# Joint transformation planning template

## Planning template – Hammersmith and Fulham

## 1. Mobilise communities

### Governance and stakeholder arrangements

**Describe the health and care economy covered by the plan**

Hammersmith and Fulham population was measured at 182,493 at the time of the 2011 Census and has increased by 10.4% since 2001; this was the eleventh lowest population growth in London.
Excluding the City of London, it is the third smallest of the London Boroughs in terms of area, covering 1,640 hectares.

London Borough of Hammersmith and Fulham (LBHF) and Hammersmith and Fulham Clinical Commissioning Group (HF CCG) have section 75 arrangements in place which include Learning Disabilities and Mental Health services.

For children and young people appropriate placements are identified through a collaborative approach with social care and education, local authority partners and CAMHS, through a monthly panel that takes into account the complex needs of the young person, their family and individual needs.

- Learning Disability Services are provided by Adult Social Care and Central London Community Healthcare NHS Trust (CLCH)
- Mental Health services are provided by West London Mental Health Trust (WLMHT)
- Hammersmith and Fulham have a compact provider landscape locally.
- Local supported accommodation solutions include accommodation and support services.
- Yarrow housing and Metropolitan are the two main provider of supported living in borough.
- Yarrow are also the registered provider under contract to provide residential care

There are no Assessment and Treatment inpatient settings in Borough and these placements are spot purchased outside our Borough boundaries.

**Describe governance arrangements for this transformation programme**

LBHF and HF CCG have arrangements in place with Housing, providers through existing mechanisms such as our Learning Disability Health Steering Group (LDHSG), Learning Disability Partnership Board (LDPB) and Learning Disability Executive Board (LDEB).

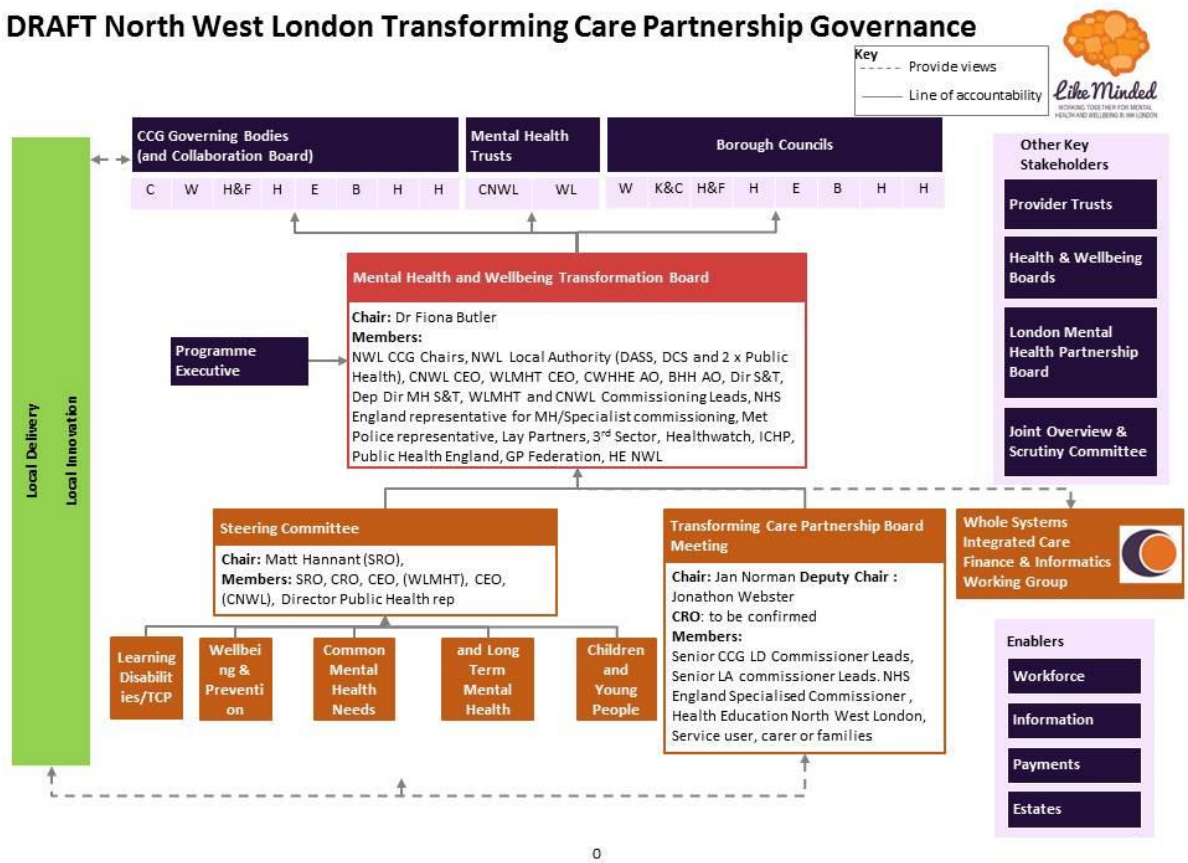
In addition to this there is an Autism Partnership Board (APB) that includes people on the Autistic Spectrum who do not have a Learning Disability.

The Boards cover the geographical areas of Hammersmith and Fulham, Kensington and Chelsea and Westminster.

The attendance includes commissioning, operational and provider staff, which enables us to look at strategy, implementation, performance, and delivery across a fairly wide area and to share challenges, solutions and good practice. This also means that we are able to utilise shared resources by having efficient representation on our TCP Board and feedback to a wide range of stakeholders through a range of mechanisms as well as feeding in to the TCP from wider stakeholders.

**North West London Governance**

The North West London Transforming Care Partnership Board provides leadership and assurance on the delivery of the TCP plan and will oversee progress of all the agreed work streams. The Transformation Board is chaired by the Senior Responsible Owner (SRO), Jan Norman, Director of Quality and Safety, Brent, Harrow and Hillingdon CCGs Federation. The Deputy SRO is Jonathan Webster, Director of Quality, Nursing and Patient Safety for Central London, West London, Hammersmith and Fulham, Hounslow and Ealing CCGs. Membership includes senior commissioning representation from learning disability, mental health, and children's commissioners from local authorities and CCGs.




In addition to the Partnership Board, a working group is being developed to drive implementation with fortnightly meetings scheduled. This will feed into the Partnership Board.

The NWL TCP Board is established as a strategic commissioning forum – with agreed

routes for wider engagement across our provider base outside of the Board. The TCP Board reports to the NWL Mental Health and Wellbeing Transformation Board which has the senior executive and clinical leads from key partner organisations – including representatives from the West London Alliance from Directors of Adult Services, Directors of Children's Services and Directors of Public Health.

We welcome the membership of NHSE as a full partner and critical member of the Board.

**Describe stakeholder engagement arrangements**

There has been engagement between LBHF, HF CCG Housing and a small number of family carers through the Boards identified in our Governance arrangements above, as well as ad hoc discussions with family carers who have raised the challenges that they face with mainstream general acute pathways outside of the Mental Health pathway. This includes the cohort with very complex health needs.

We have engaged with our Safeguarding Board which includes a wide range of providers across the health and social care economy and presented a progress report in relation to transforming care.

We are clear that we need to engage a wider cohort of stakeholders across the whole age pathway to ensure that we are able to achieve the outcomes identified in our strategic plan. This will need to include:

- People that use services or are likely to use them in the future
- Family carers
- CCG commissioners
- Local Authority Commissioners
- Housing
- Education
- Providers

We have already developed some mechanisms for this including, but not restricted to:

- LD Partnership Board (next meeting in May)
- LD Executive board
- LD Health Steering Group
- Carers Partnership board
- Safeguarding Board
- Local offer group
- Preparation for Adulthood Steering Group
- Green Light toolkit meetings
- Accessible Mental health awareness events

Local strategies for Transition and Learning Disabilities Housing in consultation with stakeholders have highlighted issues for this cohort of people.

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

Due to the time constraints of this first draft of our plan we have not been able to co-produce the content fully.

We do however have plans to do so and this will inform our final plan. This approach will test our planning assumptions and provide a real opportunity for challenge.

We will use our local existing resources to achieve this through our third sector partners including MENCAP Parents Active and Safety Net People First (specifically for children and young people).

We will also utilise the skills of people with lived experience of Autism through our Autism partnership Board and local Autism services including our assessment and diagnosis service.

Ongoing planning will also build on existing coproduction structures through partnership boards, sub-groups, groups such as the Parents Reference Group and Carers groups. Engagement of care coordinators will be key to ensure a realistic focus on the holistic needs of the people they are planning with and the issues or barriers they are facing on the ground.

**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**

**Any additional information**

The process of locally developing plans for the numbers of inpatient beds we will commission in the next 3 years - in compiling the NWL picture it is clear that we have a significant ambition to transform the experience of people – and our ability to support individuals outside inpatient settings. It is also clear that as a first submission we need to fully interrogate the data and define implementation plans for delivering this ambition. We anticipate that numbers will change It is acknowledged that there is more to do in order to strengthen the financial and activity modelling ahead of the submission on 11st April

## 2.Understanding the status quo

### Baseline assessment of needs and services

**Provide detail of the population / demographics**

Our data from the last Learning Disability Self Assessment submission identifies that there are 503 people with Learning Disabilities in Hammersmith and Fulham. This is broken down in to the following age cohorts:

People with Learning Disability

| | |
|---|---|
| 0-13 years | 40 |
| 14-17 years | 21 |
| 18-34 years | 192 |

35-64 years 215
64 and over 35

Learning Disabilities with complex or profound disability
18-34 years 15
35-64 years 13
64 and over 31

Learning Disabilities with an Autistic Spectrum Condition
0-13 years 9
14-17 years 7
18-34 years 33
35-64 years 12
64 and over 2

These numbers are lower than National and London prevalence rates due in part to a lack of affordable housing locally and families leaving the area to access specific education requirements.

The National Service Model identifies 5 groups of 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 people with personality
- disorders, which may result in them displaying behaviour that challenges;
- Display self-injurious or aggressive behaviour (not related to severe mental ill health), some of whom will have a specific neuro-developmental syndrome where there may be an increased likelihood of developing behaviour that challenges;
- 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);
- Often have lower level support needs and who may not traditionally be known to health and social care services, from disadvantaged backgrounds (e.g. social disadvantage, substance abuse, troubled family 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.

Our information on these groups of people under 14 is underdeveloped as we do not collect data that categorises people with a learning disability and/or autism into these distinct groupings. We have however started to develop our At Risk of Admission registers to reflect these groupings since the publication of the National Service Model in October 2015.

The “at risk of admission” registers will reflect the 5 needs groupings to ensure that we have appropriate levels of risk stratification. Work is ongoing with transition and children’s services as although we are including age 14 years and upwards there is a gap in the out of area 52 week residential educational placements.

The development of our registers will link young people from age 14 to the interventions that will keep them well for longer and identify local solutions to some of the triggers to their

behaviour that will challenge services.

The main risk here is related to those not already in touch with services; we believe that the highest numbers will be from those on the autistic spectrum. The local Learning Disability teams may not pick up these people without a Learning Disability. We hope that the local autism assessment and diagnosis service will identify this cohort, but we may need to develop this pathway further.

**Analysis of inpatient usage by people from Transforming Care Partnership**

There are five people using inpatient services funded through Hammersmith and Fulham CCG, currently in inpatient services and one additional person remains with NHS England under specialised commissioning arrangements.

There have been no new admissions or readmissions in year.

As identified in the wider North West London plan there are challenges in relation to the provision of accommodation and care services in Borough, however we are exploring the use of shared ownership schemes with this cohort.

The total Continuing Healthcare costs for Hammersmith and Fulham in 2015/16 is £3,836,300

The cost of the low secure forensic bed for the occupancy this year (full year NHS England funded) is £143,365

The cost of the CCG commissioned placements for this year (full year) is £1,094,118, the individual annual costs range from £101,957 to £413,214, dependent on need and placement.

These placements are all spot purchased on an individual basis according to the needs of the patient.

Two of these placements are in Special Residential Services previously known as long stay Hospital placements at Harperbury Hospital. There are some risks with this due to the legal challenge in relation to move on arrangements with this placement.
It may be likely that both of these patients when discharged will need/choose to remain in Hertfordshire as this is where their local community has been for many years.

Our other three patients are currently located in Colchester, Hemel Hempstead and Norwich.

There is no inpatient provision in Hammersmith and Fulham.

Prior to the development of at risk of admission registers; the community LD Team were working with people who were at risk of admission to avoid acute assessment and treatment admissions in favour of other approaches including neuro physiotherapy with good results.

We are currently developing our “at risk of admission” registers to formalise this activity and improve the range of opportunities and the people that may benefit from these approaches.

**Describe the current system**

Within Hammersmith & Fulham; Queensmill School specialises in supporting pupils with autism. They provide satellite units and outreach support to other local schools. They are extending to provide post 19 education provision for young adults with autism.

The commissioning of support services for people with Learning Disability in Hammersmith and Fulham is governed by robust section 75 arrangements. The Learning Disability team is integrated with care management overseen by the Local Authority and clinical staff overseen by Central London Community Healthcare (CLCH) NHS Trust.

Support needs are identified through a holistic health and social care assessment and referred to appropriate support services within the team for specialist support via a wide range of clinical support including Nursing, Speech and Language Therapy, Physiotherapy, OT, Psychology and Psychiatry. A transition worker is embedded within the team and Learning Disability Nurses are involved in the assessment process.

The all age population of Hammersmith and Fulham population estimate is 178,685. Hammersmith and Fulham have identified a target of no more than 2 people in inpatient services by the end of 2018/19. This fits with the National target in building the right support of between 10-15 patients per million population.

This will require a reduction of three people over the next three years, which we feel is achievable, despite the complex nature of the current cohort of patients.

As identified above currently 4 out of the 5 cohorts outlined in the national service model are supported through a caseload model through the Learning Disability team if they have a learning Disability, whether they are on the Autistic spectrum or not. People on the Autistic spectrum without a Learning Disability are assessed, diagnosed and referred on to support services by the specific Autistic Spectrum Condition diagnostic service that sits within Park View Centre for wellbeing in Hammersmith.

There is a challenge in terms of capacity due to the changing nature of the requirements of the community team in respect of improving quality within budgetary constraints. Transforming care reporting requirements have an impact on the capacity of key roles within the Learning Disability team as well as our joint commissioners.

Local housing stock that is suitable for this cohort remains a challenge, despite the relatively low numbers of people. Work is ongoing to find local solutions but this is likely to remain a significant challenge.

Developing the local provider workforce will also present challenges as will the move away from block placements in supported and registered accommodation towards personal budgets and personal health budgets.
We have recently run a market development event to stimulate the provider market, where we were outlining the approach to personalisation including Individual Service Funds.

Providers at this event have issued some challenge to this approach identifying risks to local organisations as well as identifying the difficulties in recruiting staff of sufficient quality.

In Hammersmith and Fulham we faced significant challenges in providing Annual Health Checks to people with Learning Disabilities, however by connecting our CCG primary care

leads to our Nurses in the Learning Disability team we have improved performance last year to 95% health checks with a similar rate of health action plans.

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

There are 14 Supported Living schemes for LD offering tenancies for 59 people. These are through 3 main providers including LBHF.

2 residential care homes through block contracts housing 12 people.

19 residential care placements are spot purchased locally.

We have secured a Learning Disability quota for the Housing Register:

Housing Options quota of 5x 1-bedroomed/studio properties of general needs accommodation within its Housing Allocations Plan for people with Learning Disabilities who require general needs accommodation.

5 bed residential short break services –(LBHF)

3B Shared Lives Scheme commences March 2016 – will utilise properties of Shared lives Carers for long term arrangements and short breaks.

**Co-ordination**
An LD housing project group including commissioning, care management and housing co-ordinates work to progress access to appropriate accommodation.

**Developments:**
There are links with 3 regeneration developments in H&F. This could yield over 20 properties for LD, including fully accessible units over next few years.

Contracts for 12 schemes expire in 2016 and 2017 so opportunity to move to more personalised and flexible contract arrangements being explored. Property assessments underway at 9 schemes.

Work is underway by one provider to move to individual service fund arrangements.

Two Shared ownership schemes are currently being explored

**Challenges**

- Cost of inner London properties and land.
- Much existing stock not of the size or accessibility that is required.
- Limited properties with outside space
- Limited space to build new properties
- We have identified that the current inpatient cohort need for housing is a core and cluster model, which is not currently feasible in Borough.

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

The current provision does not always produce the best outcomes for this cohort and we need to "flex" our local offer to meet the changing needs of people currently using inpatient services. We also intend to consider the needs of children and young people currently engaged (or needing to engage) with our CAMHS and residential educational placements, to ensure that our plan reflects future needs and assists us in meeting our target of reduced educational residential placements and future inpatient numbers that are avoidable. We understand that a range of approaches will be required to meet the diverse needs of this cohort and this may include some short term intensive support and interventions in an inpatient setting, we expect that in the future this will be the exception and most people will have their physical and mental health needs met in the local community.

We believe that our starting point for accommodation (including care and support) will be the family home or an independent accommodation setting where the individual will live with appropriate levels of support.

For those individuals who want to live with their family they should be supported to do so with a family support service, helping families to work through areas of conflict, identifying triggers and developing a plan to manage behaviours that challenge and risk.

This support may include a strong respite offer (if supported by the family), or community access, and employment. We would like to make more use of volunteers with training as remuneration. Ideally these volunteers will have lived experience of Learning Disability (and Mental Health where appropriate) and use this as a route in to employment.

The overarching principle must be that it is needs led and integrated support through a single assessment process and that the individual feels supported through the process.

We need to develop skills in the workforce to support people most effectively and provide similar support for families to ensure that they are well equipped to provide an appropriate level of support.

Access to high quality advocacy is required to help uphold people's rights and ensure their voices are heard

**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**

Gaps remaining:

- Community provision for former inpatients (from 2009) we are currently unable to access this data set, but will seek this information for the final report.
- Community Learning Disability costs- bottom line is correct but LA/CCG split had to be adapted as the format will not let me enter any more than £1000,000
- Capital investments/receipts- not currently aware of this, but will establish for our final plan

- Transforming care funding requirements (3rd Tab) are currently being scoped
- Children costs are unavailable in this format at the moment but we are working on isolating these costs to be included in our final plan

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## 3.Develop your vision for the future

### Vision, strategy and outcomes

**Describe your aspirations for 2018/19.**

a model of care that will ensure that people with Learning Disabilities and/or Autism are able to live life with the same access to opportunities that any other member of our community is able to access. This will mean that individuals and their families are part of the decision making of where they live and what support they will access to live a meaningful and productive life.

We want this cohort to have:

- An opportunity to learn
- Appropriate employment or volunteering opportunities that may lead to work
- Choice and control
- A home to call their own
- Community participation
- A sense of being part of the local community
- Opportunities to manage their health with the level and quality of support that they need in the community wherever possible
- Opportunities to avoid behaviours that will lead to the criminal justice pathway

For the Tri-Borough CAMHS there is currently a review being undertaken of the whole short break offer made to children, young people with disabilities and their families aged 0-18 across each of the three boroughs. This seeks to inform the journey experienced by families from initial contact through to provision of information, assessment, allocation and offer of service. The scope of the review includes provision across social care, education, third sector and health where they interface for families of disabled children. The aim of the review is to develop mechanisms that improve access, positive user experience, equity and efficient use of resources.

As part of this review we are identifying how many children are currently known to disabled children teams (DCT) and those who access targeted services without assessment. An understanding of services available at a universal, targeted or specialist level and the methods for accessing provision is key to informing the commissioning arrangements 2016 onwards.

We know that currently services are accessible only for children that meet the criteria for DCT and thus those with high functioning Autism or MH are often excluded. People

accessing lighter touch support mechanisms such as key-workers may not be able to access short break services. The review is seeking to address this by ensuring criteria allows for assessment of impact rather than diagnosis and that non statutory assessment can access appropriate services. We are also seeking to strengthen the publicity surrounding universal and targeted services allowing more direct access.

We are seeking a series of contractual arrangements for 2016-18 that support growth of provision, choice and inclusion whilst ensuring efficient use of resources. We are working with colleagues in health to ensure collaborative use of resources i.e. key-working and to review joint funded behaviour support services. With youth/ early years colleagues we are seeking to re-design provision to maximise youth club/after school access within a special school location and the extended school offer.

A key strand of our commissioned offer will be the development of day and overnight short break provision from Queensmill ,a highly specialist school for children with Autism, from Summer 16. This has been done in conjunction with parents and pupils.

Key principles to be incorporated in the commissioning arrangements 2016 onwards are:

1. Choice
2. Safe provision provided by credible providers
3. Age appropriate provision that is outcome focused
4. Clear link between EHC outcomes and provision available
5. Services meet identified local need
6. Services should be flexible and open to those who could benefit and not constrained by artificial constraints such as diagnosis
7. Co-morbidity of need should not be a constraint to provision
8. Provision should be available to be purchased by direct payments and personal budgets
9. Timely intervention to avoid escalation of need

For H&F specifically we are developing our joint relationship across health and social care even closer; with health professionals running programmes within a new build children with disability provision with indicators to include:

- more resilient parents
- improved navigation of health provision
- reduced inappropriate use of GP and A&E
- improved take up of health checks, sleep management etc.
- programmes around healthy eating exercise, diabetes avoidance etc. could also be provided.

Other plans include:

- work around personal care,
- relationship management,
- well-being, healthy choices and more specific support around mental health.

We anticipate that young people and their families will be involved in:

- Development of the centre in H&F
- Developing the `offer`
- Reviewing specifications
- Interviewing providers
- Monitoring, secret shoppers
- Testing the Local offer system to rate ease of access,

- Potentially in managing a pilot direct offer scheme to young people
- Commenting on the effectiveness of early intervention approaches
- Reviewing findings of the residential modelling

We aim to review behaviour support services, mapping capacity and demand and to up-skill staff with recognised, evidence based training. Closer working relationships between core CAMHS and other complimentary services will be promoted.

A second review currently being undertaken is concerned with the need for planned long term care, shared care and respite overnight care. We know that a significant proportion of young people placed away from home are there because their family cannot manage, often because of challenging behaviour. Due to excellent local schools an appropriate curriculum could be offered locally but we know that families breakdown. Thus we are seeking to understand what could have been done differently to achieve a different result. We are starting to map the experience of children and the costs associated with their care. Modelling will take place to understand the outcomes and costs associated with alternatives models of provision i.e. improved early support, improved range of service offer as short break etc.

It is understood that enabling children to remain within their families and communities not only achieves the most positive outcomes in terms of social capital but is also cost efficient. Thus we seek to work with SEN and Adult services to develop a range of provision that support families to care and avoid unnecessary move away from their communities. If this cannot be achieved alternatives for shared care or local full accommodation will be explored

**How will improvement against each of these domains be measured?**

In accordance with the national guidance, we will monitor progress on delivering against the overarching outcomes of the programme using the suggested measures.

For the aim of reducing reliance on inpatient services, we will use the Assuring Transformation Plan data set to monitor progress. This will include defining baselines and setting KPI trajectories and end states in collaboration with our providers and service users for the following:

- Registers of people with a learning disability and/or autism
- Numbers of patients on registers
- Numbers of patients with a care co-ordinator
- Numbers of patients who have had a formal care plan review/CTR within 26, and 52 weeks
- Number of patients with a planned transfer date
- Awareness of Local Authority to transfers
- Number of patients with an independently appointed advocate (family member, independent person, formal Independent Mental Capacity advocate (IMCA)
- Numbers of patients admitted to inpatient care
- Number not on at risk of admission registers prior to admission
- Numbers of patients transferred out of inpatient care
- Numbers of patients considered not appropriate for transfer to the community and the reasons why
- Number of readmissions
- Number of readmissions resulting in Root Cause Analysis

For the aim of improving quality of life, we will use measures based on the Health Equality

Framework tool. Our measures will capture information on:

- **Social determinants of health**: accommodation, employment, financial support, social contact, and safeguarding. An example KPI could be a 10% increase in the number of people with a learning disability and/or autism who are in employment by March 2019.
- **Genetic and biological determinants of health**: assessment and review of health needs, care plans, crisis plans, medication passports, and access to specialist services. An example KPI could be 100% of people in specialist learning disability services have a care plan that has been co-produced with the person and their family/carers and is accessible.
- **Communication and health literacy**: body and pain awareness, communication of health needs, recognition by others of pain, recognition of health needs and response by others, understanding health information, and making choices. An example KPI could be 100% of patient information leaflets in community learning disability and/or autism services are available in easy read format.
- **Behaviour and lifestyle**: diet, exercise, weight, substance use, sexual health, risky behaviours. An example KPI could be a 75% of people with a learning disability and/or autism achieve the health outcomes identified in their health action plan.
- **Access to and quality of healthcare and other services**: reducing organisational barriers, understanding consent, managing transitions, uptake of health screening/ promotion, access to primary and secondary health services. An example KPI could be that people with Learning Disabilities access screening for Breast, Cervical and Bowel screening to within 50% of the non-Learning Disabled population.

For the aim of improving quality of care, we will use the suggested basket of indicators, where these are not covered by the measures above. As a start, this will include (but not be limited to) measuring and developing KPIs on:

- The number (and %) of people receiving social care primarily because of a learning disability who receive direct payments or a personal managed budget.
- Readmissions to hospital for people with a learning disability and/or autism.
- Number of people reporting that they are given information/communication in a way that they find accessible

**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.**

The principles we are adopting in how we offer care and support to people with a learning disability and/or autism who display behaviour that challenges reflect the principles inherent in our current practice, and the ideals we are striving towards that are linked to the Transforming Care agenda. These are:

**Person centred care**

- We will work with people with a learning disability and/or autism and their families to plan and care and support that is focused on the individual and their unique circumstances.
- We will give people more influence over their care and will promote a culture of positive risk taking.
- We will be committed to achieving the outcomes that we co-produce with each person as part of their care planning. Overall, we will all be working towards

supporting people to have good and meaningful everyday lives.

- We will provide people with a learning disability and/or autism, and their carers and families with the right information at the right time to enable them to make informed decisions about care and support. We will ensure that the ways in which this information is provided takes into account the communication needs of the person with a learning disability and/or autism.
- We will ensure people are supported to use personal budgets, direct payments and Personal Health Budgets as part of their personalised care to extend choice, control and flexibility

**Support for families and carers**

- We will provide support to families and carer to enable people with a learning disability and/or autism to live at home or in their community wherever possible.
- We will make learning available for families and carers in managing challenging behaviour.
- We will look at how we can develop our respite offer within our budgetary constraints

**Choice and control**

- We will ensure people with a learning disability and/or autism have choice and control over how their health and care needs are met – with information about care and support in formats people can understand and the development of advocacy services.
- We will provide choice of housing options including type of accommodation and tenure, including support to live with families where that is the preferred arrangement.
- Our plans will be co-produced by and our services will be evaluated by people with a learning disability and/or autism, their families and carers. The opinions of people who use services will be listened to we will use their comments to initiate change.

**Access to mainstream services**

- We will encourage the use of mainstream services as a starting point, including employment and leisure opportunities. These services will be available and accessible for people with a learning disability and/or autism.
- We will monitor our mainstream services through quality checks using the Green Light Toolkit and evaluation by people with a learning disability and/or autism and their carers.
- Where mainstream services are not sufficient to meet a person's needs, we will explore the use of specialist support service in a community setting to meet their assessed needs wherever possible.

**Lifelong approaches**

- We plan to develop early intervention and preventative support programmes to address challenging behaviour from an early age.
- We will improve the continuity of care across different stages of life.

**Specialist support**

- We will ensure that people with a learning disability and/or autism are able to access specialist health and social care support in the community – via integrated specialist multi-disciplinary health and social care teams.
- We will make the support that is available out of hours accessible for people with

Learning Disabilities.

- We will develop the workforce so that all staff working with people with a learning disability and/or autism have the appropriate training, skills, knowledge and expertise to manage behaviour that challenges appropriately.
- We will seek to develop community forensic health and care so that people with a learning disability and/or autism have support to reduce offending and anti-social behaviour
- We will commission high quality assessment and treatment services in hospital settings for those people whose needs that cannot be met in community. We will ensure that where a hospital admission is required, it is safe and expedient, and pre admission checks ensure that hospital care is the right solution and discharge planning is commenced from the point of admission or before.

**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)**

**Any additional information**

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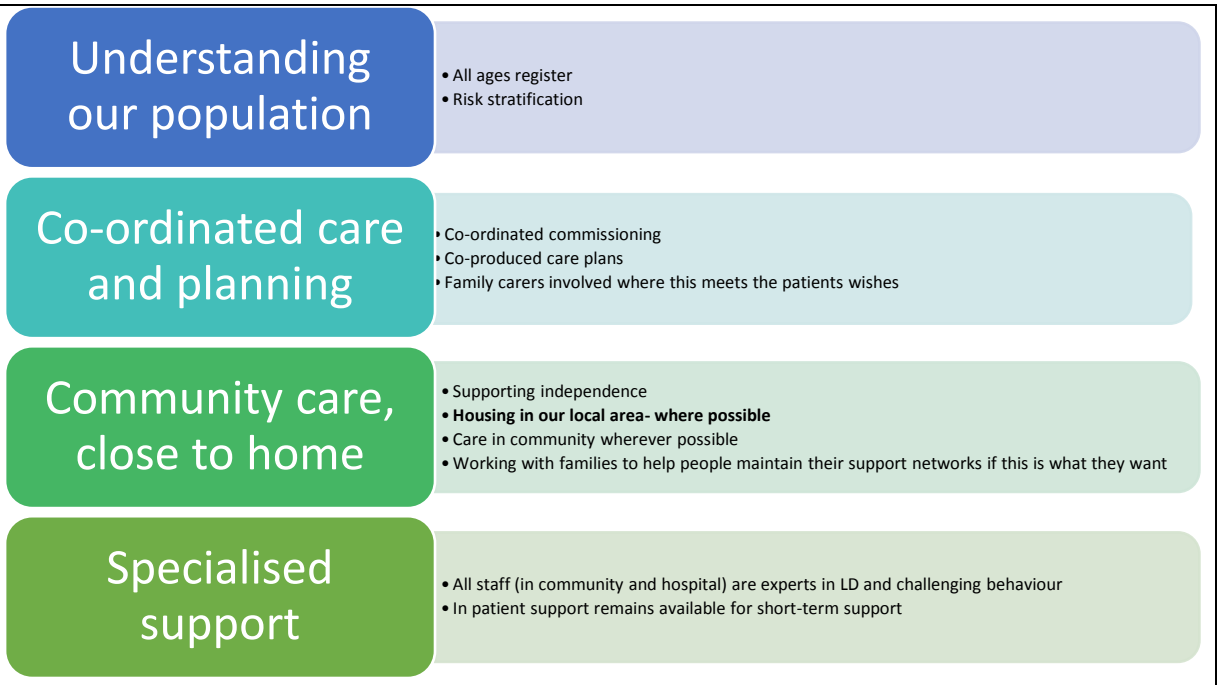
## 4.Implementation planning

**Proposed service changes (incl. pathway redesign *and* resettlement plans for long stay patients)**

**Overview of your new model of care**

ur model of care will build upon the successful elements of our existing services to strengthen our community care and support offer and will look to address some of the challenges we face in Hammersmith and Fulham with finding suitable and affordable housing options.

The fundamental elements of our new model of care are:




**Understanding our population**

We currently have a range of information about our local population through our JSNA, Learning Disability Self Assessment framework (LD SAF) and Whole Systems Integrated care work but acknowledge that we have challenges identifying children with Learning Disabilities as family and children services simply do not use the same classifications. We will work with Family and Children's services to attempt to validate our registers if we are unable to adapt our systems to synchronise data in the way that we need.

We will also Talk to our third sector provider organisations to improve our referral services to identify those that are not currently engaged with statutory services at the moment, but may benefit from support in the future. We understand that there will be some people that will choose not to engage and will not give their permission to share information, but we will improve the promotion of our local offer to ensure that people are able to make informed choices.

**Co-ordinated care and planning**

We currently have joint commissioning roles across Adult and children services in our CCG and Local Authority. Our CCG Adult and Children joint commissioners are co-located and cover Vulnerable Adults and Mental Health (including Children and Older People).. There are equivalent post holders in our Local Authority Teams too. We have strong partnership arrangements in place through Section 75 arrangements covering our joint commissioning responsibilities.

The Learning Disability Commissioner sits in the Joint Commissioning Team but also has strong links with our operational team so is able to influence operational policy and implementation. This is achieved through a range of workstreams including the LD SAF, JSNA implementation and Transforming Care.

Work has already commenced between our Adult and Children commissioners across Health, Social Care and Education through our Education, Health and Care Plan (EHC) workstream and this is formalised through preparing for adulthood, EHC and Local Offer meetings.

We will make best use of Care and Treatment Reviews to ensure all our resources are used effectively to avoid admissions where possible and to ensure a clear and ongoing focus on well co-ordinated discharge to the community.

Planning of services will also stretch beyond health care and housing. We will ensure that people with a learning disability and/or autism are enabled to participate in society in meaningful ways. This means improving access to mainstream services for people with a learning disability and/or autism by making reasonable adjustments, utilising the Green Light Toolkit and contractual levers. We will also work towards improving access to learning, employment, and volunteering opportunities. We are developing new ways of providing information and communicating with people in more accessible ways and have signed up to be an early adopter with provider colleagues to Health Easy Read Online in order to meet the requirements of the Accessible Information Standard.
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**Community care, close to home**

At the centre of our new model of care is our current multidisciplinary community support team consisting of psychiatrists, nurses, psychologists, social workers, speech and language therapists, occupational therapists, physiotherapists and transitions. We intend to further develop this team, incorporating knowledge and skill development and expertise across our Learning Disability and Mental Health pathway. The health services offered by the team are integrated with social services and have a single point of access.

When someone is referred to the service, they are offered a comprehensive assessment of their needs. We want to improve the way that people with a learning disability and/or autism and their family or carers work with the team to develop an accessible shared care plan that covers their health, social care, and support needs as well as their goals for independent living.

**Specialised support**

We recognise that specialist skills are required to provide high quality care and support for people with a learning disability and/or autism. These specialist staff are a fundamental element of our community care teams; we intend to develop the expertise by sharing existing skills across the LD and MH pathway to enable us to manage more complex cases and challenging behaviour more consistently to reduce our reliance on inpatient facilities and residential schools placements. Our aim is to reduce our reliance on inpatient admissions, and where they are required, to reduce length of stay and ensure that discharge planning commences alongside the assessment and treatment process and that this is streamlined within agreed parameters to ensure safe but timely discharge.
We also recognise that we need to develop the skill base of our local providers of other support services such as residential and supported living services, this includes small community services who may not have access to the resources required and we intend to implement skill share arrangements and ensure that care is delivered consistently in line with existing care plans and behavioural support plans.

With this in mind we will fully engage our third sector and community providers in our planning arrangements. We have already started this with a market development event with providers to develop personalised approaches to accommodation.

**What new services will you commission**?

Our plans for new services require further consultation across our commissioner, provider and public landscape to ensure success. We are considering the following new services:

- Shared ownership

We have already secured funding for this project and have capacity for two people from this cohort to enter this scheme.
Our model of shared ownership involves forming a partnership with a local Registered Provider, and working with "my safe home" to promote and enable a HOLD (Home Ownership for People with Long term Disabilities) model of shared ownership. This means finding suitable properties on the open market, and using the financial modelling to purchase the property.

- Outreach services

We would like to implement an approach similar to the Flexible Response Service that currently operates in Westminster. This will provide community based interventions in a safe space with specialist toolkits to implement positive behaviour support.

The Flexible Response Service is a combined team of skilled support workers, and clinicians from the Learning Disability Partnership. The Flexible Response Services develops personalised sessions of support for each young person so that they can access activities and services in the community. Outreach models are used which build activities around the person's interests rather than being day centre based.

- Crisis services

A safe space similar to a respite service where people with a Learning Disability are unable to stay in their home may be able to stay for short periods of time until they can return home. Some clinical input if required but a community based service with staff skilled in appropriate techniques for managing behaviour that challenges services. The individual should leave with a plan for future episodes of crisis. Connections to local LD and MH services including forensic support.

- Appropriate respite provision

This is intended to provide time away from the family environment, regardless of the age of the person being cared for, this should include links to other local services to facilitate community access/participation.

- Family support service

This is intended to provide support to the whole family to reduce episodes of escalation and conflict, with a view to establishing sustainable plans moving forward. This will require some specialist, highly skilled staff with mediation skills.

- Whole age employment pathway

Starting from school preparation for employment moving through to apprenticeship or volunteering options with a view to some form of meaningful employment. This will include people with more complex needs.

- CAMHS

There are plans to extend the excellent behavioural support and treatment team in RBKC across to Hammersmith & Fulham. This is being planned jointly with the Local Authority Tri-Borough Disabled Children's Teams. This plan is in its early stages but is likely to look at

moving resources from expensive residential placements to extending this model.

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

We do not currently commission under block contract arrangements, so there will not be an impact on local community inpatient providers for this cohort.

We will commission fewer:

- Inpatient beds commissioned via spot purchasing – via both reduced numbers of admissions and reduced length of stay
- Residential schools placements

This reduction in commissioning will be heavily dependent on the development of specialist community support services that are able to manage the increasing demand and complexity of cases. Therefore, we expect this decommissioning to be gradual over time as the community services embed. This should enable inpatient services to develop and add flexibility to their offer, including the offer of hybrid services including community based outpatient care.

**What existing services will change or operate in a different way?**
We anticipate that the main change will be an enhanced community team

- Current community services will be strengthened, in terms of capacity, skills mix, and ability to manage complex cases and challenging behaviour. There will also be more in-reach into inpatient services to support discharge and more outreach to other health and social care teams to support more independent living and integration with mainstream services.
- It is likely that many new or existing community based services will link to the local community learning disability team and autism diagnostic service.
- Mainstream services will, through training and support for staff and changes in protocols and procedures, have increased awareness of learning disabilities and autism and will be adjusted to provide appropriate care and support.
- Waiting times for an assessment for learning disability and/or autism in CAMHS will be reduced. Children and young people will receive a quicker assessment, diagnosis, and access to support and treatment.
- Quality assurance and service development will be fundamental elements of all services and include feedback and service improvement mechanisms
- More services will be able to be responsive to people's individual needs with direct accountability to individuals and their families through personal budget and Individual service fund arrangements.
- There will be more effective links with the criminal justice system.
- More children and young people Hammersmith and Fulham will be offered a support package at home and in their local community, rather than a placement out of borough.

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

Work is underway in Hammersmith and Fulham to introduce ISFs (Individual Service Funds) to maximise accountability to, personalised approaches and choice and control for people

with learning disabilities.

The roll out of pre-payment cards should help the uptake of direct payments as these reduce administrative requirements on the customer.

A 3B market engagement event (Feb 2016) encouraged proposals from providers for more flexible and personalised models of delivery.

We plan to learn from areas that have a high take up of Direct Payments such as Kensington and Chelsea.

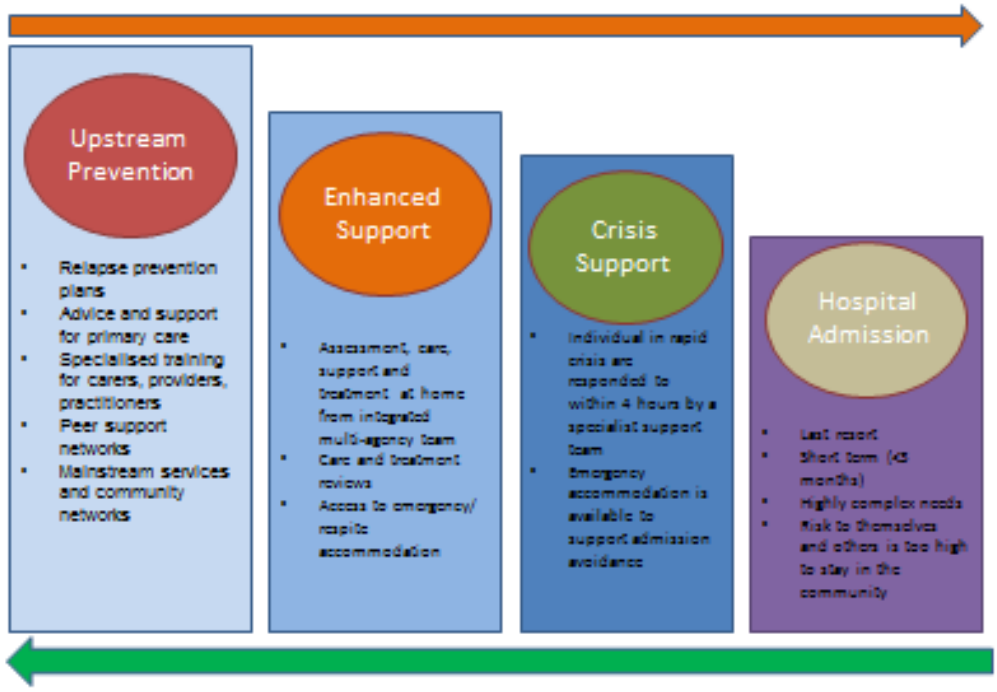
Work is ongoing to look at implementation of Personal Health Budgets for this cohort and for people with Learning Disabilities more widely. Part of the plan is to establish the scope of opportunities that this approach may support.

**What will care pathways look like?**

As noted in *Building the Right Support,* people with a learning disability and/or autism who display behaviour that challenges are a highly heterogeneous group. As a result, care pathways can be very diverse and will in every case be dependent on the individual and their family or carers. There are however some over-arching principles that will underlie every care pathway.

Our care pathways will be:

- Planned, in collaboration with the person with a learning disability and/or autism and their family and carers;
- Proactive, considering future care and support needs as well as the current situation;
- Co-ordinated, linking up health, education, social care, and the voluntary sector to provide a joined up approach to support that meets the range of needs of the person.



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

Our ambition is to develop an all ages offer for people with a learning disability, removing the need to "transition" from children's to adult services. The needs of service users do change with age, however the fundamental elements of support and care remain the same. In our proposed new model of care, all people with a learning disability and/or autism will have access to support for their health, education, and social care needs regardless of age. On turning 18 they will not be required to be reassessed according to different criteria or change services; instead needs will be assessed on an annual basis and will change with each individual rather than at pre-determined age points.

As we move towards this new model of care, we will continue to support young people moving through the current system through careful planning and joined up working between social work teams. Our education, health and care plans also provide a bridging step between children's and adult services to assist with transition up to the age of 25.

**How will you commission services differently?**

We currently have strong partnership arrangements in place through robust section 75 arrangements. Some discussions have commenced in relation to the transition to capitated budgets but this is underdeveloped and unlikely to form part of our plan going forward at the moment.

This will be reviewed by the Partnership Board and the decision will be included in our final plan submission following engagement exercises with partners and the public.

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

We have housing plans and transition plans setting out the ongoing requirements for accommodation. Ongoing fine-tuning to profile the accommodation needs of each individual is required to ensure specifications are fit for purpose and will match actual demand. We have established Housing sub-groups that are addressing this detail.

The general requirement is accommodation with sufficient space, outdoor space and consideration to any shared space that best supports people without aggravating or causing them stress. Similar issues may apply to families who want to stay living together but who may have outgrown their living space as a young person reaches adulthood.

**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 are currently working with people in long stay placements such as Harperbury Hospital and while these are relatively low in number the personal impact is significant. We have held care and treatment reviews and will continue to work with these patients to achieve their desired outcomes.

This may have an impact on areas outside of our TCP (Hertfordshire for example) as it may be in the best interests of the individual to remain local to where they have been located if they choose to and it is where their natural circles of support are.

Some further discussion will be required with those areas through individual planning.

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

Both this Transforming Care Plan and the North West London Children and Young People's Mental Health and Wellbeing Transformation Plan have been developed in collaboration with children's commissioners from CCGs and Local Authorities. In the CAMHS Transformation Plan 8 priority areas are identified, one of which relates to Learning Disabilities.

To achieve our ambition, we will map local care pathways for children and young people with learning disabilities and mental health difficulties to ensure a seamless experience of care for all children in Hammersmith and Fulham. This may improve and add value to the work around our local offer to families.

We intend to strengthen the links further between specialist services and primary care from a younger age.

We already have an Autism Steering Group, with representation from people on the Autistic Spectrum and a strategy to implement the outcomes of the autism act and refreshed guidance. This includes a support group for carers of people on the spectrum.

The TCP plan is a good fit with a number of our other priorities including our out of hospital strategy, shaping a healthier future and whole systems integrated care.

**Any additional information**

## 5.Delivery

**Plans need to include key milestone dates and a risk register**

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

1. **Estates**: We will look at our estates in order to map them and establish what property might be used better to offer outpatient and community support, we will do this in partnership with our NWL TCP to address the challenges with limited estate and high costs unique to London.

2. **Workforce Development**: utilising our community teams to support the local provider market in learning the requisite skills to better manage behaviour that challenges and complex cases. Skill sharing across Learning Disability and Mental Health services to better meet the holistic needs of people with a learning disability and/or autism.

3. **Market Development**: we have already held a market engagement event to support with shaping the market around our personal budget, personal health budget and Individual Service Fund approach to accommodation and care. A range of existing and potential providers attended this event. We will continue to develop the scope of this work through this plan, as there will be a requirement to join up further

opportunities across the health and social care economy at all ages.

4. **Specification of existing services**: work is already underway to update specifications for existing inpatient and community services in North West London to ensure clarity of existing offer and that this meets the needs of service users and their families and carers as well as our direction of travel towards community based provision away from inpatient care. This will also provide a foundation on which to develop services, providing an understanding of our starting point and any further developments that are required to deliver our Transforming Care plan.

5. **Pathways and Protocols**: as we co-produce new care and support services across, it will also be important to develop clear service user pathways and protocols for transfer between services to reduce hand offs, share information (with consent) and provide a more integrated approach for people with a learning disability and/or autism. We acknowledge that people on the autistic spectrum without a Learning Disability will have very different needs and our pathway will need to reflect this.

6. **Green Light:** this work stream will focus on ensuring that people with a learning disability and/or autism are able to access mainstream services, and that mainstream services are able to adapt to meet the needs of people with a learning disability and/or autism. There will be a focus on training, leadership, and staff development; including skill sharing and joint approaches with forensic services for both people with learning disability and those on the autistic spectrum.

7. **Communication and Engagement**: this work stream will ensure that a range of audiences are aware of the work being done to deliver our Transforming Care Partnership plan. This will include communicating changes with referrers, people with a learning disability and/or autism, families, carers, and other professionals. There will also be a focus on awareness raising with the general public, improving the understanding of learning disabilities and autism and reducing stigma.

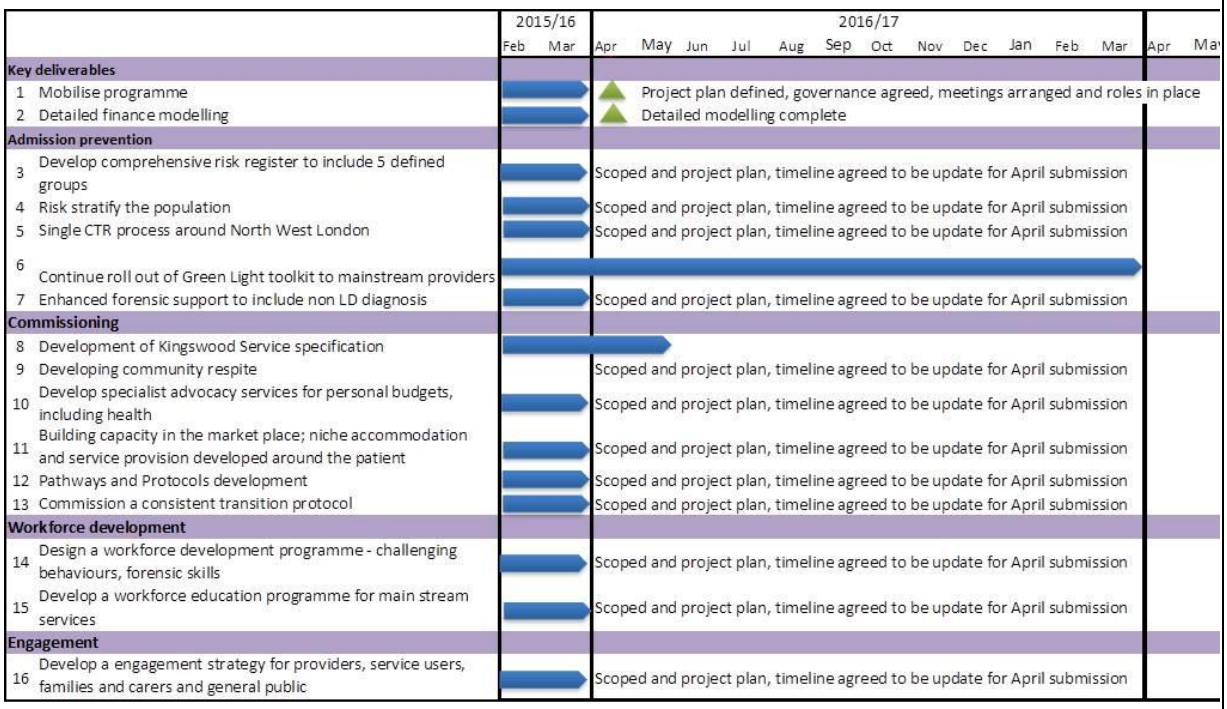
**Who is leading the delivery of each of these programmes, and what is the supporting team.**

We are currently outlining the roles that will be required to implement our plan in Hammersmith and Fulham. The coordination is likely to fall within the function of the strategy and transformation team, with local implementation being picked up by joint commissioning leads across Learning Disabilities, Mental Health and Children's services as well as operational leads.

We are currently establishing the resources that are likely to be required within the Strategy and Transformation team, but work will clearly need to be done to establish how we release capacity within commissioning and operational services.

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

The key milestones for our Transforming Care plan are covered in the project plan below. As we develop clear implementation plans for each work stream, we will develop project plans with timescales for each key milestone.




**What are the risks, assumptions, issues and dependencies?**

**Issues**

The timescales to create the initial plans for the 8th February, has meant that we have not been able to undertake as much focused engagement on the overarching Transforming Care Plan however, we have clear lines of engagement through a range of sources including LD Partnership Board, and our LD Health Steering Group both of which cover Hammersmith and Fulham, West London and Central London and their respective Local Authority areas. We also have individual Green Light Toolkit meetings in each of our Boroughs.

It has proved difficult to identify the costs of Children support in the finance template as this is not separated out for people with Learning Disabilities and/or Autism but rather across CAMHS. Local Authority children's spend is also not categorised in the same way.

We do have plans in place to engage wider with service users, providers and other key stakeholders prior to the next submission on the 11th April as we recognise that there is much more work needed to secure buy in to the plans and as such our plans may change dependant on the feedback we receive.

**Dependencies**

The success of your plan will be dependent on a number of additional factors:

- National changes to allow budgets for specialised commissioning to be pooled with CCG budgets for non-forensic services for those with a learning disability and/or autism. (we need to test out if this is correct with the finance colleagues)
- CAMHS Transformation Plans: the work to transform CAMHS services has

commenced across North West London and will include the redesigning of services for children and young people with a learning disability and/or autism. The Transforming Care Partnership plan will need to build upon the work done in CAMHS services to ensure that the new pathways and services align.

**Assumptions**

The following assumptions underpin our Transforming Care plan:

- Joint working across sectors and boroughs is achievable and sustainable.
- Savings will be released by transferring patients to community care settings, and that these savings will then be invested in community care.
- Additional funding will be provided by NHS England to support transformation, including double running of services during transition.

**Risks**

| Risk description | Probability (High, Med, Low) | Impact (High, Med, Low) | Mitigation |
|---|---|---|---|
| Provider Response: The market does not develop as envisaged. The system may not support new entrant to any market development. | Med | High | Clear market position statements signalling commissioning intentions<br>Good on-going provider engagement including actively working with providers to resolve issues and concerns. Work with providers to support a more personalised approach to provision. |
| Workforce skills, required workforce skills and capacity do not develop sufficiently | Med | High | Agree standards required and promote this. Clear workforce development plans<br>Work with HENWL on workforce development models<br>Sufficient funding to develop workforce skills and recruit appropriate staff. |
| Mainstream services do not make the reasonable adjustment to accommodate LD/autism needs. | Med | Med | Senior leadership engaged so mainstream services make adjustments a priority, use contract levers where necessary |
| **Risk description** | **Probability** | **Impact** | **Mitigation** |

| | (High, Med, Low) | (High, Med, Low) | |
|---|---|---|---|
| Pooling budgets: nationally changes are not made to allow specialised commissioning spend to be pooled. | High | Med | Raise nationally as a key issue |
| Pooling budgets: locally there is still some reluctance to pool health and LA spend. | Med | Med | Leadership and use of the Better care fund and section 75 agreements |
| CCGs and LA are not able to afford new packages of care in the current financial climate with cuts to existing budgets. | High | High | Developing the market place and competition would lead to fairer pricing. Develop an effective pricing structure |
| Lack of commissioning leadership and operational service delivery capacity: business as usual (including CTR guideline recommendation and reporting requirements) takes up everyone's time and there is no availability to take forward the Transforming Care work. | High | High | Provide additional support and capacity via short-term funded posts to cover business-as-usual, allowing experienced staff with local knowledge to get involved in redesign and service development planning. |
| Population growth: the population of North West London is growing, as is the number of people with a learning disability and/or autism. This will impact on the capacity of services to respond to demand. | High | Med | Include modelling of population growth into service redesign and business case development. Delivering a community-based model will help mitigate by providing care at a lower cost than inpatient care. |
| Culture change: lack of a single vision and aims across all organisations and team | Med | Med | Effective leadership of the TCP<br>Stakeholder engagement to ensure building of positive and effective relationships. |
| Negative publicity regarding the media coverage of closure of inpatient beds. | Med | High | Effective strategic communications plan which patient stories promoting better outcome for people |
| Estates: lack of available, affordable local housing to develop community in Borough accommodation | Med | High | Look at change of use for some premises that are underutilised/changing function of our Mental Health provision |
| Local Authority redesign of commissioning and contracting may impact on knowledge/capacity | Med | High | Utilise additional support identified above |
| **Risk description** | **Probability** | **Impact** | **Mitigation** |

| | (High, Med, Low) | (High, Med, Low) | |
|---|---|---|---|
| Care act implementation has had a cost impact for Local Authorities | Med | Med | The care act implementation is likely to improve quality and opportunity especially through strengthened advocacy arrangements Extent of impact will need to be established. |
| Any potential reduction in funding for operational teams is likely to have a negative impact on performance | Med | High | Sign off by LA SMT on plan will be essential with clarification on managing this risk. |

**What risk mitigations do you have in place?**

Please see above

**Any additional information**

## 6.Finances

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

The process of locally developing plans for the numbers of inpatient beds we will commission in the next 3 years - in compiling the NWL picture it is clear that we have a significant ambition to transform the experience of people – and our ability to support individuals outside inpatient settings. It is also clear that as a first submission we need to fully interrogate the data and define implementation plans for delivering this ambition. We anticipate that numbers will change It is acknowledged that there is more to do in order to strengthen the financial and activity modelling ahead of the submission on 11st April

## End of planning template

# Annex A – Developing a basket of quality of care indicators

Over the summer, a review led by the Department of Health was undertaken of existing indicators that areas could use to monitor quality of care and progress in implementing the national service model. These indicators are not mandatory, but have been recommended by a panel of experts drawn from across health and social care. Discussion is ongoing as to how these indicators and others might be used at a national level to monitor quality of care.

This Annex gives the technical description of the indicators recommended for local use to monitor quality of care. The indicators cover hospital and community services. The data is not specific to people in the transforming care cohort.[1]

The table below refers in several places to people with a learning disability or autism in the Mental Health Services Data Set (MHSDS). This should be taken as an abbreviation for people recorded as having activity in the dataset who meet one or more of the following criteria:

1. They are identified by the Protected Characteristics Protocol - Disability as having a response score for PCP-D Question 1 (Do you have any physical or mental health conditions lasting, or expected to last, 12 months or more?) of 1 (Yes – limited a lot) or 2 (Yes – limited a little), and a response score of 1 or 2 (same interpretation) to items PCP-D Question 5 (Do you have difficulty with your memory or ability to concentrate, learn or understand which started before you reached the age of 18?) or PCP-D Question 13 (Autism Spectrum Conditions)
2. They are assigned an ICD10 diagnosis in the groups F70-F99, F84-849, F819
3. They are admitted to hospital with a HES main specialty of psychiatry of learning disabilities
4. They are seen on more than one occasion in outpatients by a consultant in the specialty psychiatry of learning disabilities (do not include autism diagnostic assessments unless they give rise to a relevant diagnosis)
5. They are looked after by a clinical team categorised as Learning Disability Service (C01), Autistic Spectrum Disorder Service (C02)

[1] Please refer to the original source to understand the extent to which people with autism are categorised in the data collection

| Indicator No. | Indicator | Source | Measurement[2] |
|---|---|---|---|
| 1 | 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 | Mental Health Services Data Set (MHSDS) | Average census calculation applied to:<br>• Denominator: inpatient person-days for patients identified as having a learning disability or autism.<br>• Numerator: person days in denominator where the following two characteristics are met: (1). Face to face contact event with a staff member flagged as the current Care Co-ordinator (MHD_CareCoordinator_Flag) in preceding 28 days; and 2. Care review (Event record with MHD_EventType 'Review') within the preceding 12 months. |
| 2 | 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 (Not possible to include people with autism but not learning disability in this indicator) | Short and Long Term Support statistics | This indicator can only be produced for upper tier local authority geography.<br><br>Denominator: Sum of clients accessing long term support, community services only funded by full or part direct payments, managed personal budget or commissioned support only.<br><br>Numerator: all those in the denominator excluding those on commissioned support only.<br><br>Recommended threshold: This figure should be greater than 60%. |
| 3 | Proportion of people with a learning disability or autism readmitted within a specified period of discharge from hospital | Hospital Episodes Statistics (HES) and Assuring Transformation datasets. Readmission following discharge with HES main specialty - | HES is the longest established and most reliable indicator of the fact of admission and readmission.<br>• Denominator: discharges (not including transfers or deaths) from inpatient care where the person is identified as having a learning disability or autism<br>• Numerator: admissions to psychiatric inpatient care within specified period |

[2] Except where specified, all indicators are presumed to be for CCG areas, with patients allocated as for ordinary secondary care funding responsibility.

| | | | |
|---|---|---|---|
| | | Psychiatry of Learning Disabilities or diagnosis of a learning disability or autism. | The consultation took 90 days as the specified period for readmission. We would recommend that this period should be reviewed in light of emerging readmission patterns. Particular attention should be paid to whether a distinct group of rapid readmissions is apparent.<br><br>NHS England is undertaking an exercise to reconcile HES and Assuring Transformation data sets, to understand any differences between the two. At present NHS England will use Assuring Transformation data as its main source of information, and will be monitoring 28-day and 12-month readmission. |
| 4 | Proportion of people with a learning disability receiving an annual health check. (People with autism but not learning disability are not included in this scheme) | Calculating Quality Reporting Service, the mechanism used for monitoring GP Enhanced Services including the learning disability annual health check. | Two figures should be presented here.<br>• Denominator: In both cases the denominator is the number of people in the CCG area who are on their GP's learning disability register<br>• Numerator 1. The first (which is the key variable) takes as numerator the number of those on their GPs learning disability register who have had an annual health check in the most recent year for which data are available<br>• Numerator 2. The second indicator has as its numerator the number of people with a learning disability on their GPs learning disability health check register. This will identify the extent to which GPs in an area are participating in the scheme |
| 5 | Waiting times for new psychiatric referral for people with a learning disability or autism | MHSDS. New referrals are recorded in the Referrals table of the MHSDS. | • Denominator: Referrals to specialist mental health services of individuals identified in this or prior episodes of care as having a learning disability or autism<br><br>• Numerator: Referrals where interval between referral request and first subsequent clinical contact is within 18 weeks |

| | | | |
|---|---|---|---|
| 6 | Proportion of looked after people with learning disability or autism for whom there is a crisis plan | MHSDS. (This is identifiable in MHMDS returns from the fields CRISISCREATE and CRISISUPDATE) | Method – average census.<br>• Denominator: person-days for patients in current spell of care with a specialist mental health care provider who are identified as having a learning disability or autism or with a responsible clinician assignment of a person with specialty Psychiatry of Learning Disabilities<br>• Numerator: person days in denominator where there is a current crisis plan |