1. Document Details

This document contains the following:-

- Full text—Where respondents to the questionnaire were given the opportunity to make additional comments to support their response to the question
- Notes from all meetings where the CTPLD Redesign was discussed. Where the Redesign formed only part of a meeting, only the notes covering that part have been included.
- The formal response from Sussex Partnership Foundation Trust [the NHS organisation who currently provide the clinical / NHS Community service element of the CTPLDs]
- The formal response from the Unison branch representing SPFT employees

This document is designed to provide supporting evidence for the “Summary of Responses to Consultation” document and to inform further discussion. It is not designed to form part of any formal employment consultations that may be required in the future. Any such employment consultations will be carried out as required and as a separate exercise.

The statements made in this document, particularly those recorded as additional responses to the questionnaire, have been made by stakeholders including Customers / Self Advocates, carers and family members, WSCC staff, SPFT staff and other professionals or volunteers. These statements represent the submitted views of this group—inclusion in this document is neither endorsement of the view nor acceptance of that view as fact.
Question 2 – Disability or Difficulty?

Comments from respondents who answered ‘Yes’ to the question “Do you agree the term ‘learning disability is a more useful term to describe the individuals who need to use these services?’

- The proposed term should provide greater clarity - so that referrers understand that the CTPLDs have responsibility for adults with a significant learning disability and not learning conditions such as dyslexia etc. We sometimes receive referrals for adults who are driving cars etc.
- It would be helpful as part of the re-design the criteria for accessing LD services is clarified and widely publicised.
- Specialist trainers and other professionals will use the term Disability rather than Difficulty; the latter referring to conditions such as Dyslexia, Dyspraxia etc.
- Learning difficulty is used to describe a wide range of people who do not have a significant learning disability. This causes confusion as often people are referred to CTPLD who do not have a significant learning disability.
- The current use of the term ‘learning difficulty’ is misleading and can cause confusion to those referring to CTPLD, resulting in inappropriate referrals. I agree with the proposed change of term.
- At long last both groups will be talking the same terms
- Absolutely, the terms difficulties / specific disabilities do not describe people who would be eligible for CTPLD services. These people would be able to access mainstream services.
- Sometimes the political correctness becomes so difficult it is stupid. It is better than all of the past words we have had. The problem is it does cover a wide range and can even be used in schools where someone is dyslexic - very different from genetic/brain injury/trauma or under development for whatever cause.
- Already in use by health service - but this alone may not mean that referrers are clearer about who are client group is - may need more detailed information about the description of an LD and perhaps prompts for referrers to check this, e.g. did the person have a statement at school etc.
- Good idea

- I would be very pleased if you went back to 'learning disability'. It is the term I have always used, because this is what they have. Dressing it up doesn't make them any better.
- Learning difficulty can be misleading as refer to dyslexia for example.
- More useful term to use as service has changed and will change further as well
- Although many like my son are not only disabled in some way but do have difficulties in reading and writing which is both a 'disability' and a 'difficulty'. Neither word actually covers the needs of a lot of people who attend Day Centres etc.
- Well I think the words learning disability is much better word because that is the word we use at Chichester and Bognor Voice
- Yes because in order to get the required help you need to accept that this is a lifelong problem and because of this the person does have a disability
- I feel strongly that 'learning disability' is a more appropriate term to use to describe individuals who use our services rather than 'learning difficulty' which can mislead people into thinking that we deal with topics such as dyslexia etc. It can be very distressing for people to go through the referral process and then discover that they have approached the wrong team completely. We try as much as possible to redirect people and support them but it is extremely difficult for them to find their way through the maze at times.
- Learning Difficulties is a confusing team. E.g. the inability to read / write should be classed as a disability in addition to road sense, handling money. They are lifelong issues and should not come under the umbrella of 'difficulties; where there is permanent impairment.
- Yes, however when a young person has very complex needs - how do you differentiate between the young people who may have slight / moderate learning difficulties. The Challenging Behaviour team is an excellent differential.
- I agree with this term as it aptly describes my brother who has cerebral palsy.
Comments from respondents who answered ‘Yes’ to the question “Do you agree the term ‘learning disability is a more useful term to describe the individuals who need to use these services?’”

- The term learning difficulties can often mislead people, as the majority of people relate this to specific educational learning such as dyslexia or “not very good at Maths”. Learning Disability is a more accurate description as it implies that the person may be needing a range of support from various agencies at some time in their lives.
- Quite a lot of other areas use the term Learning Disabilities now-so it better fits.
- I suffer with anger management and I need help to deal with it, i.e. psychiatrist, psychologist, Group Therapy.

Comments from respondents who answered ‘No’ to the question “Do you agree the term ‘learning disability is a more useful term to describe the individuals who need to use these services?’”

- Should be called disabled person
- I think we should concentrate and high light individuals abilities, not their disabilities
- The use of the term 'disabled' implies a deficit, whereas 'difficulties' are experienced by us all. My daughter hates to be referred to as disabled because of the stigma attached to the word. Please retain 'learning difficulties' to avoid damaging labels and stereotypes.
- It turns them from being a person into a patient. I thought we had got rid of that with the adoption of Care in the Community (not the hospital)
- Either word is appropriate - but I don't think disability is a more 'useful' term.

Comments from respondents who answered ‘Unsure’ to the question “Do you agree the term ‘learning disability is a more useful term to describe the individuals who need to use these services?’”

- I do not like the term 'disability' as it highlights what people cannot do. I personally prefer 'difficulty' as it highlights areas that people can do with help. However, I understand that this is not shared by service users.
- More useful than what? If you mean more useful than 'learning difficulty' then yes, it is marginally better, but both terms are hopelessly inadequate and misleading.
- I was always under the impression that the term ‘learning difficulty’ was the preferred term, that people with learning difficulties would like society to use in describing their disabilities.
- I feel the changing of 'terms' used to describe the learning problems could create gaps in the services for people to fall into as this has happened to me and my family in the past when names of teams has been changed leaving me and my family without any support or diagnosis for my daughter. I do wonder if this next change will make for more people and families like me to be failed by the social services and other professional teams of the medical sector.
- More useful than what?
- What alternative term is being suggested?
- The view I had about terminology for people we work with was that the word 'disability' was felt to be a derogatory & maybe even discriminatory one. This was a view I gained from the start of my employment with WSCC Learning Difficulties. It may be because this view has been instilled in me but I do tend to see the term 'disability' as being quite a negative one. I also feel that descriptions of those we work with change & change again with no great value i.e. Client, Service User, Resident, Customer.
Question 3 – Health Facilitation Team

Comments from respondents who answered ‘Yes’ to the question “Do you support our proposals to increase the number of staff working in the Health Facilitation Team?”

- Hospital liaison work is really helpful but there is not always enough of it. Could hospital liaison or CTPLD’s work more closely with hospital discharge social work teams? Support to access sessions such as Crawley Wellbeing and WOW are good.
- ...if doing so does not jeopardise existing services
- I am concerned that the proposal would not supported by a sufficient number of staff and therefore that it would not be workable.
- As long as they have clearly defined roles and a big focus is placed on training primary care services to work with people with LD.
- Very helpful to have a member of health facilitation team linked to specific GP practices and would encourage communication / contact when individual identified.
- So long as resources are not taken from other areas to fund this. Some people have no problem accessing services - but it is the quality of the services that matter.
- It is important that these people have a voice into the general social community as they often get side-lined by people who are over stretched
- Would there be separate members of the team for inpatient vs community services? I think it would be helpful for anyone referred here to have a named person who could liaise from GP/ community practices into hospitals and back again should someone be using both sorts of service. Is it only nurses who will be in this team? Will this team be located with the assessment and/or intervention teams? This could be helpful re joint working. Helpful to have a named worker for each GP practice. Could this team have a remit around preventative/proactive health work and education? Will this team be involved in the provision of physical interventions for those who require it for certain medical procedures?

- All integration will help streamline services. As a provider of primary care for such people I would like a single point of contact for advice. Do you have a plan for integrated IT services - even if only at a basic database level? Remember role of existing LES for primary care check on PLD
- Yes having been a nurse practitioner in primary care for 20 years the problem was the RGN's have limited training in care of people with learning difficulties and many lack skills in communicating confidently. For example the nurses did the health action plans including asthma reviews, diabetic reviews but I feel the LD nurses perhaps need to increase their skills in these areas too. Perhaps an idea to link with primary care nurses?
- My biggest concern is that mainstream services will not be in a position to deliver a service of quality, as there needs to be a major investment in training of staff (in practice & attitude) prior to any individual with a LD accessing these services.
- I think people with learning disabilities should be accessing mainstream services and this requires thoughts and planning to accessibility. I think this has the potential to work however I am concerned without clear access /accountability/ obligation (which could be around financial gains), this could drift and become ineffective.
- I would really welcome more help for people to access GP services and also to help us in primary care provide the health care that people need- I think the support suggested will be really helpful.
- Accessing health appointments and services is difficult for many of our customers, so any additional support would be welcome
- But the CTPLD help us already
- Yes, to support doctors who have little experience of adults with learning difficulties.
- I think they should work together so some doctors learn to understand the needs of people with learning disabilities and mental health problems
Comments from respondents who answered ‘Yes’ to the question “Do you support our proposals to increase the number of staff working in the Health Facilitation Team?” [Continued]

- I would be better to ensure that all carers had the skills needed to recognise when it was appropriate to facilitate a GP appointment and that they were less passive and actively followed up health concerned. I think ensuring this basic training was given to carers would be in the long term more cost effective and a more timely method of improving access, however increasing the health facilitation team in the short term would be useful.
- I think more staff are necessary to work with so many people who are unfortunately incapacitated in some way. My only worry is - according to statistics - many care homes, day centres etc. are employing staff who have either little or no sympathy with those they are put in charge to help.
- This would be very helpful and would reduce the stress for the person and carer also. This should include dental services both at practice and hospital dentists.
- A already has a check-up once a year by our local doctor for the last three years and we think that everyone should have this.
- There are not enough social workers to meet the needs of all the young people / adults with disabilities. As a result parents get very frustrated with the lack of progress, especially when a situation becomes urgent. The Duty Desk can put up 'barriers' to prevent progress.
- It sounds like a more joined up team- and a lot more accessible
- This is something I very much favour; I believe that Community Health staff need to be much more visible within primary health care. During the implementation of Health Action Planning, some community nurses forged links with GP practises to raise awareness and liaise with current issues
- Yes, as when C (my brother) has been admitted to hospital he has been little understood by hospital staff. Maybe this team could help educate hospital staff about learning disabilities to improve C's experiences and ensure his happiness and comfort.
- People with LD seem to get a second rate service unless they have a lot of support from dedicated carers.

Comments from respondents who answered ‘No’ to the question “Do you support our proposals to increase the number of staff working in the Health Facilitation Team?”

- We have reservations about this as the current health facilitation role in our local hospital does not work as well as it could. Any extra resource would be more usefully be used within the integrated care management team where the work could be focused and targeted on achieving good joint work to assess and enable good discharge plans. There is little ownership at present to communicate really effectively with the CTPLD care managers who end up having to liaise themselves with the hospital wards and staff. The existing facilitator should be doing this but adopts a minimal approach according to care managers trying to work alongside her.
- GPs do not always have the experience or the time and are keen to refer on to specialist services
- It is very confusing having so many teams with different functions, it should be one team doing all
- I'm not sure that one individual working within a wider non specialist team will have much of an impact - and if they do it will be time limited for as long as that individual works within that team. I think that it could be an isolating experience for the team member and if this occurs they are more likely to bow to pressure rather than to assert the rights of individuals with LD's. I think a specialist team of workers can provide more impact - so that they act as consultants to health services helping them improve their access for PLD - this way the team is less likely to become isolated, is more likely to feel able, as a group, to challenge bad practice and will be able to motivate and train each other and prevent staid practice. This team will need a specific goal and criteria but better than having lots of separate individuals all over the place working in isolation.
- Support staff from providers are skilled in doing this, concerned that this is duplicating effort and resources.
- GPs don't listen to you
- I believe most existing NHS staff are able to cope with 'normal' disabilities. There may be a need for a very few very experienced NHS staff for the few difficult needs.
Question 3 – Health Facilitation Team [Cont.]

Comments from respondents who answered ‘No’ to the question “Do you support our proposals to increase the number of staff working in the Health Facilitation Team?”

- The philosophy of supporting people with learning difficulties in the community must be maintained and the social care model of well-being not the medical model of health needs to be its key driver. My daughter is not sick. She rarely accesses services provided by the NHS. My daughter needs help to access sustainable community services - e.g. social networks, leisure services. That is what keep people with learning difficulties healthy, emotionally, physically and mentally - not health services.

Comments from respondents who answered ‘Unsure’ to the question “Do you support our proposals to increase the number of staff working in the Health Facilitation Team?”

- While I think that it is long overdue to have this sort of input for people with LD the roles need to be clearly able to demonstrate the value to the service as a whole. I would in some way rather the resources be put into the CTPLDs, and for staff with a similar role to be accountable to the team rather than have a separate team. My concern would be that the new team might not link well into what we do or have a role in addressing social care needs alongside physical health needs.
- Not sure how effective this will be.
- I don’t know enough about the proposal to comment.
- As there will be no increase in staff other existing services will have to be provided by other staff already fully employed.
- We do not have any problems accessing a local GP. Our local practice is always very helpful and go out of their way to explain any issues. On a personal basis we do not need any extra support, but there may well be others that do.
- I would support the proposal to increase the Health Facilitation Team if I did not feel that it is at the cost of the service that is provided by the current Community Teams. The changes and removal of support for some that have already taken place because of the social work reviews over the last year are already impacting on our client groups’ lives to their detriment and I suspect that the new proposals will have an even greater, long lasting impact and will make life even more difficult for this client group.
- I have always ‘sorted out’ my daughter’s many medical conditions. Our GP surgery already does annual health assessments on her. I might feel differently if she was not living with me at home.
- I think this is helpful to a point - however adults meeting the criteria for your services also require specialist input too from your team in addition to what is available from local health services.
- I would be worried about the lack of training the GPs have in this sector, the lack of information and contacts needed for assessments to be set up. Having said that, I feel as long as this does not cause new ‘clients’ to fall through gaps the communication may improve.

Question 4 – Integrated Teams

Comments from respondents who answered ‘Yes’ to the question “Do you support our proposal to move to integrated specialist teams to meet the health and social care needs of adults with learning difficulties?”

- I think that this is the way forward - to develop an assessment process and resources within self-directed support that can be accessed by all professionals.
- Yes - as long as staff are motivated This proposal has the potential to provide much more efficient and focused use of team resources to achieve good person-centred and best value outcomes for customers.
Comments from respondents who answered 'Yes' to the question “Do you support our proposal to move to integrated specialist teams to meet the health and social care needs of adults with learning difficulties?” [Continued]

- I think that this is the way forward - to develop an assessment process and resources within self-directed support that can be accessed by all professionals.
- Yes - as long as staff are motivated. This proposal has the potential to provide much more efficient and focused use of team resources to achieve good person-centred and best value outcomes for customers.
- This is how we work in Chichester already. I think it was daft to split the Worthing and Horsham teams. Feels a little like going round in circles for them.
- I do feel that this could work if planned appropriately and consideration is given to the roles of each professional within care management in order that specialist assessments are not lost. I would be concerned if we could not readily access specialist/clinical input for our clients in a timely manner.
- Provided the integrated teams are adequately resourced (wishful thinking!)
- Providing it doesn't add to the work load of already hard pressed staff.
- It sounds like the service will be more streamlined
- In my experience, expectations of health care manager to share the same responsibilities, as the social work care managers for example equal share of duty responsibilities, equal involvement in team meetings etc. has improved cohesion, and ultimately outcomes for customers. The attitude of staff to be part of the team and share work has been the biggest difference. I think having a health care manager who puts their hand up to take a complex health case is great and a model for how team should be integrated, and works both ways, social care managers needs to be taking the case focusing on social care.
- Could be more useful for multi-disciplinary working and contacting professionals

- Clear process of line management and accountability needed. Can feel very "bitty" at times. Much improved risk assessment and management processes needed particularly to implement learning from recent SUI. Concern that there is not enough clerical/office support to support clinician/practitioner time so how is this going to be better managed in the future without wasting expensive clinical/practitioner time on routine and bureaucratic tasks. How is referral process going to be managed - needs to be linked to clearer ways of deciding who is eligible for LD services and who is not as this can be very time consuming and confusing for all most of all the customers and families, also other people involved eg GP's and adult services. Links/joint working with mental health need to be clarified, is really confusing at present. Discharge process from ATU needs to be more integrated between ATU and community teams. Health care manager role has been very welcomed all round and worked well. OT support in assessment process particularly would be welcomed particularly in areas such as transition, moving on from family home, moving from residential to supported living. Good SALT input is very important in all areas particularly as part of the assessment process, how will this work to make sure CTPLD's can access this quickly if it is in a separate team? The role of the community nurse is extremely unclear at present - why do they no longer support around management of challenging behaviour particularly where criteria for CBCST is not met? Psychology can often form a vital part of understanding and managing all areas of risk but often this seems disjointed and advice doesn't always happen in a timely way. Ways of improving this such as use of one off/short term consultations are welcomed.
- It would be better to be allocated a named social worker who could be contacted and who knows the background rather than to only be able to talk to the duty desk. Surely this would be more time and cost effecting and prevent the duty social worker having to familiarise themselves with a new file each time they are contacted.
Question 4 – Integrated Teams [Cont.]

Comments from respondents who answered ‘Yes’ to the question “Do you support our proposal to move to integrated specialist teams to meet the health and social care needs of adults with learning difficulties?” [Continued]

- I fully support integrated specialist teams and as we already know they worked much better than they are currently working in Horsham since the two sections were moved from the Martyn Long Centre where they were successfully working to be separated in County Hall North and New Park House. That move was a disaster and should never have been permitted to happen by Commissioners and Senior Management and many front line staff advised at the time that it would not work well. However as with this "consultation" process front line staff were not listened to then and have not and will not be listened to this time either.
- Hopefully they will no longer be left out in the cold health wise.
- Yes, for the same reason as I said above
- Yes, this would be more practical for all concerned.
- The Challenging behaviour team works very well at the moment. My son has very complex needs. Following the intervention of the challenging behaviour therapist and speech therapist his behaviour has improved hugely. They have worked with college / day centre / respite / home and have drawn all four units together. I have been very impressed and better behaviour has been the result. A positive result for all concerned, but this intervention needs to continue and not just stop.
- I believe that this is the future; I have worked as a Complex Health needs care manager RNLD for approx 8 months. I am still finding my feet within the care management frameworks and processes; however I find that my nursing qualification, background of community nursing skills and knowledge adds valuable benefits to this role. In addition the role is exciting demanding and offers fulfilment
- This could make it easier to access services.

Comments from respondents who answered ‘Unsure’ to the question “Do you support our proposal to move to integrated specialist teams to meet the health and social care needs of adults with learning difficulties?”

- CTPLD teams have strong social inclusion values. Need more detail on this in order for this to be a meaningful response to consultation exercise.
- Don't have enough information to know how this will impact other work currently undertaken.
- Would like more information on this
- I would need much more info as to how this would work to make a judgement
- only if this is not a cost cutting exercise
- Have not seen detailed proposals so can't comment
- I didn't know this was a proposal - or at least I'm not sure I understand the question. This could be a beneficial thing to do, if again training is given for sympathetic diagnosis and consideration to be given.

Comments from respondents who answered ‘No’ to the question “Do you support our proposal to move to integrated specialist teams to meet the health and social care needs of adults with learning difficulties?”

- it is too confusing as it is but to have some people in one team and some in another is too difficult
- I like it as it is now
- Too confusing
- I note that on page 7 of your consultation document you state "integrating teams will deliver a reduction in the staffing costs associated with managing the current services". It seems obvious that this is cost cutting exercise unrelated to the delivery of personalised care needs for people with learning difficulties.
- Difficult one this - but you can't wear two hats. One will take precedence over the other.
Comments from respondents who answered 'Unsure' to the question "Do you support our proposal to move to integrated specialist teams to meet the health and social care needs of adults with learning difficulties?" [Continued]

- There are pros & cons: Pros - more joint working between health and social care staff is beneficial. Being in the same building is also useful for networking and gathering info. Clients only have to go to 1 team for support and not lots of different services. Cons - Loss of specialist health staff skills as more emphasis is placed on social care side. Different ways of working between social work & NHS staff - whose policies and procedures do we follow WSCC or SPT.
- I am not entirely sure that these adults who need so much help really need to be combined as a whole. So many need individual care and attention so whilst I appreciate the difficulty of that (not enough trained staff) putting adults and their needs together with one specialist team may result in various difficulties of a person being ignored or overlooked - due to sometimes lack of time in the day.
- I would first need to know:- Who would do initial referrals? [social worker at present]; Who would conduct reviews? [social worker at present]; Who would we turn to in times of trouble?
- Would these specialist teams have enough training and knowledge to deal with our children?
- I need to know what moving the teams means?
- The greater linking between care management & health workers is a helpful model overall BUT I think the consultation is very unclear about how health workers will be utilised within the assessment and review teams. Presumably the named/lead worker will be expected to carry out a degree of care management tasks and I'm wondering what training will be provided to health staff around this what impact this will have on their ability to provide the specialist support related to their profession:

(e.g. an OT completing care management tasks then has less time to provide more specialist OT assessment/intervention)

How will it be decided who will be the lead/named worker?
Based on what factors/criteria? The consultation is unclear about the role of intervention from health workers within the teams - under what circumstances would an intervention be provided by a health worker in this team & when would they be referred to the intervention team? What will the intervention team's criteria be? Why are there no speech & Language therapists in the new assessment and review teams, nor in the model for the CBCST (where there currently is one)? Why are there behaviour practitioners in the assessment & review teams but not in the intervention team? Why are psychologists within a separate dotted line for the assessment & review teams? If there is a plan by the named worker to have OT, SALT and psychology assessments as part of the work, how will waiting lists for these different professions be managed in a way that maintains a coherent and timely assessment? How will clinical supervision for health professionals be managed? Why is the intervention team county wide? It is unclear why this and the CBCST are county wide & the other teams are split into 3 areas. Has the option of a challenging behaviour/specialist intervention sub team within each of the three teams been considered, who would then be more closely aligned with the assessment & review teams & their processes. How will links be made between the county wide & localised teams - this is something the local teams report having found difficult with the CBCST. How will conflicting electronic record packages be managed? This is a huge issue for CBCST who cannot upload onto ECPA due to a) not having access to it and b) even if we had access we would not have the time (partly due to no admin support) to upload/enter information onto 2 systems. Presumably the assessment teams will use Frameworki & the intervention and health facilitation teams will be on ecpa? This will make sharing information and accessing up to date information for shared clients extremely difficult. Why is there no admin support in the assessment and review teams but some in the intervention team?
Question 5 – Office Buildings, Managers and Administration

Comments from respondents who answered ‘Yes’ to the question “Given that WSCC and the NHS have to make financial savings, do you support our proposal that we look to find these by reducing the money we spend on buildings, administrative and management costs rather than on front-line staff?”

- Staff are essential. As much as hot desking is not great for staff morale, it is better than losing staff. However, there do need to be enough desks for people. Also, I am concerned that if working from home is to become more of the norm then the teams will lose their cohesion.

- No problem around savings in buildings. No problems around savings in management costs as long as there is enough to do the job in hand. Admin support needs to be targeted more effectively, it seems that there is an overload in some areas and in other areas there is not enough meaning that more expensive clinical/practitioner/management time is spend in routine and clerical tasks and not always then done as effectively as a good administrator would have achieved. It feels like the baby has been thrown out with the bathwater in this respect.

- Social care have already seen a significant reduction in admin support. Whilst this increases the work load and time spent by social workers on admin tasks, I would not want to see front line staff reduced if savings could be made elsewhere. However, consideration should be given as to whether it is actually more cost effective to retain some admin support, so that social care and health workers do not become highly paid administrators themselves to the detriment of our direct work with clients.

- Invest in people and IT which will save time, duplication and allow more face to face contact

- This would be a definite plus, as there are already too few front-line staff.

- But I don't accept the assumption. The financial savings need not be a 'given' - they are political choices. And great care is needed in reducing admin costs, otherwise front-line staff end up doing essential admin instead of their front-line work!

- If that money is used for helping people with learning disabilities and mental health problems.

- Yes I am well aware that budgets sent to care for LD clients can be spent on painting town hall walls! Far too much money in the past has always been spent on administration. The CTPLD works well as a team and could link very well with the community practice nurse for primary care in charge of the practices for west Sussex PCT and education programmes could be put in place initially as to how to take things forward.

- Buildings...yes. Managers perhaps. Office staff No as they are there to coordinate and generally work much harder than the managers.

- Definitely

- Yes, hearing about some the disgraceful attitude in some Homes and Centre towards the adults, the money should go to employ helpful, caring, experienced staff.

- Absolutely

- There should be a designated help desk team - often social workers can't do their job properly because they have to spend several days a month on the helpdesk taking up valuable time. Also there is a lack of knowledge about respite services. Maybe there should be specific people that know about the respite provision (and not just Queens Lodge / Stanhope) to meet the young people who turn 18 with more complex problems, this will also save each social worker visiting each placement and duplicating work. This will save time and money.

- We feel that this improves speed of communication between front line staff by concentrating staff in central units

- This could be a good thing all round, communication could be much improved between all services.
Comments from respondents who answered ‘No’ to the question “Given that WSCC and the NHS have to make financial savings, do you support our proposal that we look to find these by reducing the money we spend on buildings, administrative and management costs rather than on front-line staff?”

- The health facilitation team are in the hospital & the CTPLD social work teams are in Sussex Partnership buildings, not sure where the savings are to be made and Social Services have hardly any administration staff anyway - this is a bit of a red herring question.
- Front line staff still need places to work, administrative back up & support. Is this question designed to elicit a yes based on believing this will really make savings? Assuming this question has been framed in such a way to support the private sector taking on large contracts in a belief this will save money. Unconvinced that it will in the long run - please share evidence on this.
- With the closure of day centres, respite and offices already it already seems paired to the bone.
- Admin work has to be done - does this mean tasks will be now done by front line staff - thereby reducing the time spent on the front line? If so this can cause a fall in moral, loss of skills & a reduction in services. Or will processes be simplified? Buildings need to be maintained and people need to work in appropriate surroundings with the right resources. To reduce spending could be counter cost effective.
- This is a manipulative question disguising your cost cutting objectives. A focus on cutting costs in this manner will increase costs (e.g. selling buildings will just result in having to buy other buildings). Rather, if you focus on systems and processes which are wasteful and add no value to the service user experience (e.g. medical models rather than social care models) then you will make considerable savings. The capacity of an organisation = the waste + the valued work from the service user perspective.
- Buildings maybe - Managers need to be there to manage. Administrators are essential to keep the system functioning properly.
- spending less money on consultations could be a saving.

Comments from respondents who answered ‘Unsure’ to the question “Given that WSCC and the NHS have to make financial savings, do you support our proposal that we look to find these by reducing the money we spend on buildings, administrative and management costs rather than on front-line staff?”

- Closing down buildings and day centres causes disruption and changes for the people using the services. It can also cause overcrowding. However, many services are understaffed as well.
- Yes, but with reservations. Obviously superfluous expenses should be cut, but people should work in decent conditions (buildings) and need to have administrative support e.g. to answer the phone. etc. and front line workers should be well managed and supported. Why is it a ‘given’ that WSCC and the NHS ‘have’ to make financial savings I think most people would say that they would prefer not to have these services cut. Perhaps the massive bonus paid to bankers or higher taxation for the wealthy etc. could be used to pay for any shortfall. Yes as long as current overloaded CTPLD SW managers are given adequate support and resources to take on even more responsibilities.
- it should go on the services users.

we have enough cuts
- I feel moving teams into one building is useful but as already stated the fact it split the Horsham team between two buildings it must be managed more professionally and sensibly than it has been. Losing administrative staff is a false economy and will look good in the short term but will mean that clinicians are under supported and will be wasting time that could be spend with service users / carers in an office being over paid and overpriced administrators. Administration staff is vital to the smooth operation of teams and aid in keeping everything co-ordinated and together. A Management Review that actually looks at what they all do and are responsible for would be useful but if yet another one is carried out it will probably lead to another layer of management being put in place as appears to have happened in all previous reviews.
Comments from respondents who answered ‘Unsure’ or gave no answer to the question “Given that WSCC and the NHS have to make financial savings, do you support our proposal that we look to find these by reducing the money we spend on buildings, administrative and management costs rather than on front-line staff?” [Continued]

- This depends on what you are proposing - I think the integrated teams with a single manager could work well providing that manager is able to consider the role that both health & care management professionals have. My concern would be that all health professionals will be slowly asked to take on more & more care management tasks, eroding the time available that they have to offer specific skills from their own professional background. Less admin saves money in some respects, but it does then mean that time for clinical work is lost due to admin tasks, so there is a cost implication with this. Re the buildings, being based in fewer building per se is not a problem but it does become a false economy if those buildings retained/utilised are not fit for purpose. My main concerns would be: Hot desking where there are insufficient spaces so that time is wasted coming in to the office and not being able to work Buildings where there are not appropriate/ Enough available rooms to be able to offer on-site appointments for clients Buildings that are not easily accessible by public transport - this and the above point will mean more time spent by clinicians travelling to appointments, a cost in both time and travel expenses. Lack of space to store equipment, e.g. assessment tools. Lack of car park spaces - this is a huge waste of time and money if there is not sufficient car parking. Working from home at times can help with some of these issues but this is not always practical for all people, required the correct equipment to do so and it has to be recognised that more time working at home means less contact time with colleagues, presumably part of the reason for bringing the teams more closely together.

- Providing that effective management & administrative structures are in place (given that frontline staff need good management & admin support to fulfil their pressured roles) I would support this proposal

- I have put unsure because whilst I think money can be saved on buildings & sometimes management costs, I don’t think the cut-backs to admin staff are saving money. As a professional I should be focusing on the huge case load I have but instead I now have to file, format letters, write out envelopes, scan, upload, photo copy & so on & so forth. I waste at least an hour a day on these tasks - sometimes more. Times this by how many social workers there are in all the CTPLDs and I can guestimate that it's approx. 30 hrs. per day across all the CTPLD’s and CBCST that is being wasted by professional staff doing tasks that an admin person could do for far cheaper. AND - I’m also wasting time doing these tasks when I could be doing more effective and appropriate jobs - so clients are being directly affected. It's absolutely bonkers.

- Do not cut back to much with admin - Thiers’s is a vital role. The front line role is already affected by increased process and procedures. The management is important to front line staff - by all means cut back on backroom management.

- Although it seems like a way to reduce costs without effecting front line staff my experience is that admin, management duties need to be done by front line staff reducing the time available to 'hands on' work

- I think there are savings to be made by combining health with social work admin facilities, however I think it is a mistake to not have admin support for CTPLD teams, with only admin hubs, who do not understand the work flows of CTPLD’s & are not accessible to CTPLD’s. As this has led to qualified care managers completing their own admin, making the team less effective, and essentially paying more for over qualified admin staff. I think it is important the is good available management within each team, however savings could be made by combining health with Social care. I would be concerned there was enough time for management to supervise the whole team effectively.
Question 6 – Getting your feedback

Comments from respondents who answered ‘Yes’ to the question “We have used a combination of questionnaires (on line and on paper) and group meetings to try and find out what you think about our plans for the community services. Was this the best way to find out what you think?”

- The mix of questionnaires and meetings is probably a good approach, but there are huge assumptions in the questions - it looks suspiciously like an exercise to get public sanction for a fait accomplis.
- Using a variety of methods means you reach more people.
- But I am not sure people with learning disabilities living in some supported living situations would ever hear about it.
- Online seems to be most effective and easiest to access and return.
- It’s about time somebody asked me for an opinion.....I have been in the business of Caring for over 50 years.
- It would be very helpful to have a named list of people and what they are responsible for.
- Group meetings - questions were asked and proposals explained in more depth.
- No
- Local Group meetings have been beneficial
- I felt that on paper the ways used look very good however in reality the earlier meetings were limited and a "select" group invited to attend leading to the views gathered being very biased and limited. There is a general feel that the result of the Consultation was already in mind and the process is all being engineered to obtain the desired outcome. Therefore why waste time, money and resources going through a "pretend" process. There is also a general concern that this process is purely cost cutting and financial and the people who will suffer most will be our service users / carers with reduced and poorer quality support.
- Group meeting was very helpful and informative
- Group meeting are best.
- You need to have different types of questionnaires as you are trying to meet a lot of different groups of people

Comments from respondents who answered ‘No’ to the question “We have used a combination of questionnaires (on line and on paper) and group meetings to try and find out what you think about our plans for the community services. Was this the best way to find out what you think?”

- You have not reached many people. Carers, staff, clients are saying they have not been made aware of this consultation by you - how can this be meaningful?
- The questions were clearly written to agree with your paper
- This is the first time I’ve been asked for my opinion.
- I want to say more
- cannot make more comments just the ones you ask
- Not good with computers to access this information. By post is better for me.

Comments from respondents who did not respond to the question “We have used a combination of questionnaires (on line and on paper) and group meetings to try and find out what you think about our plans for the community services. Was this the best way to find out what you think?”

- So many carers and those with disabled or learning difficulties in the family are often unable to attend meetings due to work or being unable to leave the person to attend evening meetings, so questionnaires are a good idea.

- It is important to use a combination of methods to elicit responses. However, group consultation methods require specific skills in facilitating responses from everyone round the table - many of whom, whether carers or service users, do not have the confidence or necessary articulation skills to contribute fully. Your starting was not the quality of service user experiences, but cost cutting. The models you are proposing are based on the latter, not former. You are looking at tweaking structure not quality outcomes. This is costly, time consuming and pointless.
Comments from respondents who answered ‘Unsure’ to the question “We have used a combination of questionnaires (on line and on paper) and group meetings to try and find out what you think about our plans for the community services. Was this the best way to find out what you think?”

- You have made a decision & now are consulting will it make any difference to the proposal, answer NO
- There are many 'service users' (how I hate that term) and their carers who are virtually house bound, so I feel there is also a place for face to face discussions. Or better still stop wasting money on organising cuts. Just don't make cuts,
- It makes sense to reach as many people as possible to get a varied viewpoint.
- The questions are quite loaded and don't really allow for a more free response
- I was invited to meetings but was unable to attend because of work pressures and distance I would have had to travel
- some questions are alright some were a bit weird
- The meetings are good, but hard to get to when you care full time. I found the format of the questionnaire and the accompanying document hard to understand. The attached document was very long and confusing. Not many people would have the time to answer this. I had to access support from a local organisation to answer this.
2. Notes from Coastal West Sussex Business Meeting – 10/04/2012
Covers of consultation had been circulated, short presentation given at CWS meeting. Criticism was made that the consultation document did not give adequate detail, and that the questionnaire had simplistic and leading questions.

Request that follow up discussion is had with CWS Communication lead concerning 'joint messages' of social care and health commissioners

Proposal 1
No Strong View either way

Proposal 2
Request for greater information and detail, of how we are proposing the operational model links effectively with primary care. Primary care unlikely to have time to comment in detail on draft service specifications, but wish to be involved.

Proposal 3
Request for additional information. Strong view expressed that the consultation document needs to set out rationale for the integration proposed, including rationale for leaving some specialist health functions in a separate team. Questions posed as to why the operational model cannot be fully integrated from April 2013.

Agreement that further details around Proposal 3 shall be forwarded to the group
3. Notes from Worthing Speakabout – 26/04/2012

Very positive meeting
About 20 self-advocates
All were given consultation documents and questionnaires which some may return individually

We went through each of the 3 proposals

Proposal 1
Change name to learning disabilities
Nearly everyone agreed this should change
There were about 2 individuals who wanted to keep learning difficulty

Proposal 2
Increase staff in health facilitation tea
There was unanimous support for this
Most people had used health facilitation team and felt it was good and would like to see it expand.

Proposal 3
Joining up of teams
Most people felt this was a good idea and agreed it should change.
Some people were concerned that they didn’t have social workers anyway and this would not improve or change that (not enough social workers).
Some people were concerned that some people (managers and office staff) might lose their jobs and they wanted to know what would happen to these staff.

Going through proposals and discussion took a good hour.

Proposal 1
Majority had no strong views on this. Two people were more vocal, suggesting it could be seen as an implicit way of excluding people from services: primarily people with autism. One suggested WSCC and Health need to up the pace of change for this customer group. All keen to have clearer access criteria and for this to be published (on line was their preference and linked to ISIS).

Proposal 2
None of the people had direct experience of the Health Facilitation Team but had heard good things and had unanimous and clear support for this proposal. All had difficulties for their sons and daughters accessing mainstream and specialist dental support. All wanted this to be a focus of an enhanced HFT and again for access criteria to be published and easily available.

Proposal 3
In support of this. 3 people have links to CBCST and spoke highly of it; want it to remain a discrete team. A strong view that more named social workers are needed. Significant frustration about accessing an LD help desk when in crisis. Attendees have agreed to send further details in questionnaire returns and they were also going to discuss at next meeting and get back to us.

One person felt more counselling support needed and that primary care based services not well equipped to provide this to LD customers.

4. Notes from Carers Support Group North – 01/05/2012

A positive meeting; attended by just 6 parents. All had seen the document; all took copies and some will be responding individually. Carers rep took further copies, and will see if we can arrange another meeting in Crawley.

5. Notes from Bognor and Chichester Voice – 03/05/2012

- Good meeting
- 18 Customers and 2 Advocates
- From Chichester, Bognor and Barnham
- All were given copies of the consultation (many had this already) and questionnaire

We talked about the consultation and worked through the 3 proposals
5. Notes from Bognor and Chichester Voice – 03/05/2012 [continued]

Proposal 1
All in agreement. If this proposal is agreed the group wanted new services to write and or visit them at one of their monthly meetings to publicise what they will do

Proposal 2
Very clear and unambiguous support
4 had experience of HFT in primary care and 1 in hospital.
At least three quarters of the group spoke up about supporting this proposal

Proposal 3
In support and felt proposal made sense
Some concern from 4 people that the managers might be working with more demands and would be under pressure Would like to see more social workers In the new model

The group then split into 3 sub-groups to work further on the proposals and will be sending in 3 group responses Some people will also want to respond individually

II. 1 of these was a non-West Sussex funded customer at United Response; 2 lived at home with their parents; 2 lived in shared living arrangements

II. In pre-discussion with 2 of the relatives prior to the meeting starting proper, the general feeling was that the consultation document was reasonable. There was a view that there were insufficient social workers, and attention needed to be given so that people were not needing to explain their circumstances time and time again to different workers.

IV. In the meeting proper, we talked through the work leading up to the consultation document, and took each proposal in turn. 2 of the relatives took the lead in much of the discussion, and felt strongly that the document failed to address wider issues about reducing social care nationally, the growth of a medical model in LD and a failure to lobby the government for more money.

V. They voiced strong views on the failure of SDS and inadequate checks on employing care staff/PAs. Mixed experiences of CTPLD teams, and very much dependent on characters of workers they had known/met

Here is the summarised feedback:

Proposal 1 Mixed views
- 2 people in the group stressed the importance of language.
  Felt learning disability entirely the wrong term to use, disabling and unfair; Learning difficulty marginally better. Preference was for 'no labels'.
- 2 gave no view.
- 1 was happy with the proposal

Proposal 2 Mixed views, majority in agreement
- The same 2 people felt this was further proof of a push to medicalise a non medical issue
- The remaining 3 tended to be in support of proposal.
- 1 had direct and good experience of HFT

6. Notes from Chichester Rural & District – Carers Meeting – 08/05/2012

A positive and challenging meeting. All want the CBCST to change its name (none had experience of this team). None had known how the teams were currently set up, ie split management. All requested allocated/named workers. 2 spoke about this being an exercise only to cut funding, and not improve services.

I. Meeting attended by 5 carers and representative from the Carers Group. All 5 had adult children with LD. All will be responding to questionnaire. All had copies of doc
6. Notes from Chichester Rural & District – Carers Meeting – 08/05/2012 Continued

- View that training workforce was a tall order, and the HFT would need to prioritise which workers to support/work with first: a request that this was doctors

**Proposal 3**
- 3 were concerned that there were inadequate social workers, and that looking to change the CTPLD Teams as set out in the document only hid this issue. They stressed the importance of having a named worker
- 1 person spoke about experience of inadequate physiotherapy support and OT support: convincing arguments

7. Carers Meeting [Coastal] – 10/05/2012

5 carers attended this meeting. All of them had sons or daughters who went to Coastal Enterprises.
3 were in touch with CTPLD Social Care; 1 with Health and Social Care CTPLD; 1 had no contact with either team.

**Proposal 1**
No strong views either way; fine with this proposal

**Proposal 2**
A very clear vote in support of this

**Proposal 3**
In support, but saying that services have to be clearer about what they provide. And that service info must be kept updated on the WSCC website

Mixed experience of workers in teams currently. Would like any new team structures on website too. Carers want a clearer point of access into CTPLDs.

8. LD Partnership Board – 17/05/2012

Presentation made at LD Partnership Board, on the proposals in the CTPLD Consultation Document. The Board has had updates on this item as it progressed at earlier meetings

**Proposal 1**
All in support of this proposal.

**Proposal 2**
Majority in support of this proposal. The Board had an earlier agenda item and presentation by self advocates on Health Facilitation Team, and customer experience of this. Customers and relatives at the Board meeting in support of this proposal. Other attendees also in support. Two supporters/staff asked for further information on the proposed role: would have liked to have seen this in the document to be able to comment further

**Proposal 3**
Majority in support of this proposal. 2 self advocates said that it is important people have named workers, and that admin/paperwork is kept to a minimum for front line workers so that they can spend time with customers. The same self advocates asked if the numbers of social workers will increase in the proposed new model. (Details were given of the new Reviewing team)

People asked about the location of teams in the new model: there does not seem to be a strong view about where the teams are based, other than the request that offices are close to public transport routes where-ever possible

Agreement that the LD Partnership Board shall have receive further updates as this work progresses through the next year or so
10. CBCST Team Meeting – 22/05/2012

General points
Concern was noted around the costs of the consultation
Concern around the need to retender at all for the health contracts
Query around evidence that this will be in the customers best interests
(noted that the retender is a legal / contract requirement under EU
Procurement rules)

Proposal 1
Re-branding all specialist services to be for adults with "Learning Disabilities" [rather than Learning Difficulties]
• No concerns raised or noted

Proposal 2
Improving support for all adults with learning disabilities to receive the healthcare they need
• Staff expressed concern around integration
• Stated desire for clarity around the proposed role for HFT staff - concern expressed that they could be used as a "sticking plaster" for failings in other service areas
• Noted that HFT would support referral back into integrated / specialist team if customer needs change
• Agreed that hospital discharge planning is key activity - feel that lots of work is needed in this area
• Strong feeling that better / more liaison should be formalised for MH services / MH hospital admissions

Proposal 3
Integrating specialist social and health community teams for adults with learning disabilities
• Will need clarity around roles
• Training needs for integrated staff will be needed to support new model [Query: Would a skills audit be useful?]

11. CTPLD Team Meeting: Northern – 22/05/2012

Proposal 1
Re-branding all specialist services to be for adults with "Learning Disabilities" [rather than Learning Difficulties]
• No concerns raised
• Agreement that this change may support clarity of role of CTPLD Teams
• Noted that change would feed through to leaflets etc.
11. CTPLD Team Meeting: Northern – 22/05/2012 [Continued]

Proposal 2
Improving support for all adults with LD to receive the healthcare they need
- Team agreed that hospital in patient support was a real issue - service variable across the county
- Felt that numbers are key - more LD liaison staff in hospitals are needed
- Felt that hospitals do not always follow their own / WSCC guidelines - need to educate staff
- Could link nurse from community team support when Discharge Nurse not available
- Felt that generally, links between CTPLDs and hospitals could be improved
- Query whether the mainstream hospital social work teams have a role to play
- Felt that the process needs to be simple, effectively communicated, understood and enforced
- Also noted that carers have fed back support is also needed in community services - for example dental services. Team agreed this was the case
- Felt that full time cover is needed across county for this function

Proposal 3
Integrating specialist social and health community teams for adults with learning disabilities
- Concern that all professional roles will be diluted
- Concern that roles will not be adequately defined
- Felt that training / change / support will be needed around the change
- Felt that lots of change is hitting the teams at the same time
- Concern expressed around need for integration - would same effect be achieved by joint working?

12. West Sussex Provider Forum – 25/05/2012
- One group of attendees expressed concern around the procurement / tender / contracting of the health service and wanted some clarity around who provided what - and why WSCC would look to be undertaking a tender exercise for the health contract - it was explained that there were EU rules around contract values, types and length of contract that WSCC had to abide by and that the project was seeking urgent clarification for WSCC legal services and the other parties to the contract to clarify this issue
- Concern was expressed around the role of psychiatry, particularly that there could be reduced access under the new arrangements. It was explained that the rules set out by the Royal College of Psychiatrists dictated to a degree the service provided by this group of clinicians and also about work within SPFT to ensure that mental health services were more accessible and responsive to the needs of adults with learning difficulties. If anyone had any specific queries, please could they forward them to the LD Transformation mailbox.
- Concern was expressed around the location of the Health Intervention Team. The meeting was advised that this would be an issue for the organisation providing the Health Intervention service, but that there would be desk space and meeting space made available in WSCC offices for this team to access.
- Concern was expressed around the role of the CCGs and how their stance could impact on service development, including whether there would be a need for specialist services at all. Sue acknowledged that this was a developing area and that relationships were being formed and nurtured. It was noted that this development of relationships was not just being done at an LD / JCU level, but work was ongoing at a chief officers / senior management level to put the right relationships in place.

Concern that the detail in the paper was insufficient for staff to make informed contributions [agreed a further team meeting will be held on 6th June to discuss this. KE said that questions / requests for more information could be sent to this email address and she would make sure they were passed on for response]
### 12. West Sussex Provider Forum – 25/05/2012 [Continued]

- A query was raised around the CHC team - how will this fit. The meeting was advised that currently the LD budget is a pooled budget and includes CHC funding for individuals whose health needs are directly related to their learning disability eg those with autism/challenging behaviour. Where CHC eligible needs relate to other physical health issues such as epilepsy, funding is not from the LD Pooled Budget. It was acknowledged that this may not be the best way of organising things, but. This issue was too complex to address at this time with the CTPLD Redesign and would not form part of this work.

- One group of attendees expressed concern that it was not just about 'who' made up the teams - but how many of the 'who's there would be – it was explained that there were no plans to reduce the number of clinical/professional staff and whatever was put into the new teams would be done with the aim of supporting and enabling joint working and an efficient co-ordinated approach. It was noted that the project has been speaking with staff who make up the CBCS Team to see what learning could be gathered there and used to help develop the new teams. All agreed there was a need to get ‘slicker’

### 13. Notes from Carers Meeting [Coastal] – 28/05/2012 [Continued]

#### Proposal 2

None had experience of the HFT
All were in support of this proposal
Questions as to whether movement of staff would diminish the core health team, but in discussion seemed to be reassured on this

#### Proposal 3

All in support
2 would like to have seen more detail on the job roles/functions
Majority feel that the current arrangement for the duty social work system does not work: they understand why a duty system is used, but talked of their experience of the same questions being asked many times, and they ask if records are routinely read from case files

All would like to see more social workers in post
No preference as to where the CTPLDs are based so long as there is some form of satellite provision

2 people interested in the Autism Strategy work - and details have been sent to them via Martina

### 13. Notes from Carers Meeting [Coastal] – 28/05/2012

6 people attended. Of these: 1 managed a Shared Lives Service
3 had adult children in touch with CTPLD and with Day Service Provision
2 had teenage children/transition planning

All had seen the consultation, and have or will be returning the questionnaire

**Proposal 1**

5 of the 6 in agreement.
The person who managed Shared Lives Service was less keen

**Proposal 2**

- 5 of 6 in agreement.
The person who managed Shared Lives Service was less keen

### 14. Notes from CTPLD Team Meeting: Western – 30/05/2012

#### Proposal 1

- All agreed Learning Disabilities better term

#### Proposal 2

- Generally supported more support in health facilitation team - but some important developments requested for example, wanted to see clarity in any future service specification, a greater consistency in roles across the county, and a greater emphasis on support to inform commissioning of social care decisions
14. Notes from CTPLD Team Meeting: Western – 30/05/2012 [Continued]

Proposal 3
- Generally supported development of integrated teams
- Questions about how the new reviewing team will work alongside the existing teams
- Strength of feeling that social work was under-resourced by some way
- Questions about office move: uncertainty about dates of proposed move to Chapel Street, and uncertainty about whether they will require 2 moves over the next year or so

15. CTPLD Heath Team Meeting – Western – 07/06/2012

Proposal 1
- All agreed learning disabilities better term

Proposal 2
- A general support with the proposal to enhance support at primary care, but a concern that movement of staff away from the specialist health team might make this latter team too reduced in number
- A request for more information on the functions in both Health CTPLD and HFT to be able to comment more fully
- A comment that the consultation document does not give enough detail to any potential bidder

Proposal 3
- In support of further integration, as outlined in the consultation document
- A question as to whether the CBCST works with non-West Sussex funded customers (ie those funded by other local authorities)
- A view that CBCST should remain a stand-alone, specific team
- A concern that there is inadequate admin support to social care CTPLD teams now, and that attempts should be made to improve this. A concern that a reduction in health admin staff will make the situation worse

16. CTPLD Team Meeting: Coastal – 11/06/2012

Around 10 staff at meeting
- All agreed Learning Disabilities a better term
- Generally supported more support in health facilitation team
- Generally supported development of integrated teams - Felt would need good clarity about roles of health staff in integrated teams - Lots of discussion around the residual health functions/team - Some query around whether should just go with full integration now
- Query about whether should retain CBCST or just have a 4th integrated team. People felt lack of clarity about pathway in and out of this team and whether this has really worked.
- Query about whether could set up a safe-guarding team - Safe-guarding work with non-West Sussex customers was raised
- Lack of clarity about role of reviewing team and how this will interact with teams
- Raised issues around challenge of WSCC managed staff having so little admin support
- Asked questions about whether might lead to an office move for integrated teams
17. CTPLD Additional Meeting – Northern 12/06/2012

1. A concern raised by the team was that there may be insufficient health staff (numbers) in the current SPFT team, to move across to the proposed new integrated teams.

2. A related concern was that this proposed staff movement could be used to bolster numbers in the integrated teams, and avoid recruiting to social work/care management vacancies now or in the future.

Linked to this, there was a strength of opinion that there is a lack of social work/care management posts across the LD service generally, and that this needs to be addressed. The new reviewing team may address some of this pressure, but a concern that this may not suffice. Greater clarity is requested on the parameters of work for the new reviewing team, and how this will inter-face with CTPLDs

3. Some of the team queried the movement of Psychology posts to the proposed integrated teams. There was a question as to how this might be beneficial to the integrated teams; what benefit did this bring that could not be found by the psychologists remaining in a health managed service.

Other people in the team gave examples of where expertise/input from Psychology had been very helpful in the completion of assessments, and felt that the proposed move of some Psychology to a new integrated team was welcome. However, attention would need to be given to ensure that both psychologists (and OTs) had capacity in any new integrated team both to have their own caseload and contribute to assessments where the named worker was another professional in the team.

4. There was disappointment that the consultation document had not given details of linkages to MH services, and proposals for how this could improve. Success for any newly configured team needs to include how effective it is in securing assessments from AMPH, especially for people with mild/moderate LD and MH issues. Will there be a place for AMPH Liaison workers in the new model? Perhaps the Psychology input could have a lever here.

5. The team spoke about the additional demands experienced over the last year or so with admin and finance demands. (examples given were the annual completion of FSA1 forms). Issues were raised about the lack of admin and finance support provided to the team. There is a strong view that this needs to be improved - either as part of the CTPLD consultation, or separate to it - to ensure that time/skills are best utilised as social workers/care managers.

6. There was mixed views on the place of brokerage (including financial negotiation/brokerage) in the proposed new integrated teams. For some this was not contentious; for others it was felt that a brokerage role better sat outside of care management functions. The team valued the work undertaken by LD Commissioning, and feel that the former's post is currently more clearly delineated.

7. Any implementation needs to take account of the time needed for (new) staff to train on Frameworki. There is concern that this is under-played.
Sussex Partnership Foundation NHS Trust: Response to the Consultation on Changes to Health & Social Care Community Services for Adults with a Learning Disability in West Sussex

Process to produce this response:
This paper has been written following a series of discussions with Health staff within each community team, joint staff workshops (including representation from Staff Side), and profession specific meetings. It summarises SPFT’s position in relation to the proposed changes to services.

The paper includes:
- Support for the changes and developments to the service
- Concerns and further questions from staff
- Ideas to operationalise the current proposed model
- Achieving efficiency savings
- Further questions and thoughts on the model

Overview:
1. Firstly we support the term ‘Learning Disability’ as a more useful term to describe the individuals who need to use services. It is in line with National terminology, reflects Department of Health guidance and is the term used by MENCAP and other representative 3rd sector organisations.

2. Team Structures—We welcome the need to redesign services and review the role and function of Health staff to ensure improved health outcomes for people with a learning disability and achieve best value in doing so. We recognise the current urgent need to release efficiency savings.

In line with the current draft CCG guidance, the likely recommendations arising from the Winterbourne View enquiry and the recent Mencap 74 deaths and counting report, the Trust:

(i) Supports the need to improve access and use of mainstream Primary and Secondary healthcare services by a continued focus of specialist LD health staff.
(ii) Feel there is a need to strengthen and improve the role of specialist health staff in the commissioning of individual services by a more integrated model of service delivery.
(iii) Welcomes the attention to the need for an ongoing specific health provider function for those individuals and their support systems (paid and unpaid) who need ongoing specialist health assessment and interventions

Concerns and Questions:
The next section of this paper focuses on comments and concerns raised by professionals currently working in the community teams. At the end of the document recommendations are made as to how staff feel the proposed model could be made leaner and more cost effective.

Complexity:
The current proposed model suggests six teams to provide LD services. This structure seems unnecessarily complex, both for users understanding their care pathway and increasing the risk of people being lost in the system or moving back and forth between teams.
Staff feel the current model has too many teams to provide integrated services to people with learning disabilities as boundaries between teams all too frequently become barriers; and can incur additional costs – i.e. in management; admin and paperwork involved moving and referring people between teams.

Staff are concerned at the lack of multi-disciplinary representation in all parts of the six teams which could therefore dilute the quality of what is needed/ can be offered to service users and their carers. Most professional groups do not have enough staff to populate all six teams so there may be staff holding different roles for different teams on days of the week, with differing managers and priorities.

In addition, some service users and professionals have needed clinical specialisms e.g. dementia/ dysphagia/ autism and it is unclear how equal access to these services will be obtained if the expertise is thinly spread.

**Health Facilitation:**
Staff welcome the ever increasing focus on health facilitation. They would like however, a far more detailed multi-disciplinary understanding and perspective on what contributes to or is included by the term and team “health facilitation”. Whilst there is a population of people with learning disabilities who can and should easily use mainstream services with reasonable adjustments and support from increased nursing, there are many more that require additional multidisciplinary support and where health facilitation is part of their specialist health ‘intervention’:

**Brief case examples:**
- A speech and language therapist assessing understanding to help decide whether someone has capacity to consent to health treatments themselves and to provide suggestions of ways to help them understand if they have capacity but need things explained in particular ways.
- A Psychologist involved working with someone re their capacity/understanding regarding understanding the decision to terminate a pregnancy;
- Specialist LD physiotherapists going onto acute wards to joint work with the acute physiotherapists to improve a person’s hospital outcomes, thereby skilling up and raising LD awareness with the acute physiotherapists by modelling good practice and joint working. This role could not be done by a nurse from a health facilitation team as it involves direct physiotherapy interventions.
- A client who needs a physical intervention holds in their best interests to have a specific test i.e. where an individual needs a specific Primary or Secondary health intervention this may need more than specialist nursing to provide it.

**Mental health needs:**
With regards to improving the uptake of primary care mental health services, commissioners need to be mindful of the limited evidence that Improving Access to Psychological Therapies (IAPT) meets the needs of people with a learning disability (Improving Access to Psychological Therapies (IAPT) : are they applicable to people with intellectual disabilities March ‘11) and therefore what the best use of Psychology and Applied Psychological support to Primary care is.
Psychology could offer training, consultation, joint assessment, supervision to MH colleagues. In some cases there may need LD psychologists to be offering individual therapy. This could be a rationale for moving some resource into mental health. Psychology holds the same role in relation to people with complex physical health needs where there is a psychological component to their presentation.

The teams fully understand and support the need to embed health facilitation within GP practices and hospitals and an increased role for the health facilitation team to include Primary and Secondary care work for individuals.

This work is currently split across two teams; the existing Health Facilitation team via training and strategic work and by the CTPLD’s via clinical interventions as well as training. The latter is multi disciplinary in its delivery. The new model will mean increasing numbers of referrals to the proposed new health provider team for specific multi-disciplinary input, so a health facilitation function will also need to be described as a core role of the proposed health provider team.

The splitting of health facilitation functions between the Health Facilitation team and a Health Provider team suggest health facilitation roles would be provided by two different organisations, potentially with different priorities and caseload management approaches.

This will need careful guidance and clarity of expectation from commissioners as to how this work would be managed between both teams, initially by agreeing integrated care pathways.

Case studies - to illustrate client need across health facilitation and specialist health provider team:

**Case Study One:**

Mr A is a man in his 40s who lives with his parents and who has not received any services since leaving school. He had no accessible wheelchair and spent most of his day lying in bed. His family had previously declined any day service or assistance with his care and his only contact with other people was with his family.

The CTPLD received a referral from the Wheelchair Service who had been contacted by the GP. The Wheelchair Service requested a joint visit with Physiotherapy due to Mr A’s complex needs. During the initial visit concerns were raised about recurrent chest infections, possibly due to aspiration and Physiotherapy referred to Speech and Language Therapy for a dysphagia assessment.

Additional health needs were also identified, including epilepsy and continence issues. A multidisciplinary meeting was arranged by the health care coordinator which included the GP, Wheelchair Service, OT Connect, Continence Advisory Service, and Physiotherapy, Speech and Language Therapy and Community Nursing form CTPLD. As a result of this meeting and interagency involvement the following improvements have occurred:

- District nursing arranged for a profiling bed
- His home has been adapted to provide him with a hoist, wet room and his own bedroom
Case Study One [Continued]:
- His continence is supported and reviewed by the Continence Advisory Service
- His dysphagia is being managed resulting in a considerable decrease in chest infections
- He has an agreed protocol in place to manage his epilepsy
- He is gradually spending more time in his wheelchair appearing more alert
- The Wheelchair Service are now considering referring him to specialist seating which will enable him to access other parts of the house and the local community
- The family have recently accepted support arranged by CTPLD Social workers to meet his care needs which is anticipated to increase over time

The family are now much more trusting of health and social care services as a result of their positive experience of well-coordinated and helpful involvement.

Case Study Two
Ms T is a 50 year old woman with a history of difficulties with services, attachment issues and a history of abuse. She self-neglects and won’t agree to important health examinations. T lives alone and her health is deteriorating. She is refusing all support into her home.

Intervention:
- Cognitive assessment. T is not as able as thought – this leads to multidisciplinary capacity and best interest decisions about her ability to decide when and when not to engage with health provision. Speech and Language therapy, nursing and psychology involved with this assessment of capacity. LD nurse supports the visit to GP. The GP also liaises with the LD psychiatrist as an advisor with regard to the recommencing medication for her depression.
- Ms T engages with Cognitive Analytic Therapy, looking at why she rejects help and how she could develop alternative responses when carers make her angry. T uses initial sessions well and begins to let staff support her again in her home
- A review of the case acknowledges that T’s ongoing need is for more social opportunities and for 1:1 social support from someone who is skilled in understanding the needs of people with learning disabilities

Integrating specialist social care and health community teams for people with a learning disability:
Staff appreciate and understand the need to integrate Health & Social Care services in the area of commissioning services for individuals. They feel they have much to offer and that their specialist skills and knowledge haven’t been used successfully in the past.

Involving health care professionals in assessment, support planning and setting-up of care packages would improve services and outcomes for individuals. However, it makes practical sense to involve all health professionals in this commissioning function. For example, Speech and Language therapists are regularly joint working with social workers assessing service user’s capacity regarding house moves.
Sussex Partnership Foundation NHS Trust: Response to the Consultation on Changes to Health & Social Care Community Services for Adults with a Learning Disability in West Sussex [Cont]

We are uncertain that it is helpful to have partially integrated teams and therefore having dual functions existing between staff and in the teams i.e. some intervention in the integrated teams and some in the health provider teams.

Separating off assessment and intervention roles is an artificial split. For example, intervention often starts at a point of assessment, and assessments may be modified by what is learnt during assessment.

Case study - highlighting assessment and intervention functions being difficult to separate

**Case Study 3**: M, a 20 year man, was referred to the LD team and Social Services by an OT in adult mental health services for an assessment of his needs and support for his family. M had attended mainstream school, but had left without qualifications and his mother acknowledged they had fought hard to keep him in mainstream education. M had then attended local college but had stopped going 6 months ago. Since then he had spent much of his time alone at home without company. He had become increasing withdrawn and aggressive. His GP had made a referral to IAPT, but he had failed to attend his appointments and current input was from OT to try and get him involved in local arts projects. The weekend prior to the referral M had attacked his mother and out his arm through the glass door of the family home.

A psychologist undertook an initial visit to the family and spent some time gaining an understanding of M’s level of ability, and to try to identify the triggers for M’s recent behaviour. It became apparent that M struggled with even the most basic tasks without considerable support and this was supported by a subsequent assessment of his cognitive ability. It was also apparent that M’s aggression occurred if he had been alone for long periods of time, and a consistent trigger was his younger brother going out with friends in the evening. Social services were able to respond by providing M with funding for 2 evenings of support to allow M to go out. An OT from the CPTLD worked with the OT from WAMHS to look at effectively support M to access art groups by providing him with clear information and helping him plan his journey to and from the classes. Psychology also supported the family to establish structure and routines for M when he was in the house alone. The cognitive assessment suggested that M had problems with both expressive and receptive language and SLT was asked to assess M and work with the family to assimilate the findings of the assessment into their understanding of their son’s needs. Although there was a significant improvement in M's mood and level of CB, at the same time it become clear that M wished to live independently and the ongoing work in conjunction with social care informed a longer term goal for M to move to supported living whilst retaining a good relationship with his family.

Staff also foresee conflict of interests arising for professional staff being both purchasers and providers of services if these are provided by the same person from within the new integrated assessment teams. If conflicts do arise then this will mean more referrals to other teams and small professional groups split between multiple teams.

If some staff are moved into care management roles it is essential that they do not have their core professional role dominated by generic tasks. Not only would this not offer value for money, but it would mean specialist professional knowledge could be lost and professional registration compromised.

Psychologists wish to raise the following regarding the potential for their role within the care management assessment function of the integrated team
Case Study 3 continued:

- Understanding of the psychological needs of complex individuals and how these can be met via social support and via more specific clinical / specialist intervention – this may include specialist cognitive assessment
- Consultation around interpreting the information gathered at the assessment stage and helping people think about the support package that should be available to the individual.
- Working with situations where clients or support services are not successfully engaging with care plans or are actively failing to engage - short term work with individuals, families and staff teams.

PbR is likely to be the way health services are paid for. We are uncertain how this tariff model will or could work in the new model with social care leadership, and the views of CCGs on this issue.

IT systems will need further consideration. At present all health assessment and interventions are recorded (including risk management and assessment) on eCPA this is considered as best practice to minimise clinical risk.

All professional groups raise the issue of governance and professional leadership in this new model particularly how caseloads are managed and prioritised given competing demands on limited resources and potential initial lack of understanding and experience of managing specialist health staff in the new integrated teams

Case study - to illustrate assessment: provider roles in integrated teams, highlighting the role of OT in particular

Case Study 4:

V has mild learning disabilities and some mobility issues. She was not known to the CTPLD until her mother passed away. She was referred to the team via a safeguarding alert due to concerned neighbours aware that V was not coping and was at risk of injury and self neglect due lack of safety awareness, poor hygiene, poor nutrition and managing her budget. She was very vulnerable, had no meaningful daily activity and was completely socially isolated. An older aunt had been providing some support but this was sporadic due to her increased ill health. V is reluctant to accept outside help.

The OT used the following standardized and non-standardized assessments to gain an in-depth profile of V.

Occupational Self Assessment (OSA) to enable V to identify goals and help build therapeutic relationship.

Analysis of V’s functional skills using the AMPS (Assessment of Motor and Process Skills)

Community risk assessment

The OT the carried out a detailed analysis of the above assessments in order to formulate an intervention plan providing

- A series of 1:1 skill training sessions to address safety risks within the home, build skills and awareness of nutrition/ food hygiene and meal planning. Focusing on V’s goals to gradually build her trust.
- Anxiety management strategies around accessing community
Case Study 4 continued:

- Working with V to develop a weekly schedule/routine of tasks and activities in line with her goals.
- Developing resources that provide a visual prompt for the tasks/activities i.e. visual timetable, safety prompt cards, budgeting plan.
- A written report with guidelines was compiled and circulated to everyone involved with V This report also informed capacity assessment around managing finances.
- As part of the multidisciplinary team, the OT worked jointly with the community nurse who addressed physical health needs and the psychologist who looked and worked with V re: bereavement and loss issues.
- Consultation session provided for support staff to demonstrate and support recommended activities and strategies to further develop V’s skills and independence.

Health/ social care outcomes

- OT specialist approach as a provider supported V’s learning of new skills
- Risks are now greatly reduced.
- V is engaging in meaningful activities within/outside home.
- V continues to live independently and is now accepting minimal ongoing support.

Health provider team:

Staff welcome the need to ensure people with a learning disability are able to receive specialist health assessment and interventions.

We continue to have questions regarding this being a separate team and particularly wish to raise our concerns that there is no Occupational Therapy role/provision identified.

The current OT role as part of the Multi-Disciplinary health team for health intervention can be summarised as follows:

- Specialist assessment and intervention addressing lack of engagement in meaningful occupation / occupational deprivation with risks to physical / mental health and wellbeing. This involves a mix of direct clinical work and staff consultation to inform and demonstrate standards required of the staff team and support health promotion through occupation
- Providing sensory processing assessments and interventions predominantly for people with challenging behaviour and / or autism. OT are currently receiving referrals for this work for clients within the health team (i.e. that do not meet the criteria of the CBCST but are referred for input to the health team for challenging behaviour), CBCST and out of county placements (High risk, complex case work that requires specialist OT intervention around skill development to reduce risk and increase independence. This is when this is required in addition to support services.

We see the above as core to health interventions in line with national best practice and an essential component of provision to be maintained in the new structures given the small but highly specialist and skilled OT resource that the Trust has been developing over the last year.
Case study - to illustrate assessment: provider roles in integrated teams, highlighting the role of OT in particular

**Case Study 5:**
B has a profound and multiple learning disability with complex physical/health needs. She engages in a range of self stimulatory and times self injurious behaviours. She was referred to OT due to a severe lack of meaningful day time activity. Staff did not recognize or understand the importance of engaging B in meaningful daytime activity that was appropriate to her cognitive, physical and sensory level. This was affecting both her physical and mental health.

The OT used the following standardized & non-standardized assessments to gain an in-depth profile of B.
- Analysis of B’s engagement abilities and motivation for activity using the Volitional Questionnaire and Poole Activity Measure.
- Sensory Integration Inventory measuring B’s sensory processing skills.

The OT and physiotherapist completed an assessment of B’s physical and environmental needs and together with the Speech and language therapist completed an eating and drinking assessment. As a result B received a more appropriate wheelchair, armchair and commode to enable correct positioning for all types of activity and eating and drinking guidelines and equipment to reduce risk of aspiration and improve comfort.

The OT was the case coordinator and carried out a detailed analysis of the above assessments in order to formulate an intervention plan providing:
- A series of one to one demonstration sessions working with B and her carers to demonstrate and support recommended activities and strategies appropriate to B’s assessed level (sensory).
- A staff consultation session to raise awareness and understanding of the theory (SI / Poole) and its practical application regarding B. Members of the CTPLD MDT were also present.
- A written report with guidelines, sensory diet and advised activity routine was compiled and circulated to everyone involved with B.

**Health outcomes:**
- B is now engaging in a balanced range of activities appropriate to her level both within the home environment and wider community.
- Appropriate equipment has helped B’s posture and enabled her to better engage in her daily occupations.
- As B is now engaged in meaningful activity her self stimulatory behaviours have reduced

**Further points:**
We suggest that one of the key roles of the health provider team will be to work with clients who are not from West Sussex originally which, other than safeguarding, is not a clear integrated function. The consultation paper does not identify how these people’s specialist health needs will be met.

There are currently no Behaviour Specialist posts in community teams (other than in the CBCST) so this could not be provided by SPFT staff into the Integrated teams at the present time.
With regard to psychiatry and where this profession best sits in the proposed new model, the Psychiatrists are currently undertaking a detailed case-load audit to inform how their resource is best used. This audit will help inform:

- Which clients should be ‘held’ by the new mental health Assessment and Treatment Centres (ATCs) and which should remain within specialist LD services
- The need for sessional input from consultants into the ATCs for joint working/consultation and capacity building within secondary mental health services.

A Position Paper on the role of Psychiatry will be sent to commissioners.

Clearly whatever the outcome of this consultation, Psychiatry need to be part of both the LD multidisciplinary service delivery, and are pivotal to the Greenlight initiatives with adult mental health.

CBCST:
We would suggest that further thought is given to the need to have an ongoing separate team for people with the most complex challenging behaviour. Having a separate team could be seen as seeing challenging behaviour as a diagnostic label. Placing someone in a certain part of the service can overlook the vast range of complexity and difference in the presentation of people with challenging behaviour, which could, and should, in future be well managed within integrated community teams. With ring-fenced monies, there should be well developed care pathways, reducing the risk of people ‘bouncing’ between elements of the service, and keeping specialist professional roles.

A review of the current CBCST may be helpful in this process of redesign particularly as there continues to be unhelpful debate and movement between CBCST and the current CTPLDs as to who gets services from which team.

For example at present CTPLD’s undertake challenging behaviour assessments – work that sits outside the work of CBCST. Following a referral that indicates deterioration in behaviour/increase in self harm a comprehensive health assessment will be undertaken by a nurse, the risk will be held by the MD team who review regularly via established meetings. GP referrals are made for blood tests to identify any possible underlying causes, LD nurses assess sleep, pain management, teeth/hearing screening, continence, environmental factors, changes in home circumstances, staffing or life events to identify any possible cause for change. If no health need is identified this is taken back to community MD team and discussed, sometimes SALT and psychology assessments are needed and a review of care package.

If commissioners do wish to continue with the CBCST as a separate team, we would wish to see OT as a member and clearer pathways with psychiatry and nursing.

Specialist OT could greatly enhance this service, offering clinical skills in terms of Sensory Processing assessments and intervention, addressing the sensory component of clients with LD and challenging behaviour with complex needs, looking at meaningful occupation for clients referred to the service with an aim to improve engagement in daily activities and routines, thus preventing placement breakdown and promoting wellbeing.
The West Sussex OT service regularly receives referrals from the CBCST requesting specialist OT input for Sensory Integration (OT/SI) to address challenging behaviour. These require complex and in-depth joint working with the CBCST and other professionals involved. We are concerned how this need will be met if there is no OT post within the CBCST. This will be further compounded if there is no OT post within the Health Provider Team.

Case study - to illustrate OT role

**Case Study 6:**

The OT used the following standardized assessments to gain an in-depth profile of A:
- Sensory Integration Inventory and Adolescent & Adult Sensory Profile measuring A’s sensory processing skills.
- A series of observational sessions of A during his daily occupations
- Assessment of A’s environmental needs

OT carried out a detailed analysis of the above assessments in order to identify any sensory dysfunction and what strategies could be implemented. The assessments found that A does problems with his sensory processing, in particular that he is hypersensitive to some sensations such as some noises and light touch. However he also seeks certain sensations which had resulted in behaviours such as biting and head banging.

OT was able to make a number of recommendations in order to help A tolerate personal care, engage in a fuller range of daily activities and cope with the noise of another resident so he can be involved in group activities such as at mealtimes.

These recommendations were conveyed via a staff consultation session facilitated to raise awareness and understanding of the SI theory and its practical application regarding A.

A written report with guidelines, sensory diet and advised activity routine was compiled and circulated to everyone involved with A.

**Health outcomes:**
- A is generally much calmer and current records indicate that his challenging behaviour has significantly decreased.
- A is now able to engage in a far greater range of activities and staff better understand his sensory profile and how best to support him to cope with daily activities.
- Staff report that they are very happy to continue to support him in his current placement and it is no longer at risk of breaking down.

**Reducing spend & increasing efficiency savings:**

Team leaders, the service manager and admin staff all have a central role in the current teams. They are highly skilled, valued members of the teams and undertake a range of tasks and role to enable clinicians to be clinicians.

Savings can be made in the reduction of these roles, however there will be a net loss of clinical time overall.
Sussex Partnership Foundation NHS Trust: Response to the Consultation on Changes to Health & Social Care Community Services for Adults with a Learning Disability in West Sussex [Cont]

Core roles lost with the reduction of admin:
- Gaining additional information from referrers to inform practice and eligibility – practise to speed up decision making processes with regards to allocations at team meetings
- Data collection for performance monitoring, referral tracking, audits, data input
- Minuting and tracking actions from referral and allocation meetings
- Organising clinics, rooms etc for clinicians
- Being the front door for users and carers i.e. a known person to talk to

Losing health team leaders/ service managers:
- Initial decisions/ assessments regarding eligibility
- Managing complaints
- Leading on data collection for audits (ATC)
- Key liaison role with local mental health teams for Greenlight work
- Direct performance management of health staff

How these roles would be subsumed by the new teams and the impact of this on clinical will need to be addressed.

Operationalising the new model:
In recent discussions with specialist health staff there is a commitment to working within the proposed model. However reassurance needs to be given to the following:

1. Professional leadership embedded in the new structures to provide guidance re:
   - Capacity: demand/ well managed caseloads
   - Completion and undertaking of audits relating to e.g. implementation of NICE guidance
   - Managing Conflict of interest issue arising from new roles in care management
   - Setting standards and expected health outcome of the professions working potentially across six teams
   - National best practice
   - Maintaining Professional registration.
   - Performance management
   - Recruitment and retention of staff / Continuing professional development
2. Clear pathways described for users and staff both within and between the six teams.
   - For the health provider team this could be linked to PbR clusters where possible.
     ◦ Health Facilitation team to have a role in delivering integrated pathways jointly with Health Provider team e.g.
     ◦ Re Physical interventions for medical tests and examinations
     ◦ Dysphagia and AAC pathways
     ◦ Falls and mobility pathways linked with mainstream physiotherapists
     ◦ Multidisciplinary work re mental capacity assessments and supported decision making

3. Health provider team/ integrated teams health professionals to have a function in setting and improving and reviewing specific standards of local providers e.g. of residential care/ supported living/ personal assistants for example, agreeing set of standards with contracts for ‘Good practice in communication’ where the SLT working with a care manager can see what an individual’s personalised communication environment should look like, agreeing how this is reviewed and monitored. Working with commissioners to agree how local care providers could improve standards. Similarly an OT working to set standards for engagement and occupation within commissioned services; Physiotherapists for posture care management etc.

   It is unclear at present whether this sort of ongoing standard setting and capacity building work in specialist LD services is held by the Health provider team, the health facilitation teams, the Integrated teams or all three. Clarity is also needed as to which team would be responsible for ongoing preventative/mainstreaming work with other services such as Children & Families, Supported Employment, Housing Department etc.

4. If certain professions e.g. nursing and OT take on care management roles, then we suggest that this is most effective and viable when nurses remain as nurses, and OTs as OTs who are undertaking a clinical role which has the extended function of taking on the clients care management needs.

   This could be achieved by:
   I. Clinical supervision from a lead nurse/ OT who has joint responsibility with each social care team leader over allocation of casework.
   II. Smaller caseloads than current care managers to allow time for clinical intervention.
   III. Safeguarding role for nurses to be limited to physical and sexual investigations.
   IV. Integrated team managers will need to expand their role to include a new increased understanding of the specialist role of the learning disability nurse and OT and the specialist skill set and best use of time in this new role.
   V. Necessary levels of training and shadowing opportunities for the seconded professional staff to learn the care management role and necessary paperwork and legal frameworks.
   VI. Reassurances that the role will be regularly reviewed to ensure clinical expertise, and health interventions are not eroded overtime

   In addition a recognition that if professional staff take on roles as care managers then there will be a net loss of ‘clinical’ time directly with/for clients. There needs to be arrangements made therefore with commissioners regarding which work will be stopped from the current arrangements when staff take-on the extra work of care managers. The role for each professional laid out from the SPFT LD position paper is suggested as a platform to agree this.
5. The perspective of Health staff is co-location of Health & Social Care professionals is paramount to effective service delivery.

Further Questions and Thoughts:

A Fully integrated model

Whilst staff could work into the six teams, we would like the Commissioners to consider:

Three fully integrated Health & Social Care Teams containing the health provision function as outlined earlier, and which includes targeted capacity building for specialist LD services to prevent future referrals and placement breakdowns.

- Have performance targets of establishing integrated pathways agreed with the CCGs to address health inequalities jointly with the health facilitation team.
- Have a fully integrated leadership model between an integrated team manager with responsibility for health & social care staff supported by professional leads.
- Have all Health Care professionals more involved with care management functions, not necessarily becoming full care managers to achieve this – but working to social care priorities and being performance managed by the team manager for this work
- Capacity for non WSCC funded clients
- Integrated safeguarding function

In the above model we would envisage not necessarily needing a separate CBCST team and that challenging behaviour would be one of a number of pathways established within the new integrated teams.

Health Facilitation Team:

Whilst we can see the value of this team being integrated within hospitals and GP practices, many of the functions of this team include those continuing to be provided by a range specialist health staff not just nursing. Further reduction in cost could also be found by health facilitation staff being based and aligning with Primary care and Acute services but being provided through the fully integrated team structure with health facilitation their core business in these teams.

Case study - to illustrate the needs of the client spanning the differing teams

Case Study 7:

J lives in sheltered accommodation receiving support for tenancy issues and personal care, he has a longstanding history of back pain which has deteriorated over the last 18 months. Concerns rose about his deteriorating mobility, increase of pain which impacted upon his personal care and independence, for example he was unable to access the bathroom safely due to his reduced mobility. Issues were raised in CTPLD referral meetings by the physiotherapist and the OT due to concerns regarding delayed treatment for back and further deterioration.
Case Study 7 [Continued]:
The LD nurse undertook holistic assessment. J was waiting for spinal surgery but this had been postponed due to urine infections and infected eczema. Concerns rose re medication for infection and skin condition, that the blister pack was empty and a month out of date. J was unable to remember when he last had medication and support staff could not recall when the last blister pack was ordered. Safeguarding alert was raised and a request from the care providers received for increased hours of support.

The health assessment completed identified the following actions; Health Action plan was needed, service user needed education on maintaining personal hygiene, staff needed training and support to produce timetable to manage health needs, medication management review; liaison and coordination between medical professions (GP, acute trust, and pharmacist).

Once this health assessment and intervention was completed, no increase in support staff hours were needed and risks were reduced, surgery went ahead. J maintained independence and existing housing and support.

Since his operation, J has improved but there has continued to be a need for multiple health appointments and close liaison between different parts of his support.

Speech and Language Therapy have become involved to assess whether part of J’s non compliance with some parts of his health involvement are a result of lack of understanding. Another multidisciplinary meeting has been arranged in which it has been advocated that J should have a PA to enable him to keep on top of his health needs which should improve outcomes and enable him to continue to consent to his own treatments.

In the proposed model it could be seen to indicate that J’s needs would have been split between three teams, with health provider team initially identifying need, referring onto health facilitation team for management and a further referral to care management for safeguarding procedure and review package of support/ request for increase. Obvious delay and additional paperwork would result, however if this was managed within one larger team where roles are more inclusive of all three functions this should not occur, and J’s needs would be met quickly and consistently.
I am responding to the above consultation on behalf of the Sussex Partnership branch of UNISON.

This is a difficult situation as WSCC are the commissioner of this service and we have not been able to engage in direct dialogue with WSCC as they see their role as “arms length” in terms of contact with a union who is based in the current provider. That said, we have been in contact with our sister branch within WSCC and Dan Sartin in particular.

The document itself is, obviously, aimed at the general public and does not have enough in depth information to offer a great deal of consultation. We look forward, therefore, to more detail being provided at a later date which we will respond to as appropriate.

We are also aware that discussion are taking place over the funding of this service and, although we are not party to any information around those discussion, we would express our concern on any potential reduction in funding and the knock on effect this will have both to staff and service users.

In terms of the consultation document itself we would wish to make the following points:

We do not feel that it is appropriate to comment on the proposed structures for any redesigned service and will leave this to Sussex Partnership Trust and its staff. That said, we would strongly suggest that any new model allows for SPT to retain employment with SPT i.e. secondment rather than direct employment by WSCC.

Notwithstanding the above point, the proposed structure appears overly complex. We are aware that the model of integration used in a similar service in Brighton is working well and may give a good pointer for this reorganisation?

We strongly believe that Learning Disability is a specialist service provided by specialist staff albeit with the emphasis being on “normalisation”. This is not to take an elitist approach but is just an acknowledgement of the complex and multi layered needs that a service user with a learning disability will often present with.

We feel, however, that there may be a danger of adopting a generic approach in terms of the staff working in this service which we would not support. There is evidence to show that a health and social care team is much stronger and more effective where each team member is recognised in their own right i.e. nurse, social worker, psychologist, occupational therapist, physiotherapists, speech & language therapist etc. By recognising and respecting the different professional roles, a team is able to offer a stronger and more cohesive service to the client group it serves.

Linking into the previous point, whilst we acknowledge the importance of care management, we would also emphasise the importance of direct intervention and input with client with a learning disability. Not only is this important in terms of offering the service user the most appropriate member of the team, it also allows for team members to hone and retain their unique set of skills.
Response from Unison [SPFT] :
Consultation on changes to community services for adults with a learning difficulties. [Cont]

The document makes little or no mention of administrative staff. We feel that this is a very serious omission which, if carried through to the redesigned service, would place huge bureaucratic burdens on clinical staff and also lead to a poorly functioning service. We would therefore urgently request that admin staff are budgeted for and included in any new or emerging structure.