Barnet Clinical Commissioning Group, Barnet Parent Carer Forum & Barnet Health Providers

3rd SEND Health Conference

10th February 2020

Barnet

Facilitated by Anna Gill OBE

Welcome and housekeeping

Introductions – who is who

Barnet Parent Carer Forum

BARNET LONDON BOROUGH

NHS

NHS
Barnet Clinical Commissioning Group

What are the aims of today?

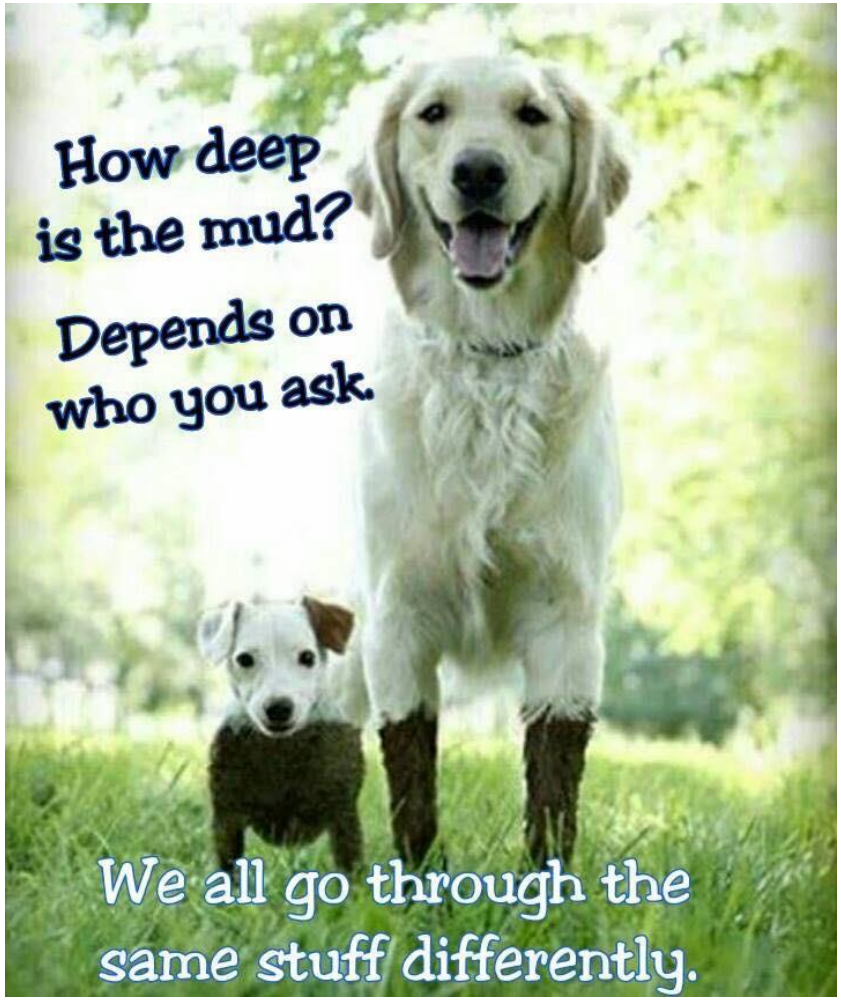
For parent carers and partners to be able to:

- Have a better understanding of the Children and Young People's Continuing Care Framework
- Discuss Transition for children and young people in preparation for adulthood
- Hear an update from Barnet Integrated Therapies Team about service developments and pathway processes
- Have an opportunity to identify key professionals and services on offer

Working together agreement

We will all:

- Respect each other
- Give each other time to talk
- Understand that we do not all have the same views, or experiences but that all opinions are valid
- Try to understand each other's challenges
- Try not to dwell on the past
- Try to avoid using jargon



Outline of the day

09:30 - 09:45 Introduction Anna Gill and BPCF Chair Teresa Bull

09:45 - 10:30 Anna Gill – Children and Young People's Continuing Care

10:30 - 10:45 Presentation from Barnet CAMHS – service update

10:45 - 11:15 Break & stalls

11:15 – 12:00 Presentation by Barnet Provider Services Local Pathways

12:00 - 12:30 Presentation from Barnet Children's Integrated Therapies update with Q & A

12:30 – 13.00 Conference Q & A

13:00 - 13:15 Anna Gill – Conference Summing up

13:15 - 13:30 Close

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National update- headlines from the world of SEND

Anna Gill OBE

Current hot topics

Health and Social Care	SEND Reforms
NHS Long Term Plan – targeted funding will be available to develop keyworkers, initial focus on CYP in inpatient mental health units	SEND Inspections – expectation that all areas will be visited 'by the summer'
'Keyworker support will also be extended to the most vulnerable children with a learning disability and/or autism'	Ongoing commitment to the inspection process and revisits are happening in areas with a Written Statement of Action
Children and Young People Transformation Board – NHSE/I includes strong focus on SEND, Autism and Learning Disability	Education Select Committee report published in Oct 2019 and SEND review announced in September 2019 underway

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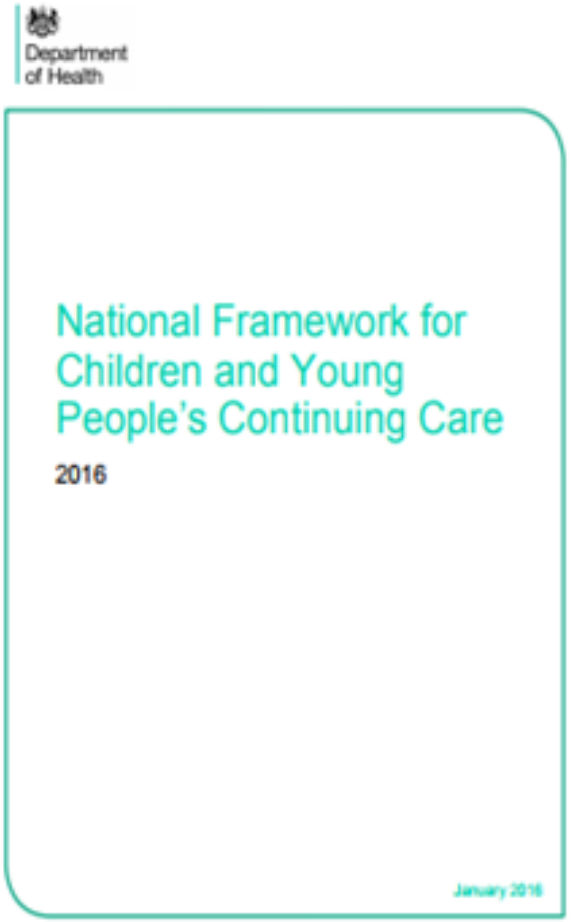
Children and Young People's Continuing Care

Children and Young People's Continuing Care

` A continuing care package will be required when a child or young person has needs arising from disability, accident or illness that cannot be met by existing universal or specialist services alone.'



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Aim and contents of the national framework

'…continuing care should be part of a wider package of care, agreed and delivered by collaboration between health, education and social care.'

*'…assessment should seek to identify needs **met and unmet***

The framework is made up of:

Introduction and background

The **continuing care process**- a step by step guide

The **Decision Support Tool**

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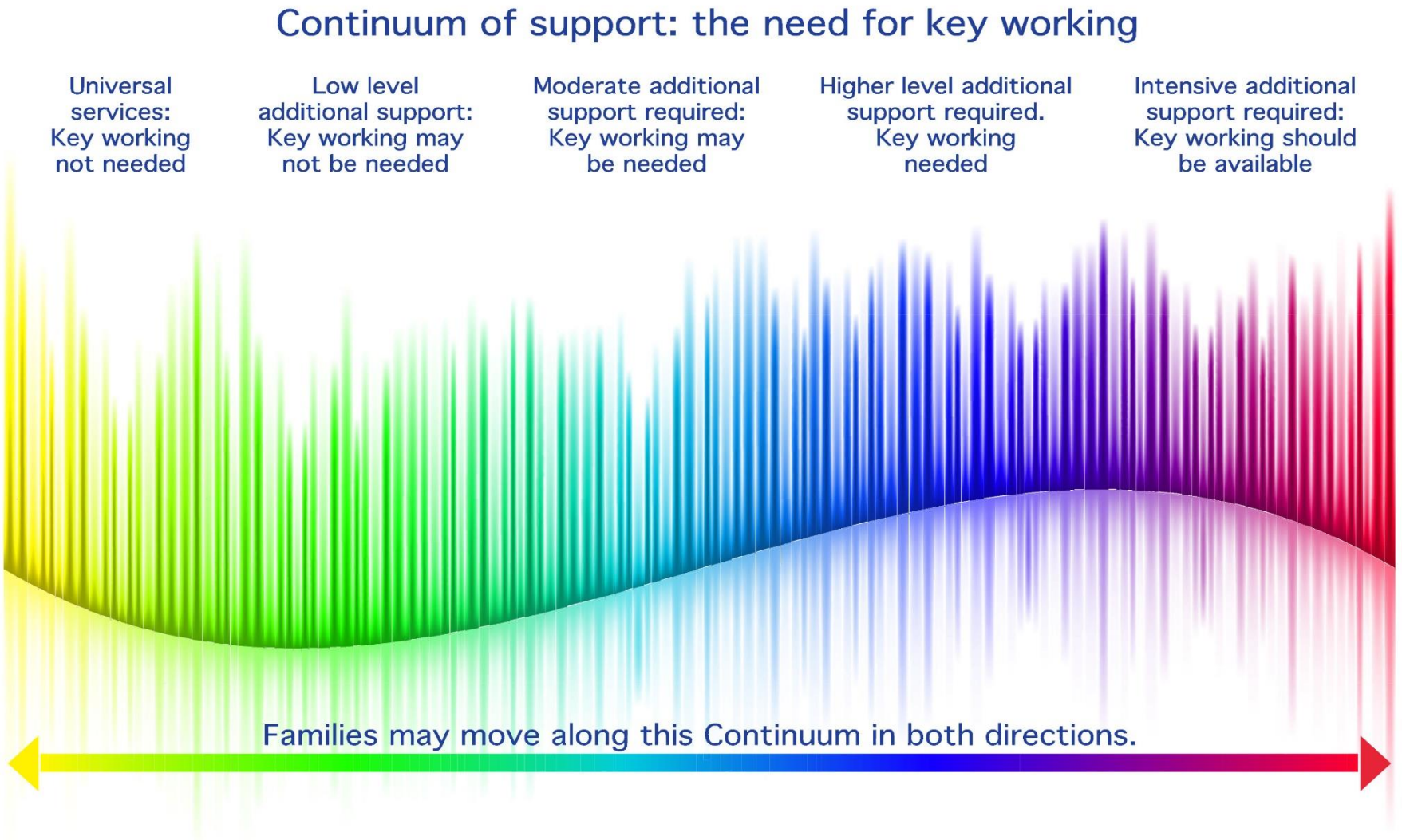
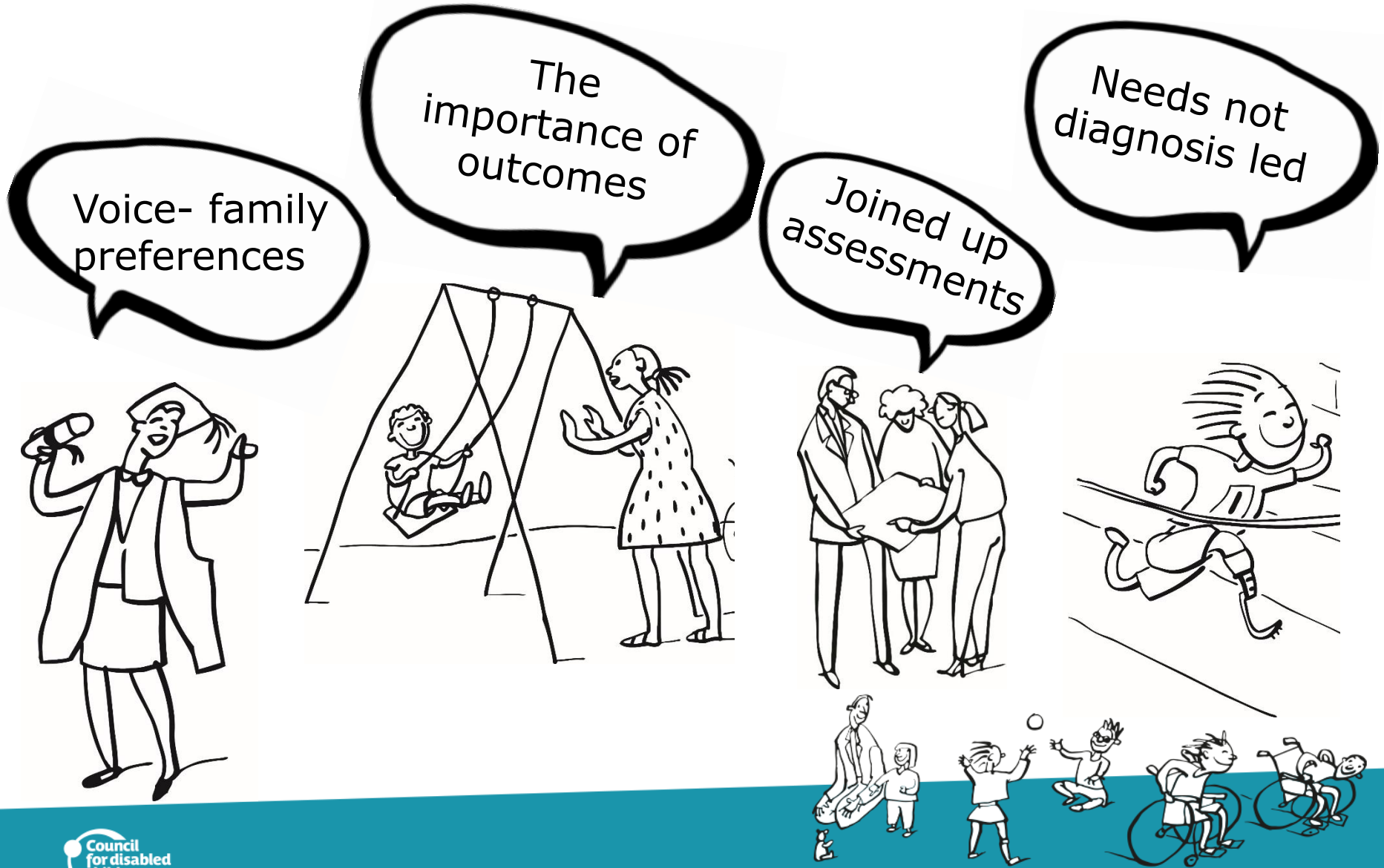
Continuum of support



Common core principles



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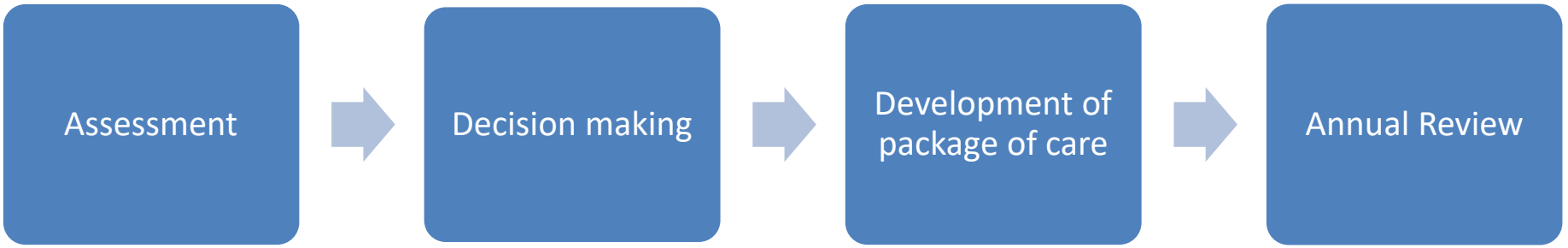
National Framework outline

Part 1: About the guidance, responsibilities etc

Part 2: Step by step process



Part 3: Decision Support Tool – 10 care domains

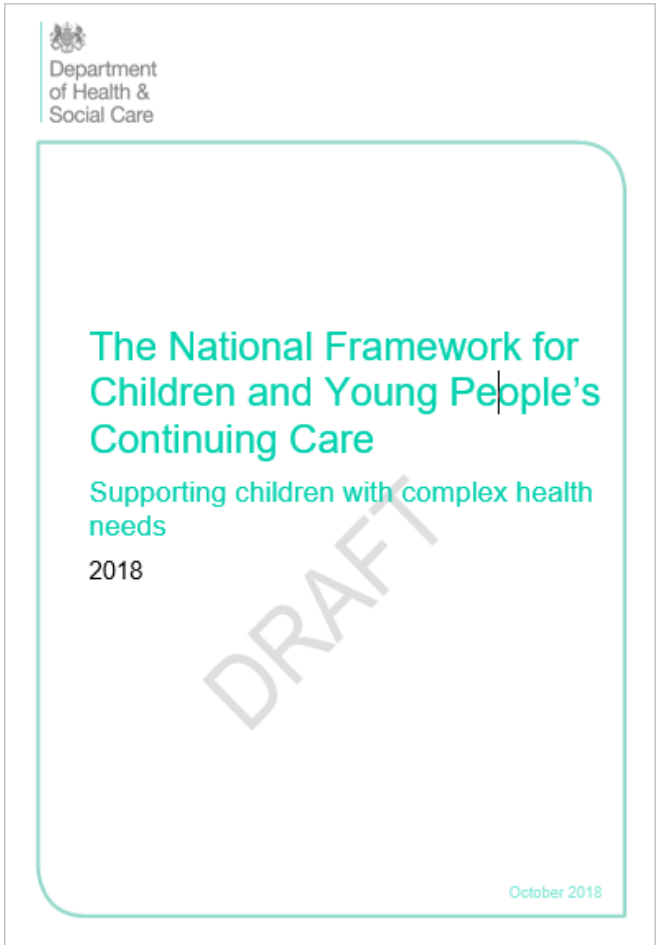
The 10 Care Domains

- breathing
- eating and drinking
- mobility
- continence and elimination
- skin and tissue viability
- communication
- drug therapies and medicines
- psychological and emotional needs
- seizures
- challenging behaviour

- A *support* tool- ranges from no additional needs to priority
- Not all needs fit into these domains
- Many needs fluctuate and others inter-relate and impact on each other
- Assessment is informed by a combination of nurse assessor's, family's and other professionals' joint knowledge

National Framework – the need for revised guidance

National Framework – suggested key revisions



- Much more on context, on difference between children's and adults' frameworks, on link with SEND and other relevant programmes
- Whole new sections on governance, accountably and joint working
- New focus on 'behaviour that challenges' – new language, new level of detail and awareness of complexity of factors

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So what about Transition?

At **14** years of age, the young person should be **brought to the attention** of the CCG as likely to need an assessment for NHS Continuing Healthcare

At **16 -17** years of age, screening for NHS Continuing Healthcare should be undertaken using the adult screening tool, and an agreement in principle that the young person has a **primary health need**, and is therefore likely to need **NHS Continuing Healthcare**

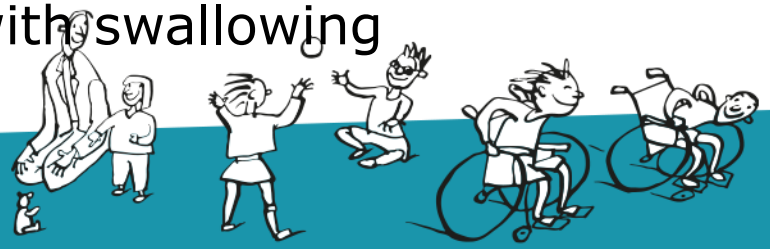
At **18** years of age, **full transition** to adult NHS Continuing Healthcare or to universal and specialist health services should have been made.

So…what we can we do as parents and carers?

- As parent carers we are experts about our own **child** – what is important **TO** them, what makes them feel happy, or what upsets or scares them and we see the daily **impact** of their needs
- If we work in partnership with the health and care professionals who are experts about their **condition** and what is important **FOR** them to keep them as healthy and safe as possible, **together** we can work towards achieving the best possible outcomes for them

For example:

- By sharing any letters, information or results you have from different hospitals or assessments
- By keeping diaries such as a seizure diary or self-harming log
- By photos/filming such as difficulty with swallowing or seizures



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To keep up with all the SEND news visit:
https://councilfordisabledchildren.org.uk

The Expert Parent Programme - resources for young people with Complex Health Needs and Transition to Adulthood
https://councilfordisabledchildren.org.uk/expertparent

Transforming Care – for Children and Young People with learning disability, autism or both
https://www.england.nhs.uk/learning-disabilities/care/children-young-people/

Children and Young People's Continuing Care Framework 2016
https://www.gov.uk/government/publications/children-and-young-peoples-continuing-care-national-framework

Adult Continuing Health Care Framework
https://www.gov.uk/government/publications/national-framework-for-nhs-continuing-healthcare-and-nhs-funded-nursing-care

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TRANSFORMATION OF BARNET CAMHS SPECIALIST CHILD AND ADOLESCENT MENTAL HEALTH SERVICES

Presentation to the Health Conference

10.2.2020

enablement
Helping people live, love, do

Barnet, Enfield and Haringey NHS
Mental Health NHS Trust

Specialist Camhs Services in Barnet

- BEH CAMHS is the Child and Adolescent Mental Health Service in the London Borough of Barnet, providing multi-disciplinary assessment and treatment of children and young people with mental health or severe emotional and behavioural difficulties. Approx 36 WTE staff currently provide the following services:
- Generic CAMHS Services in CAMHS East and West
- Barnet Adolescent Services
- SCAN – Service for Children and Adolescents with neurodevelopmental needs
- Paediatric Liaison Services to children who are patients at Barnet General Hospital
- Barnet CAMHS in Specialist Schools
- Assertive Outreach Team
- TCAPS
- Families who live in N3,NW2, NW11 will go to the Tavistock and Portman and Royal Free Hospital for treatment.

Community CAMHS

Benchmarking Network

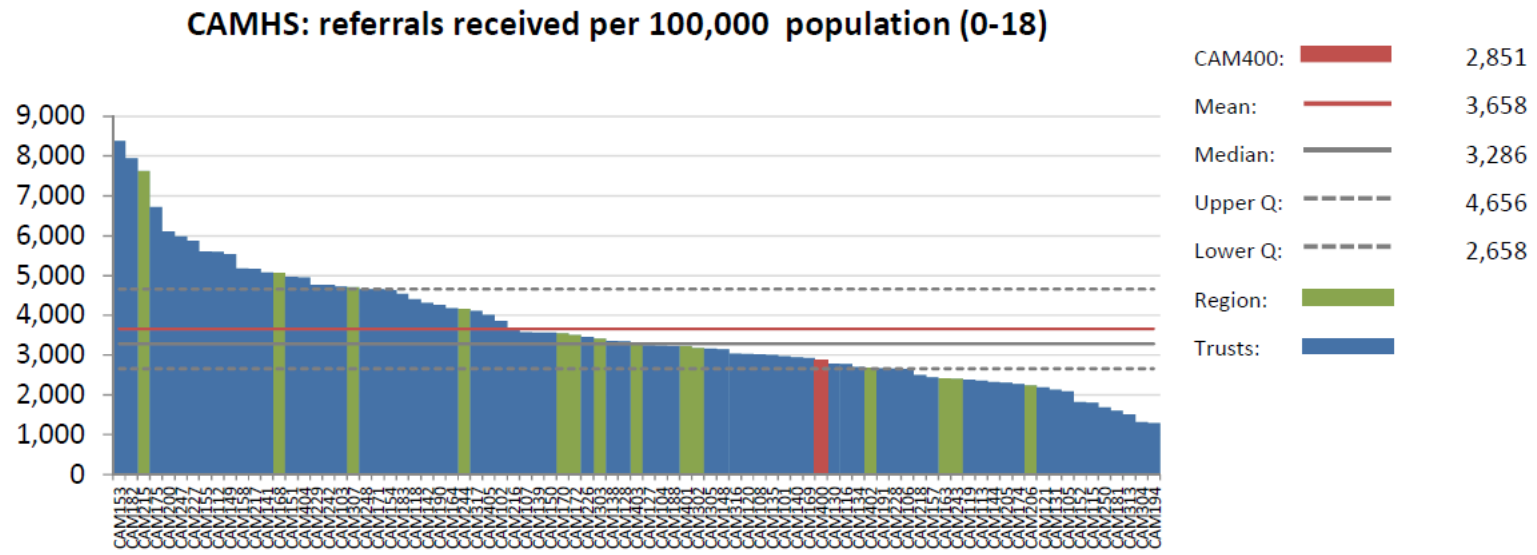


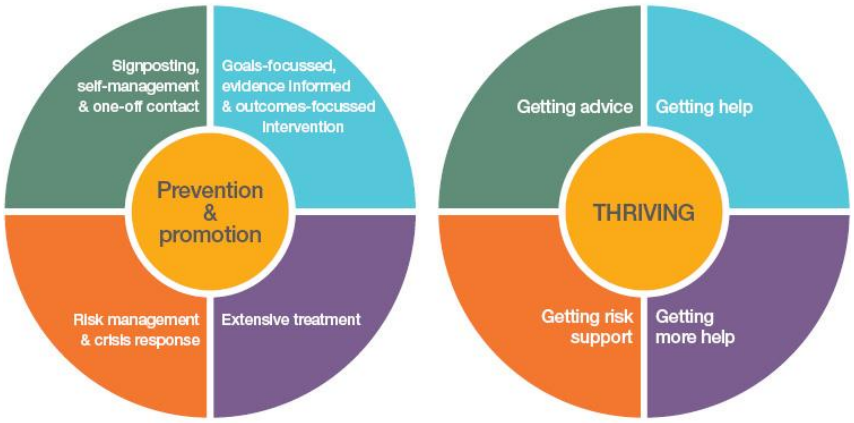
Figure 1

System challenges

- Meeting new access to treatment standards (2 appointments within 6 weeks of referral and/ or within 6 weeks between T1 and T2)
- BEH Waiting times and waiting lists
- CAPA system creating waits at key points
- 210 cases waiting for treatment every 6 months – 420 cases in year will wait up to 10 months for treatment and up to 18 months for specialist assessments
- Non standardised offer across the piece
- Postcode lottery
- Reduced critical mass and budget reduction

Proposed BEH CAMHS Services transformation

To enable BEH CAMHS to provide a service that is timely and responsive and maximises the scope for an integrated and co-produced CAMHS with our partners we have redesigned the service structure with particular reference to an Access and triage function and a new pathway design, built around the principals of the Thrive Model.



Additional CAMHS Services in Barnet

New services available in getting help:

- Camhs in Schools
- Children's wellbeing practitioners
- Mental Health Support Teams in Schools
- Rephael House
- Mencap parenting and support.

Key differences in the offer

- Swift access and triage of referrals with clear acceptance criteria.
- Self-re referral (after 4 months but no later than 6)
- Clear offer to families.

Access and Brief Intervention	3 sessions
Getting help	6 sessions
Getting More Help	12 sessions
Risk Support and Complex	30 sessions

- Clear communication to the young people and the families who use our service.
- Co-production at the design stage and on-going integration in the QI process
- Co-produced leaflets and materials for service users and their families
- Specific Neurodevelopmental pathway
- Crisis team and Out of Hours offer

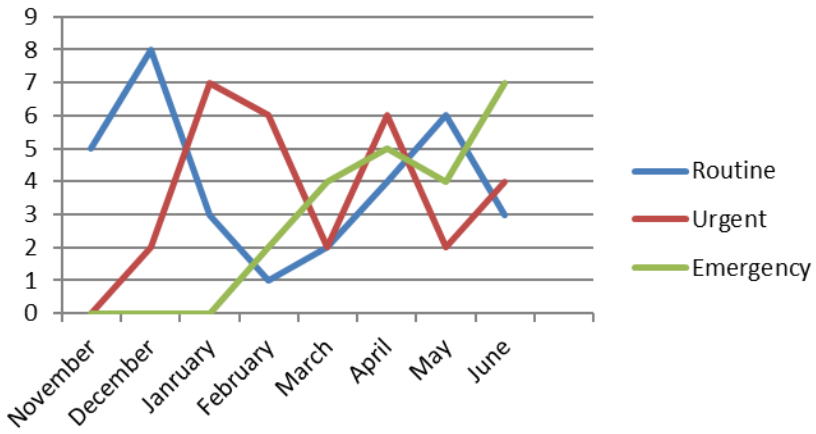
Crisis Teams for 2019-2020

2 New crisis initiatives this year the Out Of Hours Team at all the acute Hospital sites and A&E and the Adolescent Crisis Team.

Crisis Team
4 hours Emergency
24 hours urgent
5 days for routine

From November 18 to August 19 the team supported 76 CYP (in the first nine months), reduced length of admissions at Barnet Hospital and increased the number of young people discharged home (from 59% to 80-89%).

Crisis Teams for 2019-2020



Performance Data
92% response rate 4Hr KPI
74% 24 hours
84% 5 days.

Co-production

Please join us to make services better.

beh-tr.barnetcamhs.coproduction@nhs.net

Coffee Break and stalls
30 minutes

NHS

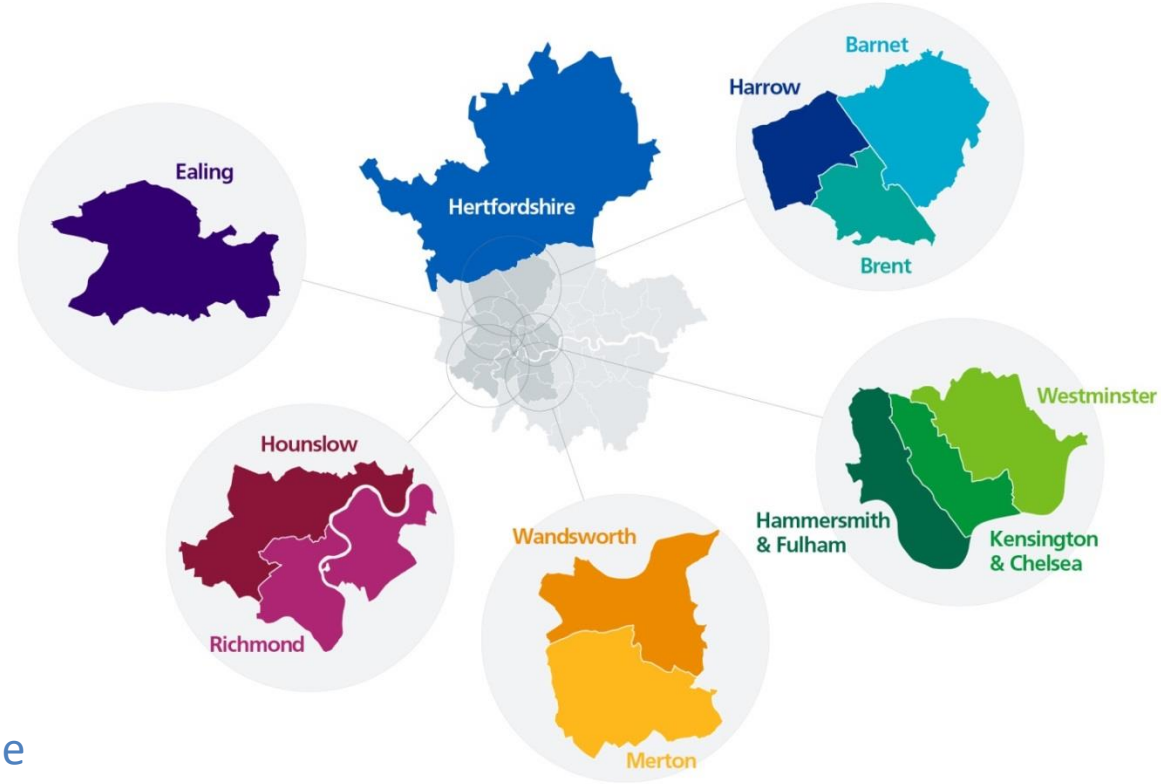
Barnet Clinical Commissioning Group

NHS

Central London Community Healthcare

NHS Trust

BARNET CHILDRENS CONTINUING CARE TEAM



Your healthcare closer to home

North Central London Network

- Commissioners and healthcare providers from 5 North Central Boroughs

- Haringey CCG
- Camden CCG
- Islington CCG

Whittington Health

- Enfield CCG

Barnet Enfield Haringey Mental Health NHS Trust

- Barnet CCG

Central London Community Healthcare NHS Trust

What The Continuing Care Team Does

- The team has delegated responsibility for carrying out continuing care assessments for children who have complex medical needs. The child/young person must be registered with a Barnet CCG GP.
- The team also provides a limited level of continuing care support for some families.
- The team provide specialist training for parents, schools, nurseries and voluntary sector staff to support the clinical needs of the child/young person with complex medical needs.
- The team are involved in supporting the CCG in the provision of Personal Healthcare Budgets (PHBs).

Team Structure

- All trained nurses are qualified registered children's nurses with additional qualifications
- All Community Children's support workers have recognised health related qualifications.
- All Community Children's nurses and support workers are trained in the 'core competencies' of the NHSE strategy 'Compassion In Practice' (May 2016).
- The 6 C's of quality for clinical staff are; care, compassion, courage, communication, competence and commitment.

Service Partners

- Child/Young Person and their family
- Commissioners
- General Practitioners
- Tertiary Centres, Hospices and General Hospitals
- Community Health Services
- Hospices / Respite Centres
- Allied Health Professionals – Health Visitors / Therapists
- Education Authority, Schools and School Nurses
- Social Services and Safeguarding Teams
- Voluntary Sector
- Specialist Services (e.g. Rehabilitation Units, CAMHS, Transforming Care).

Referrals Pathways

Referrals can be made via Barnet Child Development Service using the designated referral form.

Referrals can be made by all the partners detailed previously. The referrer must be able to provide up to date information and clinical details of the child or young person health needs, required for a Continuing Care assessment.

Verbal discussions are acceptable, and can assist in the decision making process and signposting to other areas if necessary.

All referrers must complete a pre-assessment checklist and gain written consent from parent/ carer/legal guardian, before the referral can be progressed.

Parents require an explanation as to what a Continuing Care Assessment is and why it is being requested.

THE ASSESSMENT

Assessment Process

The pre-assessment checklist is a paper based pathway to enable the nurse assessor, from CLCH Continuing Care Team to make decisions that inform partners as to whether a full assessment is required.

The clinical evidence and medical reports provided by the referrer will support the decision-making process at this point and whether the thresholds and criteria have been met for a full assessment.

DECISION SUPPORT TOOL (DST)

- Assessment completed jointly usually with a Social Worker(0-25 service) or Educational Lead / fellow professional.
- An holistic approach is used to ensure there is involvement from parents, family carers and clinicians involved with the care delivery of the child/young person.
- Collation of information is required to support the scoring of the 10 domains in the DST. Scoring is dependent on the individual's level of need. (range -no needs to priority needs).
- The nurse assessor and those present for the assessment will discuss and agree the outcomes and weighting of scores. A decision is then made as to whether the criteria has been met for Children Continuing Care health funding.

Expected Outcomes

- The DST is negative and the child/ young person (c/yp) does not meet criteria for additional health funding for a care package.
- The DST is positive and eligibility criteria is met, health will look to support the provision of an individual care package.
- Regardless of the outcome all assessments are presented to a multiagency panel (tripartite), along with the recommendations made from assessment.
- Parents /carers and professionals can expect written confirmation of all decisions agreed at panel.
- Universal services should be available to meet the needs of c/yp deemed not eligible.
- NCL 5 CCG's have a Continuing Care Policy & Appeals Policy (2018) for guidance, pathways and process.

Personal Healthcare Budgets (PHB's)

- PHB's are endorsed by NHS England (2019).
- PHB's are written into legislation – The Care Act & The Children & Families Act (2014).
- PHB's are aimed at achieving better outcomes and offering more flexibility and choice in how care is delivered.
- PHB's can have multiple uses – complex care, end of life care, wheelchairs, learning disability and transforming care, and supporting EHCP's.
- PHB's should be commissioned by health, education and social care to formulate a local offer.
- Funding can be delivered via various routes; the amount paid varies depending on the complexity and intensity of needs.

TRANSITION

- Which way now?
- Too many decisions?
- Too many new faces?
- A daunting process?

Transition – what to expect post 18 years

- Children's Continuing Care (CCC) is handed over to Adults Continuing Healthcare (CHC).
- Children and Adult services are managed differently and there are different procedures, protocols and pathways.
- Adult CHC assessments and DST's are different; there are more care domains, the scoring matrix has different thresholds, levels of care offered will differ, educational aspects of care change and some C & YP will not necessarily be eligible under the adult framework for health funding.

NCL Transition pathway

- Best practice suggests that transition should start in Year 9 (14years).
- Once a young person reaches 17 years, both Children and Adult Matron Assessor's from the CCG should complete joint assessment.
- Designated children's Social Workers are required to complete an adult checklist and submit it to the adult CHC Team.
- New referrals into adult CHC will be allocated to the appropriate specialty (e.g. mental health, learning disability / ASD, LAC, complex and physical disability).
- Checklists are screened for eligibility, if positive a full adult CHC assessment will be completed with the Social Worker and input from Multi-Disciplinary Team.

Transition

- Managing expectations can be difficult… why?
- Consultant or Physician handovers (new faces, new care pathways, new treatment plans).
- Different hospitals and clinical environments; and impact on routines and familiarity.
- Accessing services previously offered in school will require new referrals.
- Financial and benefit changes.

Transition activities

- Annual health check
- EHCP/Annual review in school
- Health Passport
- Liaising with adult service partners; social services, education and health
- DLA/PIP
- Parent forum with MENCAP etc

Feedback from a Service user

NELFT NHS
NHS Foundation Trust

Barnet Health Conference

10th February 2020

Update on Barnet Children's Integrated Therapies

Raj Guruchandran (Head of Service) & Claire Turner (Training and Transformation Lead – Job Share)

Background

- North East London Foundation Trust (NELFT) took on provision of Integrated Children's Therapy services (OT, PT and SLT) from 1st September 2018
- Prior to this therapies in Barnet were provided by different providers
- This meant different access points and IT systems and difficulty accessing / reviewing care records
- NELFT currently deliver services across London, Essex and Kent

Who do we work with?

NELFT NHS
NHS Foundation Trust

- The service will see Children and Young People (CYP) presenting with a range of needs who:
  - Meet our entry criteria,
  - Live within the borough of Barnet,
  - Whose GP or school is in the borough,
  - Aged between 0 - 25 years of age.
- Referrals may be accepted from educational professionals, parents/carers, and health care professionals including GPs, paediatricians, Health visitors and allied health professionals.

Where do we work?

- Universal services in Children's centres
- Early intervention in clinics
- Patients' homes
- Mainstream Schools and Special Schools
- Colleges where the young person has therapy recommended in their EHCP and there are no therapists in the college setting

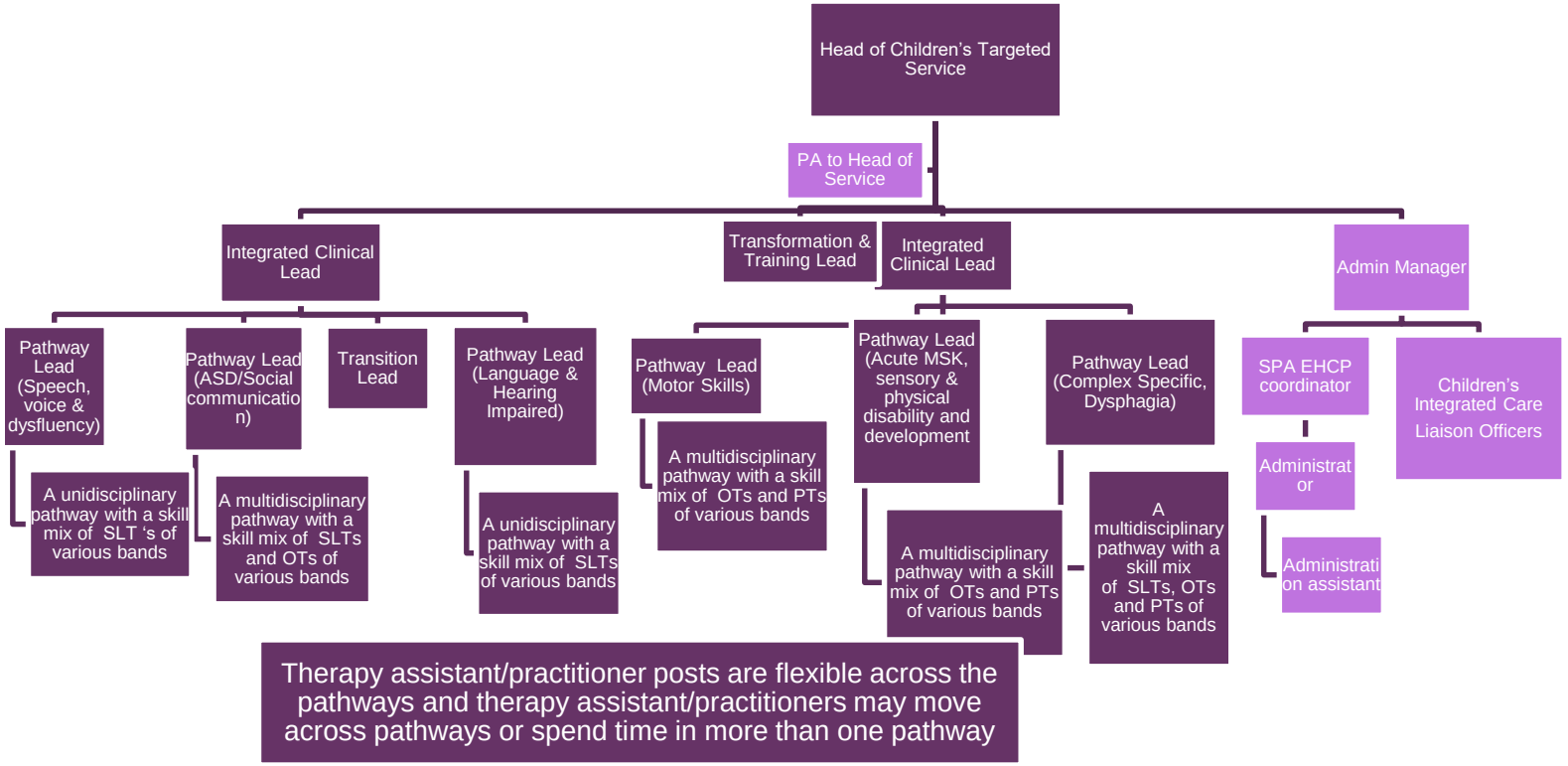
Transformation to date

NELFT NHS
NHS Foundation Trust

- Single access point for all Children's therapy referrals
- Migrated to a single IT system = remote access for all team members to the online care records system – NELFT's agile working approach
- Migrated clinical records of 4,783 children. OT = 633, Physio = 575 and SLT = 3,575. A current case load of 5484 Children
- Restructured the workforce to create a clear management structure, and the new roles of CICLO (Children's integrated care liaison officer, Transitions lead and Transformation and Training lead
- Developed various care pathways making sure the services are truly integrated

Barnet CIT Structure

NELFT NHS
NHS Foundation Trust



Pathways

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Speech, Voice and Dysfluency (stammering)

Complex Specific and Dysphagia (eating, drinking and swallowing difficulties)

Language and Hearing Impairment

Acute Musculoskeletal, sensory and physical disability and development

Autistic Spectrum Disorder/ Social Communication

Motor Skills

Pathways- Explained

NELFT NHS
NHS Foundation Trust

Speech, voice and dysfluency	Language and Hearing Impairment	Autistic Spectrum Disorder/ Social Communication	Motor Skills	Acute MSK, sensory and physical disability and development	Complex Specific and Dysphagia
CYP with difficulties pronouncing or producing sounds, with a stammer or with vocal hoarseness/ nodules	CYP with language delay/disorder across their expressive (use) or receptive (under-standing) language. CYP with hearing impairment and language/ speech difficulties.	CYP with ASD or social communication difficulties which impact on their communication and social participation.	CYP who have difficulties with fine and/or gross motor skills; developmental co-ordination disorder.	CYP who have movement or sensory needs from physical disability or delay in development; orthopaedic or musculoskele-tal needs.	CYP with complex needs and/or eating and drinking difficulties requiring significant modifications to their environment in order to meet their communica-tion, physical and sensory needs.

Co-Production

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NHS Foundation Trust

Our Core Offer has been written and is available on Barnet Local Offer and on the NELFT website.

Current co-production work streams:

- Monthly transformation meetings with service lead, team lead, transformation lead and 2 parents
- Monthly pathway development meetings with service lead, team lead, transformation lead and 2 parents
- Half termly parent focus groups open to all parents/carers run by transformation leads
- Active contribution to the work streams that are led by other stake holders

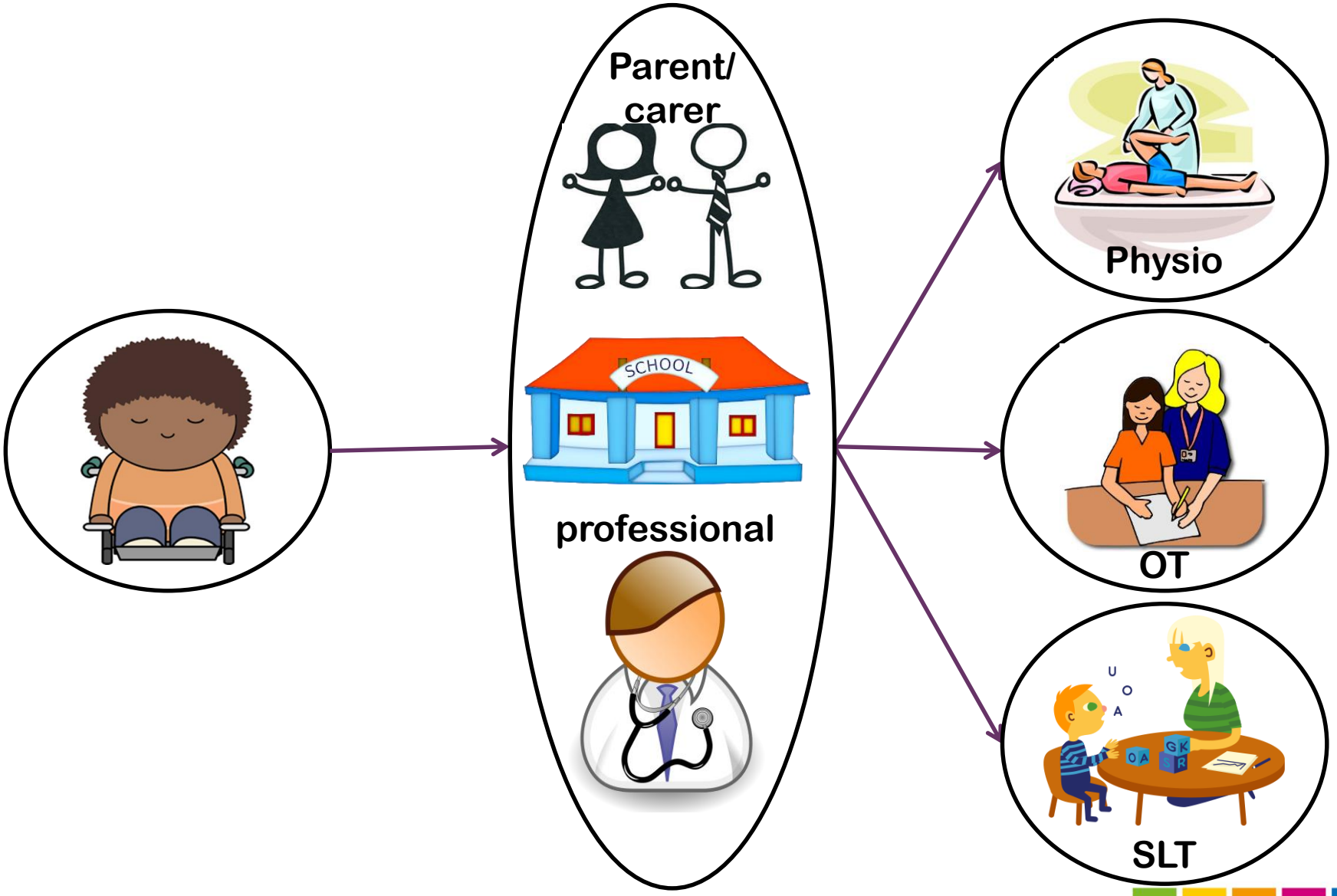
Benefits of the Integrated model

NELFT NHS
NHS Foundation Trust

- **Waiting times kept to a minimum**
  - Single referral system
  - One triage process , One integrated assessment , telling the story once
  - **Ensures a smooth journey for the child/young person**
  - One integrated assessment
  - Integrated therapy targets
  - Integrated reports
  - Integrated working
  - Link therapists to liaise between the therapy team and parents/schools
  - CICLOs (Children's Integrated Care Liaison Officers) to support liaison between therapists, families and education
- **Continuity of care**
  - Provision is based on children and young people's profile of need rather than their setting or their diagnosis

Old model

NELFT NHS
NHS Foundation Trust



Old model

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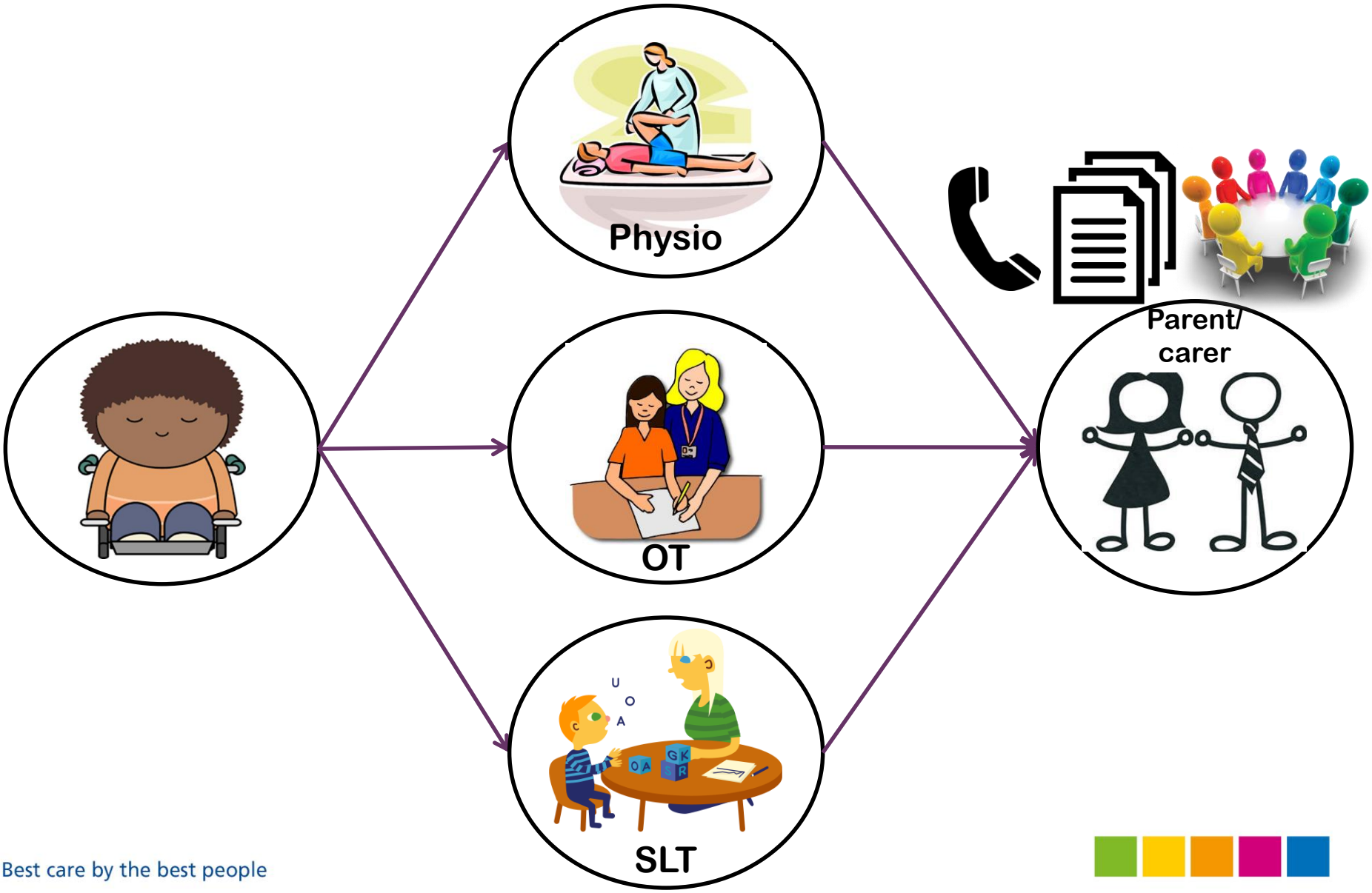

Best care by the best people

New model

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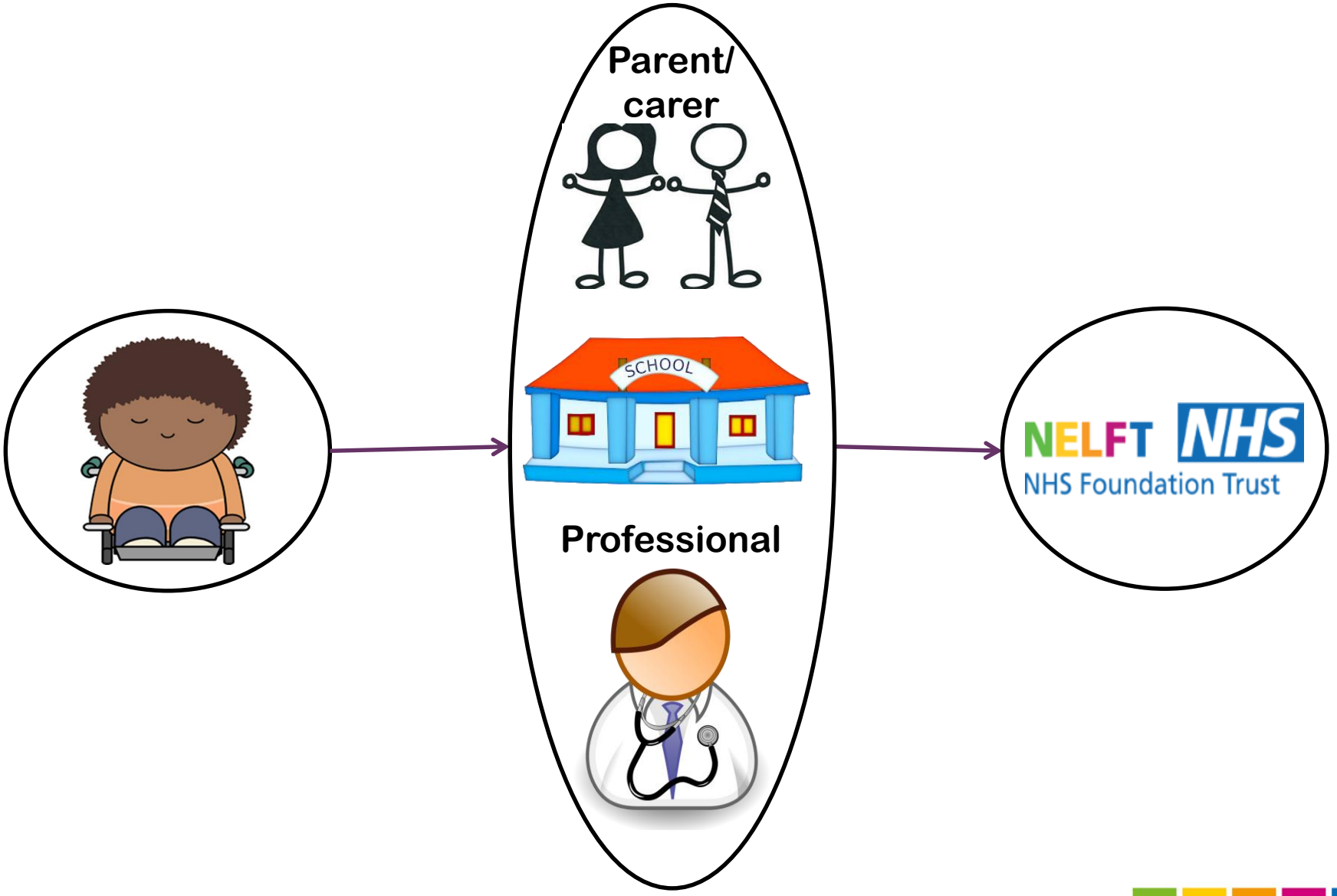
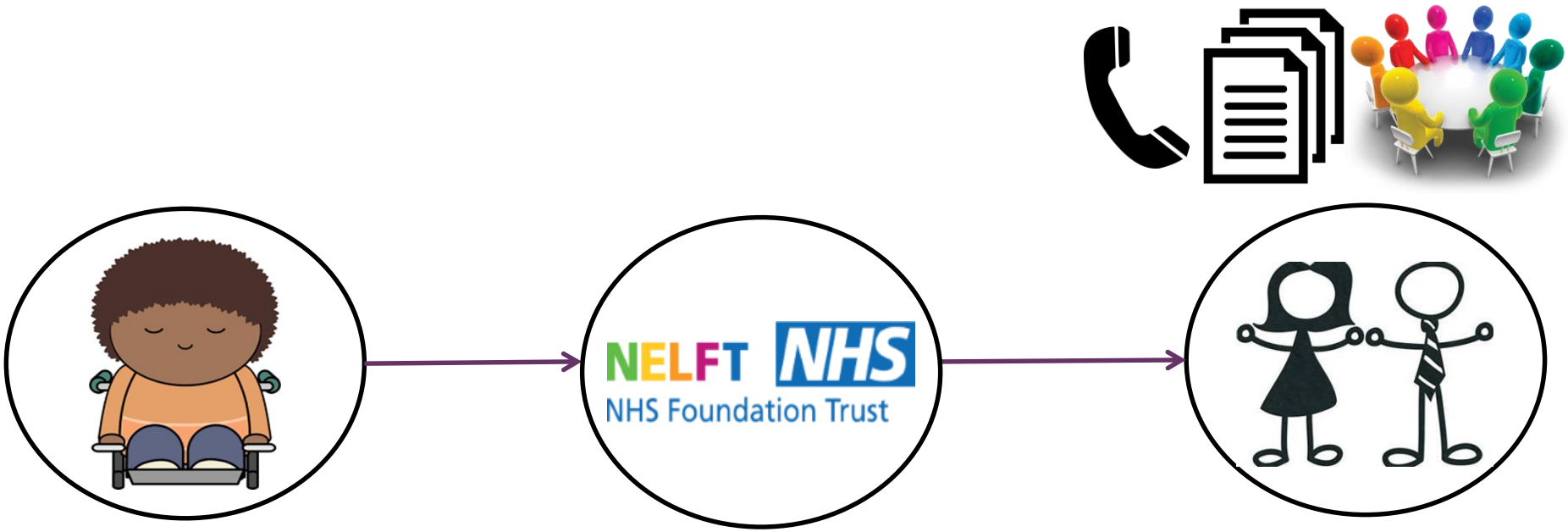


New model



Challenges

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- Children are individuals and may not always fit into one pathway.
- Needs may change over time – Pathways need to be flexible to allow movement between pathways.
- Change of service delivery model and parental /school expectation.
- Incorporating children with existing EHCP provision into the new model will require careful planning and communication.
- Working within the financial envelope whilst continuing to provide an equitable and quality service

Next steps

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NHS Foundation Trust

- **Timeline for rolling out new integrated model from April 2020**
  - Integrated initial assessments
  - Integrated target setting
  - Integrated packages of care
  - Systems to support this
- **Development of CICLO role to facilitate liaison between therapists and parents/families**
- **Grow universal offer through rolling training programme across the academic year which can be accessed by parents, school staff and professionals.**

NELFT NHS
NHS Foundation Trust

Any Questions?

Conference Q and A session

Where do we go from here…

- Key messages from today
- What happens next - opportunities for parent carer participation

Thought to take away from today…

‘If you want to know how well a pair of shoes fit you ask the person wearing them not the person who made them, or paid for them.’

Anon

Barnet Parent Carer Forum

To find out more and contact the Forum:

Barnet Parent Carer Forum

Website www.barnetpcf.org.uk

Email info@barnetpcf.org.uk

Phone 07468 029 705