PROJECT INITIATION DOCUMENT:

Creating an Integrated Community Learning Disability Team

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1. Executive Summary

This document sets out the terms of reference and the structure of the project for creating an Integrated Community Team for people with a Learning Disability. It will be a joint project between Harrow Council, NHS Harrow CCG and Central and North West London NHS Foundation Trust (CNWL). Its objectives are to:

1. Assess the feasibility and benefits of creating an integrated multi-disciplinary community service for adults with a learning disability
2. Engage with all stakeholders regarding the establishment of an integrated team consisting of Harrow Council and NHS staff under a single operational management structure with shared values and priorities
3. Develop an implementation plan for setting up such an integrated team – to be co-located (with the social care Children and Young People with Disabilities team)
4. Execution of the plan.

Section 2 sets out the national, regional and local background to LD services and current issues. Integrated community LD teams with NHS and Council staff under a single operational manager are NHS England policy, in line with recent NICE guidance and increasingly the norm, for example in Brent and Ealing.

Expected benefits include:

- Develop greater community resilience
- Better outcomes for people with LD and families
- Improved assessment
- Faster assessments
- Preventing deterioration
    - better quality of life outcomes
    - reduced costs eg of residential placements
    - hospital avoidance
- Targeted and co-ordinated support
- Promote access to mainstream services
- The right help, at the right time, in the right place
- Support for families and informal carers
- More people living at home (not institutional care)
- Improved quality of life
- Reduction in behaviours that challenge
- More expertise, sharing information, sharing best practice
- Reduction in waste, reduce duplication = savings
- Impact on whole system – better health, least expensive support options
- Meeting government policy

Governance: as a tri-partite Council / CCG / CNWL project, there will be a dedicated monthly Project Board composed of the SRO's and Project Owners, chaired by an SRO from each of the participating organisations on a rotating basis. The project manager will attend and submit a draft Highlight Report. Agreed Highlight Reports will be issued to the Health & Wellbeing Executive Board. There will also be regular project team meetings.

Key milestones are:

Month	Deliverable
November	Agree PID with Council & CCG Managers
December	Engage with CNWL management and clinical leads re feasibility Formal approval of PID at HWB Exec on 13th Engage with LBH LD Team Managers re feasibility

	Engage with local third sector bodies (Mencap, etc)
January 2019	Established clarity on total Harrow budget for LD, cohort size, current staffing profile and current IT systems. Research co-location options
February	First Project Board meeting (1st Feb – tbc) Quantitative survey of people with learning disabilities and their families (jointly with Mencap) – subject to Project Board agreement Model options for staffing & budgets
March	Develop medium to long-term outcome benefits model Analyse survey results for customer satisfaction baseline
April	Assess HR implications Engage with people with LD and families (jointly with Mencap)
May	Meetings with all affected LBH & CNWL staff Workshops with people with LD and families
June	Address IT implications for new integrated team
July	Decide on preferred location(s) for integrated team Staff consultation process begins
August	Draft formal agreement between LBH, CCG & CNWL Staff consultation process ends
September	Appoint integrated team manager(s) Develop protocols for integrated working Implement new IT arrangements
October	Prepare new location(s) - if necessary Formal agreement signed between LBH, CCG & CNWL Staff training
November	Go live

Important note re go live date: It was agreed at the first Project Board meeting that the priority is to achieve a single integrated operational management structure and that this should happen before November 2019 if possible. It is recognised that identification and preparation of suitable premises for up to 42 staff could take longer than November.

A wide range of staff across Harrow Council, Harrow CCG and CNWL as well as external stakeholders will need to contribute to the project in order to meet these milestones, including relevant managers and representatives of frontline staff, NHS providers, other local health and care providers, patients / service users / informal carers.

No high risks or issues requiring Project Sponsor involvement have been identified at this stage.

2. Background

2.1 The national context

The prevailing policy direction for adults with learning disabilities is towards empowerment, self-determination and support to live at home. There is widespread recognition that people with a learning disability should be fully included in their communities and that they aspire to citizenship, good health, friendship, employment and independent accommodation just like everyone else.

Since the closure of the large institutions in the 1980s, and the acceptance that disabled people's needs are primarily social as opposed to medical, health authorities have largely transferred their responsibilities for caring for learning disabled people to local authorities. There has been an attendant transfer of funds, sometimes resulting in the establishment of pooled budgets. In many cases the pooling of funds initiated the pooling of manpower and hence integrated joint NHS and social care teams are increasingly the norm, operating in a number of locations.

Policy

Since the publication of Valuing People[1] in 2001 policy development has mirrored that of social care for adults generally. Learning disabled people are supported to live at home (or in the least restrictive environment), encouraged to make use of main stream services, to participate in education and to engage in employment if they can. An asset-based approach (focusing on what people can do for themselves, not just on what they need) is promoted. Informal and family carers have a right to be supported at all stages, but especially through the transition from childhood to adulthood. Mental Capacity for individuals should be assumed, unless indicated otherwise, and the involvement of people who use services in co-production is encouraged. 'Person-centred' working, where services are constructed for the benefit of people who use them (not the other way around) and respecting individual preferences, has its origins in learning disability policy. Where possible, autonomy should be supported by the use of Direct Payments.

Additionally, the special characteristics that pertain to learning disability should be positively addressed. For example, poor health outcomes and shortened life expectancy, increased frailty at the end of life, people experiencing dual diagnosis such as mental health and learning disability, dual discrimination such as being a member of BME group with a learning disability, vulnerability to bullying, harassment and abuse. Many of the issues that are faced by people with a learning disability are societal, such as poor health outcomes, with the most pressing currently being the inappropriate detention of people whose behaviour challenges in Assessment and Treatment Units (in-patient services). The Transforming Care programme is designed to address this.

Definition and prevalence

A learning disability affects the way that someone communicates and understands information. This means that someone may have difficulties in understanding new or complex information, learning new skills and coping independently. The underlying condition or reason for the disability is evidenced before adulthood, with a lasting effect on development.

An estimated 1.2 million adults, children and young people (2.3% of the English population) have a learning disability and an estimated 10-17% of these display behaviour that challenges. There are an estimated 40,000 children with learning disabilities and challenging behaviour.[2]

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[1] Valuing People White Paper. A New Strategy for Learning Disability for the 21st Century 2001 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/250877/5086.pdf

[2] NICE Guildeline: "Learning disabilities and behavior that challenges: service design and delivery" – 28 March 2018

Around 350,000 people have a severe learning disability. The broad term 'learning disability' can cover a spectrum of conditions, from a mild learning disability where someone can manage independently but might take longer to learn new skills, to a profound and severe learning disability where an individual may need substantial care and support with every aspect of their life.

Autism spectrum disorder (ASD) is the name for a range of similar conditions, including Asperger syndrome, that affect a person's social interaction, communication, interests and behaviour.

It is estimated that about 1 in every 100 people has ASD, i.e. over 700,000 people in the UK. More boys are diagnosed with the condition than girls. Around 70% of people with ASD have a non-verbal IQ of below 70 and will fall under the remit of learning disability services. Up to 50% of people with severe learning disability have an autistic spectrum disorder. An increase in prevalence of ASD over time is likely to be due to a broadening of the diagnostic criteria.[3]

Challenging behaviour, or behaviours that challenge, can be defined as those which put an individual or those around them at risk, including self-harm, hurting others, destructive behaviour, eating inedible objects, smearing and running away. These behaviours cause particular strain on families and staff alike and can be ameliorated by positive behaviour strategies and support networks.

Current issues[4]

- Premature mortality

There is evidence that people with a learning disability experience inequalities in healthcare. Men with a learning disability die on average 13 years sooner, and women with a learning disability 20 years sooner, compared to those without learning disabilities. The most common reason is delays or problems with diagnosis or treatment and delays in providing appropriate care in response to changing needs. There needs to be better identification of people with learning disability within the NHS, better training for staff and increased collaboration between professionals. Regular Health Checks are another mechanism by which health inequalities can be addressed.

- Ageing

People with a learning disability are living longer. Problems of frailty and early onset dementia are consequently increasing in prevalence and services should to be geared up to meeting those needs.

- Employment

There are 3.7 million people with disabilities in employment but only 100,000 of them have a learning disability. The government is committed to increasing employment opportunities for people with a learning disability.

- Welfare benefits

[3] https://www.autism.org.uk/about/what-is/myths-facts-stats.aspx#

[4] Learning Disability - policy and services. Briefing Paper. House of Commons Library 2018
http://researchbriefings.files.parliament.uk/documents/SN07058/SN07058.pdf

Disability advocacy bodies have long voiced concerns about the assessment processes for both incapacity and disability benefits and the particular issues faced by people with learning disabilities claiming benefits.

- Criminal justice

The creation of liaison and diversion services intended to divert people with mental health needs and learning disabilities away from the criminal justice system has been successful and will be rolled out nationally by 2021.

- Integration between health and social care

Integration continues to be a broad goal in order to create a seamless service for people with learning disabilities and their families. In particular families express concern at the maze of services and professionals with whom they come in to contact and providing a single key worker is one solution to address this issue.

- Advocacy

A long-standing tradition of self-advocacy in learning disability services has been expressed as 'Nothing About Us Without Us' and is enhanced by easy read documents and circles of support. The intention of this approach is to provide good opportunities for consultation, involvement and co-production.

- Transforming Care

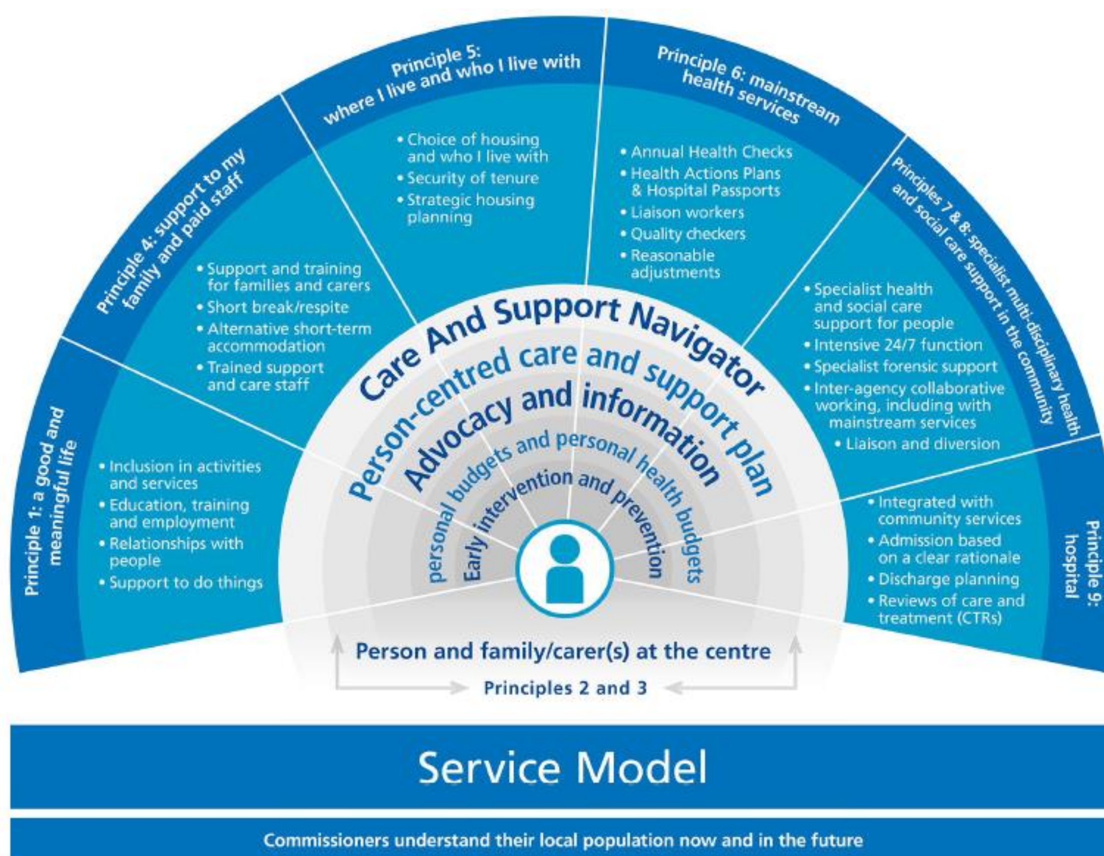
Inappropriate placement in a hospital environment of people with a learning disability, coupled with early deaths of people detained, has led to the government's stated ambition that everyone living in a (specialist) hospital should move to a community setting as quickly as possible.

More specifically, the exposure of widespread abuse at Winterbourne View private hospital in 2011 led to a review of care provided in this hospital, and across England more widely, for people with a learning disability and behaviour that challenges. The resulting report **"Transforming care: a national response to Winterbourne View hospital"** (Department of Health) started a programme of work to improve services for people with a learning disability or autism who also have mental health conditions or behaviours described as challenging. In particular, this aimed to shift emphasis from inpatient care in mental health hospitals towards care based on people's individual needs and wishes and those of their families, provided by general and specialist services in the community. The programme did not meet its original targets and was reconfigured in 2015.

A new national plan **"Building the right support"** (2015)[5] included plans for 48 'transforming care partnerships' to pilot new arrangements of services. The national plan was followed by NHS England's "**national service model"** (October 2015) that set out the range of support that should be in place no later than March 2019.

The national service model was summed up in this diagram:

[5] https://www.england.nhs.uk/learning-disabilities/natplan/



Note Principle 7 in particular:

"People with a learning disability and/or autism should be able to access ***specialist health and social care support in the community*** *– via integrated specialist multi-disciplinary health and social care teams, with that support available on an intensive 24/7 basis when necessary."*

The most recent national publication is the NICE Guideline of 28 March 2018: "**Learning disabilities and behaviour that challenges: service design and delivery"[6].** It is designed to "*help local areas shift their focus towards prevention and early intervention, enabling children, young people and adults to live in their communities, and increasing support for families and carers. This should reduce the need for people to move away from their home or community for care, education or treatment."*

Its recommendations are relevant to this project. They start with these (emphasis added):

"1.1.1 Local authorities and clinical commissioning groups should jointly designate a ***<u>lead commissioner</u>*** *to oversee strategic commissioning of health, social care and education services specifically for all children, young people and adults with a learning disability, including those who display, or are at risk of developing, behaviour that challenges. …*

1.1.3 The lead commissioner should ensure that ***<u>budgets and other resources are pooled</u>*** *to develop local and regional services for children, young people and adults with a learning disability and behaviour that challenges. These should be pooled:*

- ***<u>across health, social care and education</u>****"*

6 https://www.nice.org.uk/guidance/ng93

2.2 North West London Context

Harrow is one of eight boroughs and eight CCGs within the North West London Sustainability and Transformation Plan (STP) area. This is one of five STP areas across London. The CCGs collaborate under the brand "healthiernorthwestlondon" with a corresponding website.

A Sustainablity and Transformation Plan was published in October 2016[7]. It includes a forecast that the number of adults with a Learning Disability will increase by 29% from 7,000 to 9,000 by 2030 across the area. They currently account for 0.8% of the population and 8% of the health and care expenditure.

The CCGs are currently also moving towards becoming an "Integrated Care System" (ICS) by April 2019 and are focused on patients over 65 to trial the ICS approach.

Two examples of integrated specialist LD service delivery teams in London were included in the NHS England "Model Service Specifications". These are summarized in Appendix C and include Ealing in the NW London STP area.

Ealing and Brent have also set up integrated community LD teams. As part of the initiation of this project, meetings have been held with their managers. In both cases, operational management is the responsibility of a joint-funded Head of Disability Services and a joint funded integrated team manager. Team members continue to be employed and funded by either the NHS Trust or the local authority according to their role. Clinical oversight for health professionals is provided by the NHS Trust.

In Ealing's case, the team has been established for over 15 years and is co-located. In Brent's case, the integrated team has only been established in September 2018 and is working towards co-location.

Both team managers are clear that an integrated service offers greater flexibility in responding to issues that clients encounter with the appropriate intervention leading to better outcomes.

The Ealing managers identified these benefits:

- Culture that all adult LD cases are "our people" and therefore they all have care plans (usually written by a social worker). There is a clear ethos in the team that the preferred option is for people to be living at home and to return there as soon as possible after any hospital episode and that, if home is not feasible, then the best outcome for the person is arranged collaboratively.
- More people supported to live in the community.
- Reduced numbers and durations of psychiatric hospital admissions. (Zero in the last 12 months. A major reason for this is that people with mild LD would not normally receive any NHS interventions but these are the individuals who are out and about in the community and can get themselves into difficult situations such as involvement in gangs / criminal behaviour. A social worker would have limited options for intervention such as a care package of some sort but, with the resources of the integrated team, input from other staff is available, eg a Positive Behavioural Support therapist. It is these individuals who can often end up in secure hospitals or forensic services at great expense.)
- More efficient transition from children's services.
- Better hospital pathways and personalised support for mainstream health services

[7] https://www.healthiernorthwestlondon.nhs.uk/news/2016/11/08/nw-london-october-stp-submission-published

- Better engagement with local providers and market modelling, eg recent training for providers in PBS models and the STOMP agenda.

2.3 Local Harrow Context

Harrow has a population of around 251,960 covering 20 square miles. Harrow is an Outer London Borough in North West London and borders Hertfordshire to the north and four London Boroughs: Barnet to the east, Brent to the south east, Ealing to the south and Hillingdon to the west.

Based on the average estimated English population, Harrow would expect to have approximately:

- 5,795 adults, children and young people with learning disabilities
- 580 – 985 of these with behaviours that challenge
- 190 children with learning disabilities and challenging behaviour
- 570 - 750 adults with ASD and NO learning disability.

Harrow Council's service for people of all ages with Learning Disabilities are managed in three teams under Seth Mills:

- For ages 0 – 18 years: c 8 fte Social Work and SW Assistant staff
- For ages 18 – 25 years: c 7 fte Social Work and SW Assistant staff with 104 clients (as at August 2018)
- For ages 26+
- In addition, services are brokered by one team for residential care and supported living and another team for domiciliary care.

Harrow has a set of distinct challenges coming from a unique profile in North West London with an older than average population.

Harrow is also one of the most ethnically diverse boroughs in the country. In 2011, 43% of the Harrow population were from an Asian/ Asian British background, the percentage from a white ethnic background was almost equal at 42%, and a further 8% were from Black/ African/ Caribbean/ Black British background. Over the next ten years it is predicted that the local Black, Asian and minority (BAME) population in Harrow will increase from almost 54% to over 60%.

Alongside ethnic diversity, Harrow has great religious diversity. Harrow is home to one of the largest Hindu communities in the country, making up 26% of the population. There is also a greater proportion of people of Muslim and Jewish faith than the national average.

The Harrow Health & Wellbeing Board agreed a new Vision for Adult Social Care in March 2018. This project is in line with its key messages:

- *To pave the way for seamless health and social care integration.*
- *To respond to the continuing rise in demand for health and social care.*
- *To transform the offer of care.*
- *To enhance health, wellbeing and resilience with a preventative approach that embodies the 'wellbeing principle'.*
- *Delivering the right level and type of support at the right time and in the right place to keep people independent for longer.*
- *Manage customer expectation and increase customer satisfaction.*

The LD project will include co-production with staff in the Council and CNWL, patients, service users, carers and the voluntary and community led organisations in Harrow.

Harrow CCG has included in its Commissioning Intentions for 2019-21:

- *“Review the opportunity of integrating the Community Learning Disabilities Team with the Local Authority Learning Disabilities Team”*

3. Project Definition

3.1 Business Mandate

The project mandate was agreed by Visva Sathasivam and Garry Griffiths in May 2018 as follows:

“Harrow Council currently provides social work input and commissioned care for people with Learning Disabilities. Harrow CCG funds Central North West London Trust (CNWL) for LD health services including the commissioning of residential and domiciliary care. This project will explore the feasibility of the Council taking on management responsibility for some or all of the functions currently delivered by CNWL in order to deliver integrated specialist LD services. This may include co-location of staff. This has the potential of improving the quality of service delivery through a more integrated arrangement and releasing efficiencies.”

3.2 Project Approach

PRINCE2[8] principles will be used to manage the project. PRINCE2 provides a structured project management methodology to ensure that projects are managed on time and to budget. Every project is assigned a Project Sponsor with the responsibility for ensuring that the project is a success and for commissioning Quality Assurance of the ‘deliverables’ arising from the project.

The project is initiated by developing this project initiation document (PID). The PID sets out the agreed Business Mandate, the terms of reference and states the different roles, responsibilities, risks, milestones and products to be delivered. In addition, the PID clarifies the process for change control and escalation procedures.

A Highlight Report is produced each month for the Project Board. It identifies all tasks, which have been completed during the reporting month and all those still outstanding for the following month. Overall project status is provided and a clear statement of risks.

All project control documents are available in electronic format and are usually delivered by email.

See Appendix A for PRINCE2 roles and responsibilities.

3.3 Project Scope

The overall project scope includes:

- Assessment of feasibility and benefits of creating an integrated community support service for adults with a learning disability
- Engagement with all stakeholders regarding the establishment of an integrated team under a single operational management structure consisting of Harrow Council and NHS staff
- Development of an implementation plan for setting up such an integrated team – ideally to be co-located
- Execution of the plan.

3.3.1 Exclusions

The scope of the project excludes:

[8] PRINCE stands for Projects in a Controlled Environment

- Services for people resident outside the London Borough of Harrow unless they are registered with a GP Practice within Harrow.
- Services for people whose primary diagnosis is not a learning disability.
- Services for children with a learning disability.

3.4 Project Plan

See separate plan for details. Key milestones are:

Month	Deliverable
November	Agree PID with Council & CCG Managers
December	Engage with CNWL management and clinical leads re feasibility Formal approval of PID at HWB Exec on 13th Engage with LBH LD Team Managers re feasibility Engage with local third sector bodies (Mencap, etc)
January 2019	Established clarity on total Harrow budget for LD, cohort size, current staffing profile and current IT systems. Research co-location options
February	First Project Board meeting (1st Feb – tbc) Quantitative survey of people with learning disabilities and their families (jointly with Mencap) – subject to Project Board agreement Model options for staffing & budgets
March	Develop medium to long-term outcome benefits model Analyse survey results for customer satisfaction baseline
April	Assess HR implications Engage with people with LD and families (jointly with Mencap)
May	Meetings with all affected LBH & CNWL staff Workshops with people with LD and families
June	Address IT implications for new integrated team
July	Decide on preferred location(s) for integrated team Staff consultation process begins
August	Draft formal agreement between LBH, CCG & CNWL Staff consultation process ends
September	Appoint integrated team manager(s) Develop protocols for integrated working Implement new IT arrangements
October	Prepare new location(s) - if necessary Formal agreement signed between LBH, CCG & CNWL Staff training
November	Go live

Important note re go live date: It was agreed at the first Project Board meeting that the priority is to achieve a single integrated operational management structure and that this should happen before November 2019 if possible. It is recognised that identification and preparation of suitable premises for up to 42 staff could take longer than November.

A wide range of staff across Harrow Council, Harrow CCG and CNWL as well as external stakeholders will need to contribute to the project in order to make it a success including relevant managers and representatives of frontline staff, NHS providers, other local health and care providers, patients / service users / informal carers.

3.5 Constraints

- Time is a significant constraint and target projections will need to be monitored carefully through governance.
- Resources are a major constraint both financial and capacity of existing staff to carry out project activities without additional resources. Currently, only one part-time resource has been identified as dedicated to this project. Other staff input from Harrow Council, CNWL and Harrow CCG will have to be absorbed alongside existing priorities.
- Availability and engagement with practitioners to assist the mapping of current processes and identification of future processes.
- The culture of the different organisations is an important constraint.

3.6 Risks and issues

The Project Risks and Issues will be identified in a Risk Register. At this early stage there are no high level risks or issues requiring Project Sponsor oversight.

3.7 Highlight Reports

These will be produced monthly for discussion at Project Board meetings and form part of a formal reporting procedure to the Health & Wellbeing Exec. Each Highlight Report will state:

- Tasks completed this month
- Tasks to be completed next month
- Budget and Timescale status
- Issues to resolve and decisions to be made
- Risks and mitigations

4. Business case and costs

4.1 Expected Benefits

- Develop greater community resilience
- Better outcomes for people with LD and families
- Improved assessment
- Faster assessments
- Preventing deterioration
    - better quality of life outcomes
    - reduced costs eg of residential placements
    - hospital avoidance
- Targeted and co-ordinated support
- Promote access to mainstream services
- The right help, at the right time, in the right place
- Support for families and informal carers
- More people living at home (not institutional care)
- Improved quality of life
- Reduction in challenging behaviour
- More expertise, sharing information, sharing best practice
- Reduction in waste, reduce duplication = savings
- Impact on whole system – better health, least expensive support options
- Meeting government policy

- Better co-ordination and planning
- Help reduce health inequalities for people with LD
- Joint emergency care plans

4.2 Sustainability

Harrow Council and Harrow CCG are both under severe financial pressure. In order to improve sustainability, there are expected to be some savings in part from reduced management overheads and from earlier, more appropriate joint interventions in order to avoid situations escalating with associated long-term costs and from improved commissioning.

There are likely to be wider savings to the local health and care economy in the medium term from reduced costs of long term placements and a reduction in inappropriate hospital admissions and forensic services.

4.3 Project costs

There is a direct Council Integration Programme cost of £75,000 during 2018-19, which is shared between this project and the following:

- Integrated Brokerage
- GP Co-location
- Project Infinity / Watson Care Manager.

Costs of management and operational staff time during 2018-19 is expected to be absorbed within normal working arrangements.

Implementation costs for 2019-20 are to be established.

5. Project Governance

Governance will be provided through a dedicated tri-partite Project Board meeting monthly and reporting to the Harrow Health & Wellbeing Executive Board. The Project Board will consist of the following and will be chaired on a rotating basis by one of the Project Sponsors / Senior Responsible Officers.

Project Role	Name	Business Area
Project Sponsors / SROs	Visva Sathisivam Angela Neblett Ade Odunlade	Director of Adult Social Services, Council Interim Associate Director of Contracts – Mental Health, NHS Harrow CCG Jameson Divisional Director, CNWL
Project Owners	Seth Mills Lennie Dick Jo Carroll	Head of Service, Specialist Learning Disability Care & CYAD (Children & Young People with Disabilities, LD Team, MH, Long Term Placements), Harrow Council Commissioning Manager for LD and MH, NHS Harrow CCG Interim Service Director for Learning Disability, CNWL

Project Manager	Richard Pantlin	Contracted through the Council for the joint project

In addition to a report to the Health & Wellbeing Board, there may be a report to the NW London Care & Health Partnership Board as required.

There will also be regular project team meetings with the Project Owners, team managers and other staff such as HR, IT and Estates as required.

The roles of participants in the project are outlined in Appendix B.

Appendix A – PRINCE2 Project Roles

A. The Sponsor / Senior Responsible Officer

The Sponsor has full authority for the project and together with the Project Board will provide overall direction and final authorisation of the budget. The Sponsor will make arrangements to keep Directors, Chief Executives, the Leader, Cabinet and other Members informed on progress with the project and of any critical issues.

The Sponsor is responsible for overall business assurance of the project, (i.e. that it remains on target to deliver the projects products which will achieve the expected business benefits and the project will complete within its agreed tolerances for budget and schedule).

The Sponsor is final arbitrator if the Project Board disagree or cannot come to a consensus decision.

Sponsor Responsibilities:

- ensure the existence of a viable Business Case, the approval of the Business Case, and the responsibility for the Business Case throughout the lifetime of the project.
- ensure tolerances are set for the project.
- authorise budget expenditure and set stage tolerances.
- brief Joint Exec Board and Corporate Management Teams (CMT) and Health & Wellbeing Board about project progress.
- recommend future action on the project to Joint Exec Board and Corporate Management Teams (CMT) and Health & Wellbeing Board if tolerances are exceeded.
- chair Project Board Meetings.
- approve the Project Closure Report. This is to include the Lessons Learned from this project.
- provide overall Business Assurance.
- validate and monitor the Business Case against external events and against project progress.
- keep the project in-line with Customer Strategies.
- monitor overall Project Finance.
- monitor overall Business Risks to ensure they are controlled.
- authorise Supplier and Contractor Payments.
- review Strategic Changes and their impact on the Business Case.
- assess impact of potential changes to the business case and project plan.
- monitor for any Corporate Programme changes that could impact on the project.
- review Stage and Project Progress against the agreed tolerances set.

B. The Project Board / Health & Wellbeing Exec Board

The Project Board will exercise the main control over the project on a "management by exception basis". The Project Board will be accountable for the overall success of the project, will approve all major plans and will authorise any major deviation from the plans. It will be the authority that signs off the completion of each stage of the Project and will authorise the start of the Project, will arbitrate on any conflicts within the Project and will negotiate solutions to any

problems between the Project and internal or external bodies. In addition, it will approve the appointment and responsibilities of the Project Manager and the delegation of any of its Project assurance responsibilities.

The Project Board responsibilities include the following tasks, (broken down across Project Start, Running and Closure).

At the beginning of the Project to:

- agree the scope, objectives and constraints of the project.
- authorise commitment of project resources.
- review and approve the Project Initiation Document with respect to its accuracy and suitability for purpose.
- ensure compliance with local and regional standards including DoH expectations under STP, Five Year Forward View and any other relevant initiatives.
- agree with the Project Manager his responsibilities, objectives and the limits of the Project Managers authority.
- delegate any project assurance roles.
- commit to the project, resources required by the various Stages of the Project.
- ensure that the Scope of the project correctly reflects the Patients/Service Users, Carers requirements.
- confirm Project tolerances
- specify any External Constraints – E.g. Quality Assurance.
- agree the overall project plan.
- take “cabinet” responsibility for the success of the project.
- represent the project to their staff in a positive way throughout the project.
- authorising project expenditure against budget
- co-ordinating priorities
- representing the project to external bodies
- ensuring the interests of the staff or section they represent are met, when not in conflict with the project’s objectives
- ensuring that business and technical integrity is maintained
- reviewing the status of the project each month
- approving plans which deviate from the agreed overall project plan
- providing top level decision making and problem resolution

As the Project progresses:

- **ensure staff are available** for project tasks.
- provide overall guidance and direction to the Project, ensuring that it remains within any specified scope.
- review each completed Stage and approve progress to the next.
- review and approve any Stage Plans and Exception Plans.
- provide “ownership” of one or more of any identified project risks as allocated at plan approval time.

- monitor any such risk, advise the Project Manager of any change in status and take action where appropriate, to minimise the risk.
- approve changes.
- ensure that appropriate resources remain committed to the Project.
- ensure continued compliance with local, regional and national standards and expectations.
- attend Monthly Project Board Meetings.
- review the status of the project each month.
- provide top level decision making and problem resolution.
- ensure the interests of the staff or section they represent are met, when not in conflict with the project's objectives.
- ensure compliance with Departmental, Corporate Management Team or Investment Board directives.

At the end of the project:

- provide assurance that all products have been delivered satisfactorily.
- provide assurance that all Acceptance Criteria have been met.
- decide on the recommendation for any follow-on actions and ensure the passage of these to the appropriate group including Health & Wellbeing Board.
- arrange for a Post Implementation Review.
- approve the Project Closure Report.
- provide a Project Closure Notification to the Health & Wellbeing Board.

C. The Project Owners

Develop and implement, in co-operation with the project manager, the project activities as detailed in the Project Plan. This will include:

- assist end users reviewing and/or adjusting business practices to achieve business objectives.

Other responsibilities include:

- develop, in co-operation with the project manager, the necessary working relationships and co-operative activities with the various Task Group staff members engaged in the Project's activities.
- assist Implementation Staff with Project Planning and Reporting Tools.
- advising of changes in organisation structures and operational delivery
- analyse Budget Needs and Monitor Expenditures.
- identify and assist the acquisition of Project resources.
- act as Liaison Between Project and Officer staff across organisations.
- monitor Task Group issues and resolutions.
- assist with the development and administration of End User Training Programs.
- develop and promote communication between Task Groups.
- provide status reporting.

- assist the project manager to draw up an achievable project plan and managing the progress of the Project Team against plan
- taking responsibility for quality and performance particularly in terms of meeting project objectives, time-scales, budget and sponsor satisfaction
- liaison where necessary with progress updates to NHS England, Department of Health (DoH)
- providing top-level briefings and reports to the Sponsor, Senior Officers and Members
- helping specify and agree any changes or modifications to the project plan
- ensuring that safety and security standards are maintained throughout the project
- contributing to risk assessment and monitoring

D. Project Leaders

The Project Leaders may be appointed at various stages of the project by the project manager to carry out a work package. Project Leaders in this role have overall responsibility for the day to day management of their portion of the project as described in the work package. Project Leaders will report on a weekly basis to the Project Manager at a Checkpoint Meeting to review progress. The main tasks undertaken by Project Leaders are to:

- develop detailed product descriptions including purpose, composition, derivation and quality.
- prepare sub-project implementation plans
- ensure their portion of the project is delivered to time and meets all the required tasks as set out in the Project Plan
- understand the tolerance levels and alert the Project Manager to any deviation from the plan or timescale
- prepare progress reports for the progress meetings and other relevant progress or Project Board meetings as required by the Project Manager
- liaise with related projects to ensure that common areas of interest are identified and kept under consideration with no conflict of resources or objectives
- help specify and agree any changes or modifications to the project plan
- ensure selected individuals are trained as required
- contribute to risk assessment and monitoring
- deal with team issues as they arise

E. Project Assurance

These people are responsible for monitoring all aspects of the project’s performance and products independent of the project manager. They may represent the business, user, audit, and financial, legal, and/or technical aspects of the project delivered.

Responsibilities include:

- ensuring user needs and expectations are being met and managed
- ensuring service risks are identified and controlled
- monitoring expenditure and time schedule

- ensuring the products delivered meet the required Business Case
- constantly reassessing the value-for-money solution
- ensuring a fit with the overall programme or service strategy
- ensuring the right people (users) are being involved in specifying and testing the systems
- ensuring an acceptable solution is being developed
- ensuring the project remains viable
- ensuring the scope of the project is not “creeping up” unnoticed
- ensuring the focus on business need is maintained
- ensuring internal and external communications are working effectively
- ensuring adherence to quality assurance standards (e.g. conformance to specification)

i. Finance Assurance

Finance Assurance ensures that suitable financial standards and procedures are defined and followed throughout the project.

ii. Clinical Assurance

Clinical Assurance ensures that the project conforms to all relevant clinical requirements.

F. Project Manager

The Project Manager has the authority and responsibility for the project on a day-to-day basis, on behalf of the Project Sponsors and Owners. The Project Manager’s responsibility is to ensure that the project produces the required products, to the required standard of quality and within the constraints set for time and cost; and for the project producing a result which achieves the benefits defined in the Business Case.

Project Manager Responsibilities:

- Manage the production of the required project products and controls.
- Direct and motivate the Task Groups.
- Plan and monitor the project.
- Agree any delegation and use of project assurance roles required by the Sponsor/Project Board.
- Produce the Project Initiation Document.
- Prepare Project Stage, (and where necessary), Exception Plans in conjunction with project staff, and agree them with the Project Board.
- Manage Project Risks, including the development of Contingency Plans.
- Liaise with other projects/programmes as is necessary.
- Take responsibility for overall progress and use of resources, and initiate corrective action where necessary.
- Report to the Project Board through Highlight Reports.
- Liaise with the Project Owners or the appointed Project Assurance roles to ensure the overall direction and integrity of the Project.
- Agree technical and quality strategy with the Project Owners.

- Prepare the Closure Report for approval by the Sponsor/Project Board.
- Prepare any Project Follow-On Recommendations.
- Identify and obtain any support and advice required for the management, planning and control of the project.
- Take responsibility for project administration.

G. Project Support

Senior manager personal assistants in the Council and the CCG will provide support with booking appointments and meeting rooms, printing and other administrative arrangements.

Appendix B – Project team & project assurance roles

In addition to Senior Responsible Officers / Project Sponsors (Visva Sathasivam, Ade Odunlade and Angela Neblett), the following represent the core project team:

Project Role	Name	Business Area
Project Owner – Council	Seth Mills	Head of Service, Specialist Learning Disability Care & CYAD (Children & Young People with Disabilities, LD Team, MH, Long Term Placements)
Project Owner – CCG	Lennie Dick	Commissioning Manager for LD and MH, NHS Harrow CCG
Project Owner - CNWL	Josephine Carroll	Interim Service Director for Learning Disability, CNWL
Project Manager	Richard Pantlin	Integration Programme Manager, Harrow Council
LBH Project Leaders	Allan Meachim Mario Casiero LD Team Managers HR adviser Estates	IT Project Support & Community Engagement, Harrow Council
CCG Project Leader	Adeola Adeleke	Patient & Public Engagement
CNWL Project Leaders	Senior LD HR adviser Estates IT staff	
Local health and care providers / service user representatives	Deven Pillay Mike Coker LD Partnership Forum	Chief Exec, Harrow Mencap & Community Solutions Chief Exec, Harrow Carers

The following will provide an assurance / advisory role to the project:

Project Role	Name	Business Area
Project Assurance - Clinical	Dr Himagauri Kelshiker and Dr Hannah	Mental Health and LD Clinical Leads, NHS Harrow CCG

	Bundock	
Project Assurance – Finance LBH	Donna Edwards	Business Finance Lead, Harrow Council
Project Assurance – Finance CCG	Alex Stiles	Deputy Chief Finance Officer, Harrow CCG

Appendix C – Examples of integrated service delivery teams

C.1 Ealing Intensive Therapeutic Short Break Service[9]

For a population of 345,000, the team consists of a Clinical Psychologist (Band 8) and an Assistant Psychologist (Band 5) who specialize in learning disability.

The Ealing Intensive Therapeutic Short Break Service (ITSBS) is for young people with a learning disability who display behaviour described as challenging at imminent risk of residential placement.The aim is to enable the young person to remain within their family home and community settings longer term. The ITSBS provides families with intensive interventions and follow-up support, combining a carefully tailored package of additional short breaks and intensive clinical psychology therapy to reduce challenging behaviours and provide a break for the parents/young person.

The team is co-located in the Ealing Service for Children with Additional Needs (ESCAN) which consists of multi-agency services. They work very closely with allocated social workers from the Children with Disabilities Social Care Team. The clinical psychologist post is a job share post with each coming from the CAMHs Learning Disability team. The team is managed by the Ealing local authority, Social Care manager for children with disabilities.

As of November 2016, the team's caseload has ranged from 5-8 children and young people at any one time on the active caseload, (with an average of 2-3 years on caseload with intensity of support varying by individual and circumstances at time).

C.2 Southwark Enhanced Intervention Service[10]

For a population of 300,000, Southwark Enhanced Intervention Service (EIS) supports adults with a learning disability, or both a learning disability and autism, who display significant behaviour that challenges.

Community learning disability services in Southwark are provided by three services: the Adults with Learning Disability Team (Southwark Social Care); Community Team for Adults with Learning Disabilities (Guys and St Thomas' Foundation NHS Trust) and Mental Health and Mental Health Learning Disabilities Team (South London and Maudsley NHS Trust, SLaM). All three services contribute to the membership of the Enhanced Intervention Service (EIS), whose team members are also members of their respective services.

The EIS is led by SLaM. It has discrete functions and team members' EIS time is ring-fenced, but its clients are also the clients of the three contributing services and its staff are full members of the staff of their respective services and maintain close links with their colleagues in these services; this ensures smooth transfer of care to these services when EIS input is no longer required.

During 2016 the team's caseload has ranged from 10 – 15 adults at any one time as follows:

• 6-10 people on active caseload, depending on intensity of work

• 2-4 people on monitoring caseload (e.g. period of monitoring prior to discharge)

• Collaborative support averages 1-2 people at any point in time (e.g. direct support to other

[9] Example from the Model Service Specifications document

[10] Example from the Model Service Specifications document

services to work with an individual)

In addition, the team also provides ‘population’ level work, including:

• Training and consultation to Child & Adolescent Mental Health Service - Learning Disability (CAMHs-LD) and local providers

• Supporting local service developments for people presenting with more significant and complex behaviours that challenge through training and consultation

• Strategic developments around enhanced provision and Transforming Care within the local borough and TCP.

The Enhanced Intervention Service is in addition to services provided by the specialist community learning disabilities teams but with a focus on the Transforming Care group, with an explicit aim of avoiding more restrictive, out of area environments and with capacity to respond intensively and rapidly.

Staffing:

- 1 wte 8b clinical psychologist and lead for EIS
- 1 wte band 6 behaviour support practitioner
- 0.6 wte senior practitioner – Southwark social care
- 0.5 wte band 7 community nurse
- 0.5 wte band 7 Speech and Language Therapy

Access to psychiatry, CPNs and OT within CLDTs as required.

The key functions of support provided by the Enhanced Intervention Service are:

• Working preventatively with local services to increase their capacity to create capable environments through training and consultation

• Rapid, flexible, intensive MDT multi-element assessments and interventions at point of crisis or potential service/family breakdown to help avoid hospital admission/ placement breakdown/out of area placement

• Service design, planning and strengthening services for people returning to Southwark; additional clinical expertise to support step-down back from more restrictive environments

The service works with adult mental health, child and forensic services around interface issues, as and when it is needed.

Appendix D – Selected recommendations from NICE Guideline March 2018

The following recommendations have been extracted from the NICE Guideline : "**Learning disabilities and behaviour that challenges: service design and delivery"**[11]**.** These are deemed the most pertinent for this project (**emphasis** added). Other recommendations are also very important for detailed design of services and practitioners.

"1.1.1 Local authorities and clinical commissioning groups should jointly designate a ***lead commissioner*** *to oversee strategic commissioning of health, social care and education services specifically for all children, young people and adults with a learning disability, including those who display, or are at risk of developing, behaviour that challenges.*

1.1.3 The lead commissioner should ensure that ***budgets and other resources are pooled*** *to develop local and regional services for children, young people and adults with a learning disability and behaviour that challenges. These should be pooled:*

- *across health, social care and education and*
- *with neighbouring authorities.*

1.1.5 Ensure that funding mechanisms for service providers support ***creative and flexible community-based responses, for example, a contingency fund*** *that service providers can draw on quickly if there is a crisis.*

1.1.7 Ensure that services are planned and delivered in a way that:

- *is* ***co-produced*** *with children, young people and adults using services and their families, carers and independent advocates …*

1.1.9 Take joint responsibility with service providers and other organisations for ***managing risk*** *when developing and delivering care and support for children, young people and adults with a learning disability and behaviour that challenges. Aim to manage risks and difficulties without resorting to changing placements or putting greater restrictions on the person.*

1.1.12 Commissioners should ***establish a multi-agency group****, or make use of an existing group, including experts by experience and service providers, to monitor the quality of services and the outcomes achieved.*

1.2.10 Local authorities working in partnership with healthcare professionals should assign a single practitioner, for example, a social worker (in a disabled children's team or community learning disability team) or community psychiatric nurse, to be the person's ***'named worker'****. The named worker should get to know the person and coordinate support to meet their needs over the long term.*

1.2.19 Ensure that a range of funding arrangements are available, including ***direct payments, personal budgets or individual service funds****, depending on children, young people and adults' needs and preferences.*

1.4.1 The lead commissioner should commission services in the community for people with a learning disability and behaviour that challenges (including for people in contact with, or at risk of contact with, the criminal justice system). These services:

- *should be able to cater for lower-level needs up to intensive, complex or fluctuating needs*

[11] https://www.nice.org.uk/guidance/ng93

- *could be set up either as 1 large team with different subteams or as several separate teams*
- *should be provided wherever possible as an alternative to, and to reduce the potential need for:*
  - *inpatient care for children, young people and adults or*
  - *residential placements for children and young people.*

1.4.2 Services in the community should fulfill the following core functions:
- *specialist prevention and early intervention*
- *developing capacity in non-specialist community services to prevent unnecessary inpatient admissions*
- *giving support and training to families and carers (by following the recommendations on support and interventions for family members or carers in NICE's guideline on challenging behaviour and learning disabilities: prevention and interventions)*
- *quality assurance and service development*
- *short-term assessment and intervention*
- *longer-term complex intervention*
- *crisis response and intervention.*

1.4.3 Ensure that children, young people and adults with a learning disability can get specialist support through their community learning disability team that meets their needs, for example, in relation to:
- *behaviour*
- *communication*
- *social care and support needs*
- *physical health*
- *mental health*
- *education*
- *offending behaviour.*

This could be achieved by employing relevant practitioners within the community learning disability team or by developing close links with practitioners in other relevant services.

1.4.4 Services who provide support through the community learning disability team should work together and provide consultancy and support to each other.

*1.4.5 If a child, young person or adult develops, or is at risk of developing, **offending behaviour**, community learning disability teams should refer them to appropriate specialists, such as community forensic or youth justice services, as soon as possible (see recommendations 1.4.12 to 1.4.16). These services should:*
- *provide evidence-based early interventions that are adapted for people with a learning disability and address the specific behaviour*
- *work in an ongoing partnership with each other and with the community learning disability team whenever needed.*

*1.4.6 Community learning disability teams should maintain good communication and **links with the police and liaison and diversion teams** so that:*
- *they can advise on assessments of vulnerability, particularly for people with mild or borderline learning disabilities who may otherwise not be identified as vulnerable*
- *people who need support can be diverted from the criminal justice service to community learning disability teams.*

*1.4.7 Ensure that **specialist assessment and behavioural** support are available in the community so that children, young people and adults can stay where they currently live and avoid moving.*

1.4.10 Provide a local, personalised response to children, young people and adults who need ***intensive support during a crisis****. This response should:*

- *focus on keeping people in their own home*
- *have an out-of-hours helpline as a first option with the capacity to respond rapidly (within 1 hour or in line with local mental health crisis response times), staffed by people with skills and knowledge in learning disabilities and behaviour that challenges, and specialist skills in mental health problems*
- *provide face-to-face support within 4 hours if needed, based on initial triage*
- *involve partnership with other commissioners, service providers and family members and carers*
- *include giving staff access to the person's information if they are already in contact with services*
- *provide short-term support to achieve aims that are agreed with the person*
- *include clear contact details for children's services (as set out in the Local Offer) and adults' services.*

1.4.12 Commission local ***community forensic services*** *for children, young people and adults with a learning disability and behaviour that challenges who are in contact with, or at risk of contact with, the criminal justice system to prevent out-of-area hospital placement. These could be provided as stand-alone teams, or as a specialism within an existing team, for example, a community learning disability team, or a learning disability specialism within a community forensic team.*

1.5.1 Commissioners should work with local ***housing*** *and social care providers to identify the specific housing needs of adults with a learning disability and behaviour that challenges. They should ensure areas have a range of housing and care options available that meet these needs and cater for different preferences and person-centred support needs."*