

Report for Herts Valleys Clinical Commissioning Group Board Development Meeting

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1 Executive Summary and Purpose of the Report

In March 2013, Mencap created a Charter suggesting that in order to improve the quality of care for people with a Learning Disability CCGs should sign the Charter and commit to its intentions. The Charter was developed following the publication of the Confidential Inquiry into Premature Deaths of People with a Learning Disability (CIPOLD) 2013. Herts Valleys signed the Charter in June last year. I attach a copy. I was appointed Clinical Lead in June last year. I work closely with the Learning Disability Commissioning team from JCT.

The intention of the Charter is to improve the quality of care for this vulnerable group in primary care, secondary care mainstream services and in specially commissioned services. This links closely with the CCG's Primary Care Plus initiative.

This report covers progress to date with the work-plan created to develop the 13 items of the Charter within our CCG. It also reviews future plans to continue progress made. The Board need to consider whether they wish to continue with this work and how to support it. In order to do this it would be helpful to consider publishing a CCG structure with routes of communication for smoother planning and decision making. It would also be helpful to consider how the CCG wish to work with the learning disability commissioning team of JCT.

2. Main Body of Paper

I will list the sections of the Mencap Charter with progress to date and plans for next steps.

1. Have a Learning Disability commissioning lead on our executive committee to monitor and coordinate service improvement

I confirm that HVCCG has a commissioning lead on the executive committee. Dr Nicolas Small is the Board representative for learning disability.

2. Provide an ongoing programme of learning disability awareness and mental capacity training to NHS staff

I have expanded this item to cover adult safeguarding. The 3 programmes of training therefore cover: Learning Disability Awareness – being developed by the Community Learning Disability Team practice linked nurses. Mental Capacity Act training – being developed in conjunction with Javeda Jafri (Herts CC DOLS team). Adult Safeguarding Training – being developed with Tracey Cooper and Trish Orme (adult safeguarding Herts CC)

Progress towards achieving this has been made. I have attempted to develop a network of practice based learning disability leads. I gather that the best way in future of communicating directly with practices will be via the Locality Leads. I would appreciate confirmation of this as misunderstanding has slowed down progress. I have worked closely with Avni Shah (planned and primary care). The hope is that practices will be granted 2 hrs protected learning time per month. They will be given a curriculum of learning with some compulsory components. (see Primary Care Plus document) The intention is that practice leads will be trained at locality level and then will be able to cascade the training into the practice using the train the trainer approach. I suggest that practitioners are

recommended to complete on-line learning from Herts CC (hertssocialcare.learningpool.com) for both Mental Capacity Act and Adult Safeguarding training in preparation for group learning. On-line learning for Learning Disability Awareness will also be recommended. To further support this, prototype guidelines for practices for adult safeguarding and mental capacity act awareness will be circulated. This supports practice compliance with CQC. Encouraging practices to work towards achieving the Purple Star kite-mark will also be recommended (see - <http://www.hertsdirect.org/services/healthsoc/disability/purplestar/>)

3. Meaningfully involve people with a learning disability and their families and carers in the planning and review of health services, and provide evidence thereof

The intention is to seek engagement with Learning Disabled adults through a process of asking them to evaluate the services they receive at both primary and secondary care level. Alison Gardner (patient and public involvement) is closely involved with this. We have attended the Learning Disability Partnership Board and met with Louise Jenkins of the Health Liaison team. HLT already evaluate the experience of people on discharge from hospital. The tool that is used has been enhanced to include evaluation of whether reasonable adjustments have been made. The data collected will now be shared so that learning from this can be developed and used to better commission services. A tool to evaluate experience of the health check in GP practices has been developed. This will be delivered by the health liaison team. We have developed a robust team to share and use data. Monthly meetings are established – Improving Health Care data and business meetings. Membership includes JCT LD commissioners, public health, CCG clinical lead and the health liaison team including their data manager. We aim to develop a public health observatory for learning disability and a health partnership review group.

The next phase will include engagement with carers. But most importantly feedback will be given to the Learning Disability Partnership Board on learning gathered from patient evaluation and how this has helped to shape and improve services.

4. Commission all NHS providers to implement reasonable adjustments, and use contracting mechanisms to check these are in place

David Evans and I created a letter to send to Trusts suggesting that they should sign up to the Mencap Commissioning Charter. This was forwarded to Charles Allan to circulate to provider trusts. The process of developing this item has been frustrating as I do not have expertise in contractual mechanisms and have not known who to work with. The JCT LD commissioning team circulated 'commissioning intentions' for learning disability in the autumn. These cover an expectation that commissioned services sign up to the Mencap Charter, that GP annual health checks are effective, learning from the outcomes of the public health audit of the DES, maintaining ring-fenced funding for managing the Transforming Care agenda, and consideration of step-down funding for people leaving secure services.

In the last month I have worked closely with Diane Curbishley. We have developed a 5 component reporting mechanism for providers (attached). From this we will develop baseline data to move to more formal reporting of metrics within 2015/16. These have been developed and made local from the evidence based guide for commissioning services for the learning disabled for CCGs October 2012. (see

[http://www.improvinghealthandlives.org.uk/publications/1134/Improving the Health and Wellbeing of People w - \)](http://www.improvinghealthandlives.org.uk/publications/1134/Improving_the_Health_and_Wellbeing_of_People_w-)

5. Encourage and support all GP surgeries to offer annual health checks to people with a learning disability in line with the RCGP recommendations regarding process and content

We have 100% sign up to the DES. However, uptake of health checks is only around 60%. We completed an audit of the quality of health checks in the summer. None complied with all components of the DES. This work has been done with public health and the JCT LD commissioners. The DES will continue for 14-15. It now includes health checks on those aged 14 and over – it will be challenging to identify those under 18. There will be a requirement to develop a health action plan. I am working with the health liaison team to develop an easy-read explanation of a health action plan and produce a proforma health action plan for GPs to use. I have developed a simple tool to circulate to practice leads re how to organise and conduct the annual health check. In the new financial year I will circulate further guidance for lead GPs via the locality leads. Hopefully we can develop a group for mutual learning and sharing of skills. I have LD leads now in most practices but the process of developing this has been immensely frustrating and very slow.

I am working with Andy Saunders at the Area Team who commissions the DES from primary care. We are looking at ways to gather more information from practices around the health check. The aim of this is to develop the JSNA and also a local public health observatory. This information re co-morbidities is also needed for the SAF – see below. I am meeting with Andy and Avni Shah to progress this on 13/3.

6. Ensure all acute healthcare trusts are signed up to the Getting it Right Charter

See 4 above and appendix

7. Participate in the National Joint Health and Social Care Self-Assessment Framework (Learning Disabilities) and work closely with social care colleagues to ensure implementation

The requirements for the SAF have been developed by the organisation 'Improving Health and Lives for People with a Learning Disability' (<http://www.improvinghealthandlives.org.uk/>) from the learning gathered from CIPOLD – see above. This year's completion (see appendix) was largely aspirational and has driven the development of the JCT learning disability strategy for the next 5 yrs. (consultation re this has been available via HVCCG website)

We have developed a core group (Improving Health Group) to develop ways of extracting the required data and use it to inform the JSNA thereby creating a local public health observatory for learning disability. We hope that from this group will evolve a pan-health group to monitor and review quality of provision, learning from each other, morbidity data etc. We need to extract disease specific data for patients with learning disability – difficult to do and probably needs to be done at practice level. We are looking at working together with the area team to see if any financial incentive to practices could enhance both the quality of the annual health check but also the useful data that can be extracted from it. I have met with Andy Saunders who is commissioning the DES at AT level to take this forward. We need to extract data around the uptake of screening in breast, bowel and cervical screening for people with a learning disability. I have met with the screening manager and public health to see how we could highlight those patients with learning disability on the Exeter

screening software. I will be discussing this with our Caldecott Guardian as there are real governance issues to manage. The bonus would be that screening could make more purposeful reasonable adjustments to encourage uptake. We have a JHSCSAF improvement plan in place.

8. Work closely with local authorities to ensure that public health, social services, housing services, employment and NHS commissioning are well-coordinated and, where responsibilities overlap, aim to jointly deliver services

This is done at the Strategic Commissioning Group for learning disability which I co-chair (part of JCT). I work closely with JCT LD commissioners. Jan Gates has created a draft 5yr learning disability commissioning strategy – see above. HCC commissioners have created a ‘market position statement’ for adults with learning disability – this covers the aims of keeping people out of hospital, supporting people in their home in the community, creating personalised opportunities for people around what they do during the day, increase employment opportunities, supporting people to stay healthy. Research suggests this needs further development. The aim is to identify what is lacking in terms of provision. It is also important to support people with a forensic background whose risk level is high. Jan Gates has worked regionally to produce the requirement for social care staff to understand and monitor the health needs of people with a learning disability that they care for.

9. Identify people with a learning disability using NHS services, closely monitor quality outcomes for people with a learning disability and act to improve them when inequalities of outcome are identified

In Herts we already know that the practice held QOF LD registers have larger numbers than the local authority LD registers. I am working with the Community Learning Disability Service, especially the health liaison team to encourage GP practice CLDT link nurse to help practices with identification. The SAF is asking for large amounts of data around the experiences of people with a learning disability. Much of this data is as yet, difficult to extract. However, through the SAF mechanism we will be monitoring uptake of screening services, quality of chronic disease management for LD patients eg their epilepsy and diabetic care etc. The health liaison team is already collecting a lot of data around morbidity and mortality for people with LD. We are now sharing this data. The CIPOLD recommendations include developing local public health observatories to monitor this data. This is being taken forward by public health and will inform the JSNA.

I have worked with Diane Curbishley and Lucia Contino. We will now get monthly reports from providers re numbers of people with a learning disability –having spells of inpatient treatment, attending outpatients and attending A&E. Andy Saunders at the Area Team is looking at matching local authority and GP learning disability registers to try to get accurate figures for Herts. We are asking the RAID team to review people on hospital admission who may have undiagnosed learning disability. The reporting mechanisms process will help to identify and improve inequalities.

10. Strategically plan and commission specialist learning disability services based on sound evidence and best practice

This is done at SCG level. This reviews the quality of provision by regular contract monitoring – done by JCT. Progress is regularly reviewed through QPRs at the learning disability strategic commissioning group this includes - HPFT performance reports and HCC dashboard.

11. Commission local services for children and adults with a learning disability and behaviour that challenges, and robustly monitor their quality

The NDTi has recently completed a brief audit in the County. The SAF is also asking for data collection around children's services through transition to adulthood. 'Children with a disability' is one of the jointly commissioned children's committees. The strategic commissioning group, as suggested by NDTi is defining behaviour that challenges as those at risk of placement breakdown. The adult commissioning team is developing close relations with the disabled children team. A new joint plan is being developed, hopefully with the aim of creating an emergency response team. The aim is to improve outcomes for the most challenging people. The team will use PATH, a person centred planning tool. The challenging behaviour pathway has been developed by the Managed Clinical Network for LD. The aim of this statement is to reduce the numbers being placed in private hospitals such as Winterbourne View in the future.

12. Ensure that the recommendations set out in the Department of Health's final report of the Winterbourne review and the accompanying Concordat are implemented locally in a timely manner

The DOH regularly asks for data on progress. See - <https://www.gov.uk/government/publications/winterbourne-view-progress-report> . The Govt has recently completed a census of all in health funded placements. For us these are people in secure settings, HPFT beds and private placements. The numbers are larger than the original Transforming Care Group and create an ever-changing group of people as they step up and down through services. These now require quarterly monitoring and reporting. This is a CCG responsibility but done on behalf of CCG by the LD commissioning team. Monitoring visits to inpatient facilities are reviewed regularly at SCG. I have recently done a monitoring visit of a Cambian facility in Hemel Hempstead and contributed to the report. This will be circulated to Jan Norman and to Cambian head office. Recommendations will be monitored.

13. Ensure that the recommendations of the Confidential inquiry into premature deaths of people with a learning disability are implemented locally in a timely manner

These requirements are covered by the SAF and will form the basis of the LD commissioning strategy and the workplan for the health partnership review group.

3. Risks and Mitigating Actions – The transforming care group is a widening and evolving group of highly complex people placed with providers who are very challenged by their care.

4. Recommendations – that the CCG maintains its commitment to the Mencap Charter for CCGs and allows this work to continue. It would also be helpful to link this work with the children's workstream and with the Primary Care Plus Agenda.

5. Conclusion and Next Steps – these are listed for each point within the body of the paper.

6. Appendices

- The Mencap Charter for CCGs
- the reporting mechanisms for providers
- the health and social care for learning disability self assessment framework return for Herts 2013

