

# Report to the Meeting of the

**BOD 130/2017**

(Agenda item: 07)

# Oxford Health NHS Foundation Trust

# Board of Directors

**19 October 2017**

**Access to Healthcare for People with Learning Disabilities**

**October 2017 including Specialist Healthcare Transition**

**Information for assurance**

**For: Information**

**Executive Summary**

The purpose of this report is to provide an update as to the transition of specialist health services for people with learning disabilities and assurance to Board in regard to compliance with the six ‘Healthcare for All’ criteria. Since the last report, we have work with NHSI to pilot their draft ‘The NHSI Provider Improvement Standards for Learning Disability’, consisting of 4 key standards.

**Governance Route/Approval Process**

This is a quarterly update report.

**Recommendation**

The Board is asked to note the assurance contained within the report.

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1. **Situation**
	1. Oxford Health NHS Foundation Trust Board has received regular updates on learning disabilities and compliance with the ‘Six Lives’ report’ of the Parliamentary Ombudsman which followed Mencap’s 2007 report ‘’Death by Indifference’’ and the 2008 inquiry ‘’Healthcare for All’’, which looked at the provision of NHS services to people with learning disabilities.
	2. The LD Steering Group reconvened on the 6th June 2017, refreshed terms of reference and agreed how best to provide oversight of the work programme from a clinical and patient experience perspective. The agreed main areas to focus on were:
* Transition of specialist services
* An all-age strategy for people with LD across all Oxford Health geography, which will include progressing the Healthcare for All criteria

The Steering Group agreed to working groups to progress each area.

* 1. Significantly, since the last report there have been a number of national and local developments which impact and will need to inform the contents and actions within the strategy
* A local Transforming Care Plan mid - point review in October 2017.
* SEND services whole system inspection in late September looking at the services that identify, assess and make a difference to children, young people and their families.
* NHSI draft ‘Provider Improvement Standards for Learning Disability’, which will reflect national policy and guidance (used here as we are a pilot partner, full publication awaited).
	1. Further, the ‘Review of deaths of people with a learning disability people within Oxfordshire’s commissioning responsibility who died between 1 April 2011 and 31 March 2015’ paper has been published.
	2. The Board is asked to consider the progress within this paper.
1. **Background**

**2.1** The following reflects the current position of the transition of specialist services; a RAG rated current position against the Healthcare for All; and the Mortality Review.

**3. Transition of specialist health services for people with a learning disability**

**3.1** The transition of specialist health services for adults with a learning disability within Oxfordshire happed as planned on the 1st July 2017.

**3.2** The ‘first hundred days’ project plan has been completed and any outstanding or required actions have been identified to be passed into the LD Strategy. The Executive team have requested updates on a monthly basis, whereas they had received weekly updates during the first hundred days.

**3.3** A review of the project process, against the Verita 2 report is underway.

**4. ‘Healthcare for All’/ NHSI Provider Improvement Standards for Learning Disability**

**4.1** The Provider Improvement Standards for Learning Disability are in development to enable Providers to measure and assure a number of objectives specific to services for people with learning disabilities.

**4.2** The Standards relate directly to the range of current strategic objectives arising from national policy, in particular, Transforming Care and its associated guidance and the policy/frameworks relating to the premature deaths of people with learning disabilities.

**4.3** There are four key standards within the current draft format (\*subject to change)

* **Standard 1**: Improving the Workforce by supporting providers to develop the skills and capacity to meet the needs of people with learning disabilities, achieving safe and sustainable staffing and effective leadership at all levels.
* **Standard 2:** Improving Equity through Reasonable Adjustments by supporting providers to address inequalities, improve outcomes, prevent premature deaths and promote rights based care.
* **Standard 3:** Improving Specialist Learning Disability NHS services by supporting Provider Trusts to fulfil the objectives aligned to national policy and strategy.
* **Standard 4:** Improving Inclusion & Engagement by supporting providers to empower the people who use services and their family carers to be partners in the care they receive.

**4.4** Each standard is supported by specific ‘Improvement Deliverables’. The Standards and deliverables incorporate and align to the 6 Healthcare for All criteria where these are still reflected in current national policy.

**4.5** Each Standard is considered below. Any corresponding Healthcare for All criteria and rating is referenced, alongside a revised rating against each ‘Deliverable’.

**4.6** **STANDARD 1:** **Improving the Workforce** by supporting providers to develop the skills and capacity to meet the needs of people with learning disabilities, achieving safe, sustainable and productive staffing and effective leadership at all levels.

* Healthcare for All criteria in regards to workforce asked if ‘*the NHS foundation trust had protocols in place to routinely include training on providing healthcare to patients with learning disabilities for all staff?’.*
* In July 2017 this was rated as amber as some training had been completed as part of the transition of specialist adult services and some joint discussions had been scheduled with Learning and Development.
* The deliverables within the NHSI Provider Improvement Standards are detailed below with a current update.

| **Deliverable** | **Rating and narrative.** |
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| NHS Provider Trusts should be able to describe and evidence the measures they have in place to ensure they are providing the **right calibre of staff with the right skills** to meet the needs of people with learning disabilities. **Provider organisations should have/be developing learning disability expertise across all care settings.**   | As part of the OCCG assurance process, OHFT outlined the commitment to ensuring the right calibre of staff were considered. The learning support lead has been supporting the newly transitioned team in an analysis of their training needs and ideas for a sustainable workforce. To be prepared for the future, NHSE and OHFT leadership development opportunities have been taken up. Targeted offers of training and developing networks from the specialist health teams have been offered e.g. epilepsy, network in MH, support to medics on call. A wider analysis and plan is needed.  |
| NHS Provider Trusts should have **workforce plans** in place which illustrate how they intend to **manage/plan for the growing shortage of professionally qualified staff** in the learning disability workforce and how they will mitigate this and its potential impact on care delivery. | The learning environment lead has been assessing the current specialist staff teams jointly with the operational teams. A comprehensive plan is not yet in place, but this will be developed. We are part of an NHSI project led by the University of West London to consider a tool developed to deliver safe sustainable staffing. We will use this tool to inform our planning (potential funding is available to support this).  |
| **All NHS Provider Trusts should ensure all staff receive appropriate training on learning disability** relevant to the area in which they are working; this is particularly relevant in the case of training staff to understand the needs of people with learning disabilities and autism, physical health and wellbeing, delivering Positive Behavioural Support, ensuring adherence to Safeguarding, Mental Capacity and Best Interests.  | The mandatory training needs for specialist staff has been completed and training as outlined above. A wider analysis and plan is needed. |

In order to progress these to green, the deliverables will be added to the LD strategy plan under the working group assigned to workforce.

**4.7** **STANDARD 2**: **Improving Equity through Reasonable Adjustments** by supporting providers to address inequalities, improve outcomes, prevent premature deaths and promote rights based care.

This standard and the deliverables encompass several of the Healthcare for All criteria, which are as follows.

* *‘Does the NHS foundation trust have a mechanism in place to identify and flag patients with learning disabilities and protocols that ensure that pathways of care are reasonably adjusted to meet the health needs of these patients?’*This was rated as amber.
* *‘Does the NHS foundation trust provide readily available and comprehensible information to patients with learning disabilities about treatment options, complaints procedures and appointments?’*

| NHS Provider Trusts should be able to provide evidence which details the type of support they have in place to ensure people with learning disabilities receive services which are reasonably adjusted to achieve equality of outcome. As examples, this is likely to include evidence from some of the following areas, aligned to the accessible information standard and including: eating and drinking, postural care, taking medication, behavioural support, reducing stress and anxiety, understanding treatment, provision of easy read materials, effective risk assessments and care planning, mental capacity and assessing the patient’s best interests, pre appointments, information and preparation.  | The current evidence is either historical or anecdotal. To ensure that we have an evidence base, the following actions are underway: The IC5 group has agreed to amend its peer review methodology to ensure data is collected about reasonable adjustments. The EHR team are working with the specialist learning disability team to ensure the team can see both the mental health and physical health data bases, to be able to offer support to teams for patients known to the specialist LD team in making reasonable adjustments on a case by case basis. The Medical Director is supporting a project to be able to flag people with learning disabilities using diagnostic criteria. The learning disabilities communication plan has been developed further to encompass post transition actions and support the embedding and development of specialist services. This includes the redesign of learning disabilities pages on the Trust’s internet and intranet, the review and development of service and Trust-wide leaflets to make them more accessible to people with learning disabilities, for example easy read versions, as well as the promotion of specialist services both internally and across external organisations  |
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| NHS Provider Trusts should have a mechanism in place to identify and flag patients with learning disabilities from the point of admission through to their discharge and share this information with other providers involved. Attached to the flag should be a record of the Reasonable Adjustments required by the person in order that they can access healthcare services equitably. In addition, the needs of family carers should be considered. | See above, there is a project team aware of this deliverable and senior level leadership. This is a workstream in the LD strategy and plan.  |
| NHS Provider Trusts should collect information related to the number of deaths of people with a learning disability within the services they provide. This should include evidence of best practice in relation to identifying, reporting, investigating and learning from serious harm, near misses and deaths in care.  | This information is already being collected and OHFT process (the VAM review group) is linked to the system wide and national process (Leder).  |
| NHS Provider Trusts should have mechanisms in place to ensure death review processes are inclusive, timely, robust and that recommendations from these reviews are acted upon. | The mechanisms are in place and managers have recently been trained to complete these reviews.  |
| NHS Provider Trusts should be able to suitably evidence their adherence with the five key principles of the Mental Health Act Code of Practice 2015 including where departures from the Code have been applied. | This is a new deliverable (not directly part of the healthcare for all criteria) and will be included into the LD Strategy plan.  |

**4.8** **STANDARD 3:** **Improving Specialist Learning Disability NHS services** by supporting Provider Trusts to fulfil the objectives aligned to national policy and strategy

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| NHS Specialist Provider Trusts should have plans in place outlining alternatives to existing care and delivery models with a focus on the development of community based intensive support, treatment for forensic issues and shared protocols with adult mental health services and the Criminal Justice system | OHFT have an intensive support team for adults in Oxfordshire and HPFT provide a similar service in Buckinghamshire. Joint work with local commissioners of children’s and adults services in Oxfordshire has concluded this should be joined up ‘all age’ with some additional investment available. The detail of this is currently being worked up for consideration. Adult teams are now represented and contribute to the’ ‘Ox CAMHS Mobilisation: Neuro Pathway’. The forensic team are currently reviewing the treatment model for forensic inpatients and the CCG are leading on an STP wide forensic treatment model due to the low numbers. Currently people with forensic needs within the community are supported by the community learning disability teams under the forensic ‘clinical area of practice’. There is a mental health policy which is due for review.  |
| NHS Specialist Provider Trusts should be readily adopting the Care & Treatment review process in order to ensure that stringent assessment is made if there is an anticipated risk of admission, at the point of request for admission and that discharge arrangements ensure no individual has to stay longer than is necessary.  | The CTR process has been readily adopted. These are led by the CCG and OCC with OHFT as active participants. An agreed template including everyone in an inpatient bed and at risk of admission is completed weekly and used in monthly multi agency meetings, which focus upon proactive discharge and delayed transfers of care.  |
| NHS Specialist Provider Trusts providing inpatient services should have robust clinical pathways in place which support evidence based assessment and treatment, time limited interventions and measurable discharge processes to ensure inpatient episodes are kept to a minimum.  | We do not currently offer specialist in patient services. |
| NHS Specialist Provider Trusts should have plans in place to deliver the ambition of a 50% bed reduction across learning disability assessment and treatment units by 2020. | We do not currently offer specialist in patient services. However we do commission beds when a person with a learning disability needs one through the CTR process as identified above. Reduction in the use of beds is a locally derived target against population figures and is scrutinised nationally by NHSE. The targets include people with autism without a learning disability. We currently have double the number of people against the local 2019/20 target (18). This does include a technicality, where people with autism are experiencing long periods of Section 17 leave so are not present on inpatient wards but are counted as inpatients against this target. There are also four people with a learning disability who are experiencing delays in discharge. The impact upon the needs for admission, length of stay and delay in discharge are being addressed in two ways in order to meet targets: Through the Patient Safety Academy Human Factors programme which will include a specific deep dive project into the circumstances around the admission of patients. Recent offer to take part in an NHSI Collaborative ‘Criteria led discharge collaborative, which we have accepted jointly with the Quality Centre.  |
| NHS Provider Trusts must ensure they have robust governance processes in place which measure the use of restraint. Including detailed evidence and recommendations to support the discontinuation of planned prone restraints and reduction in unwarranted variation in the use of restrictive practices. | As part of the transition, work has been completed to align the learning disability agenda into the wider Trust work.  |

**4.9** **STANDARD 4:** **Improving Inclusion & Engagement** by supporting providers to empower the People who use services and their family carers to be partners in the care they receive.

The Healthcare for All criteria asked *‘does the NHS foundation trust have protocols in place to provide suitable support for family carers who support patients with learning disabilities?’.*

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| NHS Provider Trusts should have processes in place to ensure they work alongside and engage with families and carers of people with learning disabilities. For example this may include work with individuals, service design/improvement, complaints, investigations, training & development, recruitment.  | OHFT sit on the local Transforming Care Partnership Board where groups representing people with learning disabilities and family carers have equal voting rights. Our ‘I care, you care: Family, Friends and Carers Strategy 2017-2020’ includes everyone. We have committed to co-locating specialist health teams with carer and user groups where practical. Anecdotal evidence suggests increased joint working between professionals and care advocacy groups to support families post transition. Following concerns raised about working with families, staff were invited and have been attending carer led training for carers. Specialist carer led sessions have been booked for all specialist staff including OCC colleagues during December (‘Working Successfully with Families’). We are active design partner in the ‘Leading Together programme’, a regional programme led by OAHSN, which aims to develop partners in leadership between those with lived experience and those with decision making power across the systems.  |
| NHS Provider Trusts should be able to illustrate improvements in how they work alongside people with learning disabilities, their families and carers in order to ensure there is meaningful and productive engagement which ultimately reduces health inequalities, improve quality and outcomes, and make services more sustainable.  | We will need to work jointly to consider how to meaningfully evidence this, including uses of stories, case studies, film, etc. We are partners in an OUH project, which includes an Oxfordshire baseline of health needs (led by NDTi). IC5 has agreed to amend the peer review template to include questions about equality of access for people with learning disabilities, so we will build a picture through this method.  |
| NHS Provider Trusts should be able to demonstrate how they are learning from complaints, investigations and mortality reviews by improving how they engage with and involve families and carers throughout these processes. | Mortality review work is being progressed and learning is/ will emerge. Human factors project work with the Patient Safety Academy (led by Dr Dawn Benson, Natalie Meehan and Dr Sara Ryan) in conjunction with OHFT Quality Centre includes an offer via OXFSN to families to join the 6 sessions of human factor training/ more in-depth investigation training for smaller cohort and to participate in the two project deep dives, one into dysphagia (Mazars retrospective response) and one into retrospective analysis of the admission of people to inpatient wards to inform process and future models ( as previously referenced). Two of the three researchers leading this work are family carers.  |

The LD strategy and plan is also subject to amendment given the following two recent system wide reviews:

* TCPB Mid-Point Review 13th October 2017
* The recent SEND review in September 2017

**5 Mortality Review**

**5.1** The ‘Review of deaths of people with a learning disability people within Oxfordshire’s commissioning responsibility who died between 1 April 2011 and 31 March 2015’ was published in July 2017.

**5.2** An overview of this report was presented on the 17th August 2017 to the Trust Wide Mortality Review Group.

**5.3** The review contained a number of learning points, many of which have system wide implications. These were:

* Excellent care coordination is essential and is a central part of care planning.
* Services should work in partnership with families and carers.
* Annual health checks have been established as good practice for a number of years. However, in Oxfordshire, the number of people with learning disabilities receiving an annual health check is low. A regular comprehensive health check would help to detect health issues early. Work on full implementation of health checks is ongoing through the Transforming Care Programme.
* High skilled workforce is essential for learning disabilities care. The development of a workforce plan is a key part of the TCP
* Knowledge and correct application of the Mental Capacity Act should be promoted. All employers should ensure that their staff are competent in this area. In particular, providers should ensure their support staff have a good level of health literacy
* There needs to be a robust quality assurance process to ensure that providers are delivering care to a high standard. Where quality falls below the expected standard there needs to be a clear process for addressing this.
* Mainstream services should make reasonable adjustments to ensure equality of outcome.
* The quality of care provided to people who are placed out of Oxfordshire should be equal to that provided in county. An enhanced level of scrutiny of out of area placements is necessary.

**5.4** The learning points which require direct and indirect action from OHFT will be added as actions within the OHFT LD Strategy where they do not already feature within the Healthcare for All Criteria or the NHSI Provider Improvement Standards. The Transforming Care Partnership Board has asked that all partners offer their responses and any gap identified to ensure all actions are completed.

**5.5** Appendix One of the review contained a list of themes that had emerged from the study of the cases. The report indicated that some of the themes required further research.

**5.6** The Patient Safety Academy had received funding from Health Education England for a programme to improve patient safety for people with learning disabilities and agreed that part of their overall programme offer would include a project looking at one of the themes.

**5.7** The agreed theme was dysphagia given that a high number of people with learning disabilities had gastric and/or respiratory causes of death. Further research was reported as required as it was not clear how much of this morbidity would be amenable to better quality healthcare.

**5.8** The Learning Disabilities Mortality Review (LeDeR) Programme was established as a result of one of the key recommendations of the Confidential Inquiry into the premature deaths of people with learning disabilities (CIPOLD) to contribute to improvements in the quality of health and social care for people with learning disabilities in England.

**5.9** It does so by supporting local areas to carry out local reviews of deaths of people with learning disabilities, and for any learning to be fed back into service improvements.

**5.10** On the 19th September OHFT staff completed ‘Learning Disability Mortality Review Programme (LeDeR) reviewer training’ along with colleagues from other agencies.

[*http://www.oxfordshireccg.nhs.uk/documents/meetings/board/2017/07/2017-07-27-Paper-17-50-Mazars-Mortality-Review.pdf*](http://www.oxfordshireccg.nhs.uk/documents/meetings/board/2017/07/2017-07-27-Paper-17-50-Mazars-Mortality-Review.pdf)

**6. Recommendation**

* The Board is asked to acknowledge the progress made to date.