General Release

REPORT TO:	**Health and Social Care Scrutiny Sub Committee 17th January 2017**
AGENDA ITEM:	**8**
SUBJECT:	**Transformation of services for people with Learning Disabilities**
LEAD OFFICER:	**Barbara Peacock, Executive Director People,** **Paula Swann, Chief Officer, Croydon CCG**
CABINET MEMBER:	**Councillor Louisa Woodley, Cabinet Member for Families, Health and Social Care**
PERSON LEADING AT SCRUTINY COMMITTEE MEETING:	**Stephen Warren, Director of Commissioning, Croydon CCG** **Caroline Baxter, Assistant Director of Disability 0-65.**

ORIGIN OF ITEM:	**This item forms part of the Committee's work programme**
BRIEF FOR THE COMMITTEE:	To review and consider the progress of the transformation programme in place for people with learning disabilities

1. EXECUTIVE SUMMARY

This report looks at the developments, plans and actions that have or are transforming the way the London Borough of Croydon is supporting people presenting with Learning Disabilities. Much of the work is encompassed in the broader Transformation of Adult Social Care Programme (TRASC) that is currently underway.

This report details the current actions and the plans for the future of Learning Disability Services including information on The TRASC Programme, an Asset Based Approach to Social Care, Support Planning and Brokerage, In-borough provision, Safeguarding, Co-Production and moving forward.

2. TRANSFORMATION OF SERVICES FOR PEOPLE WITH LEARNING DISABILITIES

2.1 Introduction

The Transformation of Adult Social Care (TRASC) Programme is key to enabling the Council to deliver personalised services, "a life not a care plan", as well as a financially sustainable adult social care system. It is a response to reducing budgets and increasing demand arising from an aging population and an increase in clients with increasingly complex needs.

The Programme will also reduce underlying cost pressures through better demand management, effective commissioning and promoting independence at every opportunity to release further cost efficiencies. The intended benefits of the Programme are:

- People will have better access to advice, information and targeted prevention that will help them to live their lives without support from the Council;
- People will be supported through re-ablement to be as independent as possible;
- People will have more choice and control, leading to higher satisfaction levels; and
- More people will be supported to live independently.
- In line with the Care Act we are moving toward delivering services through an Asset Based Approach.

The focus of the Care Act is about meeting need not simply providing services. Promoting wellbeing is not always about local authorities meeting needs directly. It is about ensuring that a system is also in place for people to access the information they need to take control of their care and support and choose the options that are right for them. The system has not always offered enough choices about the range of ways that the needs of the individual could be met.

- The asset based approach in part, is about financial sustainability within adult social care. It is about increasing peoples' independence, reducing dependency on services and to ensure those requiring long term support receive this for those needs which cannot be met in any other way.

- The emphasis is to find solutions with the person to address their needs utilising their own assets during all interactions with adult social care.

This is a cultural shift for staff as well as service users.

2.2 What is the Asset Based Approach?

To protect and maximise the individual's independence, resilience, ability to make choices and to promote well-being by focussing on:

Resilience, ability to make choices and to promote wellbeing by focusing:

- A person's strengths, capabilities, skills, knowledge and potential.
- The person's existing network – including family, friends and neighbours and community resources.

Thinking differently - moving away from a services orientated approach and focussing more on promoting independence:

- Asking different questions
- Finding out what a person wants to achieve
- What is important to the service user?
- What is already working well for them?

- In revising the customer journey from the front door onwards, whichever route a person comes into the council, similar conversations should be occurring.

Case Study – a resident with high learning disability needs

The TRASC High Needs Review Team, led by Dan Fisher and Caroline Peters, focuses on finding alternative more proportionate forms of support for people with high learning disability needs. An example of the work they have conducted with one of our residents is captured in the case study below:

> "*Mr. A is an intelligent gentleman who had a successful career in education. Mr. A was married with one child but sadly divorced and lost contact with his family. Following a period of alcohol misuse, it was reported that he was living on the streets and then admitted to hospital after collapsing. Mr. A was later admitted to a specialist nursing home out of borough and was treated for a number of years for a chronic memory disorder resulting from alcohol misuse.*
> *Following a review by a Social Worker from the TRASC High Needs Team, it was found that his placement was no longer suitable because he was more physically and cognitively able than some of the other residents. Mr. A agreed to move back to Croydon where he received a period of Reablement in Extra Sheltered Accommodation. He has now moved into another flat where he continues to be mostly self-reliant which has a positive impact on his health and wellbeing.*
> *Mr. A informed the High Needs Team of new outcomes he would like to achieve including volunteering in education again. According to Mr. A, it will give him 'great joy' if he can use his knowledge in education to assist the next generation and he can give back to the community*".

2.3 Developments to in-borough provision for people with learning disabilities:

Building work is being carried out to partition the current Cherry Orchard Day Centre site to enable us to share the building with the White Horse Youth Centre. For health and safety reasons the council decided to move the Cherry Orchard Day service into Addington Heights Day Centre (which was empty) and Peter Sylvester Centre (PSC) during the building work which commenced on 1 October 2016. Annette McPartland (Head of Service Day Operations) and her management team, Kaye Carter, Caz Clark and Paul Wallingford are leading on the move.

One half will be used for White Horse Youth Centre – no decisions have yet been made regarding the other half of the building as the council will wait until the end of the process of co-production.

The council are aiming to co-produce a modern and personalised service offer for people with learning disabilities in Croydon and therefore will soon be extending an open invitation to attend a variety of events to help shape and produce this plan for the future.

The initial feedback from clients using the new sites is positive and we are continuing to work with service users and their families to develop the most appropriate model of care.

There have been some small issues regarding transport due to clients having extended journeys. This is currently being addressed. There was a specific and unforeseen transport problem, lengthening some of the journey times, due to the additional traffic pressures and diversions as a result of the recent tram incident. This of course was a temporary issue.

Current actions:

- Attendees of Cherry Orchard Day Centre have successfully moved to alternative venues in order to vacate the site for building work that enables the Youth Zone development. The managers and staff at Cherry Orchard played a huge role in supporting and reassuring attendees and their families.

- We have procured more advocacy providers to increase the capacity available to support vulnerable adults to access our pathway and support people during reviews and any changes to services and so on.

- The co-production partner (The PublicOffice) will jointly develop a vision and blueprint for the future of services and opportunities for people with a learning disability, carers and key stakeholders by the end of January 2017.

2.4 Other innovations and generic benefits arising from the TRASC programme are:

- Safeguarding – we have liaised with the Police Service on improving our joint efforts in safeguarding adults. The phased rollout of integrating safeguarding into wider social work practice has begun with the Learning Disability (LD) Team.

- Adult Social Care Pathway – reduced staff time in processing Contact Centre referrals into AIS (our case management system).

  Referrals are received through the Contact Centre. Referrals that cannot be resolved at this first point of contact will be forwarded to the Central Duty Team or Gateway. They will be allocated after initial assessment to either the appropriate Social Care Team or Crest.

- Support Planning and Brokerage – we have worked with a partner organisation to run a pilot testing a peer support planning and brokerage model. We are currently reviewing the feedback and exploring our next steps.

- CREST – We are in regular liaison with the Gateway Phase 2 Programme who are developing CREST – a team of staff who will triage Adult Social Care queries and provide a holistic and responsive service at the front door. Adult Social Care -specific training will be provided to CREST staff.

- Carers – we have developed a carers Resource Allocation System (RAS), supported by a Carers Assessment form in order to increase our offering to this resident group. The Carers Forum have welcomed the RAS. Carers were directly involved in the development of the RAS specifically the Carers Forum and Carers Partnership.

- The 0-25 service went live in April. Subsequently, we have worked together on safeguarding, the development of standard operating procedures, direct payments and the inclusion of some transitions within the high needs review team.

- Direct payments are cash payments made to an individual directly, giving a person the choice to buy and arrange their own social care services. The level of your direct payment is reviewed regularly in line with care needs and there is also the option to split the service needs to be covered partly by direct payments and partly still receive other services in the usual way via the Council.

- People taking up direct payments are given help to manage their direct payments - both in securing the services and the support they want the direct payments to provide, and in dealing with the finances. Our Direct Payments Support Service can provide support, advice and guidance and support planning. For example, they provide assistance with employing and paying people to provide care and with managing the paperwork and the cash payments.

- There is also a direct payments user group for advice and information for all current and prospective users of the direct payments scheme. Group members can provide mutual support and advice from a user's point of view

- 0-25 service joined the All Age Disability Service on the 1st of November.

- Carers RAS launches in January 2017

The Council wishes to establish the foundations for co-production by starting to learn together with the community, what it takes to co-produce not just plans, but outcomes that are important to people too. This will therefore be much more than a consultation exercise.

"Co-production is not just a word, it's not just a concept, it is a meeting of minds coming together to find a shared solution. In practice, it involves people who use services being consulted, included and working together from the start to the end of any project that affects them." ***(Think Local Act Personal (2011) Making it real: Marking progress towards personalised, community based support, London: TLAP)***

A co-production partner (The PublicOffice Ltd) was procured in October 2016 to support the council and its stakeholders in the wider transformation of adult social care services for people with a learning disability in Croydon. There is a wide scope for this work, including day, respite, housing, employment, well-being and quality of life opportunities for people with a learning disability in Croydon.

The PublicOffice.org.uk are an organisation committed to see better life outcomes for citizens. They work with organisations that want to review what they do and how they do it, and who understand that citizens themselves have a critical role to play. Their ambition is our ambition is to create systemic change. They work to embed expertise within the system, to help organisations learn how to do things differently

themselves. Learning is the key driver: making explicit what is going on, helping people reflect on their own data, beliefs, processes and practice, and building the capability to operate in new and more effective ways.

http://www.wearethepublicoffice.com/about-us/

As part of Croydon Council's commitment to coproduction, The PublicOffice are meeting people using day services, people in supported employment, young people aged 14-25, people participating in social opportunities, people using residential centres, in supported living, people using Shared Lives, people using personal budgets/Direct Payments, and people using Heatherway and other short break services.

They will also be talking to Mencap, Croydon People First, Parents in Partnership, CASSUP, the Head of the LD Partnership Board, Croydon Employment Services, Parent/Carers, the SEN Improvement Advisors, and colleges, Council members and staff.

The PublicOffice began this exercise of listening and engagement with groups at the heart of the change, in November. They will present their indicative findings and a 'blue print' for the way forward to stakeholders at the end of January based on what they have gathered during the co-production exercise.

Given the timescales above, the Council will be able to consider the 'blue print' from the co-production and the future of Heatherway respite service in February 2017.

If our decision in February, is to close Heather Way and provide alternative opportunities for short breaks, a period of consultation would be required from the beginning of February to March 2017. The co-production exercise would not replace the requirement for formal consultation.

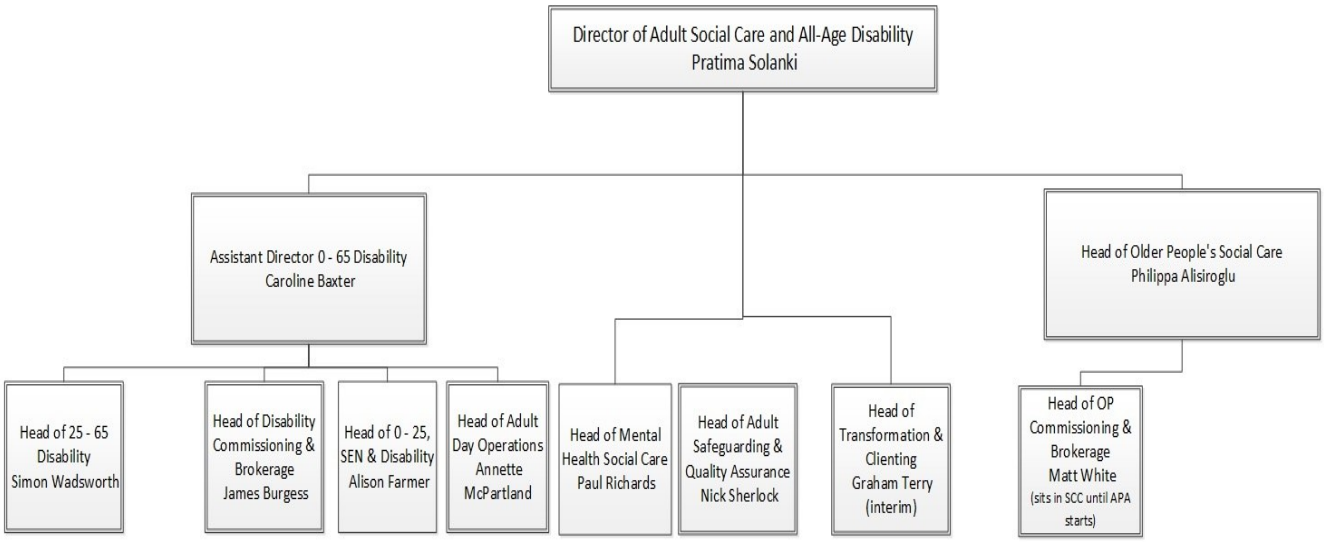
Out of the 44 service users who are eligible to access Heather Way, only 30 actually use the provision. All 44 users are to be reassessed and alternative solutions are being found for them. Therefore there is a decrease in the running costs month by month for the service.

2.5 Service Management:

The new management structure for the All Age Disability Service is now in place. This team are working on delivering the new structure for the service that will bring innovation, joined up pathways from birth to old age enabling people who use the service and their carers to achieve 'a life not a care plan'.

New management structure for All Age Disability Service.

The majority of this team commenced work with LBC in October or November 2016



Moving Forward: review processes and ongoing evaluations:

Risks

A detailed evaluation of the savings plans is being undertaken and further savings options are being developed to replace any savings plans that are likely to under-deliver due to changes in circumstances. Work is being undertaken in conjunction with the Gateway programme and Managing Demand Programme to identify areas where cost reduction savings can be obtained. More info will be available by the end of May.

Options

The budget savings were identified as part of the 2016/17 budget setting process, during which a number of options were identified and evaluated. These savings have been reviewed and updated where circumstances have changed, as part of the 2017/18 budget setting process.

Future savings/efficiencies

The programme will review savings options on a monthly basis to ensure they are on target to deliver, where delivery is not possible, alternative projects are identified and where possible further savings are identified and achieved.

Working towards standardising the way that we work –

Staff predominantly from across Adult Social Care within LBC told us they needed guidance and that our policies were out of date. Policies needed updating because of the implementation of Care Act. We have engaged with a number of staff in order to create Standard Operating Procedures (SOPs).

The SOPs describe and outline guiding policies, processes and pathways that operate within Adult Social Care.

They cover everything staff need to know to perform practitioner tasks.

The SOPs will be regularly updated. The SOPS are available on the Intranet on the "People" homepage.

To provide consistency and improve quality of practice

New assessment forms have been developed in partnership with the Making a Difference Group, CASUP and other user led organisations.
On-going monitoring of quality of practice and delivery of service will be embedded into workflows, reviewed and reported on regularly.

Assessment form has been developed in association with the Making a Difference Group and is due for launch in February

3 Update on Transforming care

3.1. Background

Post Winterbourne view and the Transforming care reports – a further publication Building the Right Support (October 2015) indicated a requirement for CCGs and local authorities to work together to prevent in patient admission and to ensure that there is support to enable individuals to access their communities in their local area inclusive of health, social care, housing and the wider community.

NHSE put in place an ambitious programme of work for commissioners to transform learning disabilities care and reduce the number of people being treated in hospital.

On 14th October 2015 Croydon CCG submitted their national return to NHSE and this document outlined the progress on achieving against the four key areas, which underpin the seven commissioning standards:

- Ensuring appropriate discharge planning for inpatients
- Preventing inappropriate admissions to inpatient services
- Delivering effective case management and discharge planning
- Ensuring governance and oversight of programme delivery at a CCG and provider level

Croydon self-reported non-achievement against each of the seven indicators at the time but since then has made significant improvements.

Eight people with learning disabilities were originally identified by Croydon as patients meeting the criteria for Transforming Care. Four were in Hospital in Essex, one in London, one in Wales, one in Nottingham and one in Northampton. Placements for these individuals were funded by Croydon Clinical Commissioning Group (CCG). The length of stay for these individuals ranged from one year to thirty and averaged 3¾ years.

Since this original cohort was identified other patients have been flagged by NHS England (NHSE) as individuals they are funding who potentially will require support from Croydon CCG once NHSE is no longer funding their care. Four people with learning disability were identified as part of this group. Additionally, there are seven people with learning disability in complex residential placements in Surrey & Borders Partnership NHS Foundation Trust.

The reported number of people being treated in a hospital setting raised concerns for the CCG along with a lack of sufficient progress in safely discharging clients to more appropriate community settings.

3.2. Progress made to date

In response the CCG committed additional resources to progress the work both strategically and operationally and undertook an independent review jointly with the council. Governance arrangements have consequently been strengthened with the creation of a Transforming Care MDT Meeting (for joint health and social care reviews) and a Transforming Care Funding Panel.

A key focus of the work has been around transforming care and building the right support for people with complex learning disabilities, autism, mental health and challenging behaviour

The eight people identified were not actively case managed by Croydon CCG and Social care. Commissioners attended Care Programme Approach reviews when possible but there was no coordinated tracking or planning for these individuals. Care & Treatment Reviews (CTRs) were introduced in October 2014, which are used to check if the person is safe, that they have good quality care and clear plans for the future including move to community based care. The quality of care was variable, sometimes with little evidence of assessment or treatment. All the care could be provided in the community but none had clear plans for this to be actioned.

Croydon CCG initially invested in two Complex Case Reviewers to focus exclusively on supporting this cohort to carry out the recommendations of the CTRs and follow up the work and Move On initiated by social care. A further appointment of a part time senior complex reviewer and a full time commissioning support officer and a temporary reviewer with Continuing Health Care background further increased the ability to move people on to more appropriate settings of care. Some reviewing activity is also undertaken with the Council High Needs review team.

Of the 8 people reported to NHSE under Transforming care in July 2015. There have been seven discharges from CCG funded in patient placements and one from NHSE step down. The destinations of these clients has been to mainly residential placements with one to supported living. A number of the Move Ons have also been cited by NHSE as exemplars of positive person centred approach.

The CCG are currently reporting 3 remaining in patients. There are two of the original cohort in hospital – one is delayed discharge pending clarity of removal of Ministry of Justice section and return to Croydon and the other is a delayed discharge because of lack of alternative provision and their family wish them to live local to them in West Sussex.

One discharge was an NHSE step down to residential and one to a community locked rehabilitation unit.

With each discharge back to the community lessons are being learned and processes adapted. As more panels and MDTs are convened fine-tuning has occurred and expectations made clearer. Consulting between providers and Croydon's clinical teams has helped develop guidelines and move on plans. Where clients & family are able to engage the plans are more person-centred and focused. The outcomes for those that have moved have been positive. Their quality of lives has improved immensely. They are engaged in more activities, have more choices & opportunities and, for those with families, regularly local contact is more possible. They are more accessible to clinicians and social care and therefore less 'out of sight & out of mind'. The costs are also lower. Thus far the project will save nearly £400,000 this year and with further discharges the savings could be greater. The key outcomes also relate to the improved quality of life for the individual and better quality of care in a least restrictive environment.

3.3. Clinical and financial Governance

A fortnightly Transforming Care Multidisciplinary team now scrutinises all proposals for Move On and provides additional clinical insight and suggestions where obstacles to discharge exist. Stakeholders include specialist Mental Health and learning disability teams as well as community learning disability team, commissioning and social care. This group also has oversight of a Risk register that look at individuals at risk of placement breakdown and hospital admissions.

Additionally funding applications are made to an LD funding panel to support Move Ons to community settings.

3.4 Risks, gaps and mitigations

There are three cases that are subject to transfer to social care as they no longer require total health funding. Discussions on joint funding arrangements have between the Council and CCG are ongoing but have not yet been resolved. There also remains a risk to health and social care budgets that are insufficient commissioned services to ensure avoidance of individuals being placed outside of Croydon and no local commissioned inpatient beds for people with LD and/or forensic presentations should one be required.

A Croydon LD Strategic review undertaken in 2015 and the South West London Transforming Care Partnership plans indicate a need to develop support and services to support people closer to home and prevent hospital admission.

As part of the conversation about resources and the possible integration of specialist pathways Croydon CCG are therefore actively reviewing current specialist contracts with South London and Maudsley NHS Foundation Trust who provide specialist Mental Health and learning disability services as well as Croydon Health Services who provide the community learning disability specialist health services to facilitate more coordinated approach to supporting people with complex needs

There are a cohort of individuals (circa 15 including 4 young people) all currently funded from NHSE specialist commissioning who will become a Croydon responsibility

and require step down to the Croydon and community pathway in the next 2-3 years They are in low, medium and high secure units often with forensic background.

Under the TCP plan there is an active modelling exercise underway to look at the impact of this next cohort on budgets and proposed service pathways across health and social care economy to minimise likelihood of unnecessary in patient provision. This includes ideas for intensive positive behavioural support as well as capital bids for building development. Work is underway to ensure that commissioner responsibility is clear for these clients and to begin to identify future needs at an early stage.

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BACKGROUND DOCUMENTS:	None