

Improving Quality of Life for people with Learning Disabilities in Bedfordshire

Our story... as it happens

Insert image to represent the work, if you'd like to (or just delete if not)

Notes for completion

- This is your document; please do adapt any way you need to. Feel free to change the fonts/colours/borders/headings, to make it personal and fit for your team. The aim is for it to reflect the heart of your work, as you and your population have experienced it.
- Add additional slides if you need more space for any section
- We'd really encourage you to add pictures, feelings, experiences, to bring life to the work. Some suggested ideas for how you could capture the detail are at the end of this document following the pink slide. If you find or come up with any other good methods, please share this with your IA, so we can let other Triple Aim teams know.
- This document should capture all elements and dimensions of the story: including the downs, as well as the ups and the challenges, as well as the wins – please do be honest.
- It might be easiest to complete via a standing item during Project Meetings, perhaps sometimes with people taking away actions to complete different bits
- Also add a longer session periodically (quarterly?) for team to review content together and think about whether anything needs to be added to give an accurate reflection of the real story of the work

Contents

Section	Slides
Overall timeframe	
Rationale for the work and background	
Understanding the problem; experience and learning from 3 part data review	
Developing the strategy 1; first driver diagram and engagement event	
Developing the strategy 2; measurement plan	
Developing the strategy 3; prioritising the first change ideas and initiatives	
etc	

Overall timeline (1)

Month	What happened
???? 2018	Project initiated to reduce antipsychotic prescribing using QI approach
September 2018	Shakeel Islam and Sam Morrison started ILP Wave 8 training
October 2018	Shift achieved, showing reduction in use of antipsychotics across caseload, using QI approach
January 2019	Decision made to shift work to using population health Triple Aim approach. QI Project team put on hold. Core leadership group of Dr Shakeel Islam, Sam Morrison (project leads) and Dr Sanjay Nelson & Ruth Klawza (local sponsors) + Improvement Advisor and Executive Sponsor set up
February 2019	3 part data review undertaken rapidly by service to be ready for Trissa Torres from IHI visit
19 February 2019	Session to share learning from 3 part data review, supported by Trissa Torres
31 May 2019	First go at draft Driver Diagram developed by Dr Shakeel Islam and Jen Taylor-Watt (IA) from 3 part data review feedback
28 th June 2019	Engagement Event held with 40+ people from across system to share learning from 3 part data review and develop draft driver diagram
1 st November 2019	1 st project meeting held
	1 st measurement plan at overall measure level developed

What is the rationale for the work

The project started as a QI project to reduce the prescribing of antipsychotics to people with Learning Disabilities, as part of the national STOMP agenda.

STOMP stands for stopping over medication of people with a learning disability, autism or both with psychotropic medicines

Most recent study - Approximately 50% of prescriptions for antipsychotics in primary care to people without intellectual disability are given in the absence of a record of severe mental illness.

Antipsychotics most commonly cause effects such increased appetite leading to weight gain, increasing the risk of high blood pressure and diabetes...

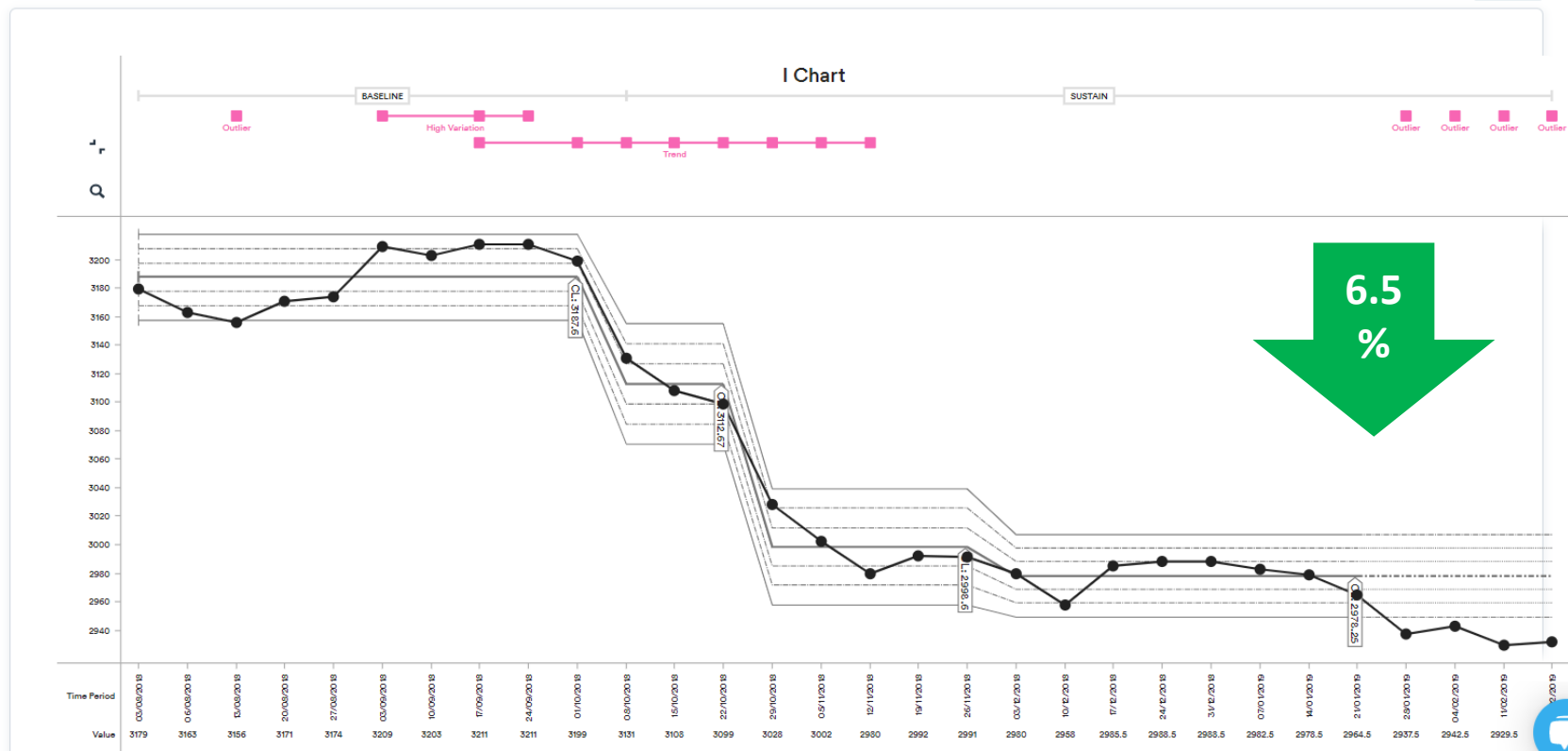
We achieved a genuine improvement of 6.5% by running our QI project within our team (😊), but we realised that to achieve a bigger change, we'd need to address the deeper reasons underneath why people experience behavioural symptoms – and this would require working beyond our organisation...

I Chart – Total % BNF max doses across caseload

Actions ↓

Chart

ⓘ Edit



Who got the work off the ground? (initial project team)

The original QI project team working on STOMP involved the following people:

- Dr Shakeel Islam, Consultant and Co-project lead
- Sam Morrison, Specialist Health Care Team Manager and Co-project lead
- Sanjay Nelson, Clinical Lead for LD and Sponsor
- Ruth Klawza, Strategic Lead for Learning Disability and Autism, and Interim Associate Clinical Director and Sponsor
- INSERT OTHERS

Who got the work off the ground? (initial project team)

Between February 2019 and August 2019 the set up of the work as a Triple Aim project involved the following people...

Local leadership

- Dr Shakeel Islam, Consultant and Co-project lead
- Sam Morrison, Specialist Health Care Team Manager and Co-project lead
- Sanjay Nelson, Clinical Lead for LD and Local Sponsor
- Ruth Klawza, Strategic Lead for Learning Disability and Autism, and Interim Associate Clinical Director and Sponsor

This was supported by Improvement Advisor, Jen Taylor-Watt, Executive Sponsor Paul Gilluley and Silvana Russo from the LD service supported a lot with administrative tasks and event organisation.

How we felt when we started the work as a Triple Aim project...



Meeting with Trissa Torres, 19/02/19

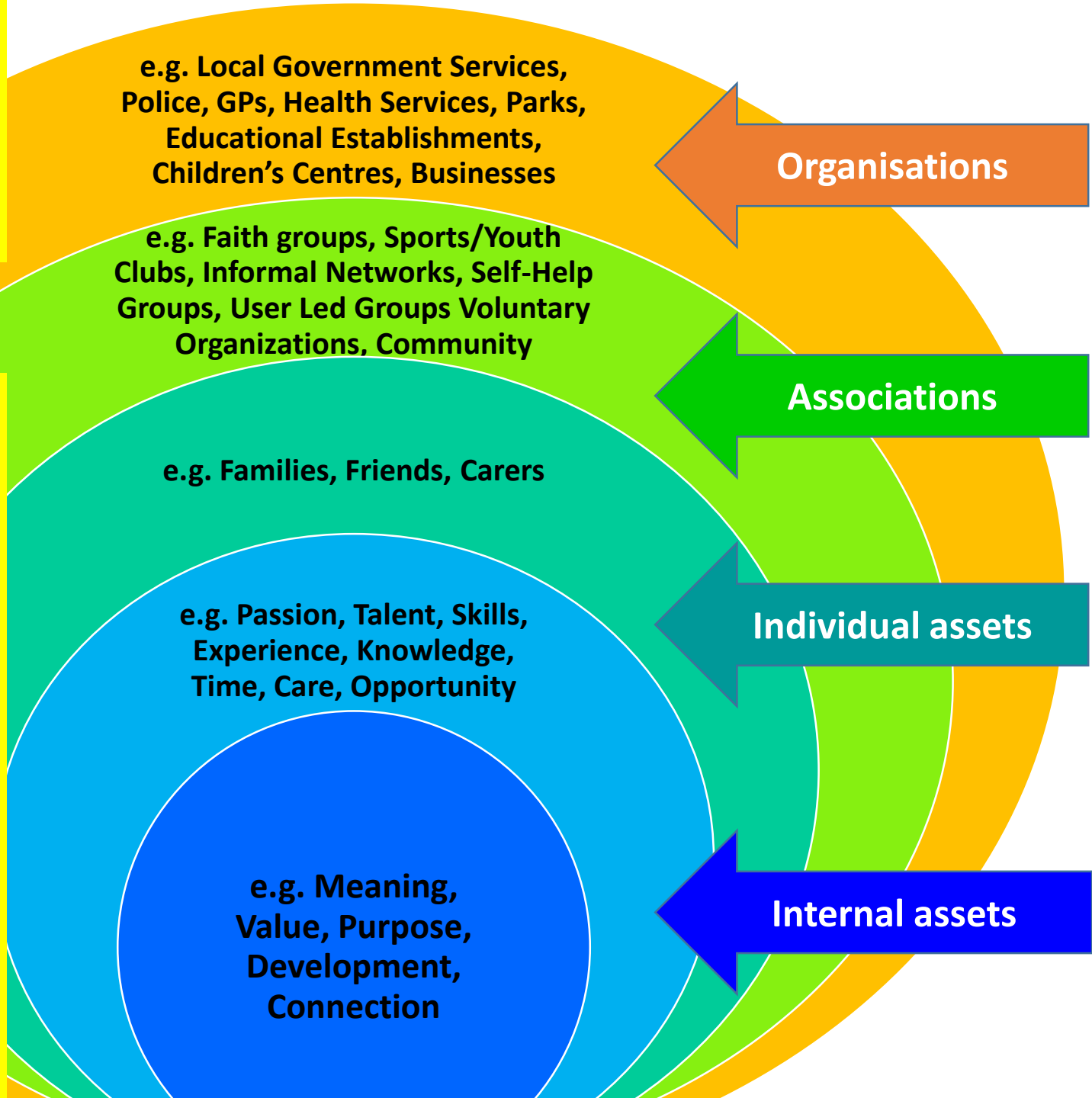
**Understanding the population
through the three part data review**

What have we learnt about the assets of this group of people?

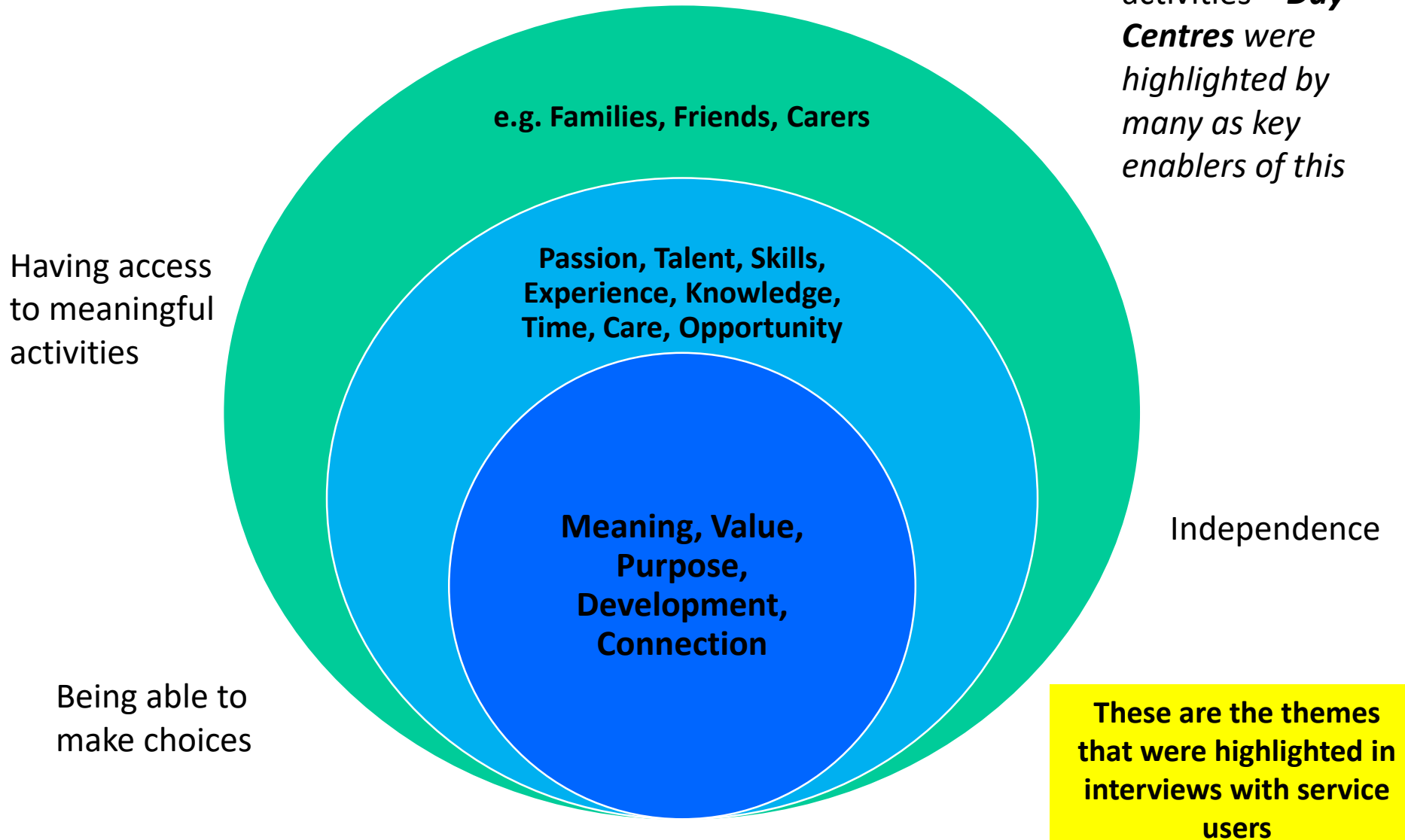
This is a useful model we can use to think about assets of a population, which includes internal assets, individual assets and assets in the broader community.

The model shows the flow from internal to external to the person.

See overleaf for what we found to be important factors for our population: people with LD at risk of antipsychotic prescribing...



Individual and internal assets



Community Assets; Organisations and Associations



Day Centres

Shops

**Places to go
on holiday**

Day Centres were the major community asset highlighted by service users and informal carers. They also mentioned the importance of places to shop and to go on holiday.

Stakeholders also identified other potential assets in the community at the engagement event, described below, which are also noted here in non-bold italic. [insert]

Interviews with Service Users/ Members of population

Summary

Strengths and Assets

- Being understood.(Daily routines, consistency, communication strategies, environment)
- Being able to make choices. (Shopping, holidays, daily activities)
- Having access to meaningful activities (Day centres, seeing friends & family, being able to attend social activities)

What is not being met?

- Having my own home
- Not enough meaningful activities away from day centres.

Summary Themes

What did the system not do right?

- Poor care and support arrangements (Life was very limited, more dependant on others, life was less fun)
- Misunderstood (restricted life opportunities, felt scared and angry, didn't feel valued, risk of harm)
- Communication (limited opportunities to express self and develop interpersonal relationships)

What are the gaps now?

- Delays in identifying needs (diagnosing mental health condition , carers not understanding what is needed)
- Having to share accommodation / home space. (no choice about who else moves in)
- Not all GPs are interested (only talk to carers, don't share enough information to hospitals or others)

Interviews with Service Users/ Members of population

Full detail

- 10 completed
- Any challenges? Questions asked may not have been specific enough to get more data about the use of medication

1. What strengths and assets are reflected in the answers

- Like going to the day centre in the week and having the weekends off.
- Seeing friends, watching and playing football, dinner with family on Sundays
- Going on holidays
- Going to day care and having days at home during the week to do own activities is good – helps to have more good days than bad days

- Being able to talk to my friends and family when dad passed away.
- Being able to manage my “head trouble “ much better in the last year because the staff recognise this now and having better medication since January
- Having carers and family to support with bad moods and behaviours

- Going into town one day a week and to my dads in a taxi – by myself (Used to have 3:1 carers support but now independent)
- Support received from social worker / support worker before meetings really helped as meetings make her anxious.
- Being on the right medication has helped.
- Being able to have family, good support workers, an Advocate, good Consultant and CPA meetings has helped me.

1. What strengths and assets are reflected in the answers (cont'd)

- Sticking to my routine each day helps – wake up early, have coffee, the breakfast. Able to stay at home indoors and play with my toys or watch TV. Someday going out for drinks. This has helped me to stay much calmer.
- Having carers who understand this helps, having a familiar, calm environment helps, being supported when I go out helps as I am registered blind.
- Going to day centre three days a week and being at home the other two. Then visiting family every Saturday. Is able to see what carers are working on duty and likes to know this. Is able to go to bowling once a week.
- Communication skills have improved over the years.
- Is supported by people who know him very well and understand him. – Providing a structure to activities has been successful and sharing information in small amounts helps to reduce anxiety
- Being able to chose what I do in the day and being able to go out independently.
- Didn't used to have good support and wasn't able to do things for myself. I still need help each day, especially with managing my money
- I have my family, my carers and the Priminister around me helping things to get better – I am interested in politics

1. What strengths and assets are reflected in the answers (cont'd)

- Having a consistent weekly routine is important – a mix of day care service, no day care service and seeing family at weekends.
- Having had more consistent support since 2011, able to communicate needs better, engaging better with people, enjoying an active life.
- Has own mobility car and consistent carers in the last four years.
- Going to day centre each day and having a consistent routine that carers understand the needs and are able to respond appropriately. Loves being able to socialise and knows lots of people.
- Being engaged in local community and being able to go out – has a very consistent

2. What needs are going unmet

- Wanting to live in own home.
- Wanting to do more activities when not at day centres

3. What did the system do that made it worse?

- When the right care and support was not in place, life was very different/ very limited. Unable to participate independently, wasn't able to live and enjoy life as much.
- Prior to current care arrangements, wasn't always understood by carers so was much more unsettled.
- Not having an agreed way of managing the behaviours, limited so many opportunities to engage. When carers didn't understand how to manage the behaviours.

4. What gaps have been identified?

- Long time getting people to understand the “head trouble” and make sure carers at day centre understood it better.
- Not being able to live in my own home – having to share with others
- GPs aren't always helpful / don't always seem interested in really helping

5. Any other themes emerging?

- Access to day centres is really important to people
- Having contact with family is really important
- Being able to visit the GP and have the GP talk about tablets and what is good to eat is good.
- Having good carers who know the person well is important to people
- Being able to see the Psychiatrist is good.
- Not having enough activities to explore out side of the day centres.
- Having experienced carers that are able to bring consistency to the care package makes the most impact.
- Better understanding and acknowledgement of peoples needs now compared to years ago.

Interviews with Professionals & Carers

Interviews

- LD Liaison Nurse, Bedford Hospital
- Bedfordshire GP with interest in LD
- Luton Borough CLDT social services
- Bedford Borough ALDT social services
- Manager – Supported Living Scheme, Luton
- Senior Support Worker Supported Living Scheme Luton
- Support workers – Luton x 2, x Macintyre, 1 x Home Farm Trust, 1 x Community Care Solutions
- LD Commissioner – Bedfordshire
- Manager – Care Home Bedford
- Day Care Officers x 2 – Central Beds & Luton Services

1. What is preventing people from this group from living well? (e.g. being able to go out, for example to visit day centres, to engage with other people, to be able to undertake daily activities and do other things they enjoy doing?)

Difficulty & lack of relationships, interaction and companionship / social isolation (lack of peer networks) - 7 people

Health & Healthcare – 6 people

- Poor physical health / mobility & health needs associated with LD & delays in support x 3
- Inequity in access to primary healthcare

Medication issues – 5 people

- Side effects of medication & over-sedation; including people coming into hospital following falls x 3
- Management of medication changes
- *“Medication continues to be used as a means for controlling people's behaviour, even when alternative evidence-based approaches were available”* – social care is in a unique position to effect change in partnership with others; provide scrutiny & challenge

1. What is preventing people from this group from living well? (e.g. being able to go out, for example to visit day centres, to engage with other people, to be able to undertake daily activities and do other things they enjoy doing?)

Problems in joint-working – 5 people

- Background information not being shared and support people in the service
- Division/disagreement between health providers around person's support plan; e.g. GPs, hospitals, CMHTs etc not on same page around screening, diagnostics, etc.
- Non-specialist health professionals don't understand LD and how they present; some behaviours/personalities will look like MH, but may be normal for that individual
- Health and social care professionals not listening to provider support staff
- Need to seek information from people who know individual well

Societal attitudes and understanding – 4 people

- Risk aversion in society, including people who care for people with LD x2
- General lack of experience with people with LD and autism

Lack of opportunities employment, education and training – 4 people

1. What is preventing people from this group from living well? (e.g. being able to go out, for example to visit day centres, to engage with other people, to be able to undertake daily activities and do other things they enjoy doing?)

Vulnerability and exploitation – 2 people

Provider Market – 2 comments, same person

- Provider market at the moment promotes “specialism”, but actually heavily relies on interventions from health and social care to meet needs, which theoretically they are supposed to be meeting
- Provider market > not promoting alternative mechanisms to support individuals; e.g. positive behavioural support, intensive interaction

1 person each of below:

- Not having enough staff on duty
- Problems around deterioration of skills
- **Lack of opportunities around activities**, appropriate to individuals needs
- **Ageing parents, no longer able to provide/care for their needs**
- **Access to appropriate housing** is a barrier to social inclusion and citizenship
- **The effects of LD**; difficulties with communication, behaviours and obsessions

2. What is contributing to people deteriorating or getting into crisis?

Physical Health Factors:

- Early indicators of physical health detection is poor
- Detailed patient history not always available
- Over sedation with medication for behaviours x 2
- Co morbidity of people who have been on long term medications.
- Respiratory problems and Dysphagia
- Lack of recognition of early deterioration signs from carers x 2
- Medication changes

Social Factors:

- Poor contact with services / Isolation
- Families not recognising future needs and impact of ageing.

2. What is contributing to people deteriorating or getting into crisis?

Commissioning Awareness / Implications:

- Lack of awareness of therapeutic interventions (PBS) x 2
- Risk averse or poor risk assessment and management
- Lack of quality support within provider organisations x 2
- Lack of resources
- Poor awareness of LD
- MH from GPs x 2
- Services not working together / not sharing information back to carers
- Inappropriate environments, disrupted routines, changes to staff, inexperienced carers

Individual Factors:

- Poor independent living skills and service users vulnerability.

3. What keeps people up at night working with this population? Where do you get stuck?

Local Resources:

- People in hospital ready for discharge but nowhere from them to go
- Not having enough local resources to meet complex needs / Having to place people away from their local area / families X 2
- Too many changes / cost cutting by the council

Service User Experience:

- If the patient journey in hospital has not been good, waiting for test results and not knowing what physical health condition needs to be treated.
- Lack of counselling services in Adult services for those coming from children's services.

3. What keeps people up at night working with this population? Where do you get stuck?

Carer Experience:

- Not always knowing what is the best thing to do or who to go to for support at the time its needed
- Having to keep up with documentation deadlines and support plans, organisational policies
- Long winded guidelines / care plans
- Not having enough information about the person to support them properly
- X 2
- Unpredictable behaviours of service users, Public perception of our service users,

Safeguarding situations !

4. What do you think is missing from the health, care and support system in the way we work with people from this group? Do you feel the system supports people at the right time?/in the right way? If not, what changes should we make?

Commissioning considerations:

- Lack of integration of services to prevent people from falling through the gaps in services
- Lack of commissioned services > supporting the needs of the most vulnerable and complex people > isn't a diversity of support offer, activities, etc. > lack of forensic facilities locally and not being able to support people with these needs in community settings locally as a result of this. X 3
- Not always the right support available at the time needed – needs to be more joined up
- Lack of local training for carers / families.
- Hospital staff not always understanding the LD needs.
- Not enough emphasis on alternative interventions to medication being prescribed. More awareness raising needed and support for carers to explore and understand the options

4. What do you think is missing from the health, care and support system in the way we work with people from this group? Do you feel the system supports people at the right time?/in the right way? If not, what changes should we make?

Carer Support:

- More health input from Psychology / Behavioural advisors and training for carers / families is needed.
- Too many meetings instead of direct support to people. Long processes, waiting times to be seen, decisions being made by professionals based on history rather than current situations, Incomplete assessments. Lack of confirmed diagnosis being made.
- Better preparation for adulthood and adult services is required

Service User Experience:

- Better patient voice and advocacy within health and social care system is needed. More accessible information needed for service users re MHA
- Need to treat people with LD the same as everyone else. GPs not always interested or sympathetic
- Local health system works well for people with LD – *GP*

5. Are there any interventions you are aware of that help you to support the people you work with?

If so, do you feel it helps you to support people with LD?

Processes:

- CTR process works well
- Reasonable adjustments being supported in the hospitals (Hospital Passports, communication passports, staff training)
- good quality care providers being commissioned (RESPOND)
- Actively promoting alternative responses to medication (PBS, Intensive Interaction)
- Involving services users in decision making and their care.
- Keeping people active and busy

Services:

- Local Health Facilitation from SPLD across primary care and acute care settings / Sensory Impairment service supporting sight and hearing services – they know our service users well and provide a good service / Service at Twinwoods is valued x 2
- Sensory Integration assessments within SPLD OT department : should be more of them
- Care teams working and supporting each other.
- De-escalation techniques

5. Are there any interventions you are aware of that help you to support the people you work with?

If so, do you feel it helps you to support people with LD?

Local Knowledge and Expertise:

- Increase the knowledge and understanding of the effects of over medicating people.
- Ensuring proper monitoring and reviewing of prescribed medications.
- Improve quality of training and opportunities for carers within provider organisations.

6. What do you think helps to keep this group of people well? How good do you feel local services are at recognising and responding to your views?

- Professionals, carers and providers needing to really understand the needs of our service users and not be focussed on financial gains X 3
- Having support from people who know them. Local service at Twinwoods is good at this x 2
- More activities to improve physical and mental health X 2 GPs not always aware of where to go to seek this support.
- Good quality , consistent and experienced carers X 5
- Good support to review physical health and support when going into hospital
- Service users having the chance to socialise away from who they live with or go to day care with x 2
- *“Having the LD Liaison nurse was particularly helpful”*

6. What do you think helps to keep this group of people well? How good do you feel local services are at recognising and responding to your views?

- Better training and education for carers / families.
- Information sharing between agencies and professionals.
- CTR
- Person centred practice
- Better commissioning strategies for managing high risk groups and having local resources to do this.
- Better medication management
- Better working with CQC, Local Quality Standards when exploring providers of concern to us.
- Having access to Twinwoods staff to support with Health Action Plans and better access to health services
- Not sure we are listened to, don't always get feedback

Three part data review; how it felt before and afterwards

Before...

After...

First go at Driver Diagram to bring together our theory of change – Primary Drivers

Population: People with a learning disability, with or without Autism, ADHD and dementia, who are at risk of being prescribed antipsychotic medication, with no confirmed diagnosis of mental illness*

Purpose statement: Improving quality of life for our population.

* e.g. psychosis, severe depression

Working better together for people with LD

Being supported well

Inclusion and experience in society

Recognising and empowering the person

Working together for people with LD

Providers & carers getting on same page. (information, signposting, timely specialist support for carers, knowing where to go to get support)

Reducing waste (?too many meetings instead of direct support to people?), long processes, waiting times

Addressing transition to adult services

Right care, right place, right time (addressing service gaps; for forensic support)

Access to therapeutic interventions

Being supported well

Stopping over-medication (STOMP), including balancing benefits and risks

Support with physical health

Being known and understood by people caring for me

Routine and consistency in care

Calm environment

Decisions based on current situation (not histories)

Understanding behaviours as unmet needs

Skills and understanding of LD

Inclusion & Experience in Society

Addressing vulnerability and exploitation/ safeguarding

Social life and relationships

Part of community

Changing attitudes

Employment, education and training opportunities

Recognising and empowering the person

Voice, including advocacy

Supporting people to take risks

Strengthening life skills

Enabling personal interests and activities

Choice and variety

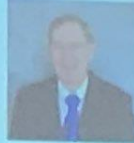
Supporting independence, including enabling people to live in own home

**1st draft Primary & Secondary Drivers
31/05/2019**

**Learning Disabilities
Partner Engagement Event**

28/06/2019

Triple Aim



- 2008: Don Berwick, Tom Nolan, and John Whittington first described simultaneously improving - population health
 - patient experience of care
 - cost per capita
- Institute for Healthcare Improvement (IHI) developed the Triple Aim for health systems
 - > Widely used in public and private health organisations
- No single sector alone can improve the health of a population
 - > Needs wider systems to cooperate eg. health care organisations, public health departments, social services, schools systems, and employers

Dr Shakeel Islam giving a fantastic introduction to Triple Aim work and the rationale and need to work in this way





Activity 1: Developing a Theory of Change

In your experience, what are the factors that enable and restrain people with Learning Disabilities living well in our community?

What contributes to people deteriorating or experiencing crisis? What can help prevent this?

[We then got people to circulate to add to Driver Diagram]



Activity 1 – part 2: Additional questions following first look and comment on Driver Diagram

1. *Is anything missing?*
2. *Is there anything your organisation finds particularly difficult in supporting people with LD to live well? What support do you need?*



Activity 3: Change Ideas

After everything you've heard today, what ideas for change do you have?

We used a different colour (orange post-its) and asked people to plot on the driver diagram

Stopping over-medication (STOMP), including balancing benefits and risks

right med
right time
evidenced
based

BETTER
SCREENING
EARLIER

GPs
To
LISTEN!

Support with physical health

Healthy living/
Exercise group
for SU's

Supporting THEM
with ASL IN AN
INCLUSIVE MANNER

PBS training
including
STOMP for
Parents / carers
to Start

Being known and understood by
people caring for me

Communication

Tr
kindly, list
to needs.
Take time
for them.

Physical
activity
group -
with support
of OT

BS training
including
-IMP for
Staff

Routine and consistency in care

DON'T EXCHANGE
ONE RESTRAINT
FOR ANOTHER
E.G. MEDICATION
FOR 1:1 support.

Good
SUPPORT

* Re-assure
Staff Re
STOMP

Rolling out
training
for Student
Nurses as
part of their
program

Calm Environment

Sensory
needs

Based on
assessments -
e.g. OT,
Sensory processing

MORE
HOUSING
OPTIONS
?

Decisions based on current situation
(Not History)

... BUT history
is also vital
e.g. trauma
neglect
MH

* PROMPT
GP'S
Re STOMP

CAREING
HEALTH
Integrity
?

Understanding behaviours as unmet
needs

UNDERSTANDING
BEHAVIOURS
MAY BE UNMET
HEALTH NEEDS

Skills and understanding of LD

Train GP'S

Staff
Support
+
Empowerment

Supporting
network
around
person

being
valued
understanding
that carers
need...

BEING SUPPORTED WELL

FAMILY
DISENGAGE
MENT

More
integrated
approach
to supporting
individuals

USE
PERSON
CENTRED
CARE PLAN

MDT input
in
Education
Health & Social
Care Plans

Consideration
of carer
involvement at
all stages

Poor
Budgets

Well
trained
Staff

Formulation
rather
than
diagnosis

Home visits
for psychiatry

idea of
culture
change -
scale of
Dementia
friends.
- community
is open to
everyone.

Educational
raising
awareness of
LD & Autism
in the community

Challenge for change
We need to work together
with all involved with
individuals to persuade
that medication is not the
answer!!
We need to look at
Strengths and
Assets

LEDER
Mortality
review
findings

Pharmacist
review
- involving
GP / PCN / care
home
- have they
- have they
- reviewed?

Physical Activity
opportunities
suitable &
accessible

technology
-> review
-> communicate

well-planned
transitions

Consistency
of support to
reflect final
outcomes of
the care plan

Autism
friendly

Form
for planning,
reducing and
monitoring any
medication reduction

LD + MH
workshops for
Carers / Services
Users

Choice

TRANSITION
TO
SERVICES

left
comp meeting
PBS in
STOMP.

helping
to help
with communication

check
with carer

involvement of
OT and capable
providers to
enable routine of
care is key

PBS
PATHWAY
*
Education for
providers &
carers.

SENSORY
ASSESSMENTS

Functional
PBS
training -
OT - which
measures
environment, sensory
needs
OT LEFT

STOMP
before
STOMP.

Specialist
support
for people with
LD and
other needs.

Family training
- meaningful
activity
- sensory integration
OT LEFT

Home visits
for psychiatry

Sense of achievement & accomplishment in meaningful work

Joint MDT working with the police & other voluntary sectors.

ACCESS TO COURT OF PROTECTION TO SAFEGUARD

Addressing vulnerability and exploitation/ safeguarding

Understanding needs Supporting agents empowerment
Ability - increasing goal communication person centred care
Raising out our profile

Lack of housing options + placements

What did our service users say was important?

- Being engaged in local community and being able to go out
- Being able to attend day centres
- Being able to do other activities outside day centres
- Being able to visit friends and family

Provide a range of options for local and national opportunities and gain skills for meaningful activity

As various holiday - annual - adventure (local) - leisure facilities - clubs - groups - advice/support.

Access to opportunities variety meaningful

MAPP ASSET + COMM PEOPLE

DROP-IN cafe

INVOLVING THE RIGHT PEOPLE THE RIGHT WAY BEING CONSIDERED WHO THE IMPORTANT PEOPLE ARE TO THEM AND SUPPORTING THEM

Social life and relations

Dating Services

Risk Management vs. Safety
Focus on negatives of historical behaviours/ risk
Focus around capabilities of individual
Challenging Collectively

Advocacy

Seeing friends - negating logistical barriers - transport etc.

Resources/ funding.

Plots - can't role + responsibility of others

Decision Dunstable

INCLUSION AND EXPERIENCE IN SOCIETY

1ST DROP IN
- Community based
- Inclusive
- Informal
- Friendly through staff
- Empowering and enabling

Mental Capacity Assessments

Part of community

reasonable adjustment in society

Capacity

restrictions to access in community

* Accessible App Empower to Luton see location details

Signposting, sharing of details of what is available.

Enriching lives with interest and opportunity

Reasonable adjustments to all areas in community

Sharing information a resource

reasonable adjustments by society

Challenging Stigma

Person Centred Risk Assessments & plans

Luton side by side model promoted / adopted wider - what can people do for themselves - what can family/friends do to support. lead to system change culture change

carers say wasn't ell?

people who care for people

and autism anyone else

and training

social inclusion and citizenship

ABILITY WEEK

Changing Attitude
Trusting that people know their own minds. - Go with it!

Taster days in different teams. office champions.

More joint work on day/night

Empowering PWD to challenge stigma.

Sexual Education in well being group

employment, education and training opportunities

Smooth WE HAVE 7 EMPLOYEES WORKERS IN LUTON

DI training for service users

not having skills - lack of training

Supported Internships

A manual/ directory or activities/ events in the county.

Strengths based approach cbc do too.

Getting the right information, support at the right time.

more reasonable adjustments around employment

Education & awareness around learning disability and autism.

Funding

RECOGNISING AND EMPOWERING THE PERSON

Enabling personal interests and activities

Supporting people to take risks

Voice, including advocacy

Strengthening life skills

Supporting people to take risks

Choice and variety

Supporting independence, including enabling people to live in own home

Link in with Enablement Services → ELFT

Strong support network consistency

Support network family, friends

Empowerment through consistent professional relationships

Access to activities they enjoy

positive risk taking + management

CHANGE OUR LANGUAGE
- NO SERVICE USER
- NO CLIENTS
- NO CUSTOMERS.
JUST PEOPLE

recognising people's strengths

Focus on psychosocial model of disability.

Reviewing service users with choice and a voice as opposed to making decisions for them

sense of security and safety

access to therapy MCA

More training for staff
- Daily DQs
- Debrief after incident
- Staff supervision
- Staff meeting
- Outing with patients
- More activities for patients

Seeing friends

DARE TO FAIL AS A PROFESSIONAL

least restrictive in all aspects

Support for carers

Robust training for Carers

People Participation

WE HAVE EXPANDED OUR ENABLEMENT TEAM FROM 2 TO 7 IN LUTON.

less medication
- right evidence based treatment
- avoid side effects
- avoid cost
- avoid hospital

Local services - right access - right care - right time - right place

Reducing Stigma

Independent Lifestyle Team Central Res

Choice
- Enabling
- Community
- Collaborative

organisation working together + communication

access to finances +

being healthy
physical health
mental health
social health

Positive risk taking

independence through consistent following of P.C care plan

Person Centred Plans.

WE'VE JUST SET UP 3 TRAINING FLATS IN LUTON

Engagement through different techniques

STUDENT NURSE

Person Centred Plans



Activity 2: Sharing our strengths and assets

- 1. How do you/ does your organisation contribute to improving quality of life for people with learning disabilities already?*
- 2. What could you offer to help this work move forwards working together and supporting each other? What support could you provide others in the system? [asked people to reflect on and connect with what others said they found difficult in activity 1]*
- 3. What other assets are you aware of in the community that we could engage further to support this group? Where is there 'untapped potential'*

Contributions

ELT Service that (help + respond) ELT Robust Assessment that IS NOT Focused

Quality Assurance

Case & Treatment Reviews

Communication

Support Main Street

Skills Support

Transition

Prevent activities

CONTRIBUTION

CONNECTING PEOPLE TO MAKE FRIENDS

COMMUNITY MAPPING

3 Training Plots

Skills Support

Transition

Prevent activities

CONTRIBUTION

Supporting young independent life

Building Trust

Supporting young independent life

Building Trust

Supporting young independent life

Building Trust

Supporting young independent life

Building Trust

Contribution

Working with Service users and families to help them voice what they need to shape the service

Family Support

Engaging with people who are leaving and their carers

Provider Market Shaping Contract and quality assure services. New business

finding housing solutions

Strategic Planning to return people living out of area

Market Shaping - Quality + services + value

PFA - CBC Facilitating transition from children's services

PFA - CBC Supporting Carers

PFA - CBC Support young people to develop independent skills - TILT

PFA - CBC Support cust parents to find dual inclusive employment

PFA - CBC Holistic Assessment and Signposting

CBC - PFA Advocating for our customers

CONTRIBUTION

Transforming care supporting children from hospital

CTR LAEP

Engaging with people who are leaving and their carers

Provider Market Shaping Contract and quality assure services. New business

finding housing solutions

Strategic Planning to return people living out of area

Market Shaping - Quality + services + value

PFA - CBC Facilitating transition from children's services

PFA - CBC Supporting Carers

PFA - CBC Support young people to develop independent skills - TILT

PFA - CBC Support cust parents to find dual inclusive employment

PFA - CBC Holistic Assessment and Signposting

CBC - PFA Advocating for our customers

CONTRIBUTION

Working as a MOT to provide support in all aspects of the case

Providing housing support to people in crisis

Supporting young independent life

Building Trust

Supporting young independent life

Building Trust

Supporting young independent life

Building Trust

OFFER / SUPPORT

Handwritten notes on sticky papers under the 'OFFER / SUPPORT' header, including phrases like 'Good quality local provision for GP's', 'Medical appointments', and 'Engagement in the community'.

Offer/Support.

Handwritten notes on sticky papers under the 'Offer/Support.' header, including 'Managing and sharing information across services' and 'Making time to help others'.

OFFER / SUPPORT

Handwritten notes on sticky papers under the 'OFFER / SUPPORT' header, including 'Engagement in the community', 'BLMK Strategic direction', and 'Joint meetings with all LD Commissioners'.

Offer / Support

Handwritten notes on sticky papers under the 'Offer / Support' header, including 'Healthcare professionals', 'Knowledge of social services', and 'Change Management'.

Offer/Support.

Handwritten notes on sticky papers under the 'Offer/Support.' header, including 'Sharing information across services', 'Making time to help others', and 'Good quality local provision for GP's'.

Is there anything your organisation/your part of the service finds particularly difficult to support people with LD to live well? *

Please write your organisation/part of the service on your post-it

Handwritten notes on sticky papers under the 'Please write your organisation/part of the service on your post-it' header, including 'Poor health access to GP's', 'Good quality local provision for GP's', and 'Capacity'.

(Big pen)

Things you find difficult (cont.)

Handwritten notes on sticky papers under the 'Things you find difficult (cont.)' header, including 'Poor quality care', 'Joint Computer Systems', 'Central Hosts', and 'Inappropriate referrals'.



King's House
Facilities
The emergency exit should be kept clear at all times.
Do not use the stairs for anything other than their intended purpose.
Please do not use the lift track to store anything.
The lift should be used for people only.
The lift should be used for people only.
The lift should be used for people only.
Thank you

Enabling personal interests and activities

Supporting people to take risks

Voice, including advocacy

Strengthening life skills

Supporting people to take risks

Choice and variety

Supporting independence, including enabling people to live in own home

RECOGNISING AND EMPOWERING THE PERSON

Strong support network takes energy

DARE TO FAIL: A PROFESSIONAL

Independence through consistent funding of P.L. call part

Some fun set up 3 training days in Luton

Video of our event

<https://www.youtube.com/watch?v=cqn5nf0DnwY>

Please tell us your experience of the event today

- *I found it a good opportunity to discuss how we can improve the lives of people with learning disabilities*
- *Great event to collaborate and work together across organisations to implement change, sharing of assets and focusing on the individual holistically*
- *Fantastic to see what some of the stumbling blocks are and how we can overcome these TOGETHER*
- *Good to hear ideas/thoughts from other professionals – from different agencies and hear that these are shared. Good to help engender partnership working between health and social care*
- *I found it very interesting and informative and thorough. I also identified areas in which we can, as services, improve*
- *Very thought provoking*

Please tell us your experience of the event today

- *Very interesting, informative and productive*
- *Very informative*
- *It's been helpful in my wider understanding of people with LD, as a student*
- *Interesting and informative. Lots of ideas to implement and share*
- *Really interesting. Lots of points raised and discussed. Was good to be able to see what others had written and areas they had raised*
- *Great to sit alongside partners across Bedfordshire to discuss how to improve lives. I am eager to be part of the difference this can make*
- *Very positive event. Great to meet a variety of colleagues*
- *Very interesting day to discuss challenges and ways forward. Look forward to making and seeing a difference in LD provision*

Please tell us your experience of the event today

- *Brilliant. Thought-provoking*
- *Good experience. Mixing with another services and getting ideas to move forwards with*
- *Good*
- *Been a great event. Learnt a lot about what other organisations are doing*
- *Informative and thought-provoking. Has given me ideas to take back and test in clinical practice*
- *Very informative. Motivated*
- *Great experience of getting to know other professionals from different departments and areas and sharing information about what is available in the community to support people with LD and what is needed*
- *Great to see everyone working together to really think about improving quality of life for people with LD*

How do you feel about working together to improve quality of life for people with Learning Disabilities?

- *This was the reason I became a social worker*
- *It is so important to work together and be fully committed*
- *I think it is very important for health and social care to work together to improve quality of life*
- *I feel that working together is the way forward, as if we want to effectively improve quality of life, we need to focus on all aspects of care and work together*
- *Feel very strongly that joint/integrated working is a positive way for people who have a learning disability*
- *I feel very positive about working together and breaking professional and organisational boundaries, in order to support people with LD to live well in the community*
- *This has been a great way to discuss and brainstorm ideas and opinions. Good to hear other professions input*

How do you feel about working together to improve quality of life for people with Learning Disabilities?

- *It is really important – working together can lead to better outcomes for the individual –more effective and efficient ways of working*
- *It is essential to work together for this. It is not something that can be achieved in isolation*
- *Made me really think about what we actually do and how small changes can make a huge difference to a person's quality of life*
- *Optimistic*
- *Great*
- *It is the core of what we do*
- *I think it's brilliant. The LD community is a wonderful community to be part of*

How do you feel about working together to improve quality of life for people with Learning Disabilities?

- *Collaboration is a big factor, what we learn should be put into practice*
- *I feel enthusiastic to give more of my time and energy to help improve people with Learning Disabilities' quality of life following my graduation as a student*
- *Working together is the only way that this will happen. Sharing knowledge is really important*
- *Passionate*
- *I think it's the way to go and I am happy to be part of that*
- *It should be central to the work we do*
- *Completely for it!*

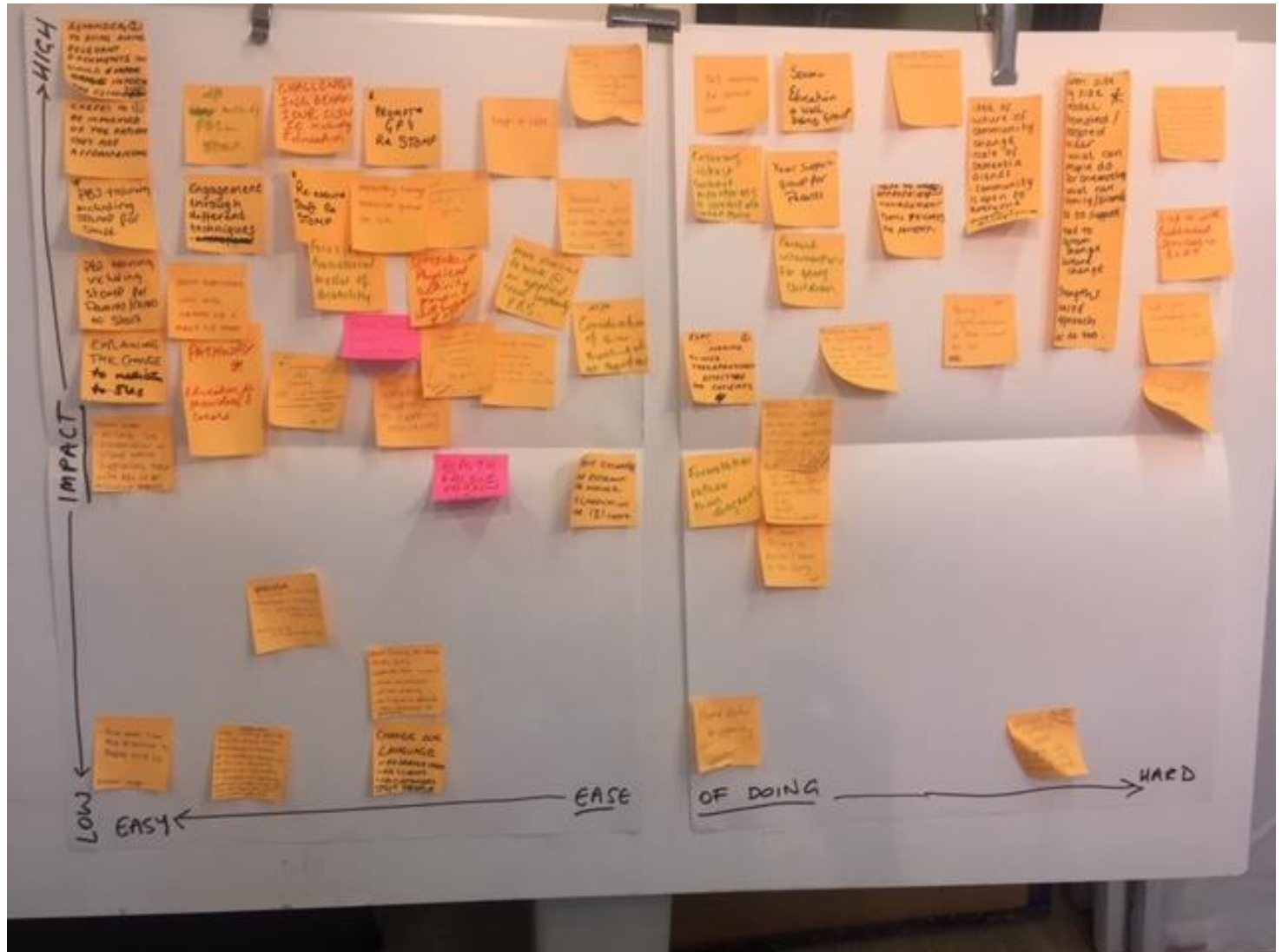
What was our first measurement plan for the work?

In development

Dimension of Triple Aim	Measure	Operational Definition	Data Collection Plan/ Notes
Population health	Total % BNF max doses across caseload	Adds up % BNF max dose for everyone on caseload BNF max dose is ...	Local Spreadsheet held by Drs
	Pending: develop tool that explores outcomes identified as important to people	Consider sampling to make manageable	PLACEHOLDER
Experience of Care		Questions TBC	Patient Experience Questionnaire (PEQ)
Value	Cost of antipsychotics (APs) prescribed to population	TBC	Local Spreadsheet held by Drs
	Cost of review appointments for APs prescribed to population	Come up with average estimate model for medical time, other clinical time, admin time. Apply this to number of review appointments conducted per month	Local Spreadsheet held by Drs
	Pending: Number of contacts with Intensive Support Team per month		Link RiO codes for people in population to use of IST

How did we prioritise our drivers/change initiatives?

Step 1: 2x2 grid considering ease and impact following engagement event



How did we prioritise our drivers/change initiatives?

Step 2: 1st Project Team Meeting following engagement event

What drivers/initiatives did we identify as our first priorities?

Initiatives/tests of change; what did we learn?

- Insert PDSA details if applicable

Population level measures gathered

- Insert dashboard

How did you manage ensuring you sustained changes (Quality Control)?

The below provides ways to capture key insights through this document whenever you think it's the right approach

Copy the below slide to keep the template version to use again in future

Challenge, Choice & Outcome (Ganz)

Challenge: Why did you feel it was a challenge? What was so challenging about it? Why was it your challenge?

Choice: Why did you make the choice you did? Where did you get the courage – or not? Where did you get the hope – or not? How did it feel?

Outcome: How did the outcome feel? Why did it feel that way? What did it teach you? What do you want to teach us? How do you want us to feel?

WOW Moment!

[e.g. a big piece of learning, a big opportunity that came up, a moment when something happened that changed how you were thinking / how you understood the issue / how you worked together, etc.]

Please insert the date it happened, add description and insert into the relevant place above to reflect the chronology of the project



**WOW (that was a tricky/challenging)
Moment!**

[flip-side of the above... not everything that happens is positive, but there is still loads of learning in this, so important to capture as well]

Please insert the date it happened, add description and insert into the relevant place above to reflect the chronology of the project