

HEALTH AND WELLBEING BOARD

26 January 2016

Title: Learning Disability Partnership Board Strategic Delivery plan update	
Report of the Strategic Director for Service Development and Integration	
Open Report	For Information
Wards Affected: ALL	Key Decision: NO
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Summary: <p>This is a report which seeks to give assurance to the Health and Wellbeing Board (HWBB) on the workplan that is being delivered by the Learning Disability Partnership Board (LDPB). In order that progress on the work-plan can be monitored and the HWBB can be assured on the delivery of this work, the Partnership Board has created a delivery plan.</p> <p>The delivery plan covers the following areas, reflecting national and local agendas in relation to learning disability and autism:</p> <ul style="list-style-type: none">• Learning Disability Self Assessment Framework (LSDAF);• Autism Strategy;• The Winterbourne View Concordat and the Transforming Care agenda;• Challenging Behaviour plan;• Carers Strategy. <p>This report summarises the work that has been undertaken to date to deliver against the delivery plan. It will enable the HWBB to note achievements made, review areas or services which require further improvement, and ensure the actions agreed to progress any improvements are implemented.</p> <p>There are currently 40 actions within the delivery plan attached at Appendix 1. Of these, 28 actions are on track to be delivered (rated as green on the attached). This report highlights the 11 actions that are rated as amber (where progress has been slow) and one action that is rated as red.</p> <p>There is one red rated action highlighting significant concerns and interventions are being</p>	

made by partners on the LDPB to ensure that progress improves as quickly as possible. The red rated action is:

- Ensuring people with a learning disability are receiving health checks.

GPs are responsible for ensuring health checks and health action plans are carried out. Discussions have begun to address the issues, with remedial actions being put in place and detailed in the report below. It is recommended that the HWBB gives due consideration to these actions and discusses any further actions that can be taken.

It is proposed that the HWBB will receive a further update on the LDPB delivery plan in six months time. The LDPB will also escalate any exceptional issues which require attention, or investment, by the HWBB via the sub-group reports to Health and Wellbeing Board meetings.

The delivery plan is attached at Appendix 1.

Recommendation(s)

Members of the Board are recommended to:

- Comment upon the progress that has been made in implementing the delivery plan.
- Discuss and agree the proposed actions to be taken forward to maintain or improve services for people with learning disabilities and autism.
- Agree actions to improve current performance around health checks and health action plans.
- Advise as to whether the Delivery Plan adopted by the LDPB provides assurance to the Board on the delivery of the LDPB workplan, and whether this approach should be replicated by the other sub-groups.

Reason(s)

The Learning Disability Partnership Board is a sub-group of the Health and Wellbeing Board. The HWBB tasked each sub-group to be responsible for reporting and implementing actions relating to national and local priorities, as well as sections of the Health and Wellbeing Strategy delivery plan that relates to its service area. This report provides assurance from the Learning Disability Partnership Board (LDPB) that the actions delegated to the LDPB from the HWBB are being delivered.

The Delivery Plan and Outcomes Framework of the Health and Wellbeing Strategy delegates the following actions to the LDPB. These have been incorporated into the delivery plan attached, although these are also covered in the Learning Disability Self Assessment (LDSAF) and the Autism Self Assessment (ASAF):

- Completion of health checks and health action plans;
- Stable and appropriate accommodation for people with a learning disability;
- People with a learning disability in paid employment;
- Greater acceptance and diagnosis of adults with autism.

1. Introduction

- 1.1 This report is the first of a new style of assurance report from HWBB sub-groups that aims to give assurance to the Board that workplans delegated to the Board's sub-groups are being delivered.
- 1.2 The Learning Disability Partnership Board (LDPB) meets on a bi-monthly basis and includes representatives from organisations who work across the local health and social care economy, from both the voluntary and statutory sectors.
- 1.3 The LDPB has three representative groups that support it – a **Service User Forum**, a **Provider Forum** and a **Carers Forum**. These groups discuss and comment upon items that go to the LDPB, and escalate issues facing people with learning disabilities and autism to the Board. A representative from each of the representative groups sits on the LDPB and attends each of the meetings. There are two service user representatives on the LDPB.
- 1.4 The delivery plan at Appendix 1 has been created to track and monitor the progress being made against key national and local agendas for people with learning disabilities and autism, including:
- Learning Disability Self Assessment Framework (LSDAF);
 - Autism Strategy;
 - The Winterbourne View Concordat and the Transforming Care agenda;
 - Challenging Behaviour plan;
 - Carers Strategy.
- 1.5 The delivery plan will be discussed at each LDPB meeting and updates to the plan are coordinated by the Integrated Commissioning Manager for learning disabilities. In future, the LDPB will escalate any exceptional issues which require attention or investment by the HWBB via the sub-group reports to Health and Wellbeing Board meetings.
- 1.6 The main areas of activity will be discussed and summarised below. In particular, the report highlights any areas which are currently rated as amber or red. An amber rating would indicate slower progress than expected on delivering the outcome required. A red rating would highlight a significant under performance with a possibility of not delivering the outcome within the specified target date.

2. Learning Disability Self-Assessment Framework (LDSAF)

- 2.1 The Joint Health and Social Care Learning Disability Self-Assessment Framework (LDSAF) began in 2007 as a guide for health and local authorities to recognise the overall needs, experience and wishes of people with a learning disability and their carers. The LDSAF is overseen nationally by NHS England and ADASS (Association of Directors of Adult Social Services).
- 2.2 The aim of this framework is to provide a single, consistent way of identifying the challenges in caring for the needs of people with learning disabilities, and documenting the extent to which the shared goals of providing care are met

locally. The LDSAF is used to identify the priorities, levers and opportunities to improve care and tackle health and social care inequalities.

- 2.3** Each year authorities are tasked with carrying out a self-assessment on how it meets a set of criteria outlined within the LDSAF for both children and adults. This year's assessment covered the period 1 April 2013 – 31 March 2014 and was completed in early 2015. The Integrated Commissioning Manager for Learning Disabilities led on the collation of the data for the LDSAF with health and social care colleagues from the CCG, Children's Services, Community Learning Disability Team Practitioners, Transport services, Leisure and Arts, Youth Offending, Probation services, as well as service users, carers and providers.
- 2.4** Each qualitative measure assessed was rated as fully met, partially met or unmet, represented as red, amber or green as detailed in the national guidance. Each service area agreed the rating of how they meet the needs of people with a learning disability and agreed to actions stating how they would maintain or improve these measures. These actions were then developed into a Borough-wide action plan which has been incorporated into the delivery plan at Appendix 1.
- 2.5** The Health and Wellbeing Board received the LDSAF on 19 May 2015 and agreed to the action plan accompanying the self-assessment. The original report and action plan can be found here: <http://modern.gov.barking-dagenham.gov.uk/documents/s90347/LDSAF%20HWBB%20-%20Report.pdf>.
- 2.6** It should be noted that there is no requirement to complete an LDSAF for 2014/15 and the Association of Directors of Adult Social Services (ADASS) have stated that they will be reviewing the position in April 2016. However, we will continue to monitor our LDSAF actions within the delivery plan to maintain and improve our performance in services for people with learning disabilities.

3. Update to the LDSAF

- 3.1** Most indicators from the LDSAF are achieving within the agreed implementation plan. However, there is one key area at a red rating, indicating that progress has been significantly slow with little chance of achieving its target. There are also two key areas rated as amber indicating progress has been slower than anticipated. These areas are:

Health checks	R
Screening programmes	A
Offender health and the Criminal justice system	A

Health Checks – RED RATING

- 3.2** People with learning disabilities have poorer health than the general population and have a shorter life expectancy compared to the general population. Mental illness, chronic health problems, epilepsy and physical and sensory problems are more common amongst this group than they are within the general population.

- 3.3** To help address these health inequalities GPs are commissioned to offer an Annual Health Check to people with a learning disability (i.e. once every financial year). GPs are required to undertake this in line with the Cardiff Health Check¹.
- 3.4** In addition each annual Health Check should result in a Health Action Plan setting out the steps to be taken to address any issues identified by the GP.
- 3.5** To further highlight the importance of robust health checks and health action plans, Walthamstow Coroner's Court published a report in March 2015. The report detailed events leading up to the death of a service user in a neighbouring London Borough. One of the contributing failures was the inadequacy of thorough health checks. The LDPB reviewed the report and used its' recommendations to support the Borough's learning. The report emphasised the crucial importance of Barking and Dagenham ensuring that appropriate systems and support are in place to support people with a learning disability accessing appropriate health care.
- 3.6** Robust health checks and health action plans are therefore important indicators that people with a learning disability living in the borough are accessing the health care services that they need.
- 3.7** In previous years, the Annual Health Checks were validated by the Community Learning Disability Team (CLDT) before full payments were approved. The NHS contracts with GPs no longer require a validation of health checks as a condition of payment. This year's figures are showing a significant reduction in the number of health checks recorded as being carried out by GPs. With the reduction in the number of health checks being carried out there has been a corresponding reduction in the number of Health Action Plans (HAPs).
- 3.8** ADASS and NHS England suggest the following RAG ratings for completed health checks for primary medical services (Directed Enhanced Service) directives 2015, which came into force on 1st April 2015. The directives include a learning disability health check scheme. The scheme is in place to encourage primary medical services contractors to identify registered patients aged 14 plus who are known to Social Care and have a learning disability:
- **Green:** 80% or more of people with a learning disability are on the GP DES Register and have had an annual health check.
 - **Amber:** Between 41% and 79% of people with a learning disability are on the GP DES Register and have had an annual health check.
 - **Red:** Fewer than 40% of people with a learning disability are on the GP DES Register and have had an annual health check.
- 3.9** The current figures available via Health Analytics state that 25% of LBBB residents with a learning disability who are logged onto the GP DES Register have had an Annual Health Check this year since 1 April 2015. This equates to 197 people. To achieve the 80% rate described above, 630 people would require a health check to be completed. It should be noted that this figure is provisional and further validation of the data is being undertaken. This is therefore a red rating and has been categorised as such on the delivery plan attached at Appendix 1.

¹ The Cardiff Health Check is the recommended health checklist for people with learning disabilities to be used by GPs.

- 3.10** Similarly, ADASS and NHS England suggest the following RAG ratings for Health Action Plans:
- **Green:** 70% or more of Annual Health Checks generate a health action plan.
 - **Amber:** 50% - 69% of Annual Health Checks generate a health action plan.
 - **Red:** Fewer than 50% of Annual Health Checks generate a health action plan.
- 3.11** More than 90 percent of people registered with the CLDT have a Health Action Plan. Work is currently underway, however, to calculate the proportion of GP Annual Health Checks that have this year resulted in an amendment (as per the SAF RAG Rating guidelines).

REMEDIAL ACTIONS

- 3.12** The quality of health checks from GPs in the borough needs to be consistent and follow the guidelines as set out in the Cardiff Health Check. The low numbers of recorded health checks and health action plans has been shared with senior officers within the CCG and the Clinical Director with a lead for primary care improvement. Further work is needed to understand where the problem lies and ensure that there are an effective set of actions to address the issue quickly.
- 3.13** The following actions have been identified which will be built upon and implemented from January 2016 onwards:
- Joint Commissioner, CLDT Lead Nurse and the Practice Improvement lead will attend the GP forums, the Practice Nurse forums and the Practice Managers forums. The Practice Improvement Lead will confirm when the scheduled meetings are taking place during early 2016. The focus will be on raising awareness of the issues and understanding support needed from CLDT.
 - Discussion of issue and action plan at Primary Care Development Group on 19th January. The action plan will be supported by the Joint Commissioner, Practice Improvement Leads, CLDT Lead Nurse, Health Facilitation and the Clinical Director for primary care improvement. The plan will identify any additional training needed and a programme for providing this.
 - Via a project management approach the CLDT will support the GPs to undertake the required Annual Health Checks and subsequent updates to Health Action Plans. The Health Facilitation team within the CLDT have provided additional resources of a scale 6 administrator to co-ordinate and monitor the number of health checks and health action plans completed by GPs on a weekly basis. The administrator will take the lead in reviewing the register and validating the data held by the CLDT and the GPs. It is expected this process will be completed by early February 2016.
 - The CLDT Lead nurse and a member of the health Facilitation team will attend each GP surgery individually and agree the most appropriate support and actions that need to be implemented at a local practice level. There are

39 GP surgeries this will programme will be implemented over a 6 months period.

- The CLDT Lead Nurse, the Joint Commissioner and a member of the Health Facilitation team will initially attend the Integrated Care meetings. The meetings are held every 6 weeks and include representation from both health and social care practitioners. There will be a new expectation introduced to the meetings where GPs will bring to the meetings a list of all patients with planned health checks in the coming 6 weeks. This will ensure the CLDT are aware of the health assessments and plan and provide support where needed to GPs. Once the process is established a member of the Health Facilitation team will continue to attend the Integrated Care meetings.
- The CLDT will monitor and encourage health checks and health action plans when completing their annual, social care reviews.

3.14 CLDT has also begun to work with providers and service users on the need for, and process of, a health check. This will empower service users to expect a health check routinely when visiting their GP. The Integrated Commissioning Manager (Learning Disabilities) has also reminded Borough Providers through the provider sub-group forum of the role that they play in supporting service users when visiting the GP. This expectation is also detailed in the Learning Disability Supported Living contracts' Outcomes Framework in which providers are asked to evidence how they support service users to have Health Checks, Health Action Plans and hospital passports.

3.15 The Integration and Commissioning team are in the process of standardising the outcomes and key performance indicators for accommodation based services. The team are undertaking a Quality Assurance programme to assess and validate all providers that have not had their services evaluated through a competitive tender exercise. This will include ensuring that provider services contribute to supporting service users to stay healthy.

3.16 Performance in health checks and health action plans will be continuously monitored by the LDPB over the coming months. The Joint Commissioner and the CLDT will meet every 6 weeks to monitor the implementations agreed. A progress update will be brought to the HWBB in 6 months time in order that the Board can be assured that performance in this area has improved.

Screening Programmes – AMBER RATING

3.17 There is a national cancer screening programme which is included within the LDSAF. This includes:

- National breast screening - The NHS Breast Screening Programme invites all women aged between 50 and 70 for screening every 3 years. In England, the screening programme is currently extending the age range to include women from 47 to 73 years old.
- National cervical screening - NHS cervical screening programme is available to women aged 25 to 64 in England. All eligible women who are registered with a GP automatically receive an invitation by mail. Women aged 25 to 49

receive invitations every 3 years. Women aged 50 to 64 receive invitations every 5 years.

- Bowel cancer screening – The screening programmes send a bowel cancer testing kit (FOB testing) every 2 years to people eligible to take part. In England, men and women aged between 60 and 74 years old take part.

3.18 The data for these indicators is captured by a national data source and this data is not yet available. Our local data is yet to be validated and maybe subject to change. Early local indicators are showing that breast and cervical screening performance is in line with expected performance. However, local indicators are showing that performance may be below average for bowel cancer screening for people with learning disabilities.

3.19 The Board may wish to consider this in terms of its earlier discussion on how to improve cancer outcomes in the Borough.

REMEDIAL ACTIONS

3.20 Cancer screening programmes remain a priority for the CCG. In order to raise the awareness and outcomes for Cancer screening specifically for people with a learning disability, a number of actions are proposed as follows:

- The CLDT will work with GPs to ensure that cancer screening is included within the patients health check. Any diagnosis identified should be recorded on the patients file and the CLDT should also be made aware of the outcome of any positive cancer screening outcomes in order that this is included in health action plans and the team can work closely with individuals.
- Joint Commissioner to work with BHRUT LD lead and Macmillan GPs/Cancer UK Facilitator to understand specific issues around people with learning disabilities participating in screening and to develop an action plan to address this. This will include:
 - Working with GPs through the Cancer programme and LD health checks work to raise awareness of screening.
 - Wider awareness raising with carers, service users and LD providers on the process and importance of screening.
 - Working with screening providers to ensure appropriate information and appointment times are provided for people with LD.

Offender health and the criminal justice system – AMBER RATING

3.21 The LDSAF states that commissioners must have a working relationship with specialist prison health commissioners to ensure that there is good information about the health needs of people in local prisons and the wider criminal justice system. Barking and Dagenham does not have a local prison, so there have been limited opportunities to engage with prison services. However there has been improved engagement with Community Safety, probation and the local police force. The recent Learning Disability week had a themed event working with the police to

raise awareness of the needs of people with a learning disability in keeping safe and the type of support the police offer to individuals with learning disabilities when they are called in response to criminal activity as either a victim or an offender.

REMEDIAL ACTIONS

- 3.22** The local authority is developing the borough's Crime and Disorder Strategic Assessment which will be used by the Community Safety Partnership to identify what the current and emerging priorities are for the people living, working and visiting Barking and Dagenham. Officers from CLDT and Commissioning are involved in developing the Strategic Assessment. There have been some improvements in engaging with the criminal justice system but further inclusion remains a target for achievement.
- 3.23** The LDPB has tasked the service user and carer sub-groups to consider ways to engage with front-line police officers to raise the awareness of learning disabilities to Police Officers and other community safety professionals.
- 3.24** The CLDT and the Joint Commissioning Manager will work with the Group Manager for Community Safety and Integrated Offender Management, to ensure the authority is tracking the number of people with a learning disability who are managed through the Multi-Agency Public Protection Arrangements (MAPPA).
- 3.25** The Group Manager for Community Safety and Integrated Offender Management, as well as colleagues from Probation, will also be invited to attend the LDPB meetings in an advisory capacity from January 2016.

4. Autism Strategy implementation plan

- 4.1** The Government's first Adults Autism Strategy was launched in 2010. It detailed the duties and developments that local authorities and CCGs should implement for Adults with Autism. These were:
- improved training of frontline professionals in Autism;
 - the recommendation to develop local Autism teams;
 - actions for better planning and commissioning of services, including involving people with Autism and their parents/carers;
 - actions for improving access to diagnosis and post-diagnostic support;
 - leadership structures at national, regional and local levels for delivery;
 - proposals for reviewing the strategy to make sure that it is working.
- 4.2** The Council, alongside its partners, is required to produce a local plan which sets out the Borough's approach to delivering the national strategy and commissioning local services.
- 4.3** Following the production of the Borough's first Autism Strategy in 2011, the Health and Wellbeing Board received the second iteration of the Barking and Dagenham Adult Autism Strategy in December 2014. The Strategy was developed in conjunction with professionals, local voluntary groups, as well as individuals with

Autism and their carers. The full report and the Adult Autism Strategy can be found here: <http://moderngov.barking-dagenham.gov.uk/ieListDocuments.aspx?CId=669&MId=7555&Ver=4>.

- 4.4** The Adult Autism Strategy was structured around nine different priorities with an accompanying action plan stating how these priorities would be delivered. The priorities were based on what service users, carers and professionals told us were priorities for adults with autistic spectrum disorders and for the services that currently exist in the Borough. The priorities were:
- There is a clear and effective diagnostic pathway for Autism with information and advice on the support that is available.
 - There is good quality care and support for adults with Autism.
 - Adults with Autism are effectively supported with their housing needs.
 - Adults with Autism are effectively supported to access employment, training and skills.
 - There are lots of opportunities to take part in meaningful activities, during the day, in the evenings and at weekends.
 - Young people with autistic spectrum disorders who ‘transition’ to adult services are appropriately supported and encounter a smooth transition.
 - Adults with Autism are involved in the design, planning and operation of services.
 - Adults with Autism feel safe from harm and abuse at home and in the local community.
 - All health and social care staff, including those commissioned to provide services, are aware of Autism and are appropriately trained to identify, assess and support those with Autism.
- 4.5** Running concurrent to the development of the Council’s Autism strategy was the submission of a national annual Autism Self Assessment Framework (ASAF). The ASAF was conducted in a questionnaire style and our submission was greatly facilitated by the work that had been undertaken to update the Adult Autism Strategy. Alongside the LDSAF, the ASAF was presented to the Health and Wellbeing Board in May 2015. The report from that meeting can be found here: <http://moderngov.barking-dagenham.gov.uk/documents/s90347/LDSAF%20HWBB%20-%20Report.pdf>
- 4.6** There was no requirement for local authorities to develop an improvement plan. However the Adult Autism Strategy collectively captures all of the priorities detailed in the ASAF.

Update to the Autism Strategy

- 4.7 The Integrated Commissioning Manager for Learning Disabilities has worked with colleagues from across the health and social care economy to take forward the actions identified in the Adult Autism Strategy. The below are areas in which it has been identified that progress has been slow or not progressing in taking the Adult Autism Strategy forward. These have been flagged as amber on the learning disability delivery plan at Appendix 1.

Housing needs	A
Diagnostic pathway	A
Accurate reporting on the social care database	A

Housing Needs – AMBER RATING

- 4.8 Historically autism has been included within the grouping of learning disability services. The government's strategy on autism gives a clear message that services can no longer assume the needs of people with autism are met under overarching services. The Council is developing its Independent Living Strategy; this will detail how the Council will meet the housing and support needs of adults with autism and also engage with ageing carers around the housing and support needs of their adult children with autism. The previous target date for completion was March 2015. This target date was not been met due to staff resourcing issues. The revised target date is now April 2016. The LDPB have received regular updates from the Group Manager of Housing Strategy and a task and finish group, specifically looking at housing for people with learning disabilities and autism, has now been put together. The strategic objectives of the Independent Living Strategy are currently being drafted and consultation on these will begin in February 2016.

REMEDIAL ACTIONS

- 4.9 The LDPB and its subgroups will continue to monitor the implementation of the Independent Living Strategy to ensure it includes the needs of people with autism. This will be particularly challenging as there is not sufficient housing in the borough to meet the needs of all the vulnerable groups. To mitigate the sole reliance on the council's Housing department, Adult Social Care is also exploring options of working with Providers and Private Investors to create additional housing solutions for people with learning disabilities and autism.

Diagnostic Pathway – AMBER RATING

- 4.10 A key driver of the success of the Autism strategy is access to information through diagnosis and assessment. The agreement within the Autism Strategy was for an autism diagnostic pathway to be provided by NELFT, including its' implementation and publication.

REMEDIAL ACTIONS

- 4.11 NELFT has set up a Diagnostic Pilot Pathway across the four NELFT London Boroughs. This pathway was developed and agreed by the Trust / CCG to provide a

diagnostic service. The local authority is working with NELFT to ensure the autism diagnostic pathway service is implemented and is accessible and publicised to service users, including publicity on the Council's Care and Support Hub. Officers from NELFT have been invited to the February 2016 Partnership Board meeting to present the pathway and how it will be accessed and publicised to service users, carers and professionals.

Accurate recording on the Social Care Service User Database – AMBER RATING

- 4.12** The diagnosis of autism has at times been recorded with the overall diagnosis of learning disabilities. In order to truly focus on meeting the needs of people with autism, the strategy highlights the need to ensure autism is recorded on service user's records when autism is diagnosed as the primary need.

REMEDIAL ACTIONS

- 4.13** The CLDT will ensure when autism is diagnosed as the primary need it is recorded as such on the Social Care service users database (AIS). This will improve our records and ensure service users and enable the authority to plan better on meeting the needs of people with autism.

5. Other updates

- 5.1** The rest of this report will focus on providing the Health and Wellbeing Board with an update on the work that has been undertaken regarding other national and local agendas and the progress of actions on the Delivery Plan in these areas.

6. Transforming Care: The Winterbourne View Concordat

- 6.1** Following the Panorama programme on Winterbourne View Hospital, the government produced a report and concordat that were to be implemented nationwide called 'Transforming Care: A National response to Winterbourne View Hospital (December 2012)'. The report clearly stated that local authorities and health services should identify those patients within a hospital setting with a learning disability who no longer require this level of care intervention and whose needs could be more appropriately met within a community setting, preferably in a location close to their family. In particular, it sets out that local authorities and Clinical Commissioning Groups (CCGs) work together to ensure that vulnerable people, particularly those with learning disabilities and Autism, receive safe, appropriate, high quality care. It states '*the presumption should always be that services are local and that people remain in their communities; we expect to see a substantial reduction in reliance on inpatient care for these groups of people.*'

- 6.2** The actions, as set out in the Concordat accompanying the review, report a commitment by CCGs and local authorities to work in partnership to:

- Reduce the number of people who are residing inappropriately in specialist learning disabilities and Autism hospitals and services;
- Reduce the length of stay in these services (where appropriate); and,
- Improve the quality of care in those services.

- 6.3** The Transforming Care report set out some particular actions for CCGs to complete in order to support the commitments of the concordat. These were:
- The development of registers of all people with a learning disability or Autism in NHS funded care;
 - Maintenance of the register;
 - A comprehensive review of all placements for individuals identified as being resident within Assessment and Treatment units (ATU).

Actions around the Winterbourne View Cohort

- 6.4** One of the key recommendations in the Winterbourne View Concordat was the development and maintenance of a register for all patients receiving treatment in a specialist hospital. The patients on the register are referred to locally as the Winterbourne Cohort. Maintaining the register is the responsibility of the CCGs.
- 6.5** The Barking and Dagenham register began in 1st April 2013 with six people on the register. Since then there have been 8 new admissions, taking the total number of people who have been on the register to 14.
- 6.6** The annual cohort of admissions breakdown is:
- **April 2013 – 2014 = 6 (Start of the register)**
 - **April 2014 – 2015 = 4**
 - **April 2015 – 2016 = 4**
- 6.7** The total number of discharges since the register began is 10. The cohort breakdown is:
- **April 2013 – 2014 = 3**
 - **April 2014 – 2015 = 4**
 - **April 2015 – 2016 = 3.**
- 6.8** At the time of writing this report there are 4 service users on the register. The breakdown of their annual admission dates is:
- **April 2013 – 2014 = 3**
 - **April 2015 – 2016 = 1.**
- 6.9** The four individuals on the register are in Assessment and Treatment Units (ATUs). Two service users within the April 2013-14 cohort are still receiving active treatment and are not ready for discharge. One individual was reviewed at the end of September 2015 (with the next review due in February 2016) and it was agreed that a discharge was not appropriate because the individual exhibited intense challenging behaviour that it was felt was best supported in the setting in which the individual currently resides. The second individual was reviewed in July 2015 and December 2015. The individual is a Ministry of Justice patient and was moved to a smaller ATU in December. The patient is scheduled to have a care and treatment review in February 2016.
- 6.10** One service user within the April 2013-14 cohort was reviewed in late November 2015 and is working towards a discharge within the next 3 months and a detailed

discharge plan is in place which has been agreed by the service user, family carers, care management and clinical advisors.

6.11 The patient within the April 2015-16 cohort was admitted in mid December 2015 and is currently being assessed prior to having an active treatment plan.

6.12 The authority is reviewing each service user's progress in a number of ways. These include:

- Setting up and chairing six monthly Care and Treatment Reviews (CTRs) attended by the service user, family carers, advocates, care management and the full medical team including independent clinical advisors and a lay advocate.
- Attending all case reviews such as Care Programme Approach (CPA) and mental health tribunals.
- Regular visits to see the patient to observe progress and treatment being offered.

6.13 The past 12 months has seen the CCG and the Council focussed on reducing the number of patients that are in Assessment and Treatment Units (ATU). This has been achieved by the CCG and the Council working together to agree those patients within a hospital setting with a learning disability who no longer require this level of care intervention and whose needs could be more appropriately met within a community setting, preferably in a location close to their family. The number of Barking and Dagenham service users (4) is slightly lower than the London average of 4.8.

6.14 The challenge for successful discharge are that patients are not re-admitted back into hospital for treatment for the same or similar reasons that led to their first admission. To date the number of Barking and Dagenham re-admissions is 0 (zero), the London average for re-admissions is currently 28%.

6.15 NHS England has set London CCGs a regional target to have a 13% reduction of patients on the register at 1st April 2015 by 31 March 2016. London CCGs are tasked to contribute to this target. At 1 April 2015 the number of patients on the B&D register was 7; there are now 4 patients on the register, a reduction of 57% within the first 6 months of the year and thereby already exceeding the national target. A further discharge is planned to take place before 31st March 2016. Achieving the additional discharge would further increase the Barking and Dagenham discharge reduction rate. This reduction has been achieved by:

- Working closely with Current Providers, potential new Providers, Service users, Advocates, Carers, Integrated Care Management team and Commissioners to ensure the most appropriate placement and process is agreed that will lead to a stable discharge outcome.
- Careful consideration is taken to identify potential Providers that have the required experience and resources to develop bespoke packages.
- Ensuring all agreed discharge transition plans reflect a timetable suited to each individual service user.
- Liaising with Commissioners from other Local authorities and CCGs to agree joint funded packages of care and support as part of the discharge plan.

6.16 Whilst progress has been made towards achieving the objectives of the Concordat, the challenges that the CCG and the local authority face are:

- Preventing unnecessary admission and re-admission into ATU services.
- Identifying Providers with the expertise to develop be-spoke packages.

The following outlines the work that is being done to meet these challenges.

6.17 Preventing unnecessary admission and re-admissions: To date the authority has not had any patient re-admitted following discharge. It is felt that this has been achieved by:

- Ensuring the patient has made significant and stable improvements whilst receiving care and treatment before recommending a discharge;
- Taking the time to identify the most appropriate Provider and environment to meet the needs of the patient;
- Allowing sufficient time for a transition into the new service;
- Collaborating well with all the relevant stakeholders.

6.18 Gate-keeping to admissions: To add further resilience to Preventing Unnecessary Admissions (PUA) into ATU services, LBBB and B&DCCG are currently considering how to implement a gate keeping process to ATUs. The gate-keeping process will include:

- Inclusive Meetings held at the provider setting
- Ensuring family involvement & meaningful input
- Experts by Experience being involved at the earliest opportunity
- Flexible & Creative approaches to funding care packages
- Extra staff being commissioned at short notice to prevent placement breakdown
- Learning from CTR's being used to change practice/thinking
- Where the principles of Positive Behavioural Support were being deployed
- Where Localities had effective ways of monitoring and tracking people at risk of admission.

6.19 'At Risk of admission' Register: Further work in preventing and minimising admission is the development of an "at risk" register. The introduction of a risk register is to identify individuals at risk of admission. This will enable commissioners to track individuals, identify existing gaps in current service provision and design the required services in partnership with relevant stakeholders. Working with NHS England each CCG and local authority will develop and hold a register of those "at risk" of admission. Providers, community teams and other organisations (as appropriate) will be involved in the development of the register. Although in its early stages, some of the identifiable risks or triggers that will assist the authority to be proactive in offering timely support are: (please note that this list is not exhaustive list)

- Significant life events and/ or change such as bereavement or abuse.
- Unstable / untreated mental illness
- Previous history of admission(s).
- Presenting significant behavioural challenges.
- Being supported in an unstable environment or by a changing staff team.

- Not being previously known to learning disability services.
- Being homeless
- Being in contact with the Criminal Justice System.
- Presenting 'in crisis' at Accident & Emergency Departments.
- Having no family carers/advocates.
- Having drug and alcohol addiction problems.
- Having no effectively planned transition from Child to Adult learning disability services.
- Being placed in specialist '52-week' residential schools or out of area specialist providers
- Having recently been discharged from long stay hospital beds.
- Having a family history of significant mental health challenges
- Having a history of safeguarding challenges.

6.20 The development and maintenance of the risk register will require the on-going support of health and social care services, in partnership with service users, carers, Providers, Housing Services and other stakeholders. It is planned to commence the development of the "at risk" register in January 2016. This action has been included in the LDPB delivery plan.

Building the Right Support

6.21 Another phase of the Transformation Care Programme is for the CCG to lead on developing community services and close inpatient facilities for people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition.

6.22 In October 2015, NHS England announced a national plan called '*Building the Right Support*'. The programme is expected to achieve a closure of 40-65 % closure of hospitals within the next 4 years. Much of the priorities for Barking and Dagenham will be centred on the "Building the Right Support" Programme. Barking and Dagenham will form part of a Transforming Care Partnership (TCP) with the other east London CCGs.

6.23 Transforming Care Partnerships will be supported to work alongside people who have experience of using these services, as well as their families/carers, clinicians, providers and other stakeholders to formulate and implement joint transformation plans; closing some inpatient provision and shifting investment into support in the community. They will bring commissioners together at a scale larger than most CCGs and many local authorities, with their geographical footprint based on:

- Building where possible on existing collaborative commissioning arrangements (e.g. joint purchasing arrangements amongst CCGs, joint commissioning arrangements between CCGs and local authorities).
- Local health economies of services for people with a learning disability and/or autism (e.g. patient flows, the provider landscape, and relationships between commissioners and providers). Where, for instance, a number of CCGs tend to use the same hospital provider for inpatient services it makes sense for those CCGs to implement change collaboratively.

- Commissioning at sufficient scale to manage risk, develop commissioning expertise and commission strategically for a relatively small number of individuals whose packages of care can be very expensive.

6.24 The final TCP membership has not yet been agreed. The work of TCP will commence in January 2016 and it is expected to run until 2019. The key commission intentions of the TCP are:

- Reduced reliance on inpatient services (closing hospital services and strengthening support in the community).
- Improved quality of life for people in inpatient and community settings.
- Improved quality of care for people in inpatient and community settings.

7. Addressing Behaviour that Challenges Services: Challenging Behaviour Plan

7.1 Additionally, in responding to preventing or minimising admission, the local authority is implementing the strategic commitments made to the Health and Wellbeing Board in March 2014 on “*Addressing Behaviour that Challenges services*”, the Borough’s Challenging Behaviour Plan. The key actions relating to this plan are:

- Developing local services that have the expertise to support behaviour that challenges.
- Developing services that offer service users and carers a respite during short term crisis.
- Working regionally to develop provisions that are feasible and sustainable across the neighbouring borough boundaries.
- Sharing good practice across the region and nationally.

7.2 The following actions have been achieved in the first phase of the Challenging Behaviour Plan:

- Improved integration with health and social care. Many service users who display behaviour that challenges often have a combination of health and social care support needs, joint assessments and joint funding solutions have been a successful outcome to meeting the needs of the service user.
- Raising awareness understanding, and knowledge of good practice in supporting service users who have challenging needs. This has included encouraging Providers through the Providers forum to implement Positive Behaviour Support as a core training element of their induction programme for staff.
- Supporting Providers to implement the Safeguarding reporting and Deprivation of Liberty Safeguard (DoLS) in a transparent, non risk averse approach that leads to service improvements.
- Reshaping the Community Learning Disability team to include specialists in behaviour that challenges and ensure these specialists offer training and crisis intervention.

- Utilising the Fulfilling Lives programme to work with existing providers/specify in the supported living tender the need to move people who have attended day services for a long time and who wish to move on to find mainstream opportunities.

Next Steps – Challenging Behaviour Plan

- 7.3** The next phase of the Challenging Behaviour Plan will take place over the next 5 years. The programme of work will require a long term commitment from all partners in order to see a sustainable change in how service users that have behaviour that challenge are supported by the borough. These actions have been captured in the LDPB delivery plan.
- 7.4** An ongoing challenge is the **availability of housing** which can be tailored to ensure that services for individuals with challenging behaviour can be delivered. This will include developing links with landlords and the Housing department. This will be incorporated into the Independent Living Strategy and monitored through the LDPB meetings.
- 7.5** It has been identified there is a need to develop a **service specification** that meets the need of service users who display challenging behaviour. It is recognised that there is a national and regional problem regarding the lack of providers with the expertise to develop bespoke packages and sustain support to people with challenging and complex needs. Working within the collaboration of the neighbouring boroughs across North East London preliminary work has began to develop a framework of “expert Providers” that would be accessible to the authority. It is planned to have the framework in operation by April 2017.
- 7.6** Barking and Dagenham are also part of a working group that is led by the Tizard Centre within Kent University. The Tizard Centre is recognised as one of the world’s leading research and study centres for learning disability. The completion of the service specification will assist the council to commission good providers that are clear on the expectations of commissioned services designed for challenging behaviour services, and ensure providers have the skills and resources to achieve the outcomes.
- 7.7** Barking and Dagenham are **working closely with all the regional authorities overseen by NHS England**. This joined up approach has led to the a number of positive outcomes:
- Sharing of information about good quality providers.
 - Sharing of safeguarding concerns across the region and therefore minimising the risk of another Winterbourne View type of incident.
 - Sharing the task of sourcing suitable providers, and therefore creating economies of scale and financially viable models that would not have been sustainable in isolation by a single borough.
- 7.8** The lack of good local services has led to many service users being offered a placement out of the borough, this happens in both children and adults services. Once the service users are settled in their new community it is often difficult to support service users to return to Barking and Dagenham, as occasionally they

are now settled in their community and do not wish to return or at times there are legal requirements restricting a return to the borough.

- 7.9** In order to minimise the number of out of borough placements that are agreed in the first instance the Council will need to work with providers and landlords to develop services in our locality, and ensure closer working between services for adults and those for children and young people.

8. Carers Strategy

- 8.1** The Care Act puts in statute for the first time, the needs of carers and their right to be recognised for the work that they do. The Care Act introduces significant and welcome measures to improve the rights of adult carers. These measures include:

- A duty on local authorities to promote the physical, mental and emotional wellbeing of carers and their participation in work, education and training;
- A duty on local authorities to provide information, advice and access to a range of preventative services which reduce carers' need for direct support;
- New assessments which put carers on an equal footing with the person they care for;
- Giving carers, for the first time, a clear right to receive services, via a direct payment if they choose;
- A national eligibility threshold, bringing greater clarity around entitlement for carers and those they care for;
- Processes in place to ease the transition between child and adult services.

- 6.2** In 2014/15 the local authority and the CCG worked with Carers UK, stakeholders and carers to develop the Borough's Carers' Strategy, *Let's Care for Carers: A Carers' Strategy for Barking and Dagenham 2015-18*. The strategy was agreed by the Health and Wellbeing Board in February 2015 and recognises the importance of the contribution made by carers to the safe and sustainable delivery of care in the Borough. The Strategy also reflects the changes made by the Care Act 2014.

- 6.3** Where actions in the Carers Strategy are relevant to carers of individuals with learning disabilities, these actions have been incorporated into the delivery plan attached and will be monitored regularly at LDPB meetings.

- 6.4** Completed actions from the Carers Strategy so far have included:

- Consultation with the LDPB and the Carers Forum sub-group to develop the new service specification for the Carers' Hub.
- The inclusion of learning disability provider services on the Carers Strategy Group.
- The inclusion of carers as a key part of the Carers Hub tender evaluation.

9. Mandatory Implications

9.1 Joint Strategic Needs Assessment

The Joint Strategic Needs Assessment has a strong learning disability analysis and the detail contained in this report aligns well with the strategic recommendations of the Joint Strategic Needs Assessment. It should be noted, however, that there are areas where further investigation and analysis have been recommended as a result of this year's JSNA. The purpose of the ongoing JSNA process is to continually improve our understanding of local need, and identify areas to be addressed in future strategies for the borough.

9.2 Health and Wellbeing Strategy

The report describes performance against priorities outlined in the strategy on service improvement that need to be provided now and in the future to enhance the lives of people with a learning disability.

9.3 Integration

The Learning Disability Partnership Board is a multi-agency Board with representation from the local authority, the CCG, NELFT, BHRUT and other partners across the health and social care economy and the voluntary and community sector. The Board also has representation from service users, carers and Providers of learning disability services. The Integrated Commissioning Manager for Learning Disabilities is also a joint appointment between the Council and the CCG.

9.4 Financial Implications

Implications completed by: Carl Tomlinson, Group Finance Manager

There are no direct financial implications arising from this report. The delivery plan would mainly be managed within existing funds available through the Council base budgets and the Better Care Fund.

9.5 Legal Implications

Implications completed by: Dawn Pelle, Adult Care Lawyer

There are no legal implications for the following reasons:

- First the Action plan is being developed with regard to all the relevant policies, the Care Act 2014, the associated regulations and guidance;
- The required actions as directed by the Winterbourne Concordat has been implemented;
- There is to be a Carer's strategy implemented and developed especially for those carers of LD/Autism Spectrum Disorders service users;
- There is recognition of the actions that have been met, those that need improvement and those for which the authority is in the red zone.

10. **Background Papers**

Adult Autism Strategy, presented at the Health and Wellbeing Board on 9 December 2014: <http://moderngov.barking-dagenham.gov.uk/ieListDocuments.aspx?CId=669&MID=7555>

Review of Learning Disability and Autism Self Assessment Frameworks, presented at the Health and Wellbeing Board on 12 May 2015: <http://moderngov.barking-dagenham.gov.uk/ieListDocuments.aspx?CId=669&MID=8156#AI55438>