**Challenging Behaviour - National Strategy Group (CB-NSG)**

**Are *we* ALL ready?**

Wednesday 26th May 2021

**Workshop 4: Commissioning**

Workshop Facilitators: Wendy Ewins and Xanten Brooker
CBF Note-taker: Kate Newrick

**Workshop agenda**

| Time | What |
|---|---|
| 10.55-11.05 (10 mins) | Introductions and facilitators' overview of the issues |
| 11.05-11.40 (35 mins) | Discussion of key questions around challenges and opportunities |
| 11.40-11.55 (15 mins) | Break |
| 11.55-12.50 (55 mins) | Action planning- allocation of actions with timescales |

**The key questions for this workshop are :**

Part 1- Discussion – emphasis on ACTION not the problems

- What needs to happen to create 'readiness' in the system and make sure all parts are working together?
- How can we overcome regional variation?
- How do we ensure 'readiness' at all levels of the system – local, regional, national all working together

Part 2- Action planning – individual and collective actions

- As a CBNSG (individually and collectively) how can we make it happen at a local / individual, regional, or national level ?
- What actions, by whom, will need to be taken following the meeting?
- Allocation of actions to make it happen, with timescales

**The objectives are to:**

- Identify what can we do ourselves, right now, to ensure commissioning delivers better outcomes for people with learning disabilities and their families.

**Challenges**

- Lack of accountability- Commissioners are not regulated and have no professional standards.
- Wide variation and areas with lack of basic and specialist learning disability and autism training and knowledge within commissioning
- Poor national use of data
- Disconnect between child and adult commissioning, contrasting to existing NICE guideline NG43 (Transition from children's to adults' services for young people using health or social care services)
- Siloed ways of working and not working in co-production with families

**Opportunities**: some examples of existing initiatives include…

- NICE guidance- recommendation of lifelong approach to commissioning for this group
- New training and oversight (in response to the CQC *Out of Sight* report and the Shelia Hollins' review)
- Provider Collaboratives and pathway panels?
- New AT data collection

**Initial presentation**

Wendy described a model she's been working with, in the Black Country, which has witnessed a 55% reduction in the inpatient population. She started by describing a case study.

In the past, the individuals had received multiple admissions, multiple placements (each of which had broken down), and multiple custodial sentences. In contrast, at present, the individual owns their own home, is part of a specialist scheme, has their own support team, and lives close to their family with her beloved pets. The cycle of failure had been broken last year through a combination of factors:

- Concerted effort to understand the individual's challenging behaviour.
- An appreciation that the institutional models weren't working for the individual.
- Adoption of a strategy which embraced individual's strengths and weaknesses.
- Everyone involved in the case worked together using *new approaches.*

*New approaches*: An extended team was made available. The team was based around the family and on call 24 hours a day, 7 days a week, including the commissioner, CAMHS and an adult clinical team all being available on call. It was also possible to access Respond support when needed.

The team's working arrangements and flexibility were achieved in part by extra funding which had been received as a consequence of previous poor performance. Everyone was asked what they needed to turn things around and make things work ("a wish list"). Approx. £1.3m in additional funding enabled staff to be available on call, IST teams were expanded to include weekend work, with additional staff being available for crisis support to prevent staff from 'burning out'. Commissioners are on call one week in five. The 'emergency response team' (a 'social care response') has been evaluated. A supported living provider has provided a team to provide extra hours/on call crisis support. In conjunction with staff

being on call, this emergency response team demonstrated a significantly reduced admission rate, and an improved discharge rate/length of stay.

**Discussion**

- We need to be clear about the hard systems and the approaches we are talking about. In Kent, the focus has been for social care to support discharging people out of hospital and improve social care provision in the community.
- The Black Country model of an emergency response team and buying 'idle time' needs to be replicated across the country. In Kent, local authority commissioners commission a 'positive response framework' (LA held and owned). In Kent there are very high numbers of people in ATUs – relying on medical professionals to discharge. This is a risk adverse process.
- We need readiness that is ongoing and 24/7.
- Key ingredients of good commissioning:
    - The right values
    - Implementing NICE guidance
    - Joined-up thinking that is informed by evaluation of how the system is working as a whole, not just of its component parts. This process needs sufficient investment, shouldn't be left to tiny, under-resourced teams.
    - Trauma awareness and trauma informed approach
- Family carers are thinking about restorative justice. People are struggling. Care, concern, commitment could be shown by commissioning some help for trauma (to regain trust).
- Systems may be very different, but as long as it is about the person, there will be an "anchor".
- We are still fixed on numbers, we need to choose the 'counter'. Numbers can force change and need to be held accountable to people.
- Need to unpick whether systems should be nationally led and nationally defined or vary locally.

**Good Practice Examples in the Black Country**

- The 'Health team' in the Black Country – all have a strong learning disability background. The 'on call' system has not been evaluated formally, although we know that we shouldn't have only one way of admitting people – (just Monday to Friday). We should have the same offer at night/weekends too. The call involves discussing what could be done differently and as a consequence, we don't have 'avoidable admissions'.
- **Action** – capture the model/evaluation to enable other areas to replicate.
- Creating an established forensic TCP team is also important – and this has also worked well.
- By being involved 'all the time' / 'in the long term' in a team, you get consistency and joined-up care. You get to know the professionals and family and can get involved before a crisis happens (culture of honesty).
- Commitment to radical change (West Sussex team- we have a small, enhanced support service but not enough funding to match Black Country model)

- One unique change (first in the country) was that the responsibility for the entirety of the pathway for people with learning disabilities/autism has passed from CCGs to provider trusts, in order to pool talent. In addition, formalising a contract should be based on outcomes not activity.

**Listening to families**

*How do we define people? Are we clear about what we need to do 'to' people, 'for' people and 'with' people, and when we need to do it? Institutions tend to have a more one-dimensional approach. How do commissioners work with families to create these definitions?*

- Black Country – there was an exec-led summit prior to change. The summit occurred before lockdown. Professionals and families attended and it was awkward at times. It wasn't a comfortable summit, a sobering moment, yet it was an opportunity to come together and align values. The resounding messages were that there wasn't 'joined up care' and 'no one listened'. Is this something that could be repeated with senior level buy-in elsewhere? A springboard.
- Families need to believe that things can change more than anything; professionals need to give this belief. The role of the family carer is to love and care for the person. Family members also need a long time to heal.
- The system needs to be inclusive and flex with cultural needs; there must be culturally appropriate care offered.
- University of West England – family carers have completed a project about the reality of "co-production". It isn't really co-production – since people with learning disabilities and families are only brought in once the design is done. Family carers need to be there from the design stage. The evidence is there. It isn't anecdotal. Whose lives, opinions and outcomes do you value?
- We need people to be involved in the design but also in all stages, including monitoring for example, or the need for a redesign! Danger of turning experts by experience into "bots" There is an imbalance of power. Co-production is about being involved from beginning to end, with responsibilities all round.

**Education**

- In Kent - education want to be involved, however, there are long waiting list for assessment/diagnosis which then unlocks services for families/individuals.
- How do we enable education to meet the need? We seem to have a reductionist approach and instead we need to focus on needs.
- Education should provide a flexible approach, until then exclusions will occur.
- When we think of readiness, we must include education in the thinking.

**Good practice in Scotland**

- Follow up on the delayed discharge working group which came out of Scotland's '*Coming home'* report; due to publish Aug./Sep. 2021
- Community living change fund to facilitate the discharge of long stay hospital patients who have been delayed (3-year fund)
- '*The Way Home'* report has good examples of the benefits when everything comes together.

- Scottish Commission for People with Learning Disabilities is an intermediate organisation, facilitating national Scottish groups like Positive Behaviour Support Community of Practice etc, with Scottish Govt. representation. Significant progress in this field. **Action:** Linda Mitchell, Head of Delivery will share this work with rest of attendees

**Actions (55 minutes)**

*The group identified several useful tools that need to be re-introduced/expanded, including:*

- Person Centred Planning (PCP)' as a tool. It makes everyone come together – helping to plan a future that is important to the person and for the person. It works. They help to identify needs and determine the 'right thing to do'. They also improve cost efficiency.
- *Question: Is there any research/literature around the value of life planning?*
- *Profile of Sam Sly and Life Planning on the Rightful Lives website: https://www.rightfullives.net/Stories/Sam.html*
- Use the SEND review to raise the profile of person-centered approach planning, starting in education, countering DfE policy to reduce the number of EHCPs.
- Using annual health checks and EHCPs as a tool for people to understand themselves.

*What national leadership is there around the kind of structures we want to see? Should there be a national template or something more flexible/adaptable? Is NHS England playing this role?*

- Black Country: There is a lot of risk in TCP and a fear of getting it wrong. Being on national escalation suffocates people. Support from organisations like the CBF has therefore been a great help. Need to be honest, be open, be courageous – fear of getting it wrong stops people from doing things the right way, and makes them play it safe
- Need a better way of sharing learning and need a better way of counting what matters. We should get assessed on the lives transformed, not the number of beds.
- From the family carers perspective,
    - We need radical change – and that won't come from big institutions.
    - We also need local and flexible solutions.

**Action table**

| What would make a difference | How it will be done | Who will do it (named person) | When it will be done |
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| Identifying the key ingredients required for people to lead good lives. | Families need to be at the heart of everything we do.<br><br>Independently facilitated life planning and life design. | | |

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| Need to recognize trauma (individual and that experienced by families). | Providing appropriate and timely trauma support. | NHSE Trauma training | |
| We need readiness that is ongoing and 24/7.<br>We need 24/7 emergency support and responsiveness. | Need to commission idle skilled capacity that is ready and willing to support people through times of crisis (which might need to be specialist or offer basic requirements).<br>Review of Black Country 'on call' model? | CBF to work with Wendy to capture learning from the 24/7 Black Country model of support | |
| Need to use data to commission intelligently. | Work with Wendy Hicks, NHSE ,Policy Lead for LD/A and the data analysts in her team to improve the use of regional data nationally | CBF and CBNSG Data group to feed back on new AT data set and continue to ask Wendy Hicks' team follow up questions | End of 2021 |
| Need to move to outcomes-based commissioning | Black Country are working towards an outcomes-based commissioning framework | Wendy Ewins to share her outcomes-based framework with CBF to disseminate | |
| Need for system leadership and system accountability | In the Black Country they had a systems summit (senior leaders asking ground workers what needed to be done differently) | Other areas to consider holding a systems summit | |
| Need to share good practice generally | Good practice session to share learning and think of ways to scale up? | Linda Mitchell will link group in with the ongoing work in this area in Scotland<br><br>CBF to produce a Best Practice paper from CB-NSG meeting and connect workshop attendees in a sharing practice network | End of 2021 |

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| Improve autism training in education | Via the Autism Education Trust network of 100 AET training hubs | Sarah Broadhurst (Director of AET) - train about 30,000 education professionals a year but we want to continue to increase this year on year. | |