, a community CTR should be organised.

**Steps 4 - 5** illustrate the interagency interventions needed to support people in crisis and avoid unnecessary inpatient admissions or placement breakdown. This includes the need for crisis and contingency planning via emergency protocol meetings where there is insufficient time to organise a community CTR. Crisis and contingency plans should be shared with relevant clinicians working in mainstream MH crisis services such as liaison psychiatry and health based places of safety where appropriate. A Social Worker or Care Coordinator should be allocated to lead on support planning, which should consider the impact on the family system and make provision for respite and additional support.

Crisis and relapse prevention treatment and therapeutic offending programmes led by a specialist forensic team should be available for adults with serious offending behaviour who are at risk of admission to hospital or prison.

If people are admitted to hospital, it should be following a Care and Treatment Review (CTR), emergency protocol meeting or court order and be in a service close to home. Where appropriate, patients with mild LD and a mental health diagnosis should be able to access mainstream MH beds. Clinicians and social workers within the relevant community teams should work with commissioners to agree the outcomes of the admission which should be made explicit in the contract with the inpatient provider as well as the patient's care and treatment plan.

Following an admission, the relevant community team in consultation with the commissioner should undertake a root cause analysis to identify any unmet needs, share lessons learned and reflect on

what, if anything could have been done differently to avoid an admission. The findings should be used to inform changes to local policies and practice.

Multi-agency reviews and discharge/transition planning and regular in-reach support from the relevant community team(s) and support providers should commence at the earliest opportunity. Training and support provided by the community teams will allow providers to prepare for a smooth transition. The forensic team would facilitate the safe and effective discharge of patients with forensic histories into suitable accommodation in the community. The forensic team would hold on to the case, with support from CLDT, until the level of risk can be safely managed in the community.