Herefordshire Council

Agenda

Adults and wellbeing scrutiny committee

Date:	**Tuesday 27 March 2018**
Time:	**2.00 pm**
Place:	**Committee Room 1 - The Shire Hall, St. Peter's Square, Hereford, HR1 2HX**
Notes:	Please note the time, date and venue of the meeting. For any further information please contact: **Ruth Goldwater, Democratic Services Officer** Tel: 01432 260635 Email: councillorservices@herefordshire.gov.uk

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Agenda for the meeting of the Adults and wellbeing scrutiny committee

Membership

Chairman	**Councillor PA Andrews**
Vice-Chairman	**Councillor J Stone**
	Councillor MJK Cooper
	Councillor PE Crockett
	Councillor CA Gandy
	Councillor RL Mayo
	Councillor D Summers

Agenda

Pages

1. APOLOGIES FOR ABSENCE

To receive apologies for absence.

2. NAMED SUBSTITUTES (IF ANY)

To receive details any details of members nominated to attend the meeting in place of a member of the committee.

3. DECLARATIONS OF INTEREST

To receive any declarations of interest by members in respect of items on the agenda.

4. MINUTES 7 - 16

To approve and sign the minutes of the meeting held on 25 January 2018.

5. QUESTIONS FROM MEMBERS OF THE PUBLIC

To receive questions from members of the public.

Deadline for receipt of questions is 5pm on Thursday 22 March 2018. Accepted questions will be published as a supplement prior the meeting.

For guidance on how to submit a question to the committee, please see: https://www.herefordshire.gov.uk/getinvolved

Please submit questions to: councillorservices@herefordshire.gov.uk

6. QUESTIONS FROM COUNCILLORS

To receive questions from councillors.

Deadline for receipt of questions is 5pm on Thursday 22 March 2018. Accepted questions will be published as a supplement prior the meeting.

Please submit questions to: councillorservices@herefordshire.gov.uk

7. PERFORMANCE UPDATE - SUBSTANCE MISUSE SERVICES PROVIDED BY ADDACTION 17 - 28

To review the quality and performance of the substance misuse service commissioned by Herefordshire Council and delivered by Addaction.

8. LEARNING DISABILITY JOINT SERVICE OVERVIEW 29 - 78

To review the services commissioned by the council and the clinical commissioning group for adults with learning disabilities in Herefordshire.

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- Inspect minutes of the council and all committees and sub-committees and written statements of decisions taken by the cabinet or individual cabinet members for up to six years following a meeting.
- Inspect background papers used in the preparation of public reports for a period of up to four years from the date of the meeting. (A list of the background papers to a report is given at the end of each report). A background paper is a document on which the officer has relied in writing the report and which otherwise is not available to the public.
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The chairman or an attendee at the meeting must take the signing in sheet so it can be checked when everyone is at the assembly point.

Herefordshire Council

Minutes of the meeting of Adults and wellbeing scrutiny committee held at The Council Chamber - The Shire Hall, St. Peter's Square, Hereford, HR1 2HX on Thursday 25 January 2018 at 10.00 am

Present: **Councillor PA Andrews (Chairman)**
Councillor J Stone (Vice-Chairman)

Councillors: CR Butler, MJK Cooper, PE Crockett, CA Gandy and D Summers

In attendance: **Councillors WLS Bowen, E Chowns and MD Lloyd-Hayes**

Officers: **Herefordshire Council: M Samuels and S Vickers**
Healthwatch Herefordshire: C Price and I Stead
NHS Herefordshire Clinical Commissioning Group: H Braund, S Hairsnape and I Tait
Wye Valley NHS Trust: J Ives
2gether NHS Foundation Trust: F Martin and J Melton

26. APOLOGIES FOR ABSENCE

Apologies were received from Cllr RL Mayo.

27. NAMED SUBSTITUTES (IF ANY)

Cllr CR Butler substituted for Cllr RL Mayo.

28. DECLARATIONS OF INTEREST

There were no declarations of interest.

29. MINUTES

RESOLVED:

That the minutes of the meeting held on 16 November 2017 be confirmed as a correct record and signed by the chairman.

30. QUESTIONS FROM MEMBERS OF THE PUBLIC

There were no questions from members of the public.

31. QUESTIONS FROM COUNCILLORS (Pages 11 - 12)

One question was received and is provided, with the answer, in appendix 1 of the minutes.

32. HILLSIDE CENTRE

A presentation was given by the managing director, Wye Valley NHS Trust (WVT) and the director of operations, NHS Herefordshire Clinical Commissioning Group (the CCG). It was explained that some of the information provided had already been shared and it was intended to give more detail and update the committee since the meeting in November. Members were reminded that officers had also attended the meeting in August 2017 and talked through the process, and had taken members' advice on the engagement process from that meeting.

In the presentation, the following key points were made:

- There was a strong body of evidence to support not keeping people in a bedded environment, which included the degenerative impact, and to provide reablement
- In terms of metrics, WVT performance compared well with other areas and as provision of care shifted it was expected to see improvement
- The early supported discharge (ESD) team had transitioned care from other sites as well as the Hillside annexe and was providing high quality community-based reablement including dedicated stroke reablement in order to provide better outcomes. It was important to recognise this if performance were to be improved in addressing length of hospital stays and increasing the number of people who had access to care at home
- 6 additional staff had been recruited with a further 4 sought in the new financial year and there was confidence over capacity to meet the change in service. Double running of provision was in operation during February whilst stepping down the number of people at Hillside for the transition to be effective from 24 February
- There was close working between the health and social care teams to support the transition

The assistant director, operations and support, explained that around £1.2m had been spent on reablement and rapid response services, leading to the council forming the home first service. Investment would increase to £1.5m next year. Where previously around 300 people would have been in receipt of this service, it was expected to increase to around 1000. It was anticipated that this number could grow further as the new service became established.

A member asked what was included in reablement and rehabilitation and whether this included soft exercise. The managing director, WVT, confirmed that the increase in reablement staff included additional physiotherapy input.

Responding to a member's concern over contingency plans in the event that the additional workforce could not be recruited, it was further clarified that there were staff in place. The assistant director added that 6 of the 11 posts in the adults and wellbeing team were being filled with 4 being recruited, and this would be an ongoing recruitment drive.
The member asked whether any staff from Hillside had joined the home first team, or if they had been redeployed elsewhere.
The WVT managing director explained that staff had a choice of vacant posts in the trust and that they were avoiding redundancies. It was not certain whether there had been any resignations as a result of the changes.

A member in attendance sought clarification on the skill-mix of the whole time equivalent number of staff mentioned in the presentation. It was clarified that these were clinical staff and not clerical staff and were additional staff as part of the wider service.
The member commented that experience had shown the difficulties in providing a stable workforce, especially in remote areas. She questioned why these changes had not been announced at the same time as the closure of the walk-in centre. She further

commented that she did not accept the council's response to the situation as she believed it had a duty of care to the population.

The CCG director of operations explained that they were in the flow of the engagement process so were not in position to say that it was the right thing to do and that the two issues were not running in parallel.

A member asked where the additional staff would be based, pointing out the issue of travelling times involved in getting from place to place in rural areas. The managing director clarified that staff would be based at different sites, such as Hereford and Leominster. The member observed, in response, that from Leominster to some of the remote parts of north Herefordshire, travelling could be a challenge in terms of geography and timing, and so it would take up a lot of time travelling from person to person in some areas. Officers acknowledged that it was better to have staff in localities and this was the plan. The director of operations added that they had visited parish councils and talked about transport and getting this network to be effective. She added that GPs were encouraged to work together to look at practical solutions, but the system needed to get better connected.

The member noted that the health centre in Leintwardine, which was currently under used, would be an ideal base rather than Leominster.
The director of operations commented that as the locality projects, such as Kington and Leominster develop, surrounding areas such as Leintwardine would be included.

The chairman commented that there were other market towns to be considered in the developments and asked whether use could be made of the community hospitals. The managing director confirmed that there were already staff out there, so the work was augmenting those teams in order to be distributed as far as possible.

The assistant director, operations and support described how adult social care was distributed and that with regard to home first, this could start to work more effectively on a locality basis to provide a standard level of support for people who need it. He added that staff could work across areas and that with the redesign of the home first service, a new scheduling service supported through mobile devices was being commissioned and this would enable staff to be better located. It was expected this would be in place by the end of February and would involve a care co-ordinator with therapists offering goal oriented support. The design was intended to bring benefits that reduced the distances covered to reach people.

The chairman asked how the disabled facilities grant (DFG) figured in the changes. The assistant director explained that the expenditure was increasing. The Director for adults and wellbeing added that the element of the better care fund allocated to the DFG had tripled and the aim was to establish greater flexibility and a wider range of facilities to provide as this was an area that was proven to make a significant difference and so it was important to ensure that funding was being used and coordinated.

A member commented that parish councils had access to funding to establish community groups such as for soft exercise but they could be difficult to set up. He asked if it would be possible for a package of support for community groups to access to support people coming out of hospital.

The director for adults and wellbeing confirmed that there was a grant scheme which had limited funding. However, the incoming director of public health would be looking at a series of prevention funding to have a more coherent approach. He added that the public health grant was reduced but this work was identified as a priority for the director of public health to ensure organisations could be linked up to work together.

The assistant director described forthcoming developments around operational practice which included the community broker function and locality based support from February to connect earlier for people who did not currently access support. The wellbeing information and signposting service (WISH) was relaunched last week to support access to schemes. He added that where there were gaps were identified by the community brokers this would inform further commissioning of support.

The vice-chairman welcomed the earlier comment raised about the remoteness of areas such as around Leintwardine. He welcome the investment in the home care service. He suggested that parish council meetings were a good way to get messages out about local issues and suggested that those meetings taking place in April and May would be a good opportunity to engage as it was more likely for members of the public to be in attendance.

Discussion took place around how these service developments were all part of a wider piece of work such as discharging people to be assessed at home or care home facility rather than assess in an acute setting, extending the use of mobile technology for community health staff. The standard of mobile and broadband coverage was noted. Members commented on involving communities more as part of the solution and making use of the formal and informal support networks that existed in villages, including good neighbour schemes.

A member asked about home care and what contingencies were in place for people who were at home alone. The assistant director explained that the adult social care pathways were redesigned to discharge to assess using a strengths-based model to assess what people could do for themselves to identify the gaps and assess eligible need that could not be provided any other way. The community brokers would feed into the commissioning strategy to bridge some of the gaps.

The chair of the CCG offered some observations from a frontline clinical perspective, which demonstrated that older people did not want care in hospital and that families wanted to know there was an appropriate pattern of care. Care would be very specific and individualised as some people were very independent in older years, and others more dependent, so it was necessary to assure people that the breadth of need was being met. The system as it stood, had a disabling effect. For example, it was tradition to keep people in bed for 2 weeks following a heart attack, whereas in the USA people were up again very quickly. It was important therefore to avoid the long hospital stays associated with a culture of safety.
The facility at Hillside tried to put professionals together to rehabilitate people but this was artificial because it was not their home with their people around them. Through evidence it was clear that people needed to be cared for at home and some of the work could be done on the acute ward so people could go home sooner. The plan was to make this more consistent for others with frailty and degenerative conditions. In allowing the shift in model it would be something that could be continued for future generations. This was achievable with the right support but it was necessary to be realistic.

A member commented that people were sceptical about changes. She believed it could work but it would be necessary to review it to see it was beneficial. She realised that people worried about going into hospital and in the majority of cases, people wanted to be in their own home with their own people around them to care for them and be with them and whilst this was not possible in all cases, but it would be better if available to more people as long as it was better care than currently in place. The member concluded that it would be good to see the benefits and it was supported with caution, although the implication needed to be better understood.

A member asked about access to exercise facilities such as Halo Leisure during rehabilitation. The CCG chair explained that all patients in the system were offered

cardiac rehabilitation through the trust as this was the most effective intervention, but people then had to sustain the changes. Halo had a charging policy so it was not accessible for all people even with reduced or supported costs.
The member commented that it was important to invest in preventive measures. The CCG chair responded that the medical model was not the only good approach and that the message was that exercise was the best medicine, as it promoted physical stability, helped to prevent falls, and promoted good mental and physical health. The opportunity to socialise was also important.

Members' final comments included that the main concern was the ability to provide individual care plans within resources, and that the timing of these changes were not ideal as people needed to get over the winter.

The chairman reminded members that there was pressure on services all year, although it was different at this time of year with winter pressures and whatever the timing, effecting a change to service provision would present difficulties.

RESOLVED
That:

a) **assurance be confirmed regarding the measures in place to effect changes as smoothly as possible; and**
b) **that an update be provided in 6 months' time**

33. HEALTHWATCH UPDATE

The director for adults and wellbeing introduced the item. In setting some context, he explained that Healthwatch was commissioned by the council and, through the Health and Social Care Act 2012, was the third iteration of arrangements since Community Health Councils were abolished in 2003 that had been established formally to provide a function for public involvement in health.
There had been long standing arrangements in place for such a function through the establishment of community health councils in 1974. Councils were required to commission Healthwatch services from a third sector body, through non-ring fenced funding. The commissioning relationship was complex as it was established on behalf of the system but also the council was subject to review by Healthwatch, and so it was important to maintain the right balance between being an effective commissioner and not disabling Healthwatch's role to hold the council to account. The new arrangements represented a significant step forward in fulfilling this role.

The chair of Healthwatch provided some background to the current arrangement, and explained that the previous iteration of Healthwatch was formed as a subcommittee through Herefordshire Voluntary Organisations Support Service (HVOSS) but was now recommissioned as a standalone organisation. It was an established company, with a new board of directors and a developing team led by a new chief officer. Further appointments to engagement and communication roles were underway. There was still work to do in continuing to improve the performance of the organisation from these good foundations and in continuing to monitor health and care provision. Accountability was established through the formal contract with the council and in the relationship with the public as users of health and social care, in taking their views and helping them to understand what is happening within local services. It was a challenge to maximise engagement but Healthwatch continued to make progress, supported by a valued volunteer network and an established stakeholder group. The Healthwatch chair acknowledged the significant role of volunteers including two who had been co-opted to the board. The Healthwatch chair also acknowledged the support that had been provided by Healthwatch Worcestershire to help establish Healthwatch Herefordshire so that it was able to become a standalone organisation.

The chief officer of Healthwatch gave an account of the work of Healthwatch over the past year, which commenced with asking the public what they thought Healthwatch should focus on. This had identified: GP access; public health and prevention; palliative care; complex conditions; adults social care pathway; and accident and emergency services.
The resulting plan was to focus on two areas at a time, making use of groups and gathering feedback and information, which had led to further emerging issues to be addressed at the same time as the key priorities.
The key point this year would be to evaluate what contact was the most effective and to develop relationships with key organisations to ensure ongoing dialogue to inform the work. An example included working with the CCG about public concerns over Hillside. Positive and more effective relationships were developing in the work to represent patients and the public.

The chair asked about the issues that the public raised the most.
The most frequently cited issue was ear syringing, which was no longer provided as a free service by GPs and which was reported as difficult to access because of price and location of service providers for those who required it. Healthwatch had responded by talking to the CCG and responding with public information about the changes. It was noted that for some people a lack of treatment could have significant impact or impairment especially when combined with other health issues. Conversely, there were people for whom syringing could have serious negative health impact or where it was of marginal benefit. It was also noted that there were elements of self-care that were appropriate for some people, and that the CCG was looking at placed-based provision for those who required essential treatment and could not easily get to Hereford. The CCG offered to provide a briefing note for members on this topic.

The chief officer described the other most frequently raised topics:

For mental health, there had been limited ways in to speak to people so a forum was set up which had identified issues including joining up services for substance misuse and emotional support. This had led to work between Addaction, 2gether NHS Foundation Trust and the CCG. The mental health forum was working well and Healthwatch was supporting the group to be self-directed, with Healthwatch raising issues on its behalf. It was noted that although the initial work with the public did not identify mental health, it came up regularly and was an important issue for Herefordshire. It was therefore important to ensure that any such emerging topics could be included in Healthwatch's work.
The director of engagement and integration, 2gether NHS Foundation Trust, welcomed the feedback that Healthwatch had provided and acknowledged the value that Healthwatch could provide to help address some of the issues. The trust now had link workers in place to connect and build on what Healthwatch had helped to raise.

The chairman welcomed this work.

The Healthwatch chief officer turned to the topic of access to dental services. A focus on children's dental health was to start in March. Feedback had suggested that in some areas such as market towns, not everyone was able to register with an NHS dentist. This had been raised with NHS England to check that there was sufficient commissioning activity, but more exploration of this issue was needed to be clearer on the situation.
The chairman commented on the significant public health concern regarding children's dental health.
The chief officer explained that Healthwatch was asking how people felt about water fluoridation and to promote awareness that children's dental healthcare was free.
The CCG chair declared an interest in the matter as his wife was a dental practitioner in the county and commented that the health and wellbeing board had identified children's

dental health as a priority focus, adding that poor dental health was a marker for health issues in later life.

A member commented that people did not realise that water supplies in the county were not fluoridated and this was not something that people tended to check when looking for a place to live. She added that some people did not want compulsory medication via their water supply, and asked if there had been any publicity on this so that parents could seek to replace it. The member also questioned whether there was evidence to support that, as role models, the public's approach to adult dental care was poor.
The chief officer responded that outcomes from the work were awaited, but some responses suggested that people did not look after their children's teeth and so Healthwatch was looking at numbers who although were registered themselves, had not registered their children, and was working with public health to increase the evidence base.

The director for adults and wellbeing explained that the council had lead responsibility for this matter, and the data for children's dental health stood out in comparison with adults and which indicated surprisingly poor dental health in the county. The public health team had been tasked to look at water fluoridation and although this was not straightforward to address, it was coming up the agenda very quickly. Public health was looking at causes of poor dental health and what the best solution might be, clinically and in terms of practicalities, which would then be brought through the democratic process to ensure the solutions were acceptable to the public. He added to the CCG chair's earlier advice by confirming that this was a priority of the health and wellbeing board to address as a strong indicator of other health issues and also in later life.

A member suggested that there was not always a correlation between fluoridation and dental health because of people moving into the county who had grown up elsewhere, and that consideration should be given to challenging peoples' ethical viewpoints and whether they researched the presence of fluoride in water supplies before they moved somewhere.

On another theme, the member also asked about the diagnosis of autism and whether this related to children or adults. The chief officer confirmed that this referred mostly to adults. The member confirmed that the children and young people's scrutiny committee would be looking at the autism strategy in April.

The chief officer reported on work that had been completed regarding GP access, on which recommendations had been presented to the CCG for response. It was noted that many opinions had been gathered regarding access to primary care which included suggestions to standardise services across all general practices, and to be able to book follow-up appointments in advance. Other feedback referred to the out of hours service, the approach to triage for appointments, access to pharmacies and requests for assistance for people with additional needs when visiting surgeries. A lot of positive feedback had been gathered which highlighted good practices.

In summarising Healthwatch's other projects, the chief officer summarised the following areas of work:
Regarding public health, the chief officer confirmed that a Healthwatch report on palliative care would contribute to regional work around end of life care.
Work on adult social care commenced this week, by identifying service users to hear about strengths based assessment, and conducting a staff survey, which would be reported back to the committee once the outcomes became available in April.
It had been decided to temporarily suspend the accident and emergency project given the current pressures but this will resume later in the year.
For complex multiple conditions there was a series of focus groups to gather views and to find out how organisations worked in an integrated way.

The chair commented on the proactive and dynamic approach Healthwatch had taken to the work and on the importance of hearing from service users.

The vice-chairman welcomed the report and noted the monthly e-bulletins, which he felt were very to the point and clear, as were articles in the Hereford Times such as on dental health. He noted that the work around the priorities had demonstrated that Healthwatch had been very active.

A member particularly expressed support for the work on mental health.

A member remarked on the high level of representation of Healthwatch at different meetings and fora. It was noted that this did not capture all Healthwatch activity and that this would be reviewed to ensure ongoing effectiveness.

RESOLVED
That:

(a) performance of Healthwatch Herefordshire to date be commended;
(b) a report be presented on outcomes from the Healthwatch review of the adult social care pathway and strengths based assessment at a future meeting; and
(c) a Healthwatch performance update be included in the committee work programme for 2018-19.

34. COMMITTEE WORK PROGRAMME 2018

Members were reminded of the workshop that was scheduled for 7 March which would cover public health, how it operates and what the strategies achieve. It was noted that the new director of public health would be in post by then.

A councillor had expressed concern regarding contract management for home care and it was agreed that this be included in the work programme. It was noted that there was a new framework for home care agencies to go through a single contract and quality management process. It was intended that the framework would be an interim step pending development of a new market strategy and which would need to be revisited for new contracts to ensure stability in the market.

With regard to scrutiny of learning disability services, it was noted that the learning disability strategy was under development and that this would embrace all age groups. Members agreed that this might be an opportunity for the committee to work in tandem with the children and young people scrutiny committee to look at the strategy in entirety and officers would make appropriate arrangements for this.

A member pointed out some clashing of timings with CCG meetings and it was agreed to look at this.

RESOLVED
That the updated work programme be agreed subject to the amendments noted.

The meeting ended at 12.14 pm **Chairman**

Questions from councillors to Adults and Wellbeing Scrutiny Committee

25 January 2018

Question 1

Councillor MD Lloyd-Hayes, Aylestone Hill Ward

There has been a great deal of public consternation regarding the proposed closure of the Hillside Centre. There appear to be no emails from the parish liaison officer, the usual conduit for consultation with parishes, nor can I find any reference to it until latterly from the CCG or Wye Valley Trust. How were parish councils or members of the public able to engage if no public notice was issued?

Answer

There was no public notice issued by the council because the Hillside Centre is run by Wye Valley NHS Trust and therefore not a council facility, nor was it a council decision to close the facility.
The council owns the building, and is purely the landlord in this instance. In fulfilling its function to review and scrutinise the planning, provision and operation of health services affecting Herefordshire, the matter has been included on the agenda at this meeting in response to concerns raised, including those made at the last meeting of this committee, about the depth and scope of engagement with the public on this matter.
Material concerns were offset by the broader reforms being proposed about rehabilitation and discharge, which, at the meeting on 16 November 2017, the committee was persuaded, albeit with some caution, provided more appropriate ways to support people to leave hospital.

Supplementary question from Cllr MD Lloyd-Hayes

I am concerned about the consultation process because of correspondence received, and that parish councils were not included, and I feel that the council has a duty to be engaged in the consultation. I request that the proposals be reviewed as they were not shared with the public and patients.

Answer

Herefordshire Council is the landlord.

Additional response to supplementary question from the accountable officer, Herefordshire Clinical Commissioning Group

Advice was followed and contact was made with all parish councils, and they were invited to participate within the engagement process.

Herefordshire Council

Meeting:	**Adults and wellbeing scrutiny committee**
Meeting date:	**Tuesday 27 March 2018**
Title of report:	**Performance Update - Substance Misuse Services provided by Addaction**
Report by:	**Contracts Officer Adults and Wellbeing**

Classification

Open

Decision type

This is not an executive decision

Wards affected

(All Wards);

Purpose and summary

To review the quality and performance of the substance misuse service commissioned by Herefordshire Council and delivered by Addaction.

The information in this report has been produced collaboratively between the council's contracts officer and Addaction's service manager.

To enable the committee to fulfil its function to review and scrutinise the planning, provision and operation of substance misuse services in Herefordshire, and to note the actions taken and provide recommendations on these matters.

Recommendation(s)

That:

(a) the committee review performance and determine any recommendations it wishes to make to the executive to consider in order to strengthen performance or improve outcomes; and

Further information on the subject of this report is available from
Kayte Thompson-Dixon, Tel: 01432 260727, email: Kayte.Thompson-Dixon@herefordshire.gov.uk

(b) the committee determine if any further provision needs to be made in the committee's work programme, relating to the performance of this service, having regard to the positive direction of travel reported.

Alternative options

1. None. The service has made significant improvements in performance and dedicated contract support continues to ensure outcomes are delivered for individuals in Herefordshire and an efficient service is in place.

Key considerations

2. The information contained within the report is provided following recommendations made by the committee at the last performance review for this service on 21 September 2017 for a further update to be provided in early 2018. The committee also recommended that an opportunity be created for a service user to share their experiences of drug services provided by Addaction to committee members and that consideration be made by commissioners to contract services for a period of five years with a mid-term review, to support the embedding of effective service provision. Arrangements are being made regarding the facilitation of a service user meeting with the committee in a less formal manner.
   With regards to contract length, a decision has been approved to extend the current term to 30 November 2020, resulting in an overall contract term of five years for Addaction.

3. The committee is asked to consider the information provided by the council and Addaction, which highlights a significant improvement in performance of the service against high level service targets, in particular for primary opiate service users. The targets reviewed relate to the successful completion of treatment and the maintenance of this, through the monitoring of re-presentation rates. The report shows an upward trajectory in performance, which began following the introduction of a formal service improvement plan in April 2017 and has continued in this direction since the plan was completed in January 2018. The target for successful primary opiate completions, set in the formal service improvement plan, was 8% by the end of Q3 2017/18. The achieved rate exceeded this target and was reported as 8.3% by Public Health England.

4. The presentation (appendix 1) that accompanies this report covers successful completions performance data, representation to treatment performance data and proposed changes to the service delivery model, following a contract value review conducted by the council. The presentation highlights current performance which shows a continued upward trajectory in successful completions for the opiate grouping and a downward trajectory in representations to treatment, as well as significant improvements to treatment outcome profile completion rates. The presentation also outlines those areas identified as target areas for further improvements, including the number of non-opiate service users in treatment and successful completion rates for this group.

5. The substance misuse service is commissioned by the council. The provider is Addaction, which is one of the largest voluntary sector substance misuse organisations in the country, with over 50 years' experience. It had not delivered services in Herefordshire before and the staff were TUPE transferred to Addaction from the previous providers, Wye

Valley NHS Trust / 2gether NHS Foundation Trust, along with an existing caseload of more than 500 clients. It is commissioned to provide both psychosocial and substitute medication interventions to service users; there are two young person recovery workers and two criminal justice workers. The service is commissioned to contact potential service users in police custody, work alongside probation and courts and in partnership with wider community agencies.

6. A review carried out by the contracts officer for Adults and Wellbeing in March 2017 found performance overall to be below the standard expected and below national and local comparator group performance averages. The review also highlighted concerns with regard to processes and completion of recovery plans and treatment outcome profiles (TOP).
A service improvement plan commenced in April 2017 to support improvements across both performance and processes, focussed on the following areas:

   1. Performance - Successful completions

   2. Performance/Recovery – Representations

   3. Performance/Process – Treatment outcome profile (TOP) completion

   4. Process/Recovery – Treatment pathways

7. The action plan ran for a period of three months initially with fortnightly reviews by phone and monthly formal action plan review meetings. The action plan was extended to 11 January 2018 to ensure that improvements seen were being maintained. The action plan has now been signed off as completed following significant improvements across all four areas identified.

8. Performance continues to be monitored via monthly data submission and quarterly formal performance reviews.

9. As one of the main identifiers for a functioning service is the rate of successful completion and maintenance of this (through monitoring of re-presentation rates) this area has been given a considerable amount of focus by the service team. A target of 8% successful completion was set for the primary opiate grouping, which was a considerably stretching target given that performance had dropped to below 3%. However, the team has successfully met and exceeded this target and Public Health England reports for successful completions at Q3 2017/18 report a rate of 8.3% for the primary opiate group. This places Herefordshire in the top 25% of services within the comparator grouping (set by Public Health England).

10. There had been significant decreases in repeat presentation rates for this group (those returning to treatment within six months of successful completion), this has risen slightly with 4 out of 18 primary opiate users returning to treatment following discharge in the first six months of 2017 by December 2017. This is a rate of two more than the minimum required to be in the top 25% of performers within the comparator services grouping and therefore will be addressed.

11. Further work is being carried out to strengthen recovery communities within Herefordshire alongside SMART UK, a voluntary recovery programme, which will ensure that there is more and easily accessible support for those who have completed their formal treatment.

12. Successful completions across the remaining three groupings have also continued to rise with the direction of travel showing an upward trajectory by the end of Q3 2017/18 although targets set have not yet been fully met.

13. Performance in relation to both successful completion and representation rates for the alcohol only and combined alcohol and non-opiate group are the furthest behind comparator groupings and national performance. Therefore, work continues to bring about stronger outcomes in these cohorts.
The performance of these groups is hampered by significant challenges in the county with regard to the number of non-opiate service users entering treatment, which has continued to decline for some time, the small numbers of this cohort mean that performance data can be negatively skewed based on the activity of one or two individuals. This is a common issue in more rural counties.

14. Addaction is looking at ways in which to increase caseload numbers for this cohort, as well as improving outcomes for those already engaging in treatment.

15. Significant effort has been made to ensure that treatment pathways are fully embedded within the service, this has included rigorous review of recovery plans and risk assessments for all service users. A number of additional training events have been held for the team and both recovery plans and risk assessments are up to date for all service users. These are reviewed regularly as a routine but are also updated more frequently based on changes observed or reported.

Next steps

- Performance will continue to be monitored through monthly data submission and quarterly formal reviews alongside the reports produced by Public Health England.
- Re-work some areas of service delivery, based on a review of the annual contract value undertaken by the council. The drafting of the revised service delivery proposal is currently underway and will be made available to members of the committee.
- Improved recovery community links, through partnership working with SMART UK.
- Increasing engagement opportunities for primary non-opiate service users.

Community impact

16. Addaction provides a vital service to vulnerable people across the county and has a significant positive impact on individuals receiving treatment and their families. Improving the performance of this service assists in fulfilling our corporate plan priority to enable residents to live safe, healthy and independent lives.
17. Without this service provision there would be additional pressure on other public services, in particular GPs, A&E departments, mental health services and police.

Equality duty

18. Under section 149 of the Equality Act 2010, the 'general duty' on public authorities is set out as follows:

    A public authority must, in the exercise of its functions, have due regard to the need to -

(a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;

(b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;

(c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

19. This service works with vulnerable individuals, many of whom will share a protected characteristic. This report supports the council in delivering its equality duty by ensuring that the service improves so it can fulfil the three aims of the equality duty as stated above. A continually improving service will have a significant positive impact on the outcomes for the individuals accessing the service.

20. The Equality Act 2010 established a positive obligation on local authorities to promote equality and to reduce discrimination in relation to any of the nine 'protected characteristics' (age; disability; gender reassignment; pregnancy and maternity; marriage and civil partnership; race; religion or belief; sex; and sexual orientation). In particular, the council must have 'due regard' to the public sector equality duty when taking any decisions on service changes.

Resource implications

21. There are no direct financial implications arising from this report.

Legal implications

22. Councils are, in accordance with Sections 4-7 of the Care Act 2014, responsible for promoting an individual's wellbeing, preventing needs for care and support, promoting the integration of care and support with health services, providing information and service, promoting diversity and quality in provision of services, co-operating in general with its relevant partners and co-operating with non-relevant partners in relation to specific cases.

23. As per Section 2B of the National Health Service Act 2006, as inserted by Section 12 of the Health and Social Care Act, councils must take such steps as it considers appropriate for improving the health of the people in its area. The Secretary of State may take such steps as they consider appropriate for improving the health of the people of England. The steps that may be taken include, amongst others, providing information and advice; providing services or facilities designed to promote healthy living; providing services or facilities for the prevention, diagnosis or treatment of illness and financial incentives to encourage individuals to adopt healthier lifestyles.

Risk management

24. If the treatment options are not delivered effectively to the individuals within the service this will have an impact on the outcomes achieved and may result in deterioration of their health and care needs. This could also impact on other service provision, in particular

GPs, A&E departments, mental health services and police.

25. There is a reputational risk to the council if the provider does not provide an effective service.

26. A risk register has been developed and any high impact risks are escalated to the council's adults and wellbeing directorate risk register.

27. Any arising risks are being mitigated through the ongoing performance monitoring of the service.

Consultees

28. Throughout the period of the service improvement plan, the council has consulted regularly with Public Health England, which has provided additional support to Addaction.

Appendices

29. Appendix 1 Presentation

Background papers

None identified

addaction Herefordshire

addaction

Progress to date

- TOPS sit at 100% completion for start, review and exits
- Risk and Recovery Plans are 100% complete
- Representations remain low across the cohorts
- Strong upward trajectory for successful completions

Performance

Top Quartile for successful completions for opiates in our comparator grouping. We have risen from a position of 33rd out of 33 to a position of 7th out of 33 in this cohort within our comparator LA.

	Bassline Period		Direction of Travel	Latest Period		Top Quartile range for Comparator LA's	Range to achieve top Quartile
	%	N	B	%	N	*National Average	
Opiate	2.4%	11/454	^	8.3%	37/445	8.21% - 9.52%	37-42
Non opiate	38.1%	24/63	^	42%	21/50	48.92% - 63.38%	25-31
Alcohol	28.1%	61/217	^	33.2%	79/238	*39.87%	-
Alcohol & non opiate	26.1%	12/46	^	29.1%	16/55	41.74% - 52.25%	23-28

Continued Improvement – Performance Focus

- Audits by team leads of casenotes, needs assessments, risk and recovery plans
- Clear targets for TOPS completion, risk assessments and recovery plans for each staff member
- Continued engagement with staff team with regards to performance trajectories including display of these in office space and review at team meetings
- Continue to target service users nearing the end of treatment with additional support to enable transition into recovery support and out of structured treatment
- Addressing those who are ‘stuck’ in treatment with a focus to encourage individuals to make small positive changes and address anxieties about ending formal treatment
- Clear and time bound pathways for new entrants into treatment

Continued Improvement – Community/Recovery focus

- Clearer links with HSUG in order to provide greater recovery support network
- Development of greater support for AA/NA groups
- CJIT group provision for DRR & ATR SU's
- Continued presence within the court system
- Further development of Addactions group provision to enhance recovery community within Hereford
- Development of co-production panels to ensure greater understanding and support from the local community
- Focus upon volunteers and peer mentors to engage with group work programme
- Link working with SMART UK

Service Development From April 2018

- Staff capacity will be more restricted following a review of the annual contract value undertaken by the council. This will have the following impacts;
- CJIT – 1 worker – group based DRR/ATR with POD testing once a month by CJIT staff member
- YP – 1 worker - Time bound and structured care – setting a specific length of time to work with Sus dependant upon need
- Leominster – 1:1 & group provision offered
- Ross/Ledbury – fortnightly presence with groups accessible at Hereford & Ross
- Hereford – 1:1 & group provision offered
- Shift towards 80% group work – clearer pathways towards time bound structured treatment
- Reduced NX opening – based on trend analysis
- Reduced outreach programme – increased education to referrers to ensure continued referrals alongside increased advertisement of service via leaflets and handouts
- Hand collection of prescriptions to ensure continuation of safe prescribing
- No rehab budget available
- Reduced inpatient detox

Herefordshire Council

Meeting:	**Adults and wellbeing scrutiny committee**
Meeting date:	**Tuesday 27 March 2018**
Title of report:	**Learning Disability Joint Service Overview**
Report by:	**Director for Adults and Wellbeing**

Classification

Open

Decision type

This is not an executive decision

Wards affected

(All Wards);

Purpose and summary

To review the services commissioned by the council and the clinical commissioning group for adults with learning disabilities in Herefordshire.

To enable the committee to fulfil its function to review and scrutinise the planning, provision and operation of health and social care services for adults with learning disabilities, and to make reports and recommendations on these matters.

Recommendation(s)

That:

(a) the committee determine any recommendations it wishes to make to health or social care commissioners in order to secure improved performance; and

(b) any areas for further scrutiny be identified for inclusion in the committee's work programme.

Further information on the subject of this report is available from
Adam Russell, Senior Commissioning Officer, Adults and Wellbeing.

Email: Senior Commissioning Officer, Adults and Wellbeing@herefordshire.gov.uk

Alternative options

None. It is open to the committee to review the report and determine whether it wishes to make any recommendations.

Key considerations

1. The aim of this report and attached appendices is to give a broad overview of the adult learning disability community and the current issues it faces, whilst introducing the development of a new health and wellbeing learning disability strategy for adults to give a new framework for services over the next few years.

2. Herefordshire has an estimated population of approximately 3,500 people (2.32% of county population) that fall within the broadest UK definition of learning disability, in that it must be:

    a. Impaired intelligence *(a lower intellectual ability that significantly reduces someone's ability to understand new or complex information in learning new skills)*; and
    b. Impaired social functioning *(a significant impairment of social functioning that reduces someone's ability to cope independently)*; and
    c. *Onset pre-natal or in childhood before the age of 18 years, i.e. neurodevelopmental.*

3. Learning disability, which can have a wide range of different underlying causes, is a spectrum in terms of impact and severity, with many people at the mild end of that spectrum not being formally diagnosed or not requiring support in adulthood. People within the moderate to severe range of the learning disability spectrum can often require support with aspects of their daily living, including some who may require 24 hours support with all areas of their health and wellbeing.

4. Using current NHS England (NHSE) data and comparing it with population estimates drawn from learning disability-specific population projections compiled by the Institute of Public Care (IPC), it is estimated that, only 23% of the total local population of people with learning disabilities are registered as such with their GP and this appears to be broadly reflective of people's need to access health of social care services; approximately 900 people with learning disabilities are currently receiving support from services commissioned by Herefordshire council or Herefordshire clinical commissioning group. However, there is currently nothing other than an anecdotal indication as to whether those recorded on GP LD registers correspond to those known to the local authority, and vice versa, resulting in possible ambiguity in the data.

5. The greater majority of the people receiving support will have a learning disability that can be defined as moderate to severe and will access services and support continuously throughout their adult lives, from entering adulthood into old age. Herefordshire has a higher incidence of learning disability (0.6%) than the regional average (0.54%) and national average (0.5%).

6. Locally and nationally, people with learning disabilities still experience greater health inequality, social exclusion and lack of economic opportunity than any other group. For example, using NHSE data from 2015-16:

a. Life expectancy. People with learning disabilities die, on average, more than 14 years younger than the general population, and are significantly more likely to have certain conditions and diseases. Women with a learning disability have an 18-year lower life expectancy than the general population, while men with a learning disability have a 14-year lower life expectancy.

b. Health inequality. People with learning disabilities are 26 times more likely to have epilepsy, 8 times more likely to have severe mental illness and 5 times more likely to have dementia. They are also 3 times more likely to suffer with hypothyroidism and almost twice as likely to suffer diabetes, heart failure, chronic kidney disease or stroke. Access to routine health screening programmes for breast and cervical cancer falls well below that of the non-learning disabled population nationally and locally.

c. Paid employment. Of the 1.2 million people with a learning disability in England, currently less than 6% are in any form of paid employment, broadly reflecting the situation locally. Work is ongoing to improve local data as part of the implementation of the new learning disability strategy.

7. The council and the Clinical Commissioning Group (CCG) currently individually commission a number of different services for people with learning disabilities.

a. The CCG is the lead commissioner for services such as learning-disability specific health care including psychiatry; psychology; occupational / physio / speech and language therapy and specialist community nursing; out-of-area special hospital beds and services provided under Continuing Health Care. These services are commissioned from other providers within the NHS or from specialist providers within the voluntary, private/independent and not-for-profit sectors.

b. The council is the lead commissioner for services such as residential care homes; supported living provision; day opportunities and employment; and domiciliary care. These services are commissioned from specialist providers within the voluntary, private/independent and not-for-profit sectors.

8. The council and the CCG additionally commission a range of health and wellbeing services for the wider population that they then make *reasonable adjustments* to, or influence other parties to do so, to enable better access by people with a learning disability. This includes services such as social housing, leisure services, public transport, primary healthcare, adult education, acute healthcare and other services across the NHS and council, plus the voluntary and independent sectors.

9. Finally, the council has growing role in what is termed ‘place shaping’, which is the influencing of all sorts of community activity to increase their potential to offer opportunities for people with a learning disability. A growing number of people with learning disabilities directly commission their own services by using their personal budget in the form of a direct payment, which they then use to purchase commissioned learning disability services and universal services from leisure providers, etc. Expanding opportunities to include self-employment, the use of micro-enterprises for niche activities and other occupations that reduce people’s needs to depend on traditional services are keenly aspired to.

10. Since 2001 the government has issued guidance and policy to health and social care organisations on creating real changes in the lives of people with learning disabilities

through changes to service design and commissioning culture. The combined aim of these changes is to enable people with learning disabilities to have greater choice over how and by whom they are supported, where and with whom they live, access to paid work and real training, have a real social role, improve long-term health and have ordinary expectations about relationships, families and being part of a community.

11. The council is working with the clinical commissioning group and partners across the learning disability community in the county to co-produce a comprehensive outcome-focused Health and Wellbeing Strategy for Adults with a Learning Disability. Currently in draft form, the governance timetable for the strategy will see it presented to Herefordshire Council's cabinet on 10 May 2018 and to the CCG's board on 22 May 2018 and if agreed, begin delivery in accordance with the draft 2018/19 implementation plan contained within the strategy itself.

12. The aim of the strategy is to jointly present a clear policy framework for the commissioning and delivery of opportunities for adults with learning disabilities by a wide range of parties, from individuals using their individual budgets and service providers improving their range of services to statutory organisations implementing large specialist services such as Community Learning Disability Service provided by the ²Gether NHS Foundation Trust, in tandem with the council's Preparing for Adulthood Protocol, this strategy also includes the needs of young people between the ages of 14 to 18, in order to ensure there is a seamless transition between the planned processes of preparing for adulthood and taking on the rights, opportunities and responsibilities of adult life.

13. Improvements are needed in the identification, collection and use of performance metrics across all commissioned learning disability services. As part of the development of the new strategy and using the information contained within the new learning disability needs analysis report (*summary attached as appendix 1*), the following measures are being put in place:

    a. New qualitative and quantitative outcomes measures linking individual aspirations to both general health / wellbeing outcomes and wider population-wide outcomes.

    b. Improved metrics across all of the outcomes identified in the strategy, in order to measure progress and provide evidence that outputs are improving and outcomes are being achieved.

Collation of like-for-like benchmarking data to compare the cost effectiveness of learning disability services nationally and across comparable local authorities.

14. In summary, the strategy will:

    a. Set out the outcomes required for the individual and the wider learning disability community, linking them to guidance, legislation and to the wider strategic aims of the council and the clinical commissioning group;

    b. Set out the inputs and actions required and by whom in order to achieve the desired outcomes;

    c. Act as a long-term framework for the ongoing implementation of the changes first set out in Valuing People and then reiterated through key policy documents and legislation such as including Mental Capacity Act (2005); Our Health, Our Care, Our Say (DH 2006); Death by

Indifference (Mencap 2007); 'Valuing People Now' (DH 2009); Disability and Equality Act (2010); Care Act (2014) and Transforming Care (DH 2015).

d. Ensure that all commissioned activity for and with adults with learning disabilities is aligned to the health and wellbeing blueprint for adult social care and with the NHS's long-term commitment to ensure reasonable adjustments are made in both primary and acute health services.

15. A number of actions are already underway or planned:

a. A review of specialist health services delivered through the Community Learning Disability Team provided by [2]Gether Foundation NHS Trust and now commissioned by the clinical commissioning group.

b. A review of the role of the Learning Disability Partnership Board to align it as a sub-group of the Health and Wellbeing Board and to lead on ongoing engagement with the learning disability community regarding meeting the outcomes laid out in the strategy.

c. The development of a comprehensive learning disability needs analysis (Appendix 1) that will be reviewed and update biannually in order to support commissioning decisions across the sector.

d. Development of a comprehensive learning disability market condition report that contains an assessment of provider resilience and market capability; details of current provider ecology (who does what, where and for whom at what cost?); gaps in provision; sub-regional price benchmarks etc. in order to support and improve commissioning decisions across the sector

e. Members of the adults and wellbeing scrutiny committee have had the opportunity to visit a service for adults with profound and complex learning disabilities. This service will be subject to reprocurement in the near future and this creates an opportunity for possible change or improvement in the way services are provided to this group of people.

f. Herefordshire Clinical Commissioning Group and 2Gether NHS Foundation Trust will be attending the adults and wellbeing scrutiny committee meeting relevant to this report and presenting information as appended.

Community impact

16. In accordance with the council's code of corporate governance the council must ensure that it has an effective performance management system that facilitates effective and efficient delivery of planned services. Effective financial management, risk management and internal control are important components of this performance management system. The council is committed to promoting a positive working culture that accepts, and encourages constructive challenge, and recognises that a culture and structure for scrutiny are key elements for accountable decision making, policy development, and review.

17. The committee's considerations should have regard to what matters to residents of Herefordshire. In doing so, the committee will wish to go beyond the pure data on process

performance in order to consider the impact on the wellbeing of people with learning disabilities in Herefordshire and their experience of commissioned services in line with the corporate priorities and the adults wellbeing plan.

Equality duty

18. Under section 149 of the Equality Act 2010, the 'general duty' on public authorities is set out as follows:

A public authority must, in the exercise of its functions, have due regard to the need to –

(a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act. Current and planned services for adults with learning disabilities help to make this a reality by;

- improving wider community understanding of the needs and capabilities of adults with learning disabilities;
- improving social value by promoting people with learning disability's visible access to roles such as paid employment and to activities linked to civil participation;
- promoting self-advocacy and citizen advocacy to support people with learning disabilities to recognise victimisation or discrimination; supporting them to be able to speak out to prevent it and by ensuring there are 'safe spaces' where people with learning disabilities can access skilled support

(b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it. Current and planned services for adults with learning disabilities help to make this a reality by;

- ensuring that for adults with learning disabilities have equal access to housing and employment opportunities;
- making 'reasonable adjustments' to public services such as primary healthcare to ensure that people with learning disabilities are not excluded from them.
- promoting a high expectation of good health for people with learning disabilities through routine access to health screening programmes; early regular cognitive function tests for dementia; an agreed standard of annual health check and effective health action plans.

(c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it. Current and planned services for adults with learning disabilities help to make this a reality by;

- encouraging use of universal services (leisure facilities, hobby clubs, sports etc.) alongside specialist learning disability services in order to support integration and to increase the perceived social value of people with learning disabilities;

- promoting diverse and integrated communities by ensuring there are multiple opportunities for people with learning disabilities to be supported in ways that allow them to choose ordinary places to live, ordinary places to work and to have ordinary lives that include loving relationships.

19. The public sector equality duty (specific duty) requires us to consider how we can positively contribute to the advancement of equality and good relations, and demonstrate that we are paying 'due regard' in our decision making in the design of policies and in the delivery of services.

20. Where services for people with learning disabilities are delivered via contracts and service level agreements with the independent, private third sector, the council's providers will be made aware of their contractual requirements in regards to equality legislation.

Resource implications

21. There are no direct resource implications arising from this report. The resource implications of any recommendations made by the committee will inform the commissioner's responses to those recommendations.

Legal implications

22. The council is under a legal duty to provide an overview and scrutiny function in accordance with Section 9 of the Local Government Act 2000.

23. The remit of scrutiny committees is set out in part 3 Section 4 of the constitution. Paragraph 2.6.7 provides that scrutiny committees have the power to scrutinise the services provided by organisations outside the council e.g. NHS services, under the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013.

24. Scrutiny functions are outlined in Section 4 paragraph 3.4.1 of the constitution, including at paragraph 3.4.2(g) the power to review and scrutinise any matter relating to the planning, provision and operation of the health service in its area and make reports and recommendations to a responsible person on any matter it has reviewed or scrutinised or to be consulted by a relevant NHS body or health service provider in accordance with the Regulations (2013/218) as amended. In this regard health service includes services designed to secure improvement —

    (i) in the physical and mental health of the people of England, and
    (ii) in the prevention, diagnosis and treatment of physical and mental illness

25. There are no specific legal implications arising directly from the report.

Risk management

There is a reputational risk to the council if the scrutiny function does not operate effectively.

Risk / opportunity	Mitigation
Performance management could be	The committee seeks to focus its attention

focused on process measures that are not reflective of the wellbeing and experience impact of services for people with learning disabilities in Herefordshire.	on matters of direct relevance to people with learning disabilities living in Herefordshire and ensure performance measures reflect these.
Progress toward the delivery of the health and wellbeing blueprint and enabling successful outcomes for this group may be compromised due to the absence of a learning disability strategy.	The committee notes the significant amount of work in progress and the current co-production of a comprehensive learning disability strategy to inform future commissioning decisions.

Consultees

26. Whilst there are no direct consultees for the performance data used for this overview report, the same data is being used for the Health and Wellbeing Learning Disability Strategy currently under development and to inform the local joint strategic needs analysis Understanding Herefordshire. As part of this, commissioners are formally engaging with people with learning disabilities, family carers, health and social care professionals and with service providers operating in Herefordshire to develop the outcomes framework underpinning the strategy. This engagement will continue for all relevant commissioning actions as the strategy is implemented and will be augmented through the changing role of the Learning Disability Partnership Board.

Appendices

Appendix 1: Learning Disability Needs Analysis (LDNA) summary 2018

Appendix 2: Learning disability services overview presentation

Background papers

None identified.

Further information on the subject of this report is available from
Adam Russell, Senior Commissioning Officer, Adults and Wellbeing.

Email: Senior Commissioning Officer, Adults and Wellbeing@herefordshire.gov.uk

APPENDIX 1

Learning Disabilities in Herefordshire Needs Assessment – Summary Report

Version 0.04
Herefordshire Council Intelligence Unit

February 2018

CONTENTS

DRAFT

INTRODUCTION

'Learning disabilities' is currently a poorly defined term. It can have different meanings in different contexts (such as in education or medical settings) and have different interpretations by different professionals and the general public. The introduction of newer terminology such as 'intellectual disabilities' and 'specific learning disorder' which refer to a subset of learning disabilities further makes it difficult to define a clear workable definition of learning disabilities. Overall, "learning disabilities", can be considered an umbrella term that covers a range of neurological disorders in learning with varying degrees of severity that leads to impairment in social, intellectual and practical skills. Predecessor terms include: minimal brain damage and minimal brain dysfunction, and mental retardation. The most widely used term in the UK is, 'learning disability' and can be considered interchangeable with 'intellectual disability.

Definitions provided by Diagnostic and Statistical Manual of Mental Disorders – V (DSM-V), British Psychological Society (BPS), National Institute for Health and Care Excellence (NICE), and the government white paper on learning disabilities, 'Valuing People' have common core features which can be used to define learning disabilities:

- *Impaired Intelligence* - lower intellectual ability (usually an IQ of less than 70) which can significantly reduce ability to understand new or complex information in learning new skills;

- *Impaired Social Functioning* **-** significant impairment of social or adaptive functioning which can reduce ability to cope independently;

- *Neurodevelopmental* **-** onset in childhood, before the age of 18 years.

Impairment in social, intellectual and practical skills can be highly varied among individual cases. Underlying neurological conditions also plays a role in the severity of disability and how functional an individual will be. Some people with learning disabilities live independently without much support, but others may require 24 hour care to perform most daily living skills due to complex needs.

This Adult Learning Disability Integrated Needs Assessment was commissioned by Herefordshire Council to provide an overview of health and wellbeing issues affecting adults (i.e. individuals aged 18 and over) with learning disabilities living or registered in Herefordshire and to outline levels of care and services currently provided. This document will inform the Learning Disability Strategy.

LEGISLATION

Mental Capacity Act 2005

The primary purpose of the Mental Capacity Act 2005 is to promote and safeguard decision making within a legal framework by empowering people to make decisions for themselves wherever possible, and by protecting people who lack capacity by providing a flexible framework that places individuals at the heart of the decision-making process.

Disability and Equality Act 2010

Under the Disability and Equality Act 2010, service providers are obliged to make reasonable adjustments to premises or to the way they provide services to ensure disabled people have equal rights of access. This is not only about physical access, it is about making services easier to use for everybody, for example longer appointment times and more accessible health promotion information.

The Care Act 2014

The Care Act 2014 came into effect on 1st April 2015 and represents the single biggest reform of social care legislation since the National Assistance Act 1948. It integrates and improves upon all previous legislation and incorporates accepted good practice as part of the legal framework and guidelines.

Our Health, Our Care, Our Say (2006)

The 2006 'Our Health, Our Care, Our Say' white paper set out a new direction for the whole of the health and social care system, building on the 'Independence, Wellbeing and Choice' green paper. Although much of this was concerned with healthcare, there was a strong emphasis on choice and control through personalised services, self-assessment and people planning and managing their own services.

'Valuing People' (2001) and 'Valuing People Now' (2009)

The 2001 'Valuing People' white paper formed the basis of the subsequent government paper 'Valuing People Now: A new three-year strategy for people with learning disabilities' (published in 2009). Both represent key benchmark documents for the principles underpinning the provision of services for people with a learning disability foreshadowing, as they do, the era of personalisation, empowerment and choice. 'Valuing People Now' set out the then Government's strategy for people with LD and responded to the main recommendations in 'Healthcare for All', which was report of an independent inquiry into access to healthcare for people with LD.

Transforming Care

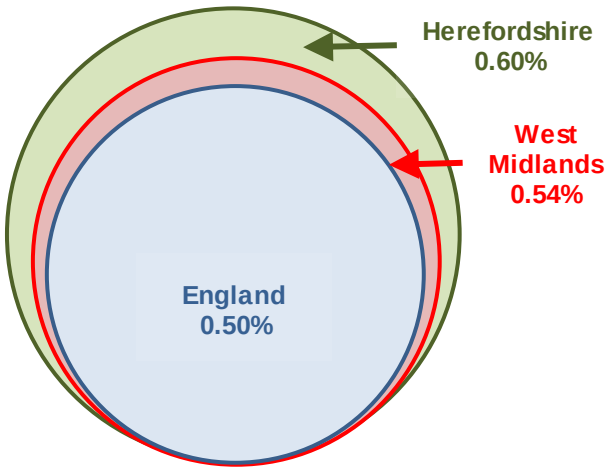
Following the 2011 BBC Panorama programme showed residents/patients with learning disability being tortured and abused by the people who were employed to care for them in Winterbourne View private hospital for specialist medical help for people with learning disability the government initiated a nationwide programme of measures to ensure the safety and wellbeing of people with LD placed in Assessment and Treatment Units. This programme was updated as recently as June 2015 and the plan re-vitalised as the 'Transforming Care Programme' which is designed to drive system-wide change and enable more people to live in the community, with the right support, and close to home.

PREVALENCE OF LEARNING DISABILITIES

The discussions concerning prevalence/numbers of individuals with LD are based on two measures:

1. Registered Patients – the number of patients recorded on their general practice's LD register;
2. Whole Population - Estimates and predictions of whole population LD prevalence provided by DoH population estimation websites "Projected Adults Needs Services Information" – PANSI and "Projecting Older People Population Information" – POPPI (it has been estimated that the numbers on the GP registers represent only 23 per cent of adults with LD)

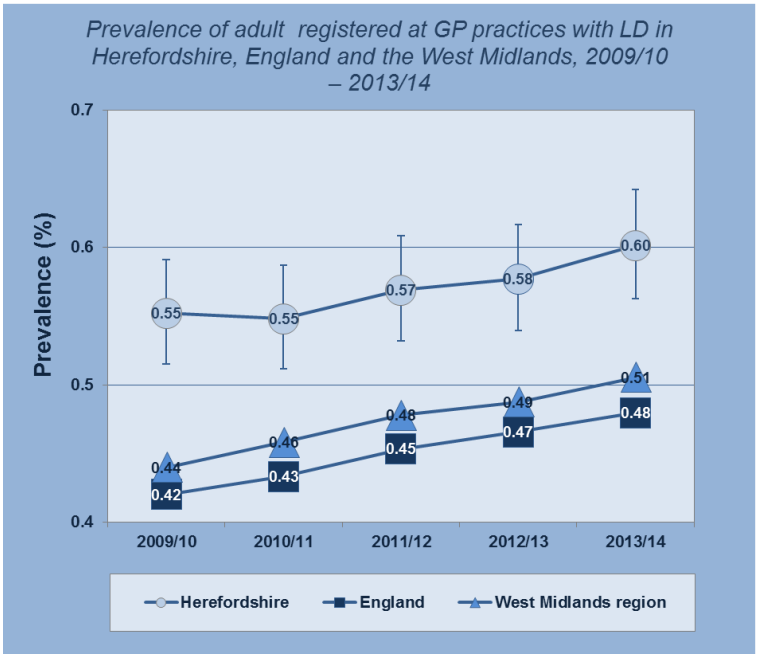
RECENT PATTERNS – REGISTERED PATIENTS



Prevalence: 2015/16

In 2015/16 there were 900 adult (individuals aged 18+) patients with LD registered as such on Herefordshire GP practice lists

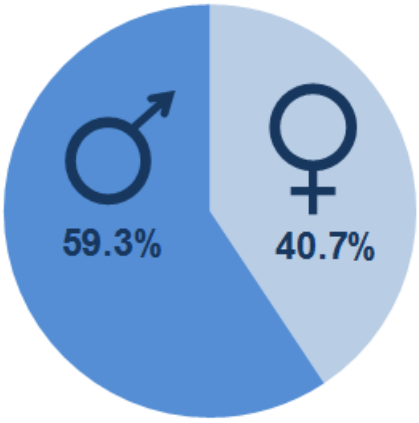
This represents a prevalence of 0.60 per cent of all adult patients in the county which is significantly higher than the figures of 0.50 per cent for England and 0.54 per cent for the West Midlands



Prevalence: 2009/10 – 2015/16

Between 2009/10 and 2013/14 the number of adults with LD recorded on Herefordshire GP practice lists increased by 81 from 808 to 889, a proportional increase of 10.0 per cent

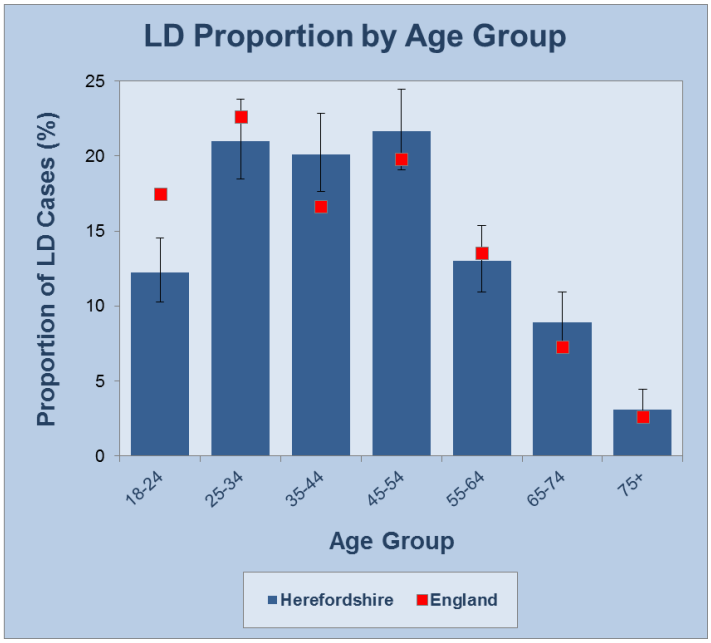
Over the same period increases in numbers of adults with LD were also observed nationally and regionally. However, proportionally these increases were considerably higher than in Herefordshire at 19.7 per cent across England and 17.5 per cent for the West Midlands



Prevalence by Gender

In 2015/16 the number of adult male on GP LD registers in Herefordshire (534) represented 59.3 per cent of all cases, with females (366) representing 40.7 per cent.

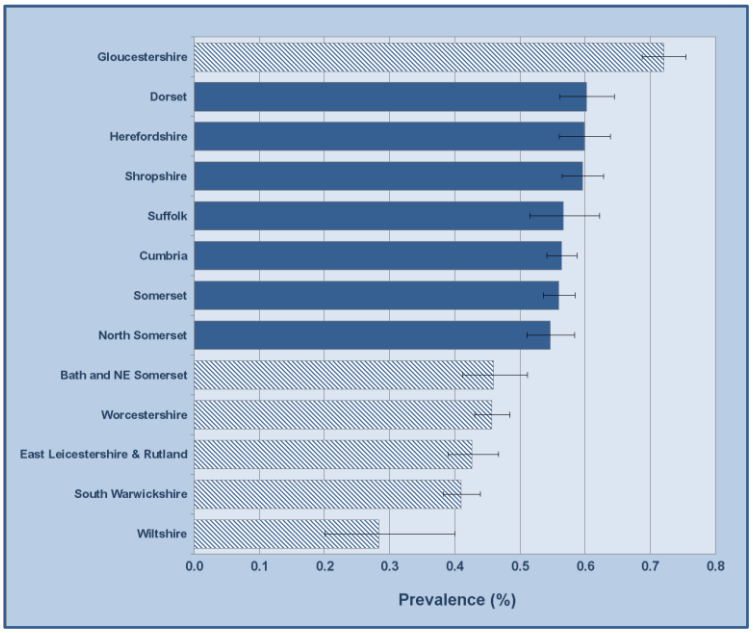
Similar gender proportions were observed both nationally and regionally.



Proportion of LD cases by Age

Locally, the number of LD cases shows some variability by age with the highest number of individuals between the ages of 25 and 54, which represented 63 per cent of all adults with LD in 2015/16.

A broadly similar pattern was evident nationally, although the proportion of adults with LD in Herefordshire in the <24 years cohort was significantly lower than reported nationally, while the local proportion for cases in the 35 to 44 cohort was significantly higher than those across for England.

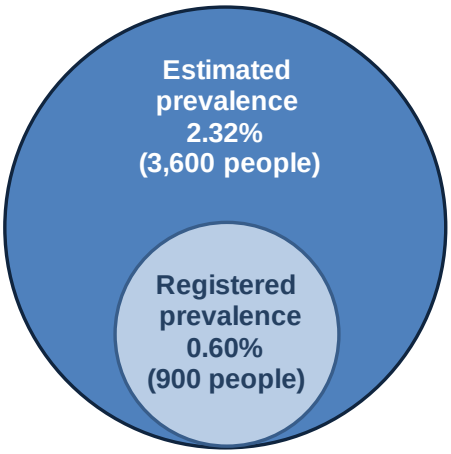


Nearest Neighbour Comparison

Comparison of 2015/16 adult LD prevalence data for Herefordshire with a comparator group of 12 nearest statistical neighbours indicates that the local prevalence (0.60 per cent) was significantly higher than that recorded in 5 out of the 12 nearest neighbours

The local figure was also significantly higher than the national and regional figures.

WHOLE POPULATION ESTIMATES

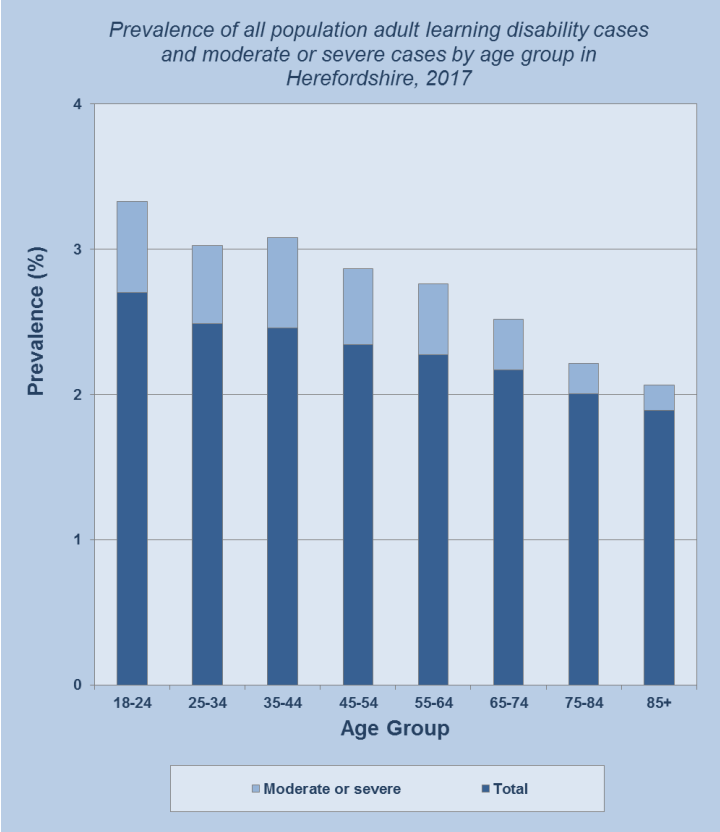


Prevalence

There are no reliable statistics characterising accurately how many people there are with learning disabilities across the UK.

It has been estimated that the numbers on the GP registers represent only 23 per cent of adults with LD.

There are estimated to be 3,600 adults with LD in Herefordshire in 2017, which represents of 2.32 per cent of the total adult population in the count.



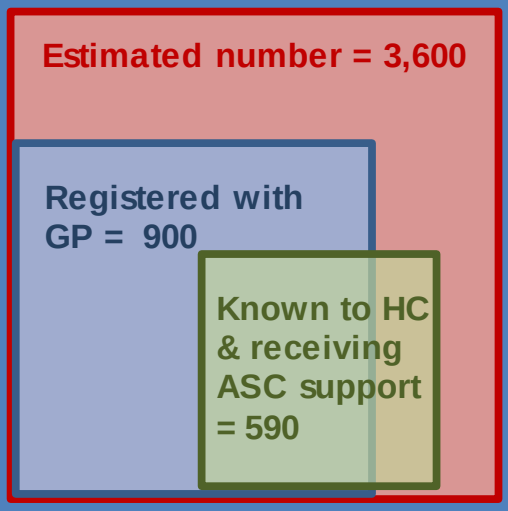
Moderate and Severe LD

The estimated number of adult LD cases varies by age with a general increase with age evident with numbers rising from 343 in the 18 – 24 cohort to 639 in the 45 – 54 cohort; the numbers then fall with age with the lowest figure of 119 observed in the 85+ cohort.
This pattern is also evident in the number of moderate and severe cases.

When examining the prevalence for each age group there is a steady decline for total cases with age from 2.70 per cent in the 18 – 24 cohort to 1.89 per cent in the 85+ group; a similar pattern is evident for moderate and severe cases. This declining trend in prevalence reflects the lower life expectancy in the LD community.

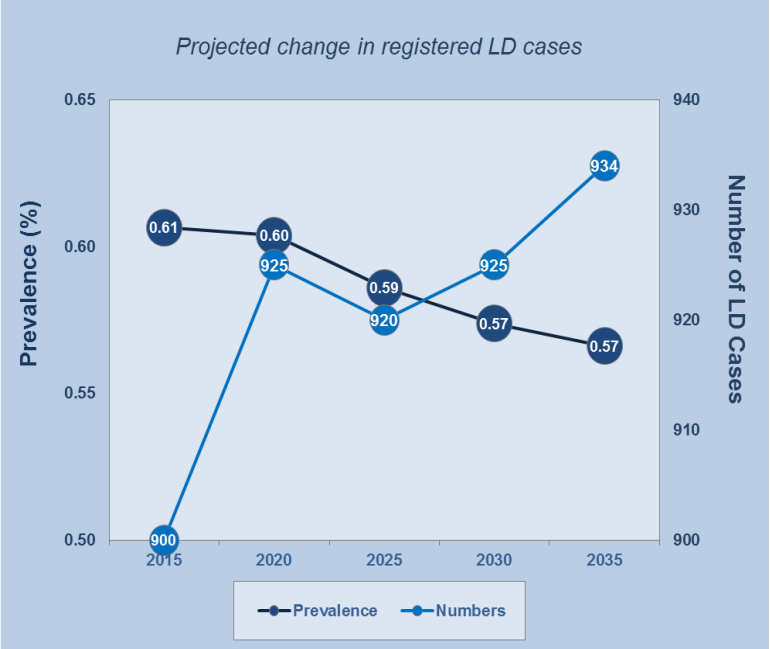
Observations

The identification of adults as having LD is poor in Herefordshire, reflecting both national and regional patterns. Better identification could be facilitated by all relevant clinicians, health workers and carers becoming more aware of LD, with a particular aim of improving the recording of adults with mild LD. An improvement in enumerating the number of adults with LD would aid accurate assessment of future demand and ensure that relevant services will be provided at the required level. Furthermore, future identification of those adults with LD who are not currently known to the Local Authority will aid the successful targeting of low level interventions which could help maintain their continued independence from statutory services.



In addition, there is currently no indication as to whether those recorded on GP LD registers correspond to those known to the local authority, and vice versa, resulting possible ambiguity in the data. Clear cross-referencing of these data between all relevant organisations would clarify this and provide a clearer picture of Herefordshire's adult LD community.

PROJECTED TRENDS

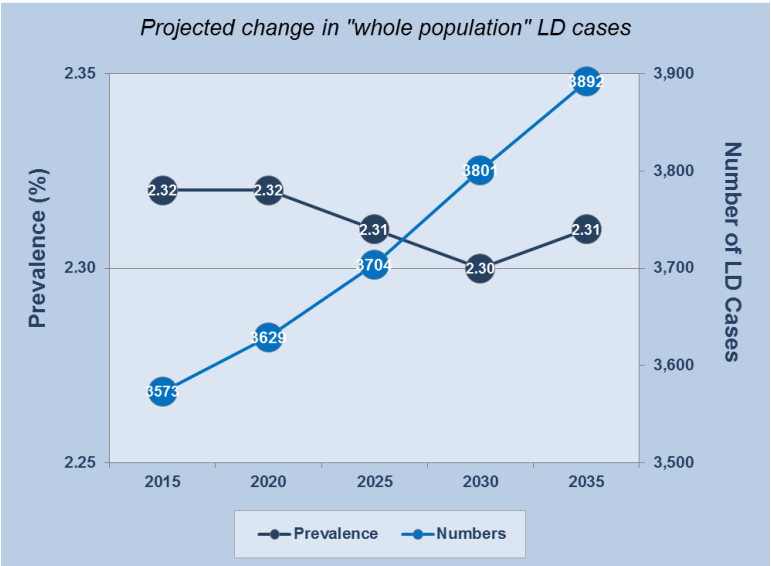


Registered Cases

Between 2015 and 2035 it is estimated that the number of registered adult LD cases in Herefordshire will increase marginally from 900 to 934, a proportional increase rise of 3.8 per cent.

While it is estimated that by 2035 the numbers of LD cases in the majority of age groups will increase this will be most evident in those aged 70 and over where a rise of 50 per cent from 60 to 90 individuals is predicted.

Although the number of adult LD cases are predicted to rise over this 20 year period the overall prevalence is predicted to fall from 0.61 to 0.57 per cent.



Whole Population

A similar pattern is projected for the number of “whole population” adults with LD in Herefordshire with numbers rising steadily from the 2017 estimate of 3,600 to 3,900 in 2035 – an 8 per cent increase. Over this period the number of adults aged 65+ is predicted to rise from 950 to1,350, an increase of 41 per cent.

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However, over this period the whole population adult LD prevalence is expected to show little change.

Observations

While the number of adult LD cases in Herefordshire is predicted to rise relatively slowly, the proportion of these individuals represented by those aged 65+ is going to increase more rapidly. As the care of these older individuals is likely represent greater complexity of need it is evident that a concomitant increase in the capacity across all relevant services will be required to ensure that future provision of support is at an adequate level to meet the needs of the county’s adult LD community and its changing age profile.

HEALTH ISSUES

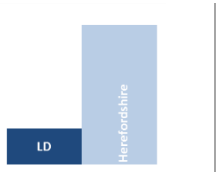
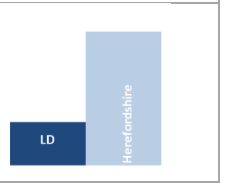
MORBIDITY

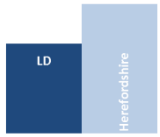
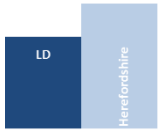
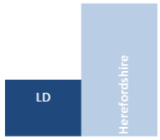
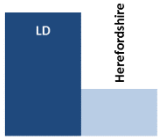
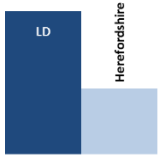
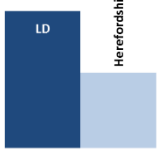
Although people with LD have the same needs as those without, it is recognised that they have specific health needs and that have significantly poorer health and a shorter life expectancy compared to the rest of the population.

For adults with LD in Herefordshire the prevalence of most conditions is broadly similar to those observed nationally and regionally. The exception to this were epilepsy where the Herefordshire figure was significantly higher than that for England as a whole, while the local prevalence of depression and dementia in adults with LD was significantly lower than that reported nationally; similarly, the local prevalence of dementia in adults with LD and a diagnosis of Down's Syndrome was lower than the national figure (see table below).

Compared to the Herefordshire adult population there was a lower prevalence of cancer, CHD, heart failure, hypertension and COPD in those with LD. Conversely, the prevalence of obesity, diabetes, epilepsy, depression and dementia in those with a diagnosis of Down's Syndrome were higher in those with LD than the population as a whole. These patterns generally reflect those observed nationally.

Prevalence (%) of major conditions in learning disability communities in Herefordshire, England and the West Midlands, 2015/16. (Compared with England lower similar higher)

Condition	England	West Midlands	Herefordshire LD prevalence	Herefordshire whole population prevalence	
Cancer	0.97	0.80	0.82	3.19	
Coronary Heart Disease (CHD)	1.14	0.95	1.13	3.49	

Condition	England	West Midlands	Herefordshire LD prevalence	Herefordshire whole population prevalence	
Heart Failure	0.89	0.84	0.82	1.18	
Hypertension (High Blood Pressure)	9.79	9.55	11.8	16.1	
Chronic Obstructive Pulmonary Disease (COPD)	1.03	0.92	0.92	2.15	
Obese	22.0	21.4	23.9	9.09	
Underweight	3.55	3.59	2.77	1.27	
Type 1 Diabetes	0.66	0.75	0.71	0.39	

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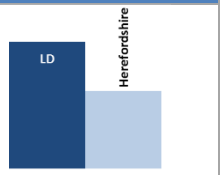
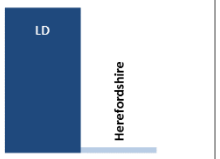
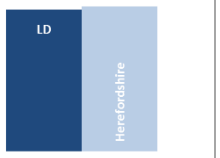
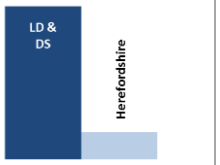
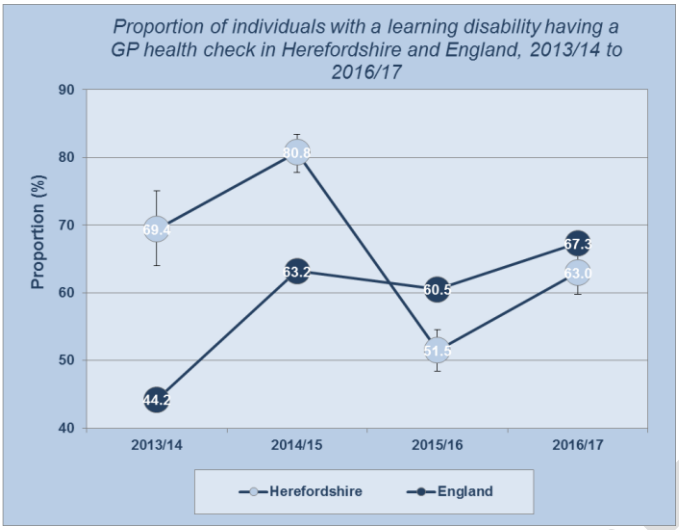
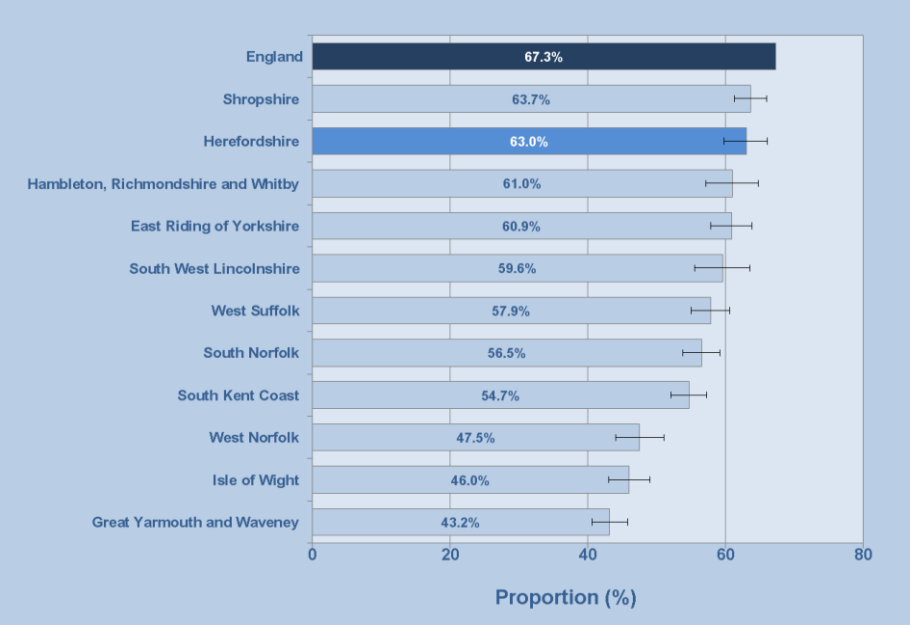
Condition	England	West Midlands	Herefordshire LD prevalence	Herefordshire whole population prevalence	
Non-type 1 Diabetes	6.81	7.28	8.20	5.02	
Gastro Oesophageal Reflux Disease (GORD)	7.34	7.04	8.40	-	-
Epilepsy	17.9	17.5	23.4	0.90	
Dementia	1.41	-	0.92	0.94	
Dementia (individuals with LD and Down's Syndrome)	7.24	-	5.32	0.94	
Depression	12.8	12.2	9.63	7.40	

HEALTH CHECK



Since 2013/14 the proportion of LD patients in Herefordshire receiving an annual health check has shown considerable variability, ranging between 51.5 per cent in 2015/16 and 80.8 per cent in 2014/15.

Over this period the national proportion has shown a general increase with the 2016/17 figure of 67.3 per cent being significantly higher than that recorded locally (63.0 per cent).



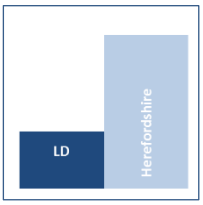
When comparing the local proportion of LD cases receiving an annual health check with nearest neighbour CCGs it is evident that, with the exception of Shropshire, the Herefordshire figure is higher than all those in the CCGs considered, although the difference is only significant in five cases. It should be noted that all nearest neighbour figures were significantly lower than the national figure.

Observations

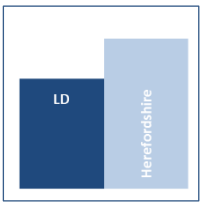
While the local proportion of LD cases receiving an annual health check is comparatively high compared to comparators since 2015/16 it has fallen below that reported nationally. It may be interesting to note that the West Midlands Quality Review Service (MWQRS) were told that the number of annual health checks had reduced since funding for the Directed Enhanced Services (DES) had ceased.

While the checks are being undertaken there are no readily available documented results outlining any subsequent treatment plans are being adopted. NICE states that a care plan for managing any physical health and mental health problems should be developed as appropriate. However, information recording of any such plans is not readily available. Consequently, it is recommended that results of health checks are made readily available to support services so that requirements are made known to and clearly understood by support providers.

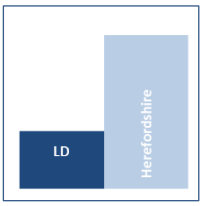
CANCER SCREENING



In 2015/16 the local uptake for **cervical cancer screening** in females with LD who were eligible was 26.4 per cent, a figure just over one third of that for the county population as a whole (71.3 per cent). The local proportion was similar to those recorded both nationally the regionally.



In Herefordshire the uptake of **breast cancer screening** in eligible female LD patients aged 50 to 69 was 50.9 per cent which was approximately three quarters of that for the county as a whole (69.6 per cent). While the local proportion was higher than both the national and regional figures the differences were not statistically significant.



In 2015/16 the local proportion of LD patients aged 60 to 69 who were eligible for **colorectal cancer** screening was 83.5 per cent which was lower than the figure for the county as a whole (86.0 per cent). Although higher than the national proportion the local figure was not statistically higher than that for the West Midlands.

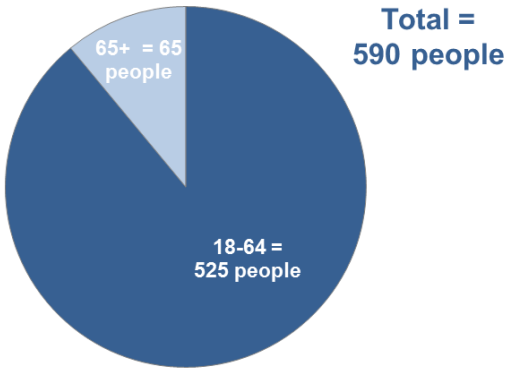
Observation

It is clear that in Herefordshire the cancer screening rates for eligible individuals with LD is are appreciably lower than for the population as a whole. This is an important factor which can lead to late and missed diagnosis as indicated by the local prevalence of cancer in individuals with LD is approximately one third of that in the population as a whole. As a result outcomes are likely to be poorer and premature mortality from cancer more likely.

Currently, the availability of health data relating to adults with LD in Herefordshire is poor. Improved sharing of data concerning all aspects of health care (health check, screening, diagnosis, stage of presentation, outcomes, etc.) would facilitate the assessment of the health of the individual and of the LD community as a whole across the county. All such information should be made readily available to all relevant services and should apply equally to all aspects of health care of adults with LD to encompass all co-morbidities and risk factors.

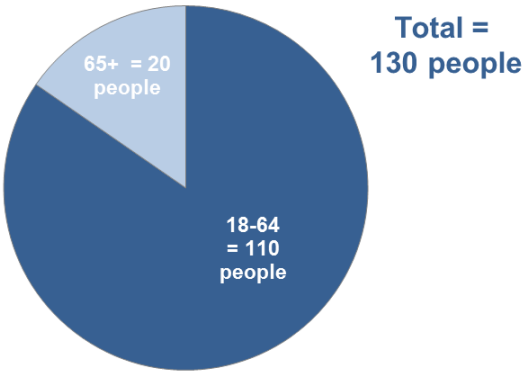
LIVING

Date is this section relates to those adults with LD who are known to Herefordshire Council and are receiving support which equates to a total of 590 individuals.



Data on social services activity indicate that of those adults with LD known to Herefordshire Council eligible for support throughout 2015/16 a total of 590 received long term LD support from Herefordshire Social Services, of which 525 were aged between 18 and 64 and 65 were 65 and over.

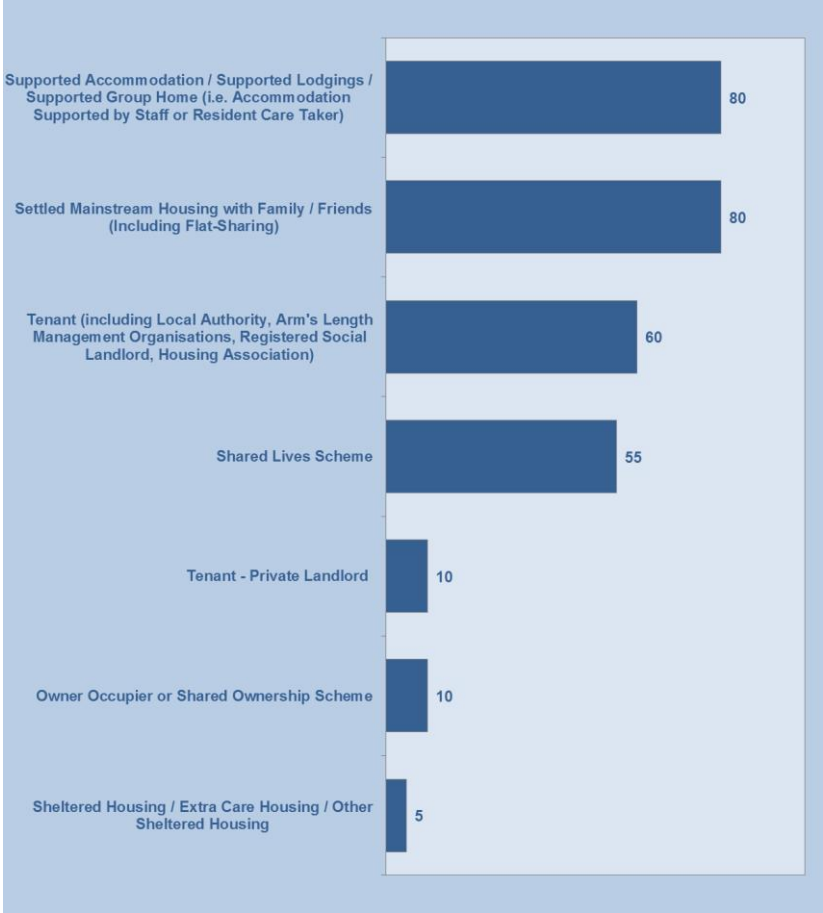
The total figure for 2015/16 represents a 9.4 per cent increase on the number of adults receiving support from Herefordshire Social Services in 2009/10 (480).



SUPPORTED RESIDENTS IN RESIDENTIAL AND NURSING ACCOMMODATION

At the end of March 2016 of those supported by Herefordshire Council 130 adults with LD were in residential accommodation, 110 of which were aged between 18 and 64 and 20 aged 65 and over

Of these individuals 125 had been in care for more than 12 months (105 aged 18-64; 25 aged 65+).

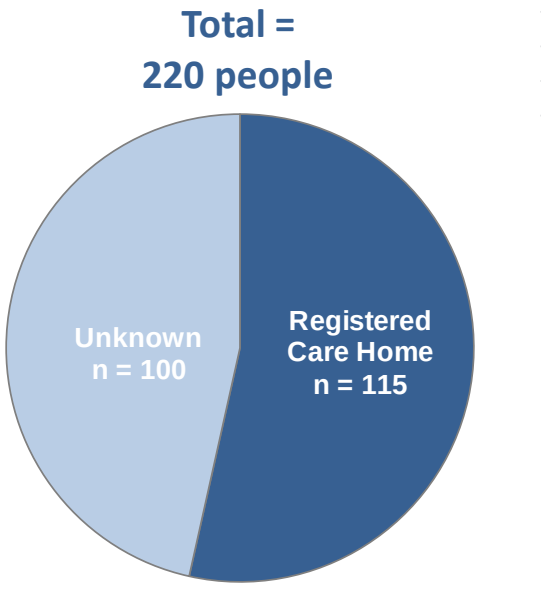


SETTLED ACCOMMODATION

'Settled' accommodation refers to accommodation arrangements where the occupier has medium to long term security of residence, or is part of a household whose head holds such security.

Of the 525 people aged 18-64 with LD who received long term care in Herefordshire in 2015/16 305 (58 per cent) were recorded as living in settled accommodation.

The most common types of settled accommodation Supported Accommodation and Living with Family/Friends both of which represented 26 per cent of those in settled accommodation; other important accommodation types are Shared Living Schemes and Tenant (private landlord) which between them represent 38 per cent of those in settled accommodation.

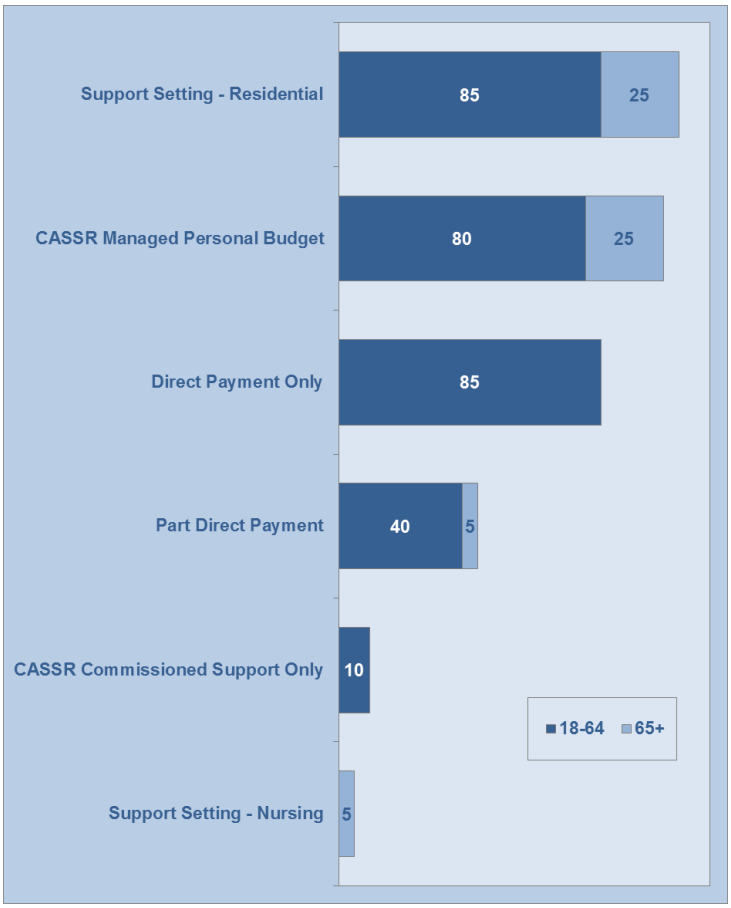


UNSETTLED ACCOMMODATION

'Unsettled' accommodation refers accommodation arrangements which is either unsatisfactory or, where, like in residential care homes, residents do not have security of tenure.

In 2015/16 across Herefordshire there were 220 supported adults aged 18 to 64 with learning disability living in unsettled accommodation, which represents 37 per cent of those receiving long term LD support.

Of these 115 were in Registered Care Homes and the residence of 100 were unknown; this latter figure represents 19 per cent of those receiving long term care in Herefordshire.



PAYMENTS

In 2015/16 of a total of 365 adults with LD receiving long term support payments in Herefordshire 305 were of working age (18 – 64) and 60 were aged 65 and over. The most prevalent payment type was to individuals in residential accommodation with a total of 110 individuals receiving support.

Of those in the community the most common all age support setting was CASSR managed personal budget while direct payments only were also important.

For those of working age the most common payment pathway for those in the community were direct payment only and CASSR managed personal budget; for those aged 64 and over CASSR managed personal budget was the most common. personal budget; for those aged 64 and over CASSR managed personal budget was the most common.

SUPPORTING CARERS

In 2015/16 there were 75 adults with LD in Herefordshire whose carer received direct support throughout the year, while a further 30 carers received no direct support. Of those receiving support 15 received direct payment 5 received part direct payment, 10 CASSR (Council with Adult Social Services Responsibility) commissioned support, while 15 received Information, advice and other universal services / signposting; a further 30 received respite or other forms of carer support delivered to the cared for person.

EMPLOYMENT

Locally in 2015/16 there were 60 individuals with LD of working age (18-64) in paid employment, which is twice that recorded in 2014/15. The 2015/16 figure represents 11.4 per cent (compared to 5.8 per cent in 2014/15) of the registered working age LD population in Herefordshire, a proportion considerably higher than the figures reported for both England (5.8 per cent) and the West Midlands (4.5 per cent). Of those individuals in paid employment in Herefordshire in 2015/16 ten were employed for 16 hours or more per week and 50 for less than 16 hours a week; males represented two thirds of those individuals in paid employment.

CURRENT PROVISION OF SERVICES

GOVERNANCE

Herefordshire Learning Disability Partnership Board (HLDPB) aims to bring together all the relevant local agencies and stakeholders and to give a voice to people with learning disabilities and their family carers. The board is established within the overall governance accountability arrangements for Herefordshire Council and CCG with the overall accountability resting with the Director of Adult Social Services and the CCG Chief Executive.

PROVIDERS – COMMUNITY SERVICES

[2]Gether NHS Foundation Trust

Currently, community services are commissioned from [2]Gether NHS Foundation Trust through the Community Learning Disability Team (CLDT).

Currently the community mental health services for people with learning disabilities or autism delivered by [2]Gether have a Care Quality Commission (CQC) rating of 'Good'

Echo

Echo is an independent Herefordshire-based charity which runs a range of activities primarily for people with moderate or severe learning disabilities in a variety of community venues.

Aspire

Aspire is a registered charity based in Hereford which provides support to individuals with LD. Services provided include residential care, support at home helping people to live independently and also helping individuals to undertake tasks such as shopping, volunteer and leisure activities. Aspire have a CQC rating of 'Good'.

Ategi

Ategi operates a Shared Lives Scheme in Herefordshire providing personal care for people who live in their homes. Ategi have a CQC rating of 'Good'.

Affinity Trust

Affinity Trust (known as Score Community Opportunities in Herefordshire) is a registered charity providing support for people with learning disabilities providing day opportunities on weekdays.

Salters Hill

Salters Hill provide accommodation for people with LD, support people with LD to live in their own homes and encourage creative learning and encourage involvement in the community. Salters Hill have a CQC rating of 'Good'.

Providers – Residential Services

- There are 36 establishments across Herefordshire which provide residential accommodation for adults with LD.
- Over a third of these establishments are located in and around Hereford with others near Ross and in Leominster; there is only one located in the west of the county at Kington.
- Of these all but one have a CQC rating of 'Good', with a single establishment rated as 'Requires Improvement'.

Day Opportunities

- Currently, around 150 people with LD supported by Herefordshire Council are provided with day opportunities at seven locations across the county.
- Individuals using the services are primarily resident in Hereford and Leominster and Ross-on-Wye with very few living in rural and semi-rural areas.
- Aspire run the St. Owens Centre and also provide other services in the city at the Aspire Community Hub and also at Widemarsh.
- ECHO delivers the day opportunities in Leominster at the Priory Centre, Eaton Barn and Bridge Street Workshop .
- Salter's Hill provide day opportunities in south and east Herefordshire.
- A range of other opportunities and support are offered across the different locations across the county by various appropriate social care providers operating in these areas.
- In the 12 months up to the end of August 2017 a total of 141 adult clients were provided with day opportunities at a weekly cost of £21,800, which equates to an annual cost of £1.05 million.

It should be noted that according to CQC reports that Herefordshire is providing some of the best care for adults in the West Midlands. The latest CQC inspection report shows that Herefordshire has the highest proportion of 'Good' or 'Outstanding' care homes and the second highest proportion of home care providers in the region. Furthermore, across the West Midlands Herefordshire has the highest proportion of nursing homes providing specialist care for medical conditions rated as 'Good' and the second highest proportion of providers delivering home care services helping people live independently in their own home rated as 'Good' or 'Outstanding'.

EXPENDITURE

AGES 18 - 64

Long Term Care

In 2015/16 the weekly unit cost of long term care for those with LD **aged 18 – 64** in Herefordshire was £1,162 per week compared to £1,359 per week in England and £1,375 in the West Midlands.

AGES 65+

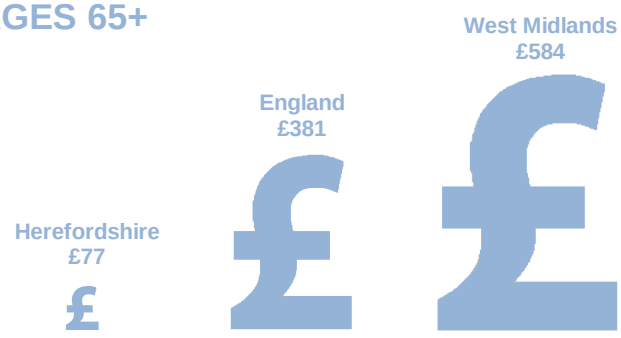
For individuals **aged 65 and over** the long term weekly unit cost for Herefordshire was £622 per week while the weekly figures for England and the West Midlands were £868 and £898 respectively.

AGES 18 - 64

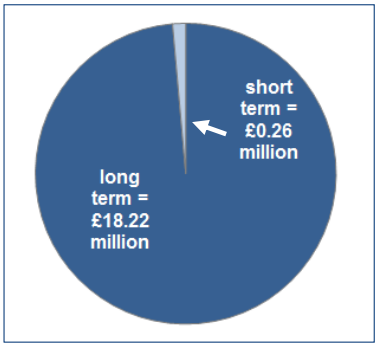
Short Term Care

The weekly unit cost of short term care for those with LD **aged 18 – 64** in Herefordshire was £214 per week compared to the national figure of £494 and the regional figure of £531.

AGES 65+

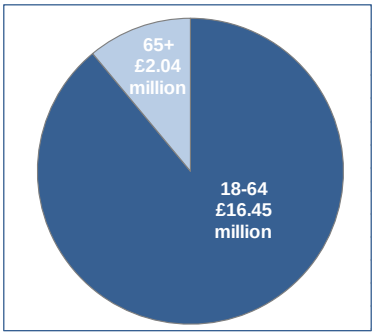


For individuals **aged 65 and over** the short term weekly unit cost for Herefordshire was £77 per week, while the weekly figures for England and the West Midlands were £381 and £584 respectively.

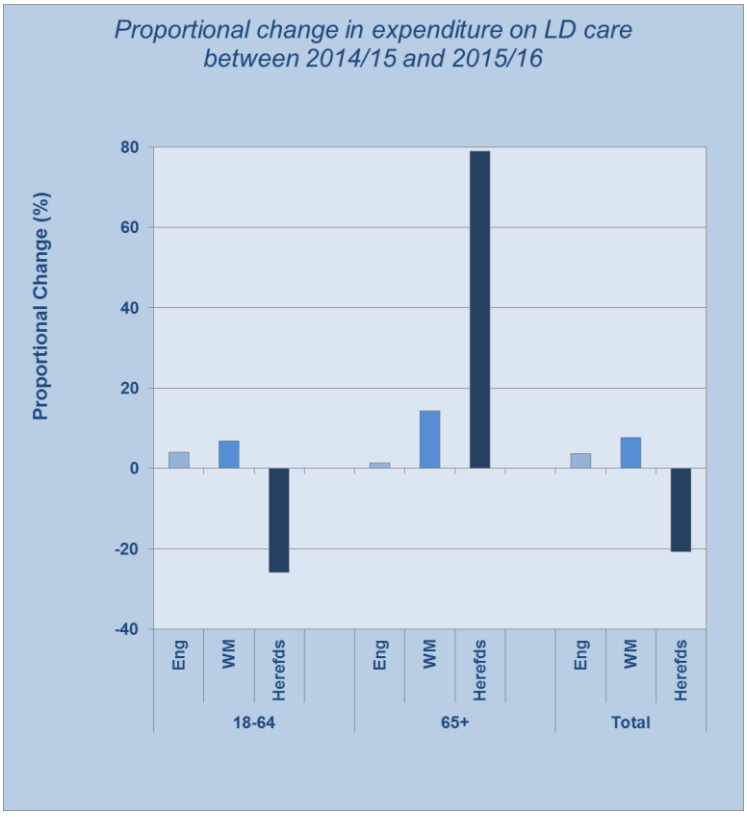


Total Expenditure

In 2015/16 the total expenditure in Herefordshire for long and short term care combined was £18.48 million, which was made up of £18.22 million for long term care and £0.26 million for short term care.



Of the total expenditure in 2015/16 £16.45 million was for those aged 18-64 and £2.04 million for those aged 65+.



Change in Expenditure

The 2015/16 overall expenditure on LD care for Herefordshire Council represented a 20.7 per cent fall on the figure for 2014/15 whilst the overall national (Eng) and regional (WM) expenditure increased by 3.7 and 7.6 per cent respectively.

For 18-64 year olds the local expenditure fell proportionally by 25.6 per cent over this period compared to 4.0 and 6.8 per cent increases seen nationally and regionally.

Conversely, for those aged 65+ the Herefordshire expenditure increased proportionally by 78.9 per cent compared to increases of 1.3 and 14.3 per cent observed across England and the West Midlands respectively.

Observation

It is evident that the expenditure in Herefordshire on the care of adults with LD is lower than across the rest of the West Midlands and England. This, allied with the god quality of services provided, as indicated by CQC reports, highlights the good value for money currently obtained for services supporting adults with LD in the county.

Transition into adult services

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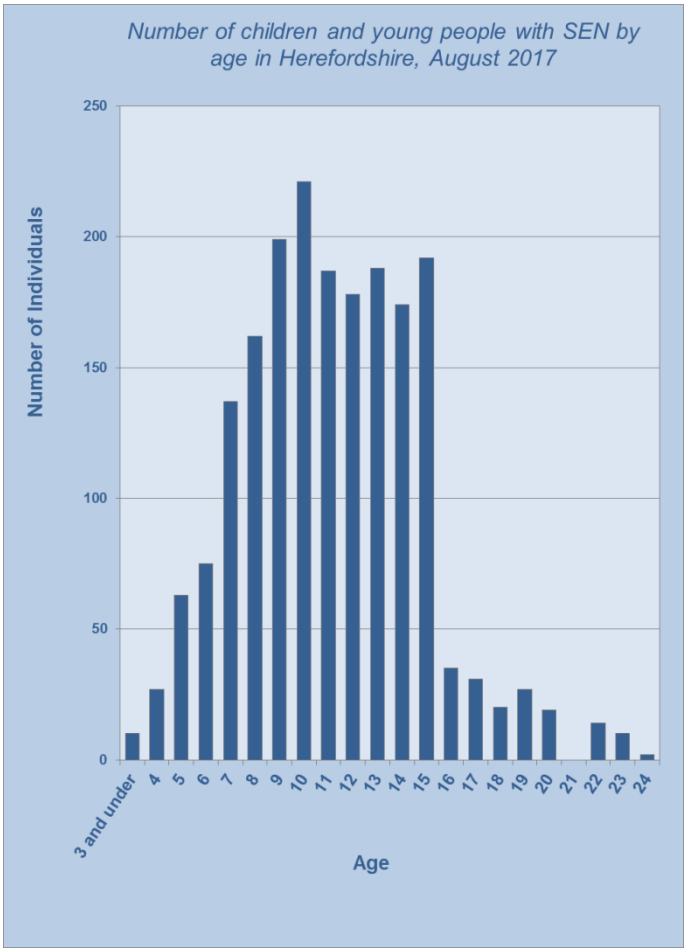


Examining at the prevalence of special educational needs (SEN) among children and young people (CYP) indicates that the proportion of children with SEN increases with age up until the age of 10 and then plateaus before declining at the age of 16 where children are likely to be leaving full time education.

Although numbers with SEN aged 16+ are small this still suggests that a proportion of people leaving education will need to transition from child to adult services.

The evident difference in the number teenagers with SEN aged up to 15 years and those older (as indicated in the graph) does not correspond with the number of registered LD cases at that age which show an increase between the 10-17 and 18-24 cohorts. This would indicate that the educational needs of these young people with LD are currently under catered for and that greater attention should be concentrated on this cohort as they move from an education setting to possible employment.

Observation

Currently there is no available data monitoring what is happening to young people with LD when they leave full-time education. Collection of such information could be used to monitor the progress of such individuals which would facilitate the identification of any support requirements and could also be used to monitor the success of current support initiatives.

It is evident that in Herefordshire (along with the rest of the country) that LD cases are being under diagnosed, a fact that can lead to individuals not being able to access support and services from which they would benefit. It is possible that this is related to the number of adult cases not being documented which may be due to a missed childhood diagnosis, or an individual "dropping off the radar". Such a pattern may be ameliorated if that throughout an individual's lifetime contact with health professionals any indicators of LD are recorded and acted upon appropriately collaboratively by all relevant practitioners and

QUALITY AND OUTCOMES

West Midlands Quality Review Service

- In September 2015 a review of the care of people with learning disabilities in Herefordshire was undertaken by the West Midlands Quality Review Service (WMQRS).

- Of the 73 applicable quality standards which related to primary care, specialist LD services and commissioning 32 were met, which represents a proportion of 44 per cent. Of these primary care met three out of eight standards (38 per cent), specialist LD services 23 out of 48 (48 per cent) and commissioning 6 out of 17 (35 per cent).

- Generally, the review found staff to be highly committed to providing good care for people with LD and it was noted that day opportunities service provided a good range of opportunities and that links with social workers were working well, including social care assessments being undertaken on the premises.

    - However, there were some concerns about the services available for a combination of reasons with the issues relating to:

        - the Partnership Board – the board was deemed not to be working effectively, having no clear work plan and no sub-groups or other mechanisms for implementing a work plan and there was no evidence that the Partnership Board was effectively planning and driving improvements in services for people with learning disabilities;

        - Commissioning of services, and the leadership and governance of the health specialist team - the number of people with learning disabilities for whom services were needed was not clear, access criteria for the services were not clearly defined, both health and social care services were commissioned by the Local Authority without effective mechanisms for the involvement of health commissioners, and health funding for the services was set at an historic level, and arrangements for the review of funding levels were not evident.

        - The leadership and governance of the health specialist team - several aspects of the governance of the team were of concern to reviewers: some members of the team were working alone without effective cover for absence; the physiotherapy assistant was working without clear arrangements for professional supervision; there was limited evidence of a competence framework or training plan; several of the policies and procedures were out of date.

- In relation to primary care reviewers were told that the number of annual health checks and Health Action Plans had reduced since funding for the Directed Enhanced Services (DES) had ceased. Reviewers did not see monitoring of numbers of annual health checks or examples of Health Action Plans. It was concluded that further work in this area may be helpful.

Adult Social Care Outcomes Framework (ASCOF)

- Adult Social Care Outcomes Framework (ASCOF) draws on data from a number of data collections which give a measure of how well care and support services achieve the outcomes

that matter most to clients. Although the information is related to adult social care in general, it also represents a measure of how LD services are perceived and how these perceptions have changed over time.

- The overall social care-related quality of life (SCRQoL) score is derived from the responses to eight questions with a maximum possible score of 24. In 2015/16 the SCRQoL reported for Herefordshire in was 19.8, a figure higher than both those recorded for England (19.1) and the West Midlands (19.0). The local figure has risen steadily since 2012/13 (proportionally by 7 per cent), while nationally and regionally the increase has been more gradual (both proportionally by 2 per cent).

- In 2015-16, 80.5 per cent of service users in Herefordshire reported they have control over their daily lives, compared to 76.6 per cent across England and 75.0 per cent in the West Midlands.

- In Herefordshire, 69.7 per cent of service users reported they were extremely or very satisfied with their care and support in 2015-16, a figure higher than both the national (64.4) and regional (64.2) proportions. The local figure has increased by approximately 6 percentage points since 2013/14 while figures for England or the West Midlands showed marginal falls over this period.

- The proportion of service users and carers who find it easy to find information about services in 2015/16 locally, nationally and regionally were similar, ranging between 72.2 and 73.5 per cent. While the latest Herefordshire figure is proportionally 10 per cent lower than that recorded in 2011/12 the proportions for England and the West Midlands in 2015/16 were broadly similar to those reported for 2011/12.

- While 71.5 per cent of service users in Herefordshire reported feeling safe in 2015-16, the national and regional figures were both below 69 per cent.

- Since 2011/12 the proportions of service users in Herefordshire and across England and the West Midlands have increased with an increase of 13 percentage points observed locally compared to 9 per cent nationally and 12 percent regionally. In 2015/16 the figure for Herefordshire of 88.0 per cent was marginally higher than those recorded both nationally (84.5) and regionally (86.7).

Observation

Although services provided for adults with LD are generally performing well as evidenced by WMQRS and ASCOF improvements can still be made. It would appear appropriate that all relevant services work closely with adults with LD and their carers/support workers to understand their particular needs and experiences within the Health and Social Care system. This should include:

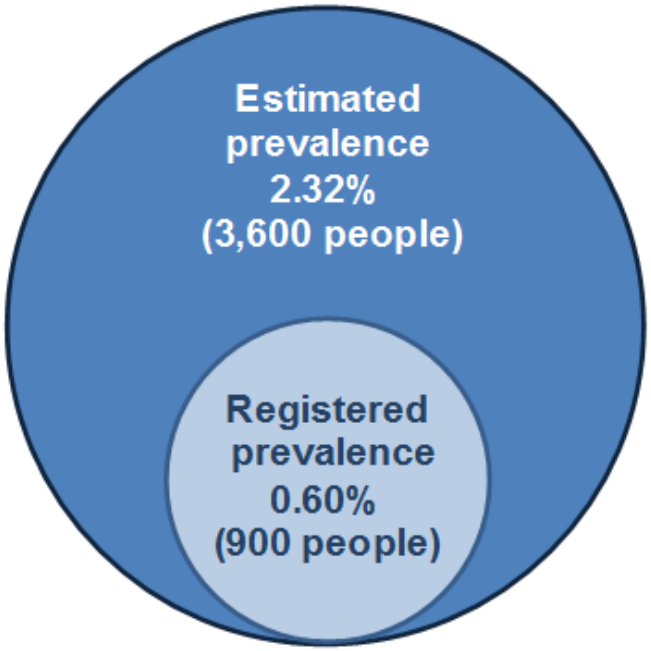
- *consultation with individuals who currently access services to identify areas that require improvement;*
- *as life expectancy increases there should be special emphasis on working with older adults with LD in order to determine requirements of this group and inform the design of service to that will best meet these needs.*

Learning Disabilities Joint Overview

Adult Scrutiny Committee

27th March 2018

Adults with a Learning Disability Living in Herefordshire

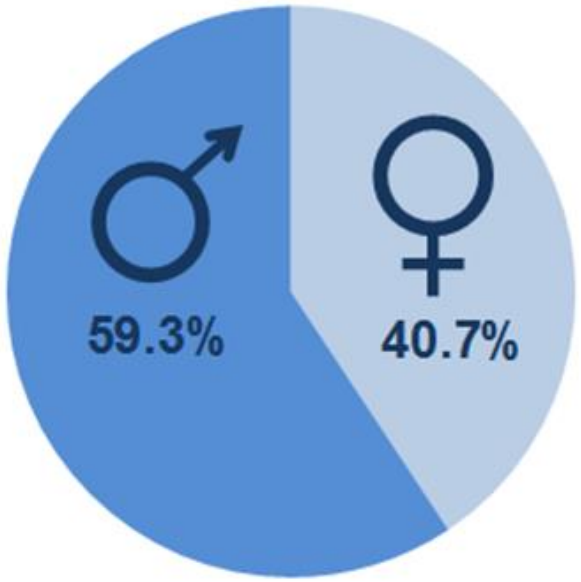


There are no reliable statistics characterising accurately how many people there are with learning disabilities across the UK.

It has been estimated that the numbers on the GP registers represent only 23 per cent of adults with LD.

There are estimated to be 3,600 adults with LD in Herefordshire in 2017, which represents of 2.32 per cent of the total adult population in the count.

Adults with a Learning Disability Registered with GP's in Herefordshire

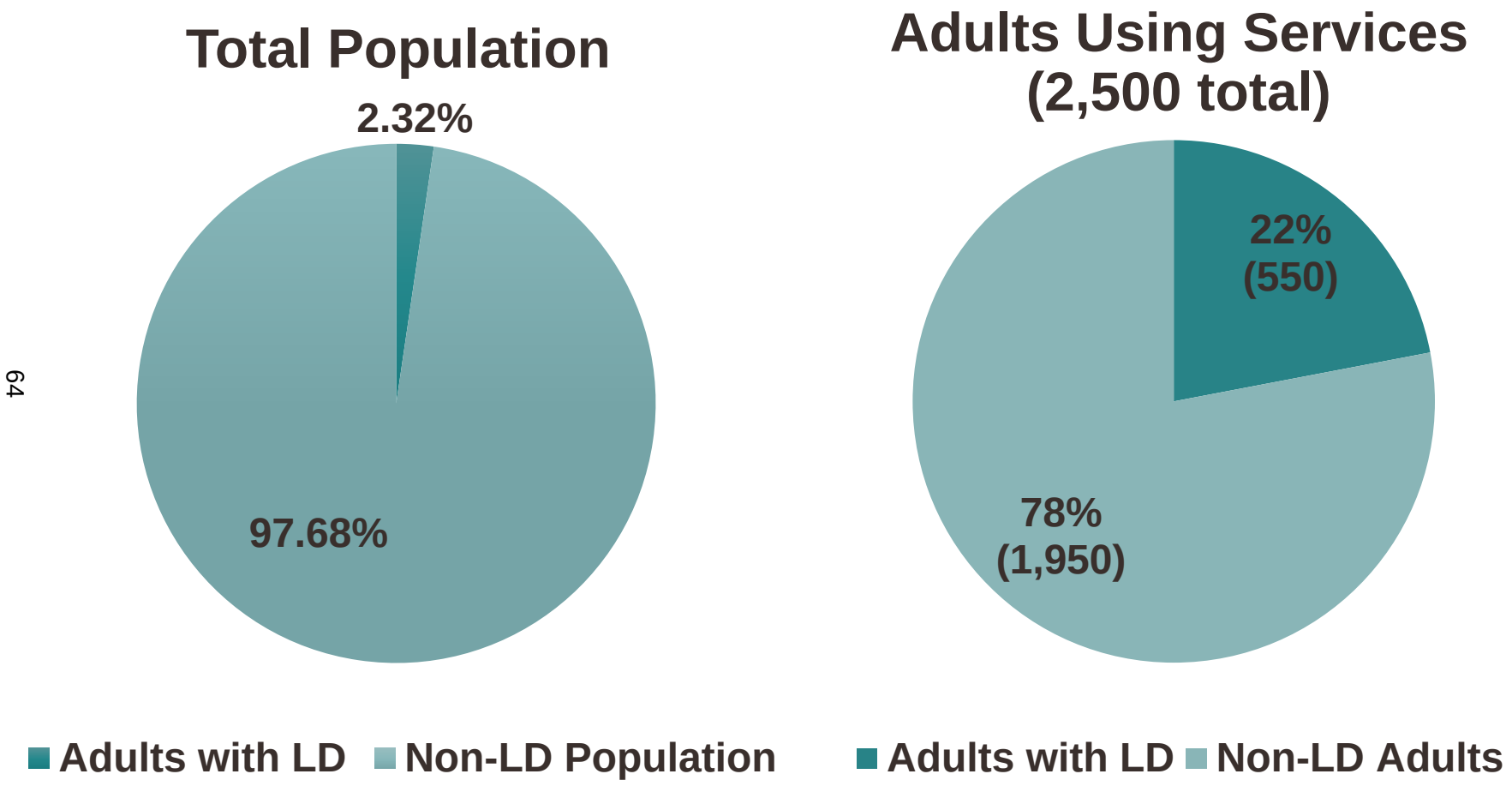


In 2015/16 the number of adults on GP LD registers in Herefordshire were:

- **534 Males (59.3%)**
- **366 Females (40.7%)**
- **Total = 900**

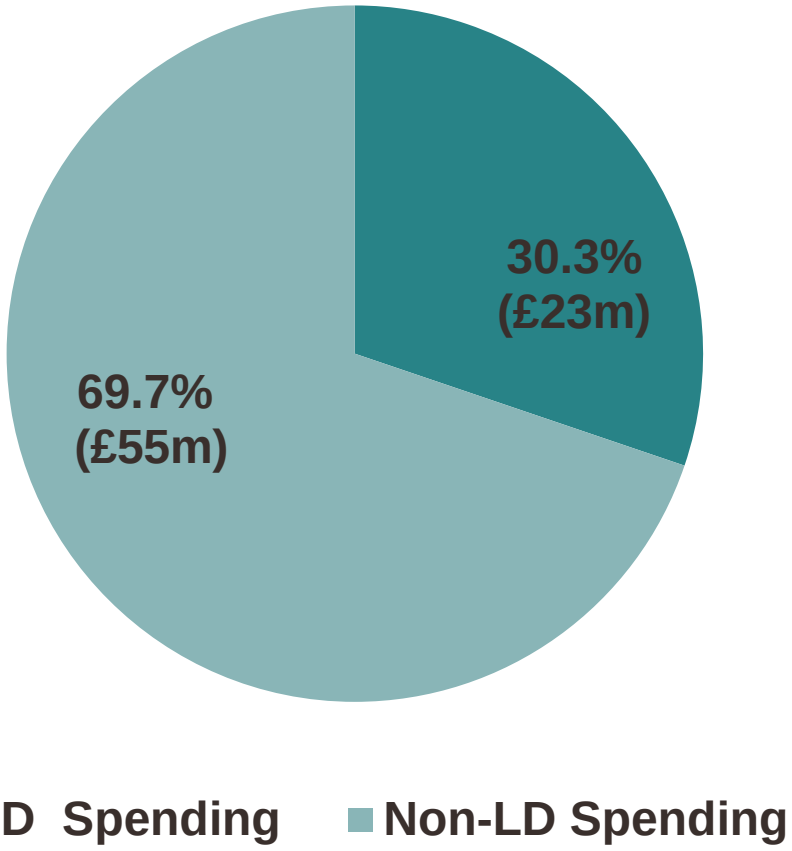
Similar gender proportions were observed both nationally and regionally.

Adults with a Learning Disability Comparative Data



Adults with a Learning Disability - Finance

Adult Social Care Expenditure (based on forecasts for 2018/19)



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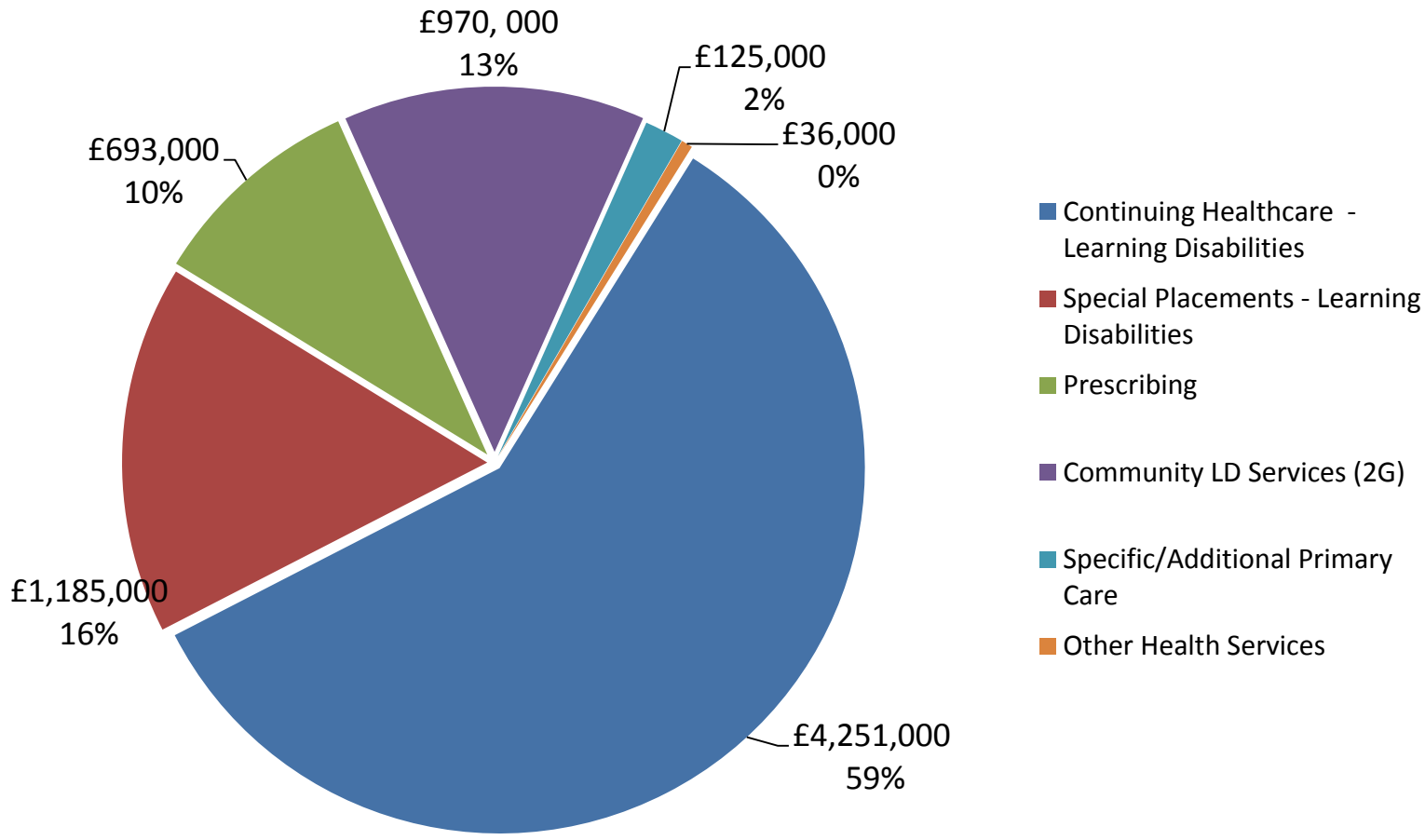
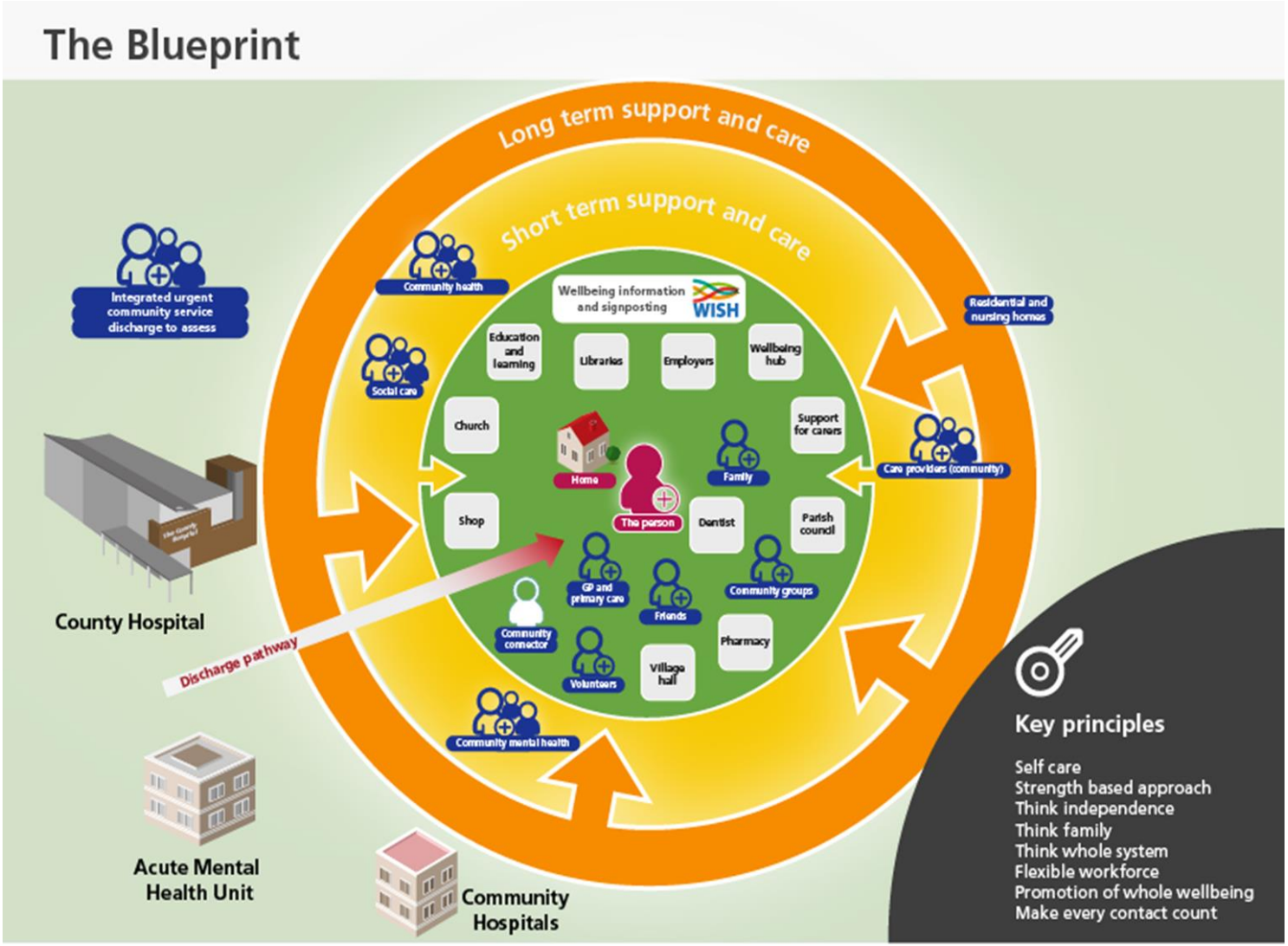
Adults with a Learning Disability - Finance

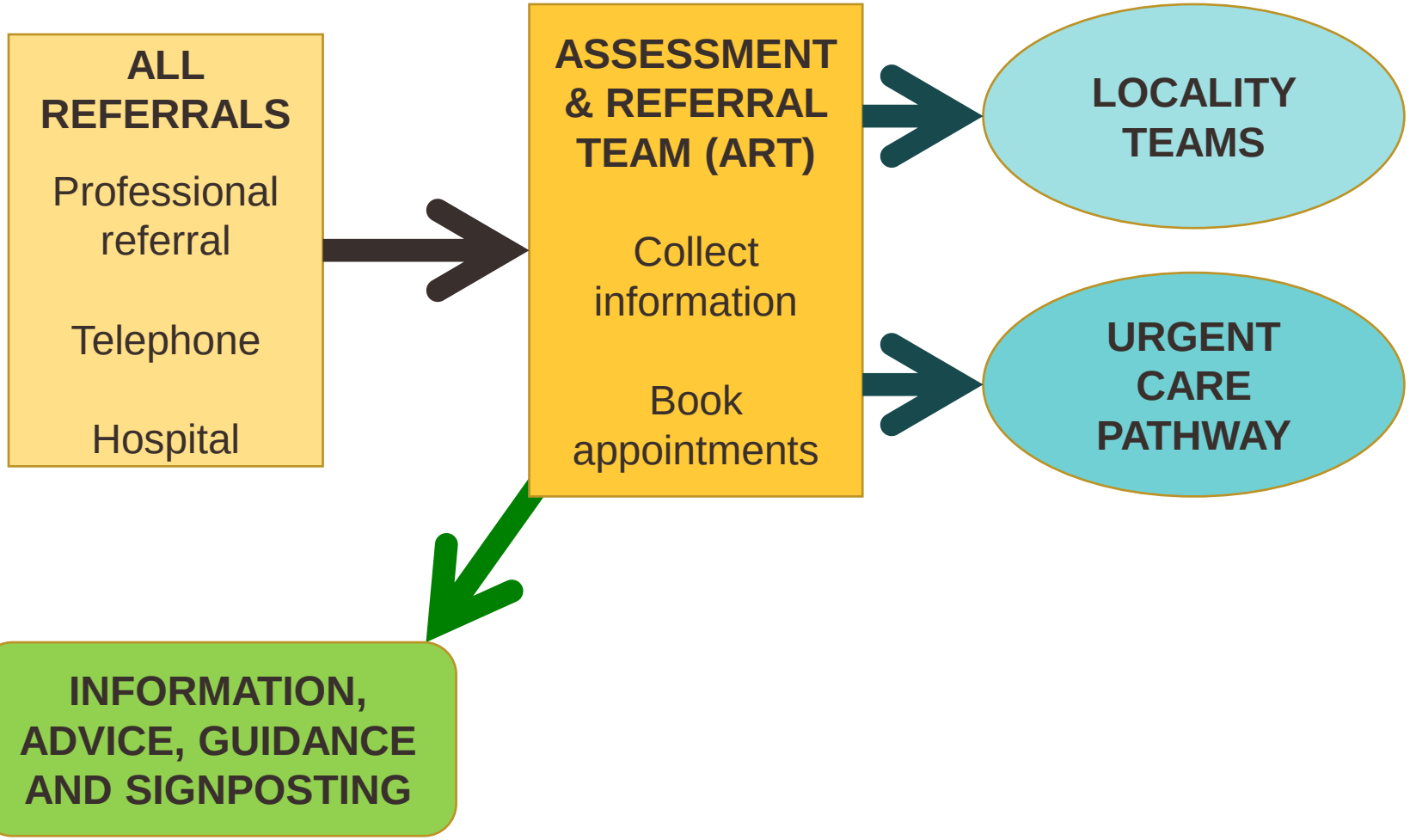
HCCG Planned Expenditure (based on forecasts for 2018/19)



Delivery of the AWB blueprint



Access to Adult Social Care



Putting the public and patients at the heart of everything we do

NHS
Herefordshire
Clinical Commissioning Group

Health Provision for People with Learning Disabilities

- Addressing health inequalities for people with learning disabilities
- Ensuring access to health care
- Providing Specialist Community Learning Disabilities Service
- Transforming Care
- Continuing Healthcare - assessments, care packages and personal health budgets

Transforming Care and Continuing Healthcare

- Transforming Care
  - Trajectory for current patients
  - Small numbers but significant challenge to resolve

- Continuing Healthcare - assessments, care packages and personal health budgets

Access to Adult Community Learning Disability Team

The Community Learning Disability Team directly provides a range of clinical and therapeutic interventions for adults with learning disabilities and their carers.

The Service supports over 750 people per annum

The Team comprises of:

- Community Nurses
- Psychologist
- Psychiatrist
- Occupational therapist
- Physiotherapist
- Speech & language therapist
- Operational Manager
- Administrative Support

Annual Health Checks for people with LD 2016/17 Data

QTR 1	QTR 2	QTR 3	QTR 4	Total
68	102	156	260	586
7%	10.5%	16.1%	26%	60.4%

2gether CLDT Aims of Service

- Enabling people with a learning disability to access effective health & social care from generic providers & systems.
- Providing responsive services in partnership with people who use our services, carers, commissioners & other providers.
- Providing safe, effective & caring services for people with a learning disability & complex needs.
- Actively participating in local, national & international learning disability development.

Overall 5 functions for CLDT

- Supporting positive access to and responses from mainstream services - Health Promotion, Health Facilitation (through Individual Consultations, Supervision, Training and Policy/Practice Development)
- Enabling others to provide effective person-centred support to people with Learning Disabilities (through targeted specialist assessments and formulations, liaison advice, person-focused training, short-term care coordination and clinical support) and including Joint 14+ Transition Work and Liaison Support
- Direct specialist clinical therapeutic support for people with complex behavioural and health support needs (through specialist assessments and formulations, advice, training, longer-term care coordination and clinical support)
- Responding positively and effectively to crisis
- Quality assurance and strategic service development in support of Commissioners

National and Local Drivers for Learning Disabilities

- Transforming Care, Building the Right Support
- Annual Health Checks
- Mortality Review (LeDeR programme)
- Enabling and promoting people with learning disabilities population to undertake health screening

What people with learning disabilities think about their healthcare…

Write down the information you give me so that I can remember it later.

'I was treated with great respect and consideration'

'The Doctor listened to ME…'

'There was no Easy Read' information on display'

'Talk to me, not my mum…'

'I have been waiting for an assessment for a long time…'

What we've learned from engagement so far:

- People lack choice about where and with whom they live
- People lack access to accommodation arrangements that support their independence

- People lack opportunities for paid work and meaningful training
- Council and NHS need to lead by example by offering employment opportunities for adults with a learning disability

- There are still huge health inequalities, e.g., decreased life expectancy and frequent barriers to primary care, acute care and universal routine screening programmes

- Too few opportunities to demonstrate social value and contribute to the community
- Too few people have real choice and control, e.g. direct payments process seen as too complex, inadequate circles of support and lack of true advocacy

Herefordshire LD Strategy
A New Approach

The new Herefordshire Council and CCG strategy for Adults with a Learning Disability aims to place greater emphasis on delivering changes that have a measurable and positive lifelong impact on people.