Debra Moore Associates

The role of specialist health services in supporting the health needs of people with learning disability

Community Learning Disability Teams

Valuing People Now

NHS East Midlands

Acknowledgements

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Debra Moore & Judi Thorley

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Executive Summary

- Specialist learning disability health professionals continue to have an important role to play in supporting the health and wellbeing of people with learning disabilities and their families. They are required to both support mainstream practice and directly serve those with the most complex needs[1].

- These professionals work in a range of settings and increasingly undertake new and challenging roles in both hospital and community based provision.

- This guide is concerned with the work of Community Learning Disability Teams (CLDT's) and forms part of a wider programme of work to support the development of specialist learning disability health services.

- This guide is not compulsory but offered as a resource, along with associated materials, to help local stakeholders consider the work of their CLDT now and in the future.

- It presents information and resources to support the contribution of CLDT's to achieving the objectives and standards within government policy and guidance for people with learning disabilities such as *Valuing People Now* and the core outcome domains for the NHS, social care and public health.

[1] DH 2007 Commissioning Specialist Adult Learning Disability Health Services

- It uses a model and outcomes framework, *Confirm & Challenge: 6 C's* (Moore 2008) to help localities to engage stakeholders in a process that enables them to check their progress and to determine and agree priorities.

- This guide is designed to be used by commissioners and providers to enable them to review and improve services. It sits alongside an easier to read version for people with learning disabilities and families.

Key messages

Put simply, CLDT's should be delivering person centred services, within the community that respect and promote the rights of people with learning disabilities as full citizens. To do this, there needs to be in place, good commissioning, a competent workforce and a robust system to check quality and outcomes.

CLDT's provide assessment, care management, care co-ordination, therapeutic intervention and health professional training and support for people with learning disabilities.

Introduction & Background

1. What the future role and function of Community Learning Disability Teams (CLDT's) will be as we move into the next decade has been a key question in many local areas. This question has been prompted by changes in commissioning, care delivery and practice and the debate informed by a number of policy documents.[23] These documents describe a future where people with learning disabilities have increasing choice and control, increased access to mainstream provision and services closer to home. Moreover, wider government initiatives across health and social care such as the drive towards increased personalisation contain inherent implications for the work of community learning disability teams.[4]

2. Accordingly, the Valuing People Now Team commissioned Debra Moore Associates to deliver a programme of work to support the development of specialist adult learning disability *health* services. As part of this work different regions in England selected to examine various parts of the 'system' that ranges from community based support and liaison with the mainstream NHS to the provision of secure hospital beds.

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[2] DH 2010 Valuing People Now

[3] DH 2001 Valuing People

[4] SCIE 2010 At a glance 22: Personalisation briefing: Implications for community learning disability staff

3. The East Midlands Region (and latterly the Yorkshire & Humber Region) chose to look at the role and function of community learning disability teams and their contribution to specialist adult learning disability healthcare delivery. Whilst the CLDT work was developed regionally, allowing a 'depth and breadth' look at the current situation, it has been informed by national information and the work of other regions and localities.

4. The emphasis of this guide is to clarify the core functions which a community learning disability team will need to perform within the *wider system* of health and social care rather than describing the exact structure of the team.

5. It is also focused on their role in *health care delivery* whilst acknowledging the fundamental partnership with social care and shared outcomes in relation to supporting health and wellbeing. This stems, in part, from the clear directive within government good practice guidance to ensure that specialist learning disability health professionals focused their efforts on *health related activity*[5][6]

> What matters is that people with learning disabilities are included as equal citizens, with equal rights of access to equally effective treatment.
>
> Sir Jonathon Michael

[5] DH 2007 Commissioning specialist adult learning disability health services - Good practice guidance

[6] DH 2007 Good practice in learning disability nursing

6. There has been much reported in the last few years about the health of people with learning disabilities. This guide will not rehearse the detailed findings of these papers but seeks to highlight some of the key issues that have a particular relevance for community learning disability teams.

7. Almost 10 years ago the government set out a clear expectation that most of the health needs of people with learning disabilities would be met by improved access to mainstream NHS services[7].

8. However, the current evidence would suggest that the capability of mainstream services (including mental health) to appropriately meet to support people with learning disabilities is still problematic. A recent raft of documents, guidance and inquiry papers describe the failings of the mainstream NHS to meet the needs of this group[8][9][10]. In particular, the Ombudsmen's report examining the deaths of six people with learning disabilities within the NHS[11].

9. Whilst we can point to examples of good progress in some services that have made reasonable adjustments, engaged well with people with learning disabilities and their family carers and trained staff this is not generalized across the NHS.

[7] DH (2001) Valuing People

[8] Mencap (2004) Treat Me Right!
[9] Mencap (2007) Death by Indifference
[10] Michaels J (2008) Access for ALL – Independent Inquiry into access to healthcare for people with learning disabilities
[11] Health Service Ombudsman and the Local Government Ombudsman (2009) Six Lives: the provision of public services to people with learning disabilities

Moreover, when access and delivery is improved, it is often precariously reliant on an individual. Often this is someone with specialist training in learning disabilities, such as a health facilitator or acute liaison nurse, who acts as a 'champion' as identified in the recent progress report 'Six Lives' (DH 2010).

10. A common theme within all these reports is a requirement to provide training for mainstream health professionals and to provide expert support and advice as required[12]. The source of this expertise is often identified as the local community based learning disability teams[13].

11. Whilst in some localities learning disability adult in-patient services have provided training and support, this is more often at the interface with mainstream psychiatry or the criminal justice system[14].

12. Initiatives to improve the health of people with learning disabilities such as health checks and health action planning have also placed appropriate, but additional, requirements on community learning disability teams. Whilst many areas have appointed new positions such as Strategic Health Facilitators and Acute Liaison Nurses they are not intended to replace the work of CLDT members. Indeed, there is some anecdotal evidence to suggest that their work can trigger increased activity for community learning disability teams. This is because their activity

[12] DH (2010) Six Lives Progress Report

[13] DH 2007 Commissioning specialist adult learning disability health services - Good practice guidance

[14] VPST (2004)Green Light Toolkit

usually leads to heightened awareness in the local area of the health inequalities faced by people with learning disabilities the need for support with health checks and other interventions.

13. Similarly, there is an increasing demand to support the needs of people with learning disabilities within the criminal justice system[15] [16]. The reports by the Prison Reform Trust and the Bradley Review set out the need for more training, advice and partnership working with the Criminal Justice System.

14. Demographic information demonstrates a growth in the numbers of people with complex needs who will need access to specialist support[17]. We know that currently the health needs of this group are substantial yet, may be poorly co-ordinated. This can be a particular problem for people who described as having a profound intellectual and multiple disability[18].

[15] DH (2009) Lord Bradley's review of people with mental health problems or learning disabilities within the criminal justice system

[16] The Prison Reform Trust (2008) No One Knows

[17] Emerson, E. (2009) *Estimating future numbers of adults with profound multiple learning disabilities in England*. Lancaster: Centre for Disability Research.

[18] Mansell J. (2010) Raising our sights

15. Equally, in some localities we are seeing difficulties creating the type of individualised support required by people who are labelled as 'challenging'[19]. Some areas have augmented provision by the creation of specialist teams such as behaviour support teams. However, a significant amount of the day to day delivery is the responsibility of the CLDT. As well as supporting the individual and their family, there is an obligation to provide training to those who provide housing and support.

16. Political and demographic changes provide the back drop in which we have to consider role and function of specialist health professionals in community teams. Specifically, how we can make best use of this valuable resource now and in the future.

17. In many areas there are currently changes taking place in relation to how and where community teams are managed and positioned. Clearly, each locality will structure support in a way that best meets their local population requirements and promotes inclusion. However, we know that, to function well, the CLDT's need to have effective partnerships with other services and agencies. This includes the wider NHS and social care but also those agencies concerned with employment, housing, leisure, education etc.

[19] DH (2007) Services for people with learning disabilities and challenging behaviour or mental health needs

18. To support CLDT's to be responsive to local need requires commissioners to ensure there are clear and up to date service specifications in place. Importantly, community teams should have the education, training and capacity to deliver agreed outcomes. Good workforce planning and development is vital.

19. In developing the workforce (in both mainstream and specialist provision) to achieve better health for people with learning disabilities, we should not underestimate the role CLDT's have in providing leadership.

20. Team members have a range of skills, knowledge and expertise in working with people with learning disabilities, families and their communities. They hold valuable information about the needs of people with learning disabilities and insight into the conditions that affect their health and wellbeing. They see 'first hand' the barriers and opportunities to good services and support. This knowledge needs to be connected to the forums where conversations and decisions about commissioning take place such as the local health and wellbeing boards.

Building a picture – nationally and regionally

21. To inform this guide and regional conversations; information from a number of sources was examined including a national electronic survey undertaken in 2009[20]. The survey, captured the views of over 500 self selecting participants who were all members of community learning disability teams across England.

22. Other sources of information included government guidance, workshop and survey feedback. This revealed a number of emergent themes that related to the current priorities, activities and contribution of CLDT's. These are broadly grouped below

- Delivering direct specialist interventions and expert advice
- Reducing health inequalities and supporting the delivery of Valuing People Now health objectives
- Supporting their colleagues in the mainstream NHS including mental health
- Reducing inappropriate use of out of area placements
- Supporting the personalisation agenda
- Safeguarding
- Effectively managing the 'transition' between teams e.g. children & older people
- Working with the criminal justice system

[20] Moore D (2009) unpublished research on Community Learning Disability Teams

23. Information sources also revealed a number of 'tensions' to be managed within teams, not least the balance of administrative and care management duties with direct or face to face interventions. Many teams report a change in their caseload over time with an increased 'weighting' of people with more complex needs who often needed intense support.

24. This might be people who have PMLD or serious behavioural challenges, but also people who may have mild learning disabilities who present in situations of high risk. This might be due to the potential danger they, or others face, by their behaviours or lifestyle. For example, a combination of learning disabilities, mental health problems and substance misuse and the impact on wellbeing, vulnerability to exploitation and offending.

25. Working with people in complex situations often requires more time and contact with the person with their family and strong partnership working across a range of agencies. However, for some teams this is not well reflected in activity or commissioning and contract specifications.

> The vast majority of liaison and diversion schemes do not have learning disability expertise….this is despite the Reed Report's recommendation in 1992 that 'court diversion and assessment schemes should develop effective links with local learning disability teams and, where possible, team members should be encouraged to contribute to schemes'.
>
> The Bradley Report 2009

26. Anecdotal evidence *would suggest that for many teams a* large proportion of time is spent putting information into IT systems that are not always seen as 'fit for purpose'.

27. Some areas have different IT systems across agencies and difficulties with access and compatibility mean that some professionals are inputting data into two or more systems. Similarly, gaining access to records across the boundaries of health and social care can be equally problematic.

28. If community teams are to be effective then local areas need to provide information sharing protocols, IT systems and tools that reduce administration and allow them to spend maximum time with people and families.

Understanding the local context

29. It is important when determining the contribution of CLDT's to an individual's health and wellbeing, to do so within the context of the wider systems. This includes not only the readiness and capacity of mainstream services but that available from natural supports, family and friends.

30. The idea that all services should work in partnership with the person and their family is central to current government policy. A recent partnership agreement describes how we should *Think Local, Act Personal*[21]. It describes how councils, health bodies and providers need to work more efficiently to personalize and integrate service delivery across health and adult social care. By working closely with people and families they will have greater choice and control over their care and support.

31. Diagram 1 maps out some of the natural and formal relationships within a locality that can work together to support better health for people with learning disabilities. Whilst not forgetting the primary relationship with people and families, it is clear that any change to the commissioning or provision of any part of the system has potential to affect the capacity, efficiency and effectiveness of the rest.

[21] Think Local, Act Personal: New sector-wide partnership agreement for transforming adult social care (SCIE 2011)

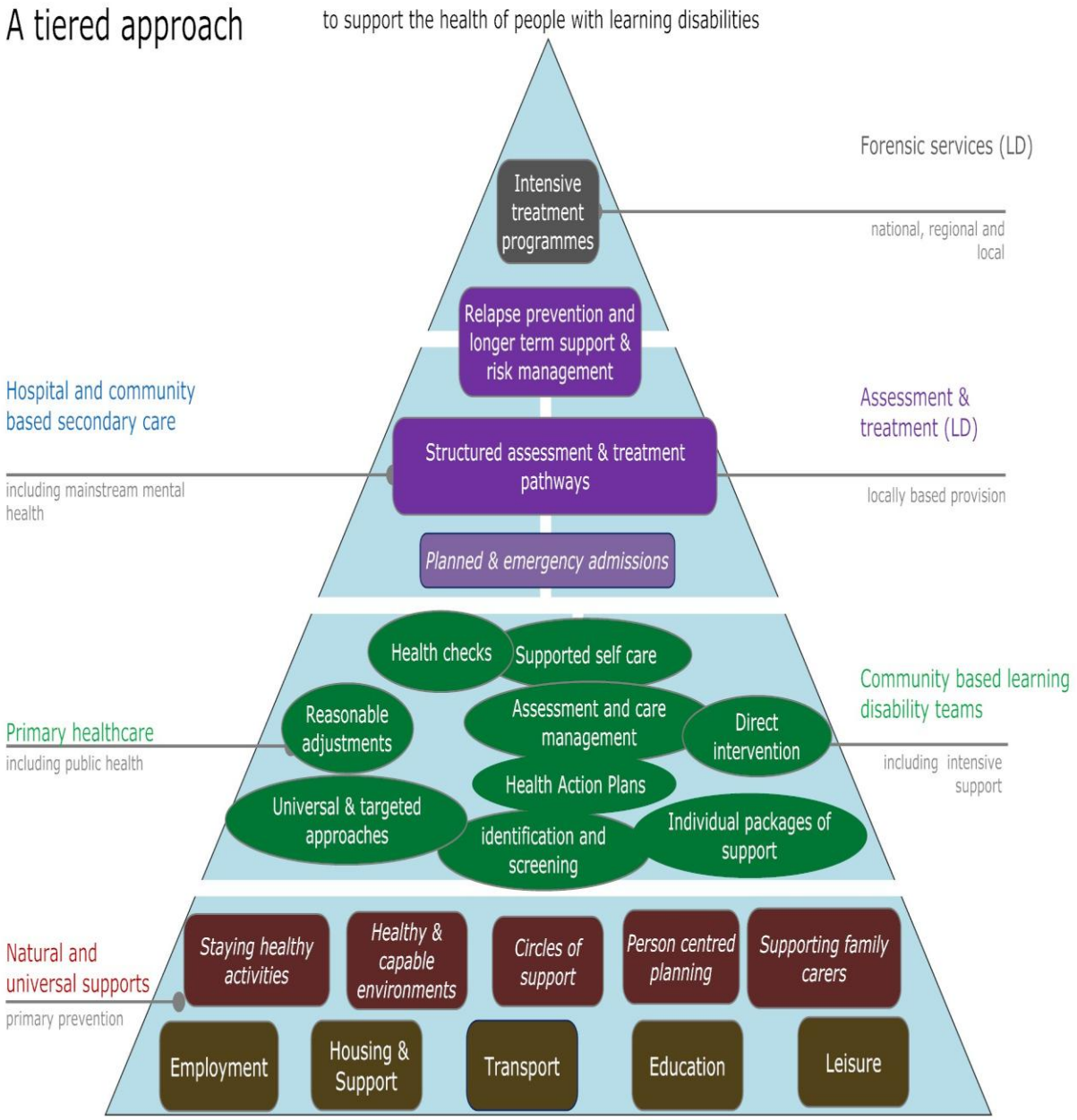

A tiered approach
to support the health of people with learning disabilities
Forensic services (LD)
Intensive treatment programmes
national, regional and local
Relapse prevention and longer term support & risk management
Hospital and community based secondary care
Assessment & treatment (LD)
Structured assessment & treatment pathways
including mainstream mental health
locally based provision
Planned & emergency admissions
Health checks
Supported self care
Community based learning disability teams
Reasonable adjustments
Assessment and care management
Direct intervention
Primary healthcare
including public health
including intensive support
Health Action Plans
Universal & targeted approaches
identification and screening
Individual packages of support
Natural and universal supports
Staying healthy activities
Healthy & capable environments
Circles of support
Person centred planning
Supporting family carers
primary prevention
Employment
Housing & Support
Transport
Education
Leisure
Supporting an active and healthy lifestyle

Diagram 1

32. Commissioning decisions about the work of Community Learning Disability Teams needs to account for local environment or 'setting conditions' in which the team operates. This includes how successful other parts of the system, such as primary care, are in positively contributing to the health and wellbeing of people with learning disabilities.

33. For example, some primary care services have made good progress on health checks for people with learning disabilities and the CLDT input into the process may be modest. In other areas there is still much work to do as the number of people with health checks and health action plans is low[22].

34. Whilst health checks are the responsibility of primary care, there is a clear role for specialist learning disability professionals. For CLDT's this might include delivering learning disability awareness training to primary care professionals. It may also include advice and support to meet a particular individual's needs.

> The training should be provided by the strategic primary health care facilitator for people with learning disabilities…. and / or members of the local community learning disability team ….in partnership with self advocates…
>
> Clinical Directed Enhanced Service (DES) Guidance

[22] DH (2010) Six Lives Progress Report

35. Whilst the core activity of the teams may be the same, the weighting on each activity will need to be flexible to accommodate local need. Contracts should be reviewed regularly and have scope to accommodate locally agreed priorities. As new local public health structures take form, it will be vital for CLDT's to have a route to contribute, and make use, of local population information.

36. Making good use of existing local data collection systems such as Joint Strategic Needs Assessments (JSNA) and tools such as the Learning Disability Health Self Assessment Framework will be important. They provide information that should guide and inform commissioners including emergent commissioning consortia about what services and supports are needed, including those provided by community based teams.

Confirm & Challenge Model & Outcomes Framework (6C's)

37. As previously described Community Learning Disability Teams are facing an unprecedented demand to support the broad agenda of reducing health inequalities experienced by people with learning disabilities. At the same time, fundamental changes in the way services are commissioned and provided are impacting on the way they support people with learning disabilities and their families. The Confirm and Challenge Model and Outcomes Framework[23] are offered as a resource to support this process.

38. This model and framework was developed to support the commissioning and delivery of specialist learning disability health services. The first version for CLDT's was drafted in 2008[24] and has been updated and improved for this guide.

39. This model and outcomes framework assimilates key policy and good practice guidance across health and social care and translates this into a structure and process for localities to work with. The outcomes framework reflects the objectives and recommendations contained within a range of government, independent, regulatory and professional publications. This includes those representing the voice of people with learning disabilities and their families.

[23] Moore D (2006) Confirm & Challenge Model and Outcomes Framework(6C's) for Specialist Learning Disability Health Services & Community Teams www.debramooreassociates.com

[24] Moore D & Hutchinson A (2008) Confirm & Challenge Model and Outcomes Framework (6C's) for Community Learning Disability Teams

40. The model and outcomes framework is not intended to be an exhaustive list of all the things that CLDT's are engaged with. It is designed to help CLDT's to *confirm* their direction of travel and contribution to the health and wellbeing of people with learning disabilities. To help them to identify and *challenge* the health inequalities faced by people with learning disabilities and assist in reducing them.

41. The model and outcomes framework is designed to help CLDT's to:

- Confirm national and local objectives as identified in key policy such as Valuing People Now.

- Clarify what their role is in relation to achieving better health and wellbeing for people with learning disabilities.

- Think about the work of specialist learning disability health professionals within the 'whole system' of services and support.

- Identify how they can improve outcomes for people and families.

- Have a process for demonstrating they are working towards meeting the objectives within relevant policy and guidance.

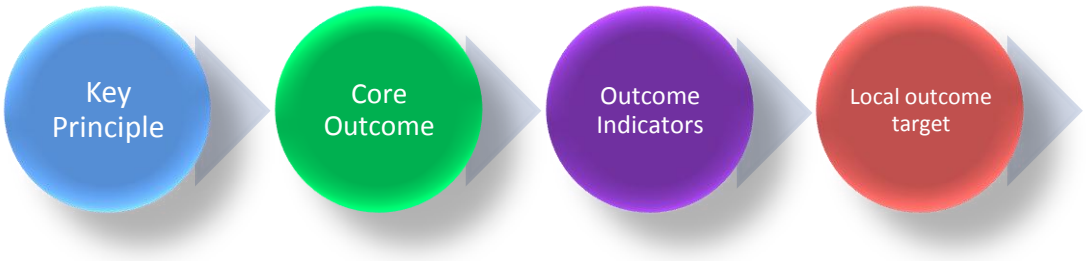
- Consider their contribution to the wider health and social care agenda. In particular, the NHS, Public Health and Social Care Domains.

42. The Confirm & Challenge (6C's) model and outcomes framework is based on 6 Key Principles or assumptions that emerge from policy and practice. These are 3 Principles that guide the design and delivery of services and support

Underpinned by 3 Principles that drive the way we work to make this happen

Put simply, CLDT's should be delivering person centred services, within the community that respect and promote the rights of people with learning disabilities as full citizens. To do this, there needs to be in place, good commissioning, a competent workforce and a robust system to check quality and outcomes.

43. Beneath these 6 Key Principles are a set of Core Outcomes which each have a brief set of Outcome indicators. These have been developed to help teams to decide if they have achieved, or are working towards achieving, the outcomes. Local areas are encouraged to set their own measurable milestones or Local Outcome Targets to help them to move along the continuum towards achievement. This process is described in more detail within the following sections.



Key Principle 1. Centredness – *person centred services and support*

44. Listening, learning from and focusing on the person and their family, has been at the heart of government policy and guidance for people with learning disabilities for over a decade[25]. *Valuing People* set out a direction of travel that has more recently gathered momentum across other groups and within mainstream services. It has been strengthened by the move toward personalisation and use of personal budgets.

45. Within the NHS there is an increased emphasis on improving patient experience and increasing their choice and control over when, how and where they receive treatment. The NHS Constitution[26] states that *'NHS services must reflect the needs and preferences of patients, their families and carers'*. Within social care the move towards personalisation[27] has embedded much of the philosophy, tools and techniques familiar to learning disability services.

[25] DH (2001) Valuing People – A Strategy for Learning Disabilities for the 21st Century

[26] DH (2010) NHS Constitution (updated)

[27] DH (2010) Personalisation through person centred planning

46. Clearly, CLDT's will need to demonstrate how they are using person centred thinking and approaches in their work. This includes the 'setting conditions' in which the team operates. For example, do working policies support the team to work in a person centred way?

47. To help teams to clarify their role and contribution to the delivery of person centred services the framework offers 3 Core Outcomes to work towards.

C1 The team plans and delivers care in a person centred way

C2 The team works in partnership with the individual and their family

C3 The team utilises a range of communication tools and approaches to meet individual need

48. Beneath the 3 core outcomes are a set of suggested outcome indicators to help the team and local stakeholders to determine whether they are achieving, or working towards, achieving the outcome (tables 1&2).

49. Each of the core outcomes can be 'rooted' back to a range of relevant policy or good practice guidance. For example if we take core outcome C3; *The team utilises a range of communication tools and approaches to meet individual need.* This can most recently be seen reflected in the report by Professor Jim Mansell *'Raising Our Sights'.* This report calls for better communication with people with profound multiple and intellectual disabilities and increased skill across the workforce in person centred communication approaches.

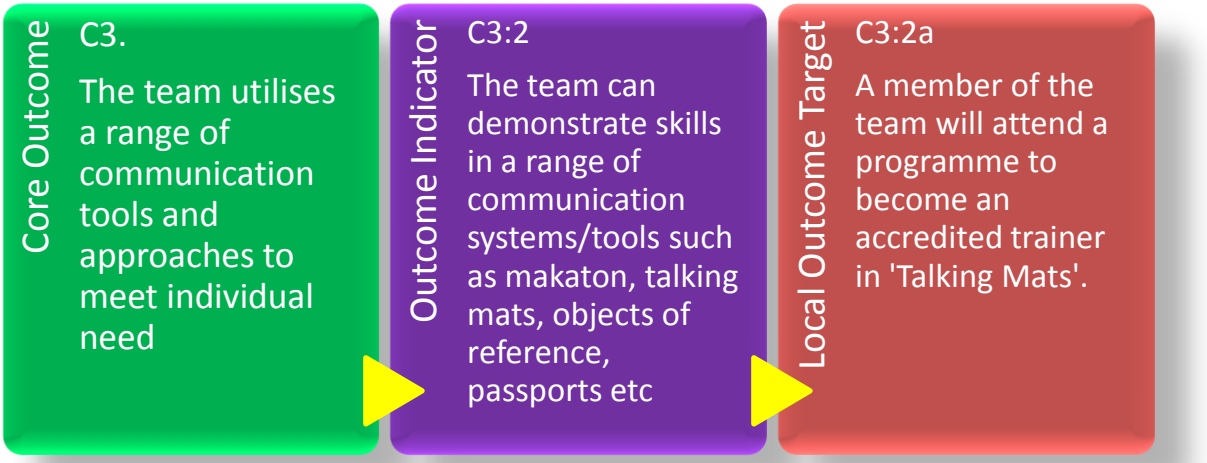
Core Outcome: C1. The team plans and delivers care in a person centred way	
	Outcome indicators
C1:1	Assessments are undertaken in a timely fashion; the person, family carers and supporters are fully included.
C1:2	There is an agreed information sharing protocol within the team; this prevents unnecessary repetition of assessment and information gathering from the person and family carers.
C1:3	Plans detailing care and support are developed collaboratively with the person, family carers and those who know and care for them.
C1:4	The team supports individual choice and personal preferences in relation to care and treatment; this is evidenced in planning and decision making processes.
C1:5	When eligibility criteria or individual preferences cannot be met, there is a transparent process for informing the person and their family. There is accessible information and a clear route to the complaints procedure.
C1:6	Staff are well trained and confident in using person centred approaches and tools and contribute to person centred planning and review meetings.
C1:7	The team is responsive to the diverse needs of the population; providing a culturally competent service.
C1:8	The allocation of care manager or care co-ordinator reflects the needs of individuals and their families and the complexity of their situation.
C1.9	Team members who are fulfilling the role of care manager are trained and skilled in individual service design and funding.
C1:10	Policies, protocols and procedures promote person centred approaches and individualised packages of support.
C1:11	Review meetings are organised and conducted (including CPA) in a manner that optimises the involvement of the individual and their family and promotes partnership working.

Table 1.

Core Outcome: C2. The team works in partnership with the individual and their family	
	Outcome indicators
C2:1	The team has an accessible referral system and clear pathways that describe the services and support available. This information is available to self advocacy, carers groups and in the wider community e.g. GP surgeries and libraries.
C2:2	Documentation detailing care and support and personal correspondence is provided in a format useful to the individual and their family.
C2:3	People with learning disabilities and their family carers are involved in reviewing and monitoring the individual services they receive from the team and participating in team development and service design.
C2:4	The team provides training and information for service users and family carers to enable them to enhance their own skills and knowledge.
Core Outcome: C3. The team utilises a range of communication tools and approaches	
	Outcome indicators
C3:1	People and their families are appropriately supported to communicate their needs and wishes. This includes how they contribute to, and participate in their own assessments and review meetings.
C3:2	The team can demonstrate skills in a range of communication systems/tools such as Makaton, talking mats, objects of reference, passports etc.
C3:3	The team has ready access to interpreter services for minority languages and British Sign Language.

Table 2.

50. Illustrated below is how a community learning disability team might work with the framework on a core outcome within the principle of centredness. In this example the team and relevant stakeholders decided that they needed to enhance their skills in augmentative communication. This relates to Core Outcome C3. The first local outcome target or milestone they set was to support a member of the team to become an accredited trainer in the use of 'Talking Mats'.



Setting a local outcome target assists teams to prioritise and clarify what needs to happen. This can be particularly useful when there is a lot to do as it helps everyone stay on track and see progress over time.

This example shows how working to this framework the community team and local stakeholders were able to improve the local capacity and competence to communicate with people with more complex needs.

Key Principle 2. Community – *inclusion and access to local services*

51. Providing services and supports 'closer to home' for people with learning disabilities, is a key objective within government policy and guidance. The problems associated with placing people at distance from family and friends has been well documented[28] and reduction in 'out of area' placements is an important target for many localities. It is also included within the local Health Self Assessment Framework.

52. Similarly, there is a drive to ensure that people with learning disabilities are not unnecessarily admitted to hospital services, and if they are, they are able to achieve a timely discharge.

53. The actions that localities can take to avoid these scenarios, and promote individualised support in the least restrictive setting, are well set out in reports by the government and regulators[29][30].

[28] Ritchie et al (2005) 'Out of area, out of sight?': review of out of area placement arrangements made by social services and health for people with learning disabilities from the West Midlands

[29] Mansell J (2007) Services for people with learning disabilities and challenging behaviour or mental health needs
[30] CQC (2007) A life like no other: a national audit of specialist inpatient healthcare services for people with learning difficulties in England

54. Community learning disability teams have a vital role in making sure everyone is included and access services within, their own local community. They are able to help construct and co-ordinate care that is person centred, particularly for people with complex needs.

55. Members of CLDT's are well placed to work in partnership with services and agencies such as mainstream NHS, leisure, housing and employment teams.

56. Within the key principle of community there are 3 core outcomes that are offered to support teams to consider their progress in supporting everyone to be included and have access to local services these are;

C4. The team works to promote individualised support for people with learning disabilities and their families.

C5. The team provides skilled local support and direct interventions to people with complex needs

C6. The team works in partnership with wider agencies to support access to universal and mainstream services

57. Beneath the 3 core outcomes are a set of suggested outcome indicators to help the team and local stakeholders to determine whether they are achieving, or working towards, achieving the outcome (tables 3, 4 & 5).

Core Outcome: C4. The team provides people and families with individualised support within their local community	
	Outcome indicators
C4:1	The team works in partnership with the person, their carer and other agencies to avoid unnecessary placement in 'congregate' provision.
C4:2	The team works with colleagues to prevent unnecessary admission to specialist hospital and to protect community tenure.
C4:3	When admission to hospital is the most appropriate option, the person and their family are provided with a clear explanation of the purpose and intended outcomes of their admission. This includes discharge planning.
C4:4	The team ensures that information about gaps in local provision is collected and used to update local commissioning strategies.
C4:5	Support is provided in the least restrictive setting.
C4:6	The team maintains good contact with individuals who are placed out of area, including those in secure services.
C4:7	The team, and wider specialist services have care pathways in place that minimise the risk of people getting 'stuck' in bed based services.
C4:8	Clear arrangements in place for people to access support 'out of hours' 7 days a week. This includes protocols for support for crisis resolution and home treatment as well as admission to hospital.

Table 3

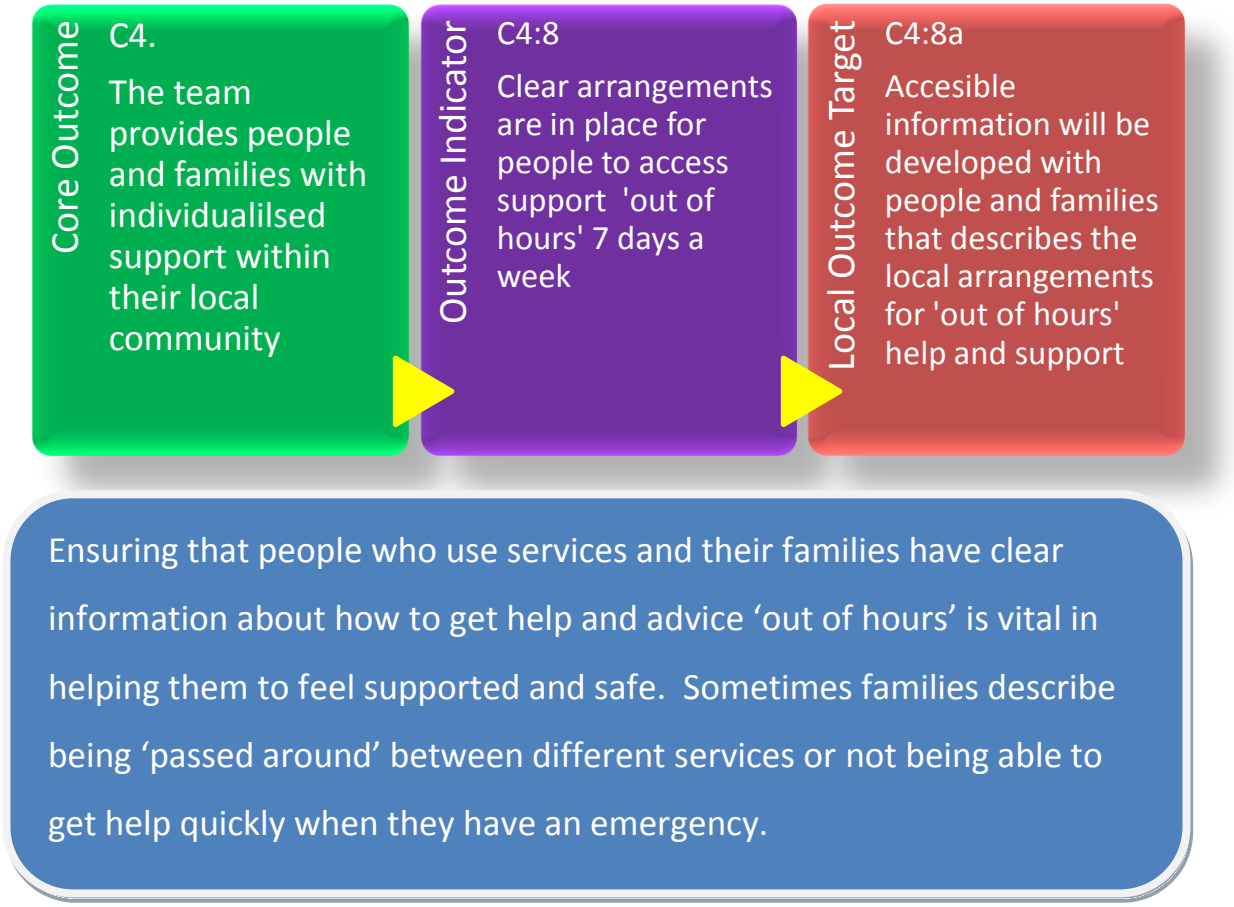
Core Outcome: C5. The team provides skilled local support and direct interventions to people with complex needs	
	Outcome indicators
C5:1	The CLDT and any associated community based teams such as 'behaviour teams' have the skills and knowledge to work directly with complex needs. Specifically people with • Profound intellectual and multiple impairments (including those dependent on medical technology) • Challenging behaviour • Mental health problems • Offending behaviour
C5:2	The team ensures that individual care plans include the agreed action in case of crisis. The plan is available to the person, their family and appropriate agencies.
C5:3	The team works in partnership with mental health services to promote access and to prevent people 'falling through the gaps' between services.
C5:4	The team has active engagement with providers of housing and support and delivers direct intervention, training and supervision as required. This includes activities to minimise the risk of placement breakdown.
C5:5	Care managers maintain regular contact with people who are admitted to hospital, including those placed out of area.
C5:6	The team, and learning disability in-patient services actively liaise and work together to minimise the risk of people experiencing a 'delayed discharge'.
C5:7	There are clear protocols that describe the arrangements for people and families to obtain advice and support 'out of hours'. This includes agreements with mainstream NHS as appropriate e.g. Crisis Resolution and Home Treatment Teams.

Table 4

Core Outcome: C6. The team works in partnership with wider agencies to support people with learning disabilities to access universal and mainstream services	
	Outcome indicators
C6:1	The team has an 'up to date' directory of services, support groups and networks within the local community.
C6:2	People with learning disabilities are supported to access community services such as local colleges, library and leisure facilities.
C6:3	The team has robust links with key agencies such as employment, housing and transport.

Table 5

Here is an example of how a local outcome target might be set to help achieve progress against core outcome C4.



Key Principle 3. Citizenship: *fairness, equality, dignity and respect*

58. *Valuing People* and *Valuing People Now* set out clearly the rights of people with learning disabilities to be treated as full citizens within society.

> *All public services will treat people with learning disabilities as individuals with respect for their dignity, and challenge discrimination on all grounds including disability.*
>
> Valuing People 2001

59. However, we know that despite legislation being in place, these rights are often not upheld[31]. In relation to healthcare we have heard many personal stories of people who were denied treatment or discriminated against within the NHS[32].

60. Failure to make reasonable adjustments for people with learning disabilities means that they continue to experience problems accessing healthcare, including mental health services. It also means that services are failing to meet the requirements of public services as described in the Equality Act 2010.

61. Reports by the Care Quality Commission[33] also describe the need to be vigilant within specialist learning disability inpatient services to ensure that people's basic human rights are not eroded or compromised.

[31] A Life Like Any Other? Human Rights of Adults with Learning Disabilities – Parliamentary Report

[32] Mencap (2007) 'Death by Indifference'

[33] CQC (2009) Specialist inpatient learning disability services – follow up audit of services 2008/9

62. As previously discussed, a lack of local provision in some places has resulted in large numbers of people in social services funded placements that distance them from their natural community. Such placements often represent poor quality and value for money and have an increased association with particular types of abuse.

63. Anecdotally, some teams have reported an increase in safeguarding activity associated with residential services for people with complex needs. The individuals concerned may have been placed from other boroughs or regions and this additional work often places strain on the local CLDT to meet needs.

64. Professionals working within CLDT's are well placed to have a positive impact on these issues. They have a key role in ensuring that the process of assessing need and organizing support is person centred and promotes inclusion.

65. Because this guide is focused on the work of specialist learning disability health professionals within CLDT's there is an emphasis on healthcare. However, this is not intended to imply a lack of contribution across other key human rights and citizenship issues. For example, in supporting parents with learning disabilities, raising awareness of hate crime or helping someone to gain employment.

66. Within this key principle of citizenship are 2 core outcomes to support CLDT's to think about their core role and contribution, these are:

C7. The team is contributing to reducing the health inequalities faced by people with learning disabilities in their locality

C8. The team promotes the legal and civil rights of people with learning disabilities and their inclusion in society

67. The 2 core outcomes C7 & C8 have a set of outcome indicators that sit below them as described in tables 6&7.

Ali's story

Ali has learning disabilities and epilepsy. He works full time in a local supermarket but recently has had a lot of time off due to an increase in seizures. He is very worried that he might lose his job.

Ali's community nurse Jim organized a review of his medication. He also helped him to put together a health action plan and some information for his manager explaining what to do if he has a seizure at work.

Outcome: C7. The team is contributing to reducing the health inequalities faced by people with learning disabilities in their locality	
	Outcome indicators
C7:1	The team can demonstrate activity to support better health for people with learning disabilities including • Helping people to get a health check. • Helping people to get a health action plan. • Working with colleagues in the mainstream NHS to identify and put in place reasonable adjustments for people with learning disabilities. • Providing training and advice to colleagues in the mainstream NHS including mental health services. • Supporting the wider health community; dentists, opticians, pharmacies etc to address and promote the health need of people with learning disabilities.
C7:2	The team provides support to ensure people with complex needs are included in public health initiatives such as screening and vaccination programmes.
C7:3	The team contributes to, and makes use of; local data to inform their own practice and priorities e.g. numbers of people with Down's syndrome and dementia.
C7:4	Gaps in provision are identified and highlighted to commissioners, for example, poor local access to psychological therapies for people with learning disabilities.

Table 6

Outcome: C8. The team promotes the legal and civil rights of people with learning disabilities and their inclusion in society		
	Outcome indicators	
C8:1	Services provided by the team are in line with legislation relating to equality and human rights specifically the • Mental Health Act 2007 • Mental Capacity Act 2005 and Deprivation of Liberty (DOLS) • Equality Act 2010	
C8:2	The team contributes locally to raising awareness of specific issues relating to the rights of people with learning disabilities. For example decisions relating to resuscitation orders.	
C8:3	The team is proactive in dealing with breaches of the rights of people with learning disabilities and in supporting people and families to challenge discrimination.	

Table 7

Here is an example of the development of a Local Outcome Target for Core Outcome C7

Key Principle 4.Commissioning – working in partnership to deliver improved outcomes

68. The need for a strong partnership between commissioners, providers, people with learning disabilities and their families is vital in order to meet need and ensure effective use of resources.

69. Community teams have a responsibility for assessment, care co-ordination and care management. They are in a key position to ensure these activities have a focus on promoting independence and increasing choice and control.

70. As the emergent GP commissioning arrangements take shape it will be vital for CLDT's to have good communication with consortia and local health and wellbeing boards.

71. We know that there will be increasing access to personal budgets for the people served by the team. CLDT's need to have the skills, knowledge and capacity to support people and families as appropriate with this. Equally, CLDT's should regularly reflect on their own services to ensure they are able to respond to changing demand and expectations from people and families.

> The system will focus on personalised care that reflects individuals' health and care needs, supports carers and encourages strong joint arrangements and local partnerships. Department of Health 2010

72. Service specifications for CLDT's need to reflect the local needs and priorities. Members within the team have valuable knowledge to contribute about the population, the local area, services and supports.

73. There are 2 Core Indicators to support this principle of working in partnership with commissioners to deliver improved outcomes. These are

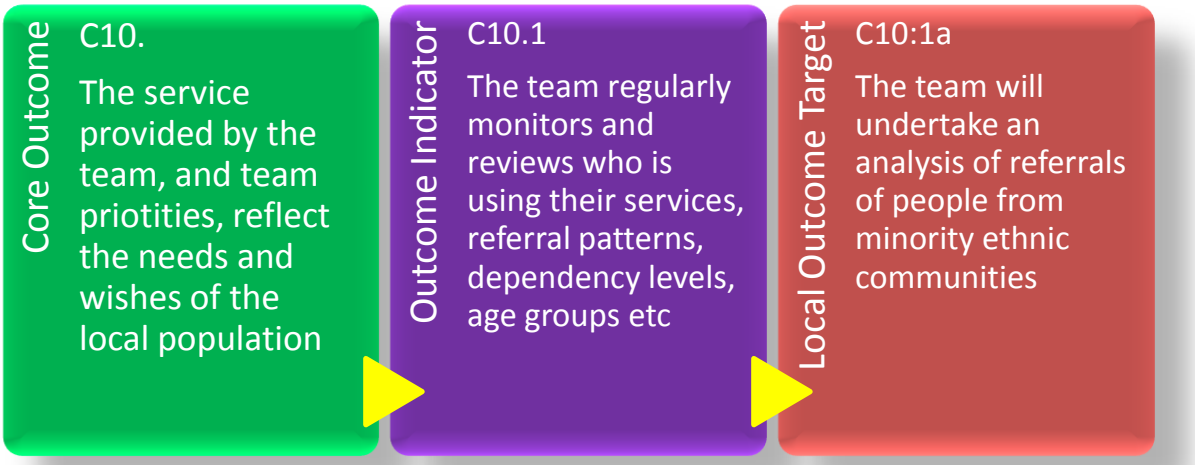
C9. The team works in partnership across agencies and sectors to support the commissioning of person centred and inclusive services and supports

C10. The services provided by the team, and team priorities, reflect the need and wishes of the local population

74. The indicators for these core outcomes are contained within table 8.

Outcome: C9. The team works in partnership, across agencies and sectors, to support the commissioning of inclusive and person centred services and supports	
	Outcome indicators
C9:1	Health and social care professionals work in partnership to ensure that people can access appropriate funding and support including personal budgets and direct payments.
C9:2	Commissioning protocols are in place to ensure that people who receive NHS funding can exercise control over it.
C9:3	The team works closely with commissioners (including specialist commissioning) to contribute expertise and to ensure that the needs of the local population are known and understood.
C9:4	Allocation of care management/care co-ordination responsibility reflects and makes best use of the individual team member's experience, skills and knowledge.
C9:5	There are arrangements in place that promote joint working to support individuals both within and across teams. For example shared protocols between CTLD and the mental health Crisis Resolution and Home Treatment Team.
Outcome: C10. The service provided by the team and team priorities, reflect the needs and wishes of the local population	
	Outcome indicators
C10:1	The team regularly monitors and reviews who is using their services, referral patterns, dependency levels, age groups etc.
C10:2	Information is collated from care plans, health action plans and person centred plans, feedback/satisfaction surveys to evaluate and inform the direction of the service.
C10:3	The team works with commissioners to make use of local and national data to inform commissioning and provider strategies.

Table 8



In this example the team, in partnership with their key stakeholders have decided it is important for them to have clearer information about the needs of people from minority ethnic communities in their locality.

Key Principle 5.Competence – *a capable community*

75. A key objective in Valuing People Now states *'workforces across services are given the appropriate support and training to equip them with the values, skills and knowledge to deliver the Valuing People Now priorities for all people with learning disabilities'.* This includes specialist and mainstream health and social care and wider community supports.

76. In relation to specialist health professionals within community teams, there needs to be a clear local workforce strategy to ensure there are sufficient people with appropriate skills to meet the demand for 'direct intervention'. In particular, to support those with the most complex needs and their families.

77. Local workforce strategies will need to accommodate the role of specialist learning disability health professionals in providing training and advice to other parts of the NHS and wider. For example to housing and support providers and the criminal justice system. This vital work to build capacity and competence within mainstream provision will continue to be needed, planned and appropriately commissioned.

78. A central part of the work of CLDT's is providing training and advice to people with learning disabilities and their families. This work might range from supporting an individual with a long term condition such as epilepsy with medication management or providing training for family carers on postural care.

David's story

David has learning disabilities and recently diagnosed bi-polar disorder. He has just been discharged from hospital following an episode of severe depression. The community team suggested that David put together a health action plan that includes his relapse prevention strategy. Using accessible information and 1:1 sessions they worked with him to better understand his condition and to identify the thoughts, feelings and behaviours that make him more vulnerable to relapse.

79. There are 3 Core Indicators to support the principle of Competence and building a capable community, these are

C11. The team comprises of staff with appropriate specialist skills and knowledge.

C12. The team provides training and advice to increase the capacity and confidence of mainstream provision to support people with learning disabilities.

C13. The team works in partnership with people and their families to utilise personal expertise and increase personal effectiveness.

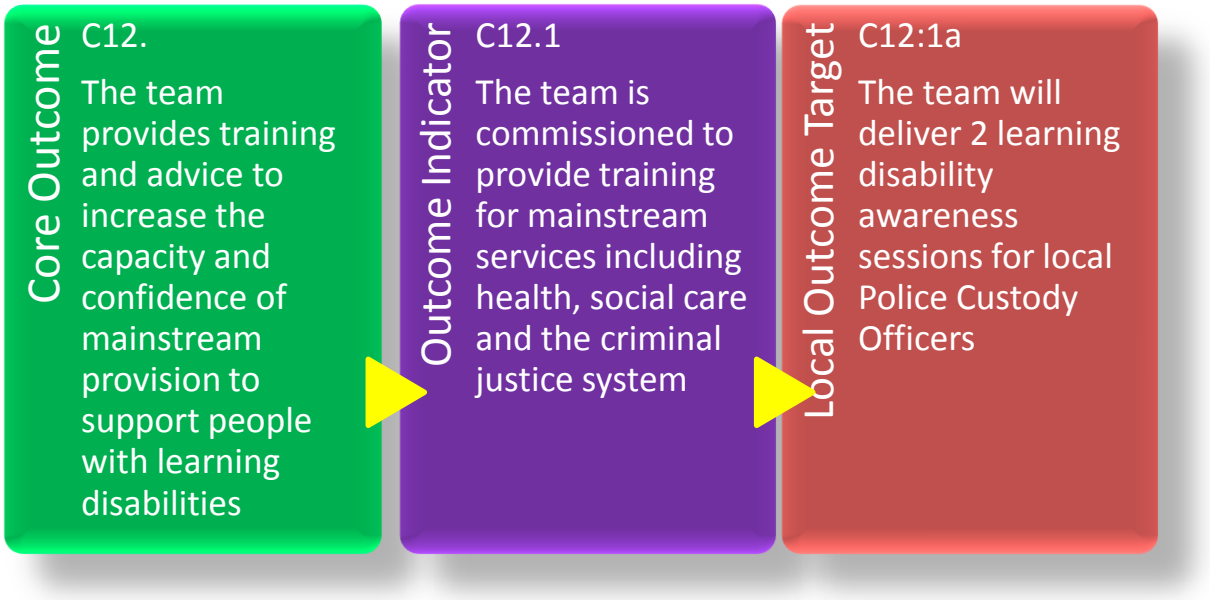
Outcome: C11.The team comprises of staff with appropriate specialist skills and knowledge	
	Outcome indicators
C11:1	Team members have appropriate qualifications to assess people with learning disabilities and complex needs and to deliver evidence based interventions.
C11:2	There is a good skill mix within the team to ensure that services are delivered by the right person at the right time including caseload management and weighting.
C11:3	Regular appraisal and clinical supervision sessions take place for all team members and training and development needs are identified and addressed.
C11:4	Team members work to their relevant professional and regulatory standards and guidance.
C11:5	The team have time allocated to meet together and reflect on practice and to undertake training, development and research.
C11:6	There is clear leadership and operational management of the team.

Outcome: C12. The team provides training and advice to increase the capacity and confidence of mainstream provision to support people with learning disabilities	
	Outcome indicators
C12:1	The team is commissioned to provide training for mainstream services including health, social care and the criminal justice system.
C12:2	The team works in close partnership with independent sector providers of housing and support and provides training and advice as required.

Outcome: C13. The team works in partnership with people and their families to utilise personal expertise and increase personal effectiveness	
	Outcome indicators
C13:1	The team provides training for people and families across key areas such as recognizing and managing health conditions, managing behaviour, postural support, communication, health action planning etc.
C13:2	The team ensures that the skills and knowledge of the individual and their family are recognised and utilised when assessing, planning and delivering care.
C13:3	The team is orientated towards identifying people's strengths and abilities whilst acknowledging and addressing needs.

Table 9

Here is an example of a local outcome target developed to support the achievement of core outcome C12



80. In this example the team worked with people with learning disabilities to design and deliver a training session to increase awareness of the needs of people with learning disabilities amongst Police Custody Officers. This included 'reasonable adjustments' they might make to help people with learning disabilities, such as easier to read information and avoiding the use of jargon in interviews. They also provided them with a list of useful publications such as the *Positive Practice Positive* Outcomes guide[34].

[34] DH 2011 Positive Practice Positive Outcomes – a handbook for Professionals within the Criminal Justice System working with Offenders with Learning Disabilities

Key Principle 6.Checking – *ensuring services are high quality, effective and safe*

81. This principle is concerned with ensuring that quality is central to 'everyone's business' and that there are good governance arrangements in place within health services. This includes making sure that there are appropriate care pathways, clear outcomes and standards. The Confirm and Challenge Model offers an overarching framework to support teams and enable them to develop local targets and action plans.

82. Important to achieving this principle is partnership working with those who use services and their families in setting standards, targets and checking the quality of the services the CLDT provides.

83. Specialist learning disability health professionals will also have to demonstrate compliance with their own professional standards and health service regulatory guidance such as the CQC Essential Standards of Quality and Safety[35].

84. To support teams well, there needs to be in place good information management systems that enable them to plan and evaluate care delivery and develop care pathways.

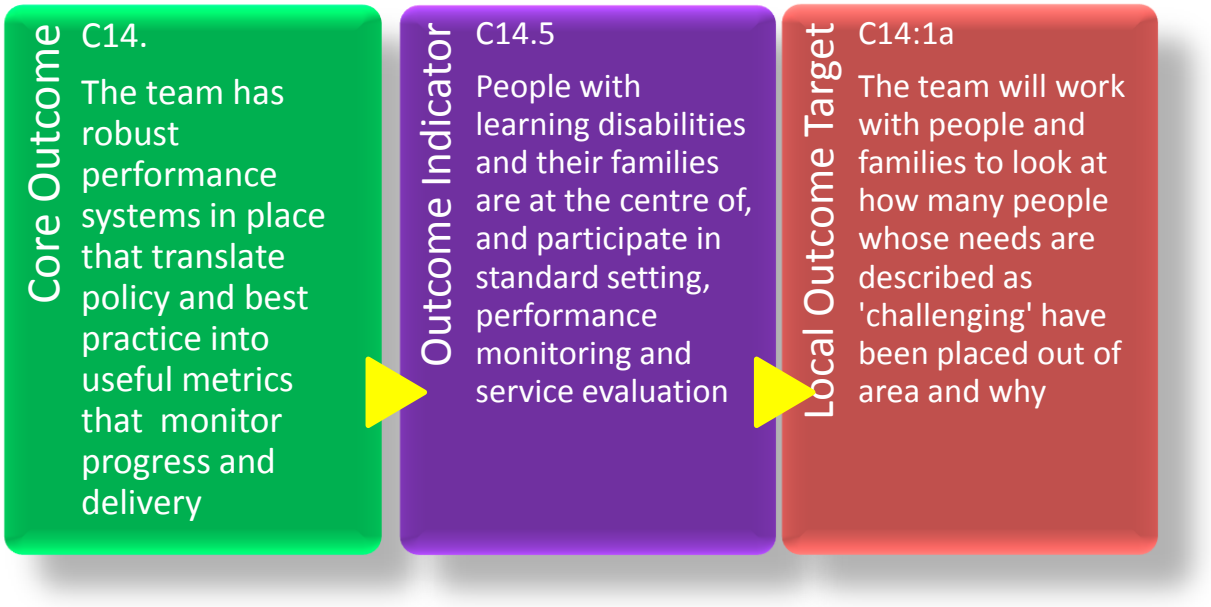
85. Core Outcome 14 supports this key principle:

C14: The team has robust performance systems in place that translate policy and best practice into useful metrics that monitor progress and delivery.

[35] CQC 2009 Essential Standards of Quality and Safety: guidance about compliance

Outcome: C14. The team has robust performance systems in place that translate policy and best practice into useful metrics that monitor progress and delivery	
	Outcome indicators
C14:1	An information management system is in place that supports joint record keeping and a single data base.
C14:2	Data within the information management system can be accessed for planning and evaluation purposes relating to the work of the team and achievement of outcomes.
C14:3	The team is working to an agreed set of expected outcomes for service users that are available in an accessible format.
C14:4	Appropriate care pathways are in place to support integrated care, smooth transitions between services and to prevent and, quickly identify, inappropriate variation in delivery.
C14:5	People with learning disabilities and family carers are at the centre of, and participate in, standard setting, performance monitoring and service evaluation.
C14:6	Quality is 'everyone's business' and all staff are encouraged to look at the way they 'measure what matters' in their work and make best use of information in person centred plans and health action plans to assess outcomes.
C14:7	Strategies are in place to safeguard vulnerable adults.
C14:8	There is an identified lead within the team for clinical governance.

Table 10



86. This example identifies the crucial role community learning disability teams have in supporting people with learning disabilities whose needs are described as 'challenging'. The Challenging Behaviour Charter is a useful tool to help teams to consider their progress in supporting this group of individuals and in ensuring their rights are respected[36]

[36] Challenging Behaviour Foundation (2010) National Strategy Group Charter

Mapping the Confirm & Challenge Outcomes against the proposed NHS, Public Health and Social Care Outcomes

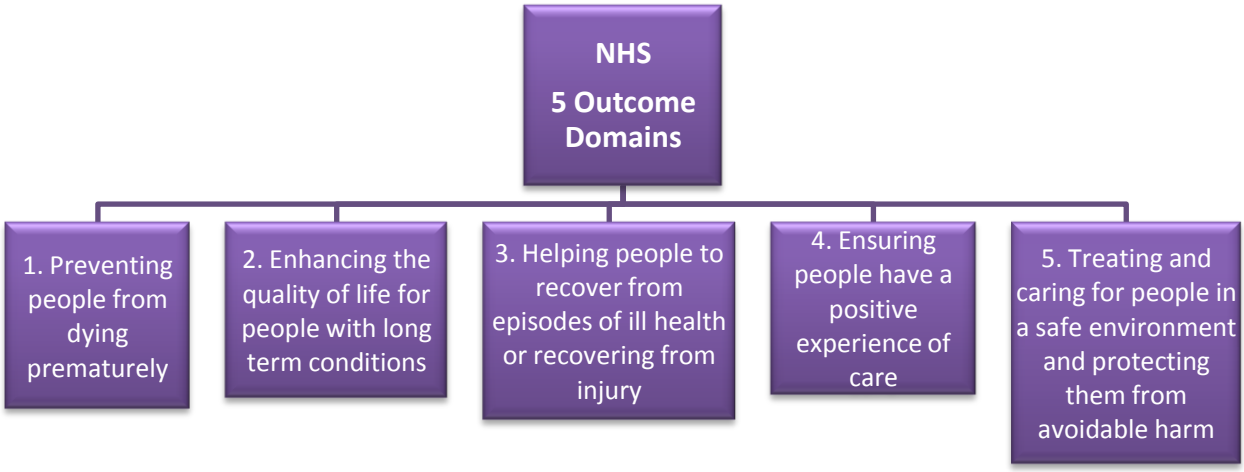
87. A key objective of the Confirm & Challenge Framework and self assessment tool is to help teams to measure progress against a range of relevant national objectives.

88. There are currently proposals to streamline the outcomes reported across the NHS, Social Care and Public Health which describe 4 or 5 Outcome Domains for each sector. The work of Community Learning Disability Teams cuts across each of these sectors and it will be important that teams can clearly demonstrate their contribution in each arena.

89. The Confirm & Challenge Framework has been 'mapped' across onto the proposed Outcome Domains for these 3 sectors. Examples are provided of how the framework relates to each domain and can provide evidence of progress. This enables us to ensure that there is a positive relationship with this and other outcomes frameworks and 'added value'.

90. Set out in this section is an overview of the proposed Outcome Domains for the NHS, Public Health and Social Care with some examples of how the contribution of CLDT's might be demonstrated.

NHS: 5 Outcome Domains proposed within *Liberating the NHS – Improving Outcomes for patients*[37].



91. Progress made against the 14 Core Outcomes of the Confirm & Challenge Model will help community learning disability teams work towards and demonstrate their contribution to the delivery of these 5 Outcomes Domains for the NHS. This compatibility will mean that they are not driven in different directions to the rest of the NHS but it does mean that their activity remains focused on improvements for people with learning disabilities.

92. If we consider the first NHS outcome domain: *preventing people from dying prematurely*. We know that there are a number of actions we can take to specifically support better health for people with learning disabilities such as health checks. These actions are embedded throughout the Confirm & Challenge Framework as the following extract from Core Outcome 7 demonstrates:

[37] DH (2010) Liberating the NHS – Improving Outcomes for patients

C7:1 The team can demonstrate activity to support better health for people with learning disabilities including:

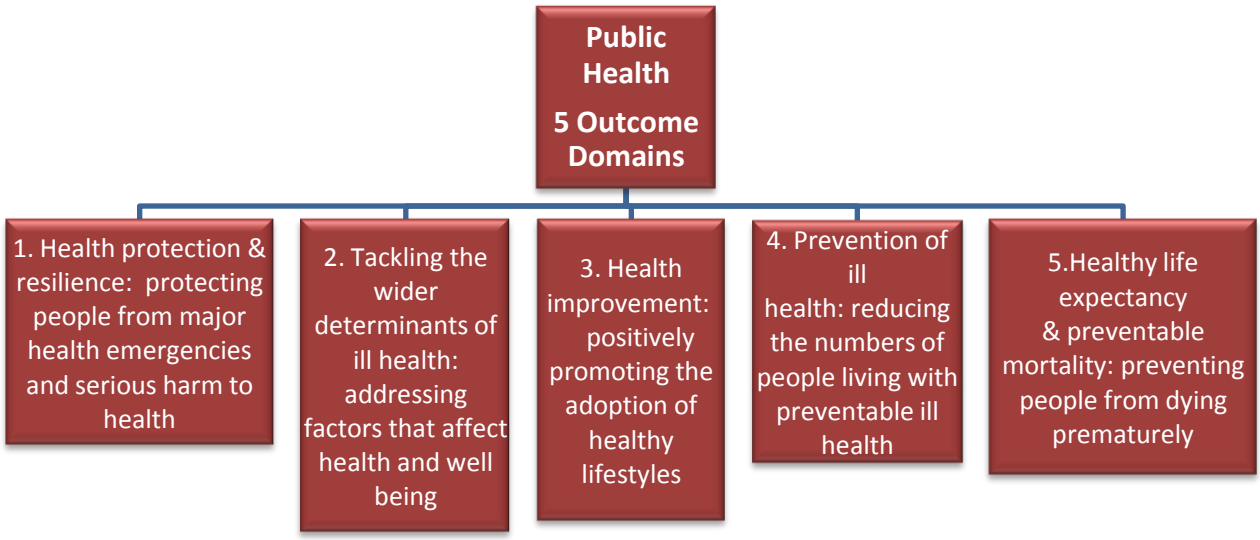
- Helping people to get a health check.
- Helping people to get a health action plan.
- Working with colleagues in the mainstream NHS to identify and put in place reasonable adjustments for people with learning disabilities.
- Providing training and advice to colleagues in the mainstream NHS including mental health services.
- Supporting the wider health community; dentists, opticians, pharmacies etc to address and promote the health needs of people with learning disabilities.

C7:2 The team provides support to ensure people with complex needs are included in public health initiatives such as screening and vaccination programmes.

93. Clearly, actions we might take to support better health for people with learning disabilities will not be limited to those examples within the Confirm & Challenge Model. People with learning disabilities will have their own individual health needs that need to be assessed, treated or supported in a person centred way. However, we know there are specific activities and interventions, such as health checks, that are helpful for most people. We also know that there are particular health conditions that are more likely in certain groups, such as people with Down's Syndrome[38]

[38] Emerson E. Baines S. (2010) Health Inequalities & People with Learning Disabilities in the UK:2010

Public Health: 5 Outcomes Domains proposed in *Healthy Lives, Healthy People: Our Strategy for Public Health*



94. Progress made against the 14 Core Outcomes of the Confirm & Challenge Model will also help community learning disability teams work towards and demonstrate their contribution to the delivery of these 5 Outcomes Domains for Public Health.

95. If we consider the Public Health Domain 2: *Tackling the wider determinant of ill health: addressing factors that affect health and wellbeing* we can see supportive action by the CLDT's across the framework. Here are some extracts from the Confirm & Challenge Model that illustrate this

C5:4 The team has active engagement with providers of housing and support and delivers direct intervention, training and supervision as required. This includes activities to reduce the risk of placement breakdown.

C6:3 The team has robust links with key agencies such as employment, housing and transport.

C12:1 The team is commissioned to provide training for mainstream services including health, social care and the criminal justice system.

96. The community learning disability team has a critical role, along with other agencies, in reducing the wider determinants and the inequalities that can cause physical and mental ill health in people with learning disabilities. Issues such as poverty, social isolation and unemployment have a negative impact on the health and wellbeing of many people with learning disabilities and their families[39]

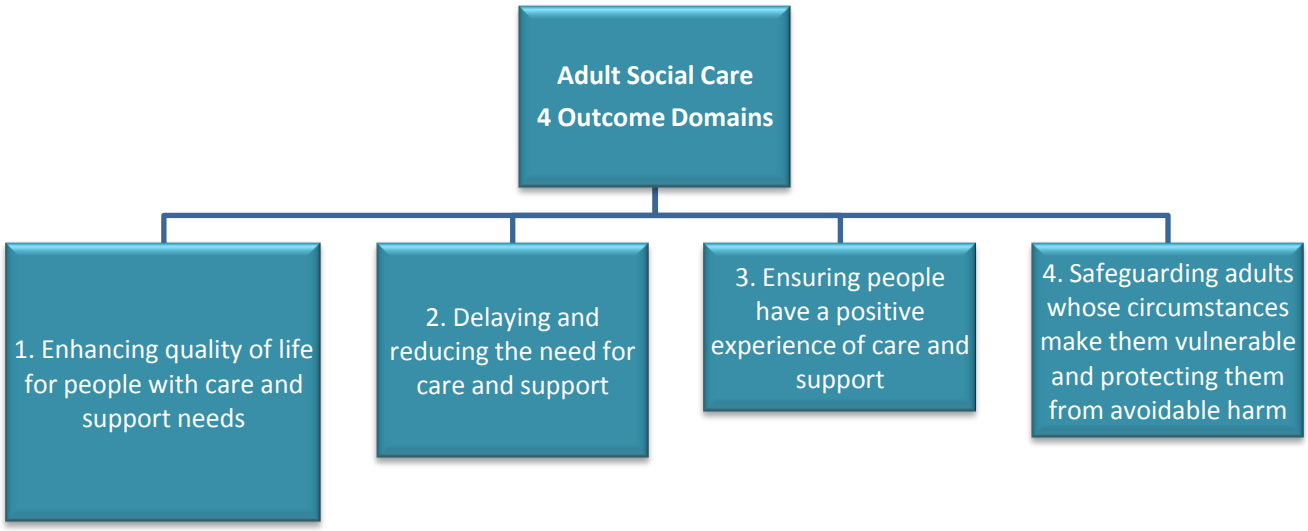
97. Similarly, helping people to adopt healthy lifestyles and to stay healthy, safe and well is a central part of the work of community learning disability teams. This includes promoting greater understanding of the effects negative life experiences may have had on their health. For example, some people with learning disabilities have experienced bullying and harassment that has had a damaging effect on their mental wellbeing.

"The bullying made me feel so unhappy and scared I would make myself ill
every day. It still affects me now even though it happened years ago. It will always stay with me because of how bad it was."

(Quote from 'Bullying Wrecks Lives' Mencap 2007)

[39] DH 2009 Valuing People Now: a new 3 year strategy for learning disabilities

Social Care: 4 Outcome Domains in *Transparency in outcomes: a framework for quality in adult social care* [40]



98. Progress towards the Core Outcomes in the Confirm & Challenge Framework will help teams to consolidate and evidence contribution to the achievement of the 4 proposed Adult Social Care Domains.

99. If we consider Adult Social Care Outcome Domain 1: *Enhancing quality of life for people with care and support needs* we can see supportive action by the CLDT's across the framework.

100. In particular, there are a number of indicators in Core Outcome 1 of the Confirm and Challenge tool that illustrate well this 'mapping across' and are identified in the following extract

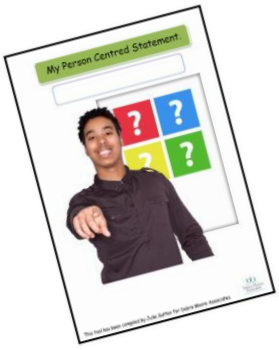
[40] DH 2011 Transparency in outcomes: a framework for quality in adult social care

C1:3 Plans detailing care and support are developed collaboratively with the person, family carers and those who know and care for them.

C1:4 The team supports individual choice and personal preferences in relation to care and treatment; this is evidenced in planning and decision making processes.

C1:10 Policies, protocols and procedures promote person centred approaches and individualised packages of support.

101. In recent years, we have seen an increase in the range of person centred materials available to promote person centred care and support. In health these include the introduction of tools such health action plans, patient passports and person centred statements and easy read resources. Publications such as the 'Getting it right charter'[41] have also helped to raise awareness in mainstream health of the individual needs of people with learning disabilities.



easyhealth.org.uk

[41] Mencap 2010 – Getting it right charter

Mapping the Confirm & Challenge Outcomes against the Care Quality Commission (CQC) Essential Standards of Quality and Safety

102. In this section we take a brief look at how the Confirm & Challenge Outcomes 'map' against the CQC Essential Standards[42].

1. You can expect to be involved and told what's happening at every stage of your care

You will always be involved in discussions about your care and treatment, and your privacy and dignity will be respected by all staff.

You will be given opportunities, encouragement and support to promote your independence.

You will be able to agree or reject any type of examination, care, treatment or support before you receive it.

2. You can expect care, treatment and support that meets your needs

Your personal needs will be assessed to make sure you get care that is safe and supports your rights.

You will get the food and drink you need to meet your dietary needs.

You get the treatment that you and your health or care professional agree will make a difference to your health and wellbeing.

You will get safe and co-ordinated care where more than one care provider is involved or if you are moved between services.

3. You can expect to be safe

You will be protected from abuse or the risk of abuse, and staff will respect your human rights.

You will be cared for in a clean environment where you are protected from infection.

You will get the medicines you need, when you need them, and in a safe way.

You will be cared for in a safe and accessible place that will help you as you recover.

You will not be harmed by unsafe or unsuitable equipment.

4. You can expect to be cared for by qualified staff

Your health and welfare needs are met by staff who are properly qualified.

There will always be enough members of staff available to keep you safe and meet your health and welfare needs.

You will be looked after by staff who are well managed and have the chance to develop and improve their skills.

5. You can expect your care provider to constantly check the quality of its services

Your care provider will continuously monitor the quality of its services to make sure you are safe.

If you, or someone acting on your behalf makes a complaint, you will be listened to and it will be acted upon properly.

Your personal records, including medical records, will be accurate and kept safe and confidential

[42] Care Quality Commission (2010) Essential Standards of Quality and Safety

Table 11 below illustrates how these essential standards are reflected within the Confirm & Challenge framework.

CQC Essential Standards of Quality & Safety	Confirm & Challenge Core Outcomes													
	C1	C2	C3	C4	C5	C6	C7	C8	C9	C10	C11	C12	C13	C14
1. You can expect to be involved and told what's happening at every stage of your care	■	■	■	■			■		■				■	
2. You can expect care, treatment and support that meets your needs				■	■	■		■	■	■				
3. You can expect to be safe				■	■			■						■
4. You can expect to be cared for by qualified staff					■		■		■		■	■		
5. You can expect your care provider to constantly check the quality of its services							■	■		■				■

Table 11

103. Expressing the outcomes for people who use services in this way has enabled them to be usefully framed as 'expectations'. Table 12 illustrates the Confirm & Challenge Core Outcomes expressed in a similar way.

104. The framework can also be used as the basis for further work that is designed to capture the experiences of people who use services locally. This supports national initiatives to capture user views such as Patient Reported Outcome Measures (PROMS).

Confirm & Challenge - Key Principles	
Centredness *Person centred services and supports*	I feel I am in control of the services I receive from the community team. Family carers and others who know and care for me are active partners.
Community *Inclusion and access to local and mainstream services*	I get support from the team that helps me to stay close to my family and within my community.
Citizenship *Fairness, equality, dignity and respect*	I get support from the team to understand and uphold my human rights. I am treated with dignity and respect.
Commissioning *Partnership working to deliver improved outcomes*	The team works well with other professionals to help me and my family to get the services and supports that we need.
Competence *A capable community*	I have confidence in the services provided by the team. Support is provided to keep healthy, safe and well. My family carers feel valued and supported.
Checking *High quality, clinically effective and safe services and support*	I am involved in deciding if services provided by the team are good and what needs to be improved.

Table 12

Getting started with the Confirm & Challenge Outcomes Framework

105. This section contains ideas and suggestions for using the Confirm and Challenge framework and self assessment tool locally. None of this is prescriptive and each locality should feel able to shape the process to reflect local structures, resources and restrictions. For example, large rural areas may have to think differently about how they get user views compared to a small urban borough. The important issue is that people who use CLDT services, their families and other key stakeholders are able to contribute to the process of checking team progress against the 14 Core Indicators. You can do this in lots of ways including face to face interviews, surveys and workshops and you may wish to use different methods for different groups.

106. However it is important to remember that the framework and self assessment tool (SAT) have been designed in a way that aims to minimise 'form filling' and free up time for discussion. Accompanying this paper will be a number of resources to help local areas to use the framework including an electronic version of the self assessment tool which will allow single or team responses to be collected and returned to a single point of contact.

107. Completion of the SAT by as many individuals or groups of stakeholders as possible will help in getting a '360' degree view of progress against the outcome indicators. It will also allow localities to look at similar or different views about specific outcome indicators held by different groups such as people with learning disabilities, family carers, health & social care professionals etc.

108. In addition to getting individual and team views we advise that you try and have a 'Confirm and Challenge' event to involve as many stakeholders as possible. The initial interpretation of the SAT from interviews, online and posted responses can be shared and stakeholders can 'Confirm and Challenge' the findings.

109. We advise that people make use of the approaches that are good at getting people to talk freely such as setting up a 'world café. In your area you may also wish to enhance the process of involving people and families by engaging in activities such as 'mystery shopper'. Peer review can also be a useful way for teams to check and monitor progress. Depending on priorities and capacity, it may be that individual teams or regions may wish to use the Confirm & Challenge Framework as a peer review tool.

110. However, as a minimum it would be advisable for all teams to undertake the basic process as outlined in the following section. This assumes collection of views online, however it is recognised that other methods may be more preferable or convenient for some stakeholders. For example, it may be easier in some localities to make use of existing local forums or networks to meet and gather responses such as self advocate or family carers groups. A key message is that this does not have to be an 'either/or' situation. Using existing groups, tools and technologies can maximize participation and enrich the process.

Process overview

Questions to think about

Stage 1.Identify key stakeholders

People who use services and family carers

Some questions to think about at this stage

- *Do we have good representation from people with learning disabilities?*
- *Have we included people with profound and multiple learning disabilities?*
- *How are we going to get the views of people who may be placed out of area?*
- *Have we included people from minority ethnic communities?*
- *How are we going to include people whose behaviour may be described as 'challenging' or people who may be in trouble with the law?*
- *Do we have good representation from family carers?*
- *Have we made sure that we hear from family carers of different ages and backgrounds?*
- *How have we included representatives of local advocacy or family carer networks?*

Partners from other agencies

- *Do we have good representation from colleagues in health, social care and the criminal justice system?*
- *Have we included people from mainstream NHS as well as specialist health services? Does this include representatives from mental health provision?*
- *Have we included local commissioners?*
- *Do we have representation from other local agencies we work with; such as those who provide housing and support or employment services?*

Stage 2.Undertake initial analysis of the responses from the CLDT self assessment tool

111. It is advisable to get together a smaller group of the stakeholders to look at the responses together. This group can also help you to think about the design of the *Confirm & Challenge* event and help with planning.

Some questions to think about at this stage

- *Are there any themes that are emerging from the responses?*
- *Are their areas of the framework where we feel we are really working well?*
- *Are there areas of the framework where we feel we are finding it hard to achieve the outcomes?*
- *Do different groups of stakeholders have different views about our progress in a particular area?*
- *What stories do we have that might illustrate some of the emergent themes?*
- *How will we make sure we focus on the 'big issues' at the Confirm & Challenge Event?*
- *Where and how will we facilitate the Confirm & Challenge event to make sure all participants are included and able to contribute?*

112. The main task in this stage is to begin to make sense of the responses and to draw out areas that need highlighting and how you will take them forward at the *Confirm & Challenge* event.

Stage3. Hold a *Confirm & Challenge* Event; confirm findings and priorities and set Outcome Targets.

113. This stage is about sharing and discussing the findings with the wider stakeholder group and letting everyone have chance to ask questions and agree priorities for action. One of the main purposes of the Confirm & Challenge event is to create a forum for all representatives of all the different stakeholders to be together at the same time.

114. However, you don't have to see this as the only opportunity to talk about the findings but rather one of a number of activities. For example, you might like to talk about the findings at local groups as part of their regular meeting; for example at the family carers network.

115. Similarly, you may find that some of the priorities discussed at the Confirm & Challenge event are things that other groups or teams are also working on or have some responsibility for. In this instance you might decide not to start a new 'action' but rather discuss with them how you might work together on shared goals. An example of such a shared objective might be around bringing people back from out of area placements where a number of different agencies and teams, including the CLDT, will have a contribution to make.

116. Before the event you may find it useful to prepare a brief summary of the findings that can be sent to participants a few weeks before.

Some questions to think about at this stage

- *What were the things that people were most energized or wanted to talk most about at the Confirm & Challenge event?*
- *What were the good stories that we heard about the work of the CLDT, how will we capture and share them?*
- *What did we agree as priorities? Who is best placed to take these forward after the event?*

- *What did we think would be good local outcome targets and who will take the development of these forward after the event?*
- *Are any of the things identified as priorities for further action shared by other local groups and could they be worked on together?*

Stage 4. Action Plan

117. This is the stage where you will focus on the things that are going to help you to move forward on the areas that you agreed as priorities. It is advisable to focus on a few areas rather than try to do everything at once.

118. It is important to be clear about what the role of the CLDT is in achieving the outcome and in turn what their action should be. For example whilst the CLDT can inform and support people to get a health check, they are not responsible for delivering them. In this example the CTLD would be *contributing* to an increase in the uptake of health checks.

Some questions to think about at this stage

- *Is our action plan clear and concise?*
- *Have we shared our plan with our key stakeholders?*

Action required	By whom	When	Comments

Stage 5. Implement and monitor action plan and feed actions and progress into related local frameworks and strategies

119. You will need some way to make sure that the actions that have been agreed are taken forward and monitored. You might choose to do this by setting up a small representative group to meet regularly and check progress. You might also think about how you could use existing groups to report into; for example your local health task group. You might also want someone to be a time limited member of another group that is responsible for a particular issue such as workforce.

Some questions to think about at this stage

- *Have you agreed how you will monitor the action plan and share progress?*
- *How will you find out about the work of other local groups and processes that might be able to help you or to offer information such as local health and wellbeing boards?*

Completing the Self Assessment Tool (SAT)

120. In this section we will look at the Self Assessment Tool provided to help localities to get a sense of progress against the Core Outcomes within the Confirm & Challenge Model[43].

The tool is available in 2 versions:

- For CLDT members and other health and social care professionals
- For people who use services and their family carers

121. The tool requires you to decide whether you agree that the indicator for the relevant outcome is being currently achieved. Here is an illustration of an indicator:

C.2:2 Documentation detailing care and support and personal correspondence is provided in a format useful to the individual and their family

122. You will be asked to choose the option that best sums up your view.

- ✓ Strongly agree
- ✓ Agree
- ✓ Not sure
- ✓ Disagree
- ✓ Strongly disagree

[43] Moore & Hutchinson (2008) Confirm & Challenge Self Assessment Tool (SAT) for CTLD's

123. Clearly this will represent your own view but to help you decide you should think about the types of evidence that you know of that would help you to decide. Here are some suggestions for the indicator we are using as an example:

Some questions to consider……

- Do we know what the person's preferred communication style is? And is this recorded somewhere that everyone who needs to can see it?

- Do we make sure that key documents such as care plans are provided in a format useful to the person or are they all 'standardised'?

- Have we informed other key people such as the GP that the person has a particular need or preference regarding communication? For example if the person prefers correspondence in a particular font size or on paper of a particular colour to aid reading?

124. Whilst the SAT will capture your own opinion it does not mean you cannot discuss it with other people. In fact, it can be really useful to have a discussion with other people before you complete it. You should also remember that there will already be local tools and mechanisms where evidence is collected that could help you to decide. For example you should have local information about the uptake of health action plans or about how many people have had a health check.

125. Holding a local *Confirm & Challenge* Event will also give you an opportunity to discuss and interpret the findings. You may find that locally you have little way of knowing how something is doing because there is no data collection. However, this should not happen often as most of the framework is concerned with things that should be known either by the team, people and families, other provider agencies or local health and social care commissioners. Inviting a wide group of stakeholders to contribute will really help to create a rich picture of how things are now.

126. Finally, an important action will be to ensure that the information that came out of the event and other stakeholder meetings is available to everyone locally. You might choose to do this in a range of ways including utilising local websites, newsletters and forums. This includes identifying and celebrating progress and good practice.

Appendix 1. National Survey of Community Learning Disability Teams

In 2009 a survey was undertaken by Debra Moore Associates in response to an increased number of enquiries about the role and function of Community Learning Disability Teams. The survey captured over 500 responses from team members from all regions in England.

The survey sought to gain views/information about the work of the teams in a number of key areas including time spent in 'face to face contact' and time spent supporting health related activities such as health action planning and supporting mainstream NHS professionals. The findings revealed that there was wide variation across the regions in the time spent on a number of core activities.

More information about this survey can be found on the website www.debramooreassociates.com

Appendix 2. East Midlands Survey

A brief electronic survey was undertaken across the East Midland region the findings from which informed this guide and related discussions. From the information returned from the survey there is a varied picture across the East Midlands of how CLTD's are made up in terms of whole time equivalent (WTE), skill mix and multi-disciplines. The picture varies greatly also in terms of WTE compared to population size and integrated or co-located with social care colleagues.

Of the 19 responses the majority of teams described themselves as co-located with social care colleagues but with separate management structures. Despite having separate management structures the majority of these co-located teams described a single point of access for referral with an open process, i.e. referrals accepted from family carers and professionals. A small number of teams described themselves as integrated with one management structure. One area of the region has a care management model where by although there are nurses within the team, they work as care managers. Allied health professionals, psychiatry and psychology in this area is accessed from the specialist health team and in terms of community nursing there are health facilitators working in primary and acute care, mental health and a community assessment and treatment service. Of the teams that described themselves as co-located the majority had teams made up of social workers and nurses only, with allied health professionals, psychiatry and psychology working separately but coming together in terms of referral to facilitate a single point of access, this was the case in the majority of cases. Both the co-located and integrated teams described a range of

roles within the teams such as carers assessor, person centred planning co-ordinator/worker, transition worker, adult placement co-ordinator, community nurse. A small number of teams identified the following: outreach teams, intensive support, community assessment and treatment, health facilitators, mental health/green light teams or facilitators, forensic and child and adolescent mental health teams, aspergers service as part of the developing community team or key partnerships. This information in terms of developing community services marries up with the information that we have from the Health Self Assessment and Performance framework, in that community services and individual roles are changing and developing to ensure equality of access to mainstream services and support to prevent admission to hospital.

There was evidence of development of care pathways and protocols to improve access to and experience of mainstream services: CPA, eating and drinking, end of life, dementia, sensory integration, falls, physiotherapy, challenging behaviour, epilepsy, mental health services, and offender health.

Overall the general themes that emerged within the East Midlands were of a changing and developing make up of community teams that very much reflect the detail in key drivers for change, for example Valuing People and Valuing people Now, Healthcare for all and six lives. Importantly it could be argued that the variation in WTE, multi-disciplinary make up and skill mix is as it should be in terms of these being influenced by local demographics, health and joint strategic needs assessment and the Health self assessment and performance framework informing the make-up of teams as opposed to population size. However population size and therefore predicted numbers of people with learning

disability is important. We know that the numbers of people in the population with complex physical health care needs, profound and multiple disability and dual diagnosis is increasing. The RCN position statement issued in January 2011 makes clear the central role for learning disability nurses in the lives of people with learning disability, particularly those with complex needs, and their family carers. Learning disability nursing is only part of the 'community team' that can support people with learning disability to have safe, fair and equal experiences of health services to ensure that they achieve a good quality of life that has been determined by the individual and from the regional and national surveys it is clear that the 'community team' may be made up in many different ways but should be commissioned based on local evidence whilst considering national trends and always following personalisation principles.

Appendix 3. The Confirm & Challenge Self Assessment Tool

On the following pages you will find a printable version of the Confirm & Challenge self assessment tool. You will also be able to download this or complete online on www.debramooreassociates.com here you will also find associated tools and resources.

Outcome C1. The team plans and delivers care in a person centred way

C1:1 Assessments are undertaken in a timely fashion; the person family carers and supporters are fully included.

Strongly disagree	Disagree	Don't know	Agree	Strongly agree

C1:2 There is an agreed information sharing protocol within the team; this prevents unnecessary repetition of assessment and information gathering from the person and family carers.

Strongly disagree	Disagree	Don't know	Agree	Strongly agree

C1:3 Plans detailing care and support are developed collaboratively with the person, family carers and those who know and care for them.

Strongly disagree	Disagree	Don't know	Agree	Strongly agree

C1:4 The team supports individual choice and personal preferences in relation to care, and treatment, this is evidenced in planning and decision making.

Strongly disagree	Disagree	Don't know	Agree	Strongly agree

C1:5 When eligibility criteria or individual preferences cannot be met, there is a transparent process for informing the person and their family. There is accessible information and a clear route to the complaints procedure.

Strongly disagree	Disagree	Don't know	Agree	Strongly agree

C1:6 Staff are well trained and confident in using person centred approaches and tools

and contribute to person centred planning and review meetings.

Strongly disagree	Disagree	Don't know	Agree	Strongly agree

C1:7 The team is responsive to the diverse needs of the population; providing a culturally competent service.

Strongly disagree	Disagree	Don't know	Agree	Strongly agree

C1:8 The allocation of care manager or care co-ordinator reflects the needs of individuals and the complexity of their situation.

Strongly disagree	Disagree	Don't know	Agree	Strongly agree

C1:9 Team members who are fulfilling the role of care manager are trained and skilled in individual service design and funding.				
Strongly disagree	Disagree	Don't know	Agree	Strongly agree
C1:10 Policies, protocols and procedures promote person centred approaches and individualised packages of support.				
Strongly disagree	Disagree	Don't know	Agree	Strongly agree
C1:11 Review meetings are organised and conducted (including CPA) in a manner that optimises the involvement of the individual and their family and promotes partnership working.				
Strongly disagree	Disagree	Don't know	Agree	Strongly agree
Outcome C2. The team works in partnership with the individual and their family				
C2:1 The team has an accessible referral system and clear pathways that describe the services and support available. This information is available to self advocacy, carers groups and the wider community e.g. GP surgeries and libraries.				
Strongly disagree	Disagree	Don't know	Agree	Strongly agree
C2:2 Documentation detailing care and support and personal correspondence is provided in a format useful to the individual and their family.				
Strongly disagree	Disagree	Don't know	Agree	Strongly agree
C2:3 People with learning disabilities and their family carers are involved in reviewing and monitoring the individual services they receive from the team and participating in team development and service design.				
Strongly disagree	Disagree	Don't know	Agree	Strongly agree
C2:4 The team provides training and information for service users and family carers to enable them to enhance their own skills and knowledge.				
Strongly disagree	Disagree	Don't know	Agree	Strongly agree
Outcome C3. The team utilises a range of communication tools and approaches				
C3:1 People and their families are appropriately supported to communicate their needs and				

wishes. This includes how they contribute to and, participate in their own assessments and review meetings.				
Strongly disagree	Disagree	Don't know	Agree	Strongly agree
C3:2 The team can demonstrate skills in a range of communication systems/tools such as Makaton, talking mats, objects of reference, passports etc.				
Strongly disagree	Disagree	Don't know	Agree	Strongly agree
C3:3 The team has ready access to interpreter services for minority languages and British Sign language.				
Strongly disagree	Disagree	Don't know	Agree	Strongly agree
Outcome C4. The team provides people and families with individualised support within their local communities				
C4:1 The team works in partnership with the person, their carer and other agencies to avoid unnecessary placement in congregate provision.				
Strongly disagree	Disagree	Don't know	Agree	Strongly agree
C4:2 The team works with colleagues to prevent unnecessary admission to specialist hospital and to protect community tenure				
Strongly disagree	Disagree	Don't know	Agree	Strongly agree
C4:3 When admission to hospital is the most appropriate option, the person and their family are provided with a clear explanation of the purpose and intended outcomes of their admission. This includes discharge planning.				
Strongly disagree	Disagree	Don't know	Agree	Strongly agree
C4:4 The team ensures that information about gaps in local provision is collected and used to update local commissioning strategies.				
Strongly disagree	Disagree	Don't know	Agree	Strongly agree
C4:5 Care and support is provided in the least restrictive setting.				
Strongly disagree	Disagree	Don't know	Agree	Strongly agree
C4:6 The team maintains good contact with individuals who are placed out of area, including				

those in secure services.				
Strongly disagree	Disagree	Don't know	Agree	Strongly agree
C4:7 The team, and wider specialist services have care pathways in place that minimise the risk of people getting 'stuck' in bed based services.				
Strongly disagree	Disagree	Don't know	Agree	Strongly agree
C4:8 Clear arrangements are in place for people to access support 'out of hours' 7 days a week. This includes protocols for support for crisis resolution and home treatment as well as admission to hospital.				
Strongly disagree	Disagree	Don't know	Agree	Strongly agree

Outcome C5. The team provides skilled local support and direct interventions to people with complex needs.

C5:1 The CTLD and any associated community based teams such as 'behaviour teams' have the skills and knowledge to work directly with people with complex needs. Specifically people with

- Profound intellectual and multiple impairments (including those dependent on medical technology)
- Challenging behaviour
- Mental health problems
- Offending behaviour

Strongly disagree	Disagree	Don't know	Agree	Strongly agree
C5:2 The team ensures that individual care plans include the agreed action in case of crisis. The plan is available to the person, their family and appropriate agencies.				
Strongly disagree	Disagree	Don't know	Agree	Strongly agree
C5:3 The team works in partnership with mental health services to promote access and to prevent people from 'falling through the gaps' between services.				
Strongly disagree	Disagree	Don't know	Agree	Strongly agree
C5:4 The team has active engagement with providers of housing and support and delivers direct intervention, training and supervision as required. This includes activities to reduce the risk of placement breakdown.				
Strongly disagree	Disagree	Don't know	Agree	Strongly agree

C5:5 Care managers maintain regular contact with people who are admitted to hospital, including those placed out of area.

Strongly disagree	Disagree	Don't know	Agree	Strongly agree

C5:6 The CLDT and learning disability in-patient services actively liaise and work together to minimise the risk of people experiencing 'delayed discharge'.

Strongly disagree	Disagree	Don't know	Agree	Strongly agree

C5:7 There are clear protocols that describe the arrangements for people and families to obtain advice and support 'out of hours'. This includes agreements with mainstream NHS as appropriate e.g. Crisis Resolution and Home Treatment Teams.

Strongly disagree	Disagree	Don't know	Agree	Strongly agree

Outcome C6. The team works in partnership with wider agencies to support people with learning disabilities to access universal and mainstream services.

C6:1 The team has an 'up to date' directory of services, support groups and networks within the local community.

Strongly disagree	Disagree	Don't know	Agree	Strongly agree

C6:2 People with learning disabilities are supported to access community services such as local colleges, library and leisure facilities.

Strongly disagree	Disagree	Don't know	Agree	Strongly agree

C6:3 The team has robust links with key agencies such as employment, housing and transport.

Strongly disagree	Disagree	Don't know	Agree	Strongly agree

Outcome C7. The team is contributing to reducing the health inequalities faced by people with learning disabilities in their locality.

C7:1 The team can demonstrate activity to support better health for people with learning disabilities including

- Helping people to get a health check
- Helping people to get a health action plan
- Working with colleagues in mainstream NHS to identify and put in place reasonable adjustments for people with learning disabilities

- Providing training and advice to colleagues in the mainstream NHS including mental health services
- Supporting the wider health community; dentists, opticians, pharmacies etc to address and promote the health needs of people with learning disabilities

Strongly disagree	Disagree	Don't know	Agree	Strongly agree

C7:2 The team provides support to ensure people with complex needs are included in public health initiatives such as screening and vaccination programmes.

Strongly disagree	Disagree	Don't know	Agree	Strongly agree

C7:3 The team contributes to, and makes use of, local data to inform their own practice and priorities e.g. numbers of people with Down's syndrome and dementia.

Strongly disagree	Disagree	Don't know	Agree	Strongly agree

C7:4 Gaps in provision are identified and highlighted to commissioners, for example, poor local access to psychological therapies for people with learning disabilities.

Strongly disagree	Disagree	Don't know	Agree	Strongly agree

Outcome: C8. The team promotes the legal and civil rights of people with learning disabilities and their inclusion in society.

C8:1 Services provided by the team are in line with legislation relating to equality and human rights specifically the

- Mental Health Act 2007
- Mental Capacity Act 2005 and Deprivation of Liberty (DOLS)
- Equality Act 2010

Strongly disagree	Disagree	Don't know	Agree	Strongly agree

C8:2 The team contributes locally to raising awareness of specific issues relating to the rights of people with learning disabilities. For example decisions relating to resuscitation orders.

Strongly disagree	Disagree	Don't know	Agree	Strongly agree

C8:3 The team is proactive in dealing with breaches of the rights of people with learning disabilities and in supporting people and families to challenge discrimination.

Strongly disagree	Disagree	Don't know	Agree	Strongly agree

Outcome: C9. The team works in partnership, across agencies and sectors, to support the commissioning of inclusive and person centred services and supports

C9:1 Health and social care professionals work in partnership to ensure that people can access appropriate funding and support including personal budgets and direct payments.

Strongly disagree	Disagree	Don't know	Agree	Strongly agree

C9:2 Commissioning protocols are in place to ensure that people who receive NHS funding can exercise control over it.

Strongly disagree	Disagree	Don't know	Agree	Strongly agree

C9:3 The team works closely with commissioners (including specialist commissioning) to contribute expertise and to ensure that the needs of the local population are known and understood.

Strongly disagree	Disagree	Don't know	Agree	Strongly agree

C9:4 Allocation of care management/care co-ordination responsibility reflects and makes best use of the individual team member's experience, skills and knowledge.

Strongly disagree	Disagree	Don't know	Agree	Strongly agree

C9:5 There are arrangements in place that promote joint working to support individuals both within and across teams. For example shared protocols between CTLD and the mental health Crisis Resolution and Home Treatment Team.

Strongly disagree	Disagree	Don't know	Agree	Strongly agree

Outcome: C10. The service provided by the team and team priorities, reflect the needs and wishes of the local population

C10:1 The team regularly monitors and reviews who is using their services, referral patterns, dependency levels, age groups etc.

Strongly disagree	Disagree	Don't know	Agree	Strongly agree

C10:2 Information is collated from care plans, health action plans and person centred plans, feedback/satisfaction surveys to evaluate and inform the direction of the service.

Strongly disagree	Disagree	Don't know	Agree	Strongly agree

C10:3 The team works with commissioners to make use of local and national data to inform commissioning and provider strategies.

Strongly disagree	Disagree	Don't know	Agree	Strongly agree

Outcome: C11.The team comprises of staff with appropriate specialist skills and knowledge.

C11:1 Team members have appropriate qualifications to assess people with learning disabilities and complex needs and to deliver evidence based interventions.

Strongly disagree	Disagree	Don't know	Agree	Strongly agree

C11:2 There is a good skill mix within the team to ensure that services are delivered by the right person at the right time including caseload management and weighting.

Strongly disagree	Disagree	Don't know	Agree	Strongly agree

C11:3 Regular appraisal and clinical supervision sessions take place for all team members and training and development needs are identified and addressed.

Strongly disagree	Disagree	Don't know	Agree	Strongly agree

C11:4 Team members work to their relevant professional and regulatory standards and guidance.

Strongly disagree	Disagree	Don't know	Agree	Strongly agree

C11:5 The team have time allocated to meet together and reflect on practice and to undertake training, development and research.

Strongly disagree	Disagree	Don't know	Agree	Strongly agree

C11.6 There is clear leadership and operational management of the team.

Strongly disagree	Disagree	Don't know	Agree	Strongly agree

Outcome: C12. The team provides training and advice to increase the capacity and confidence of mainstream provision to support people with learning disabilities

C12:1 The team is commissioned to provide training for mainstream services including health, social care and the criminal justice system.

Strongly disagree	Disagree	Don't know	Agree	Strongly agree

C12:2 The team works in close partnership with independent sector providers of housing and support and provides training and advice as required.				
Strongly disagree	Disagree	Don't know	Agree	Strongly agree
Outcome: C13. The team works in partnership with people and their families to utilise personal expertise and increase personal effectiveness				
C13:1 The team provides training for people and families across key areas such as recognizing and managing health conditions, managing behaviour, postural support, communication, health action planning etc.				
Strongly disagree	Disagree	Don't know	Agree	Strongly agree
C13:2 The team ensures that the skills and knowledge of the individual and their family are recognised and utilised when assessing, planning and delivering care.				
Strongly disagree	Disagree	Don't know	Agree	Strongly agree
C13:3 The team is orientated towards identifying people's strengths and abilities whilst acknowledging and addressing needs.				
Strongly disagree	Disagree	Don't know	Agree	Strongly agree
Outcome: C14. The team has robust performance systems in place that translate policy and best practice into useful metrics that monitor progress and delivery				
C14:1 An information management system is in place that supports joint record keeping and a single data base.				
Strongly disagree	Disagree	Don't know	Agree	Strongly agree
C14:2 Data within the information management system can be accessed for planning and evaluation purposes relating to the work of the team and the achievement of outcomes.				
Strongly disagree	Disagree	Don't know	Agree	Strongly agree
C14:3 The team is working to an agreed set of expected outcomes for service users that are available in an accessible format.				
Strongly disagree	Disagree	Don't know	Agree	Strongly agree

C14:4 Appropriate care pathways are in place to support integrated care, smooth transitions between services and to prevent and, quickly identify, inappropriate variation in delivery.				
Strongly disagree	Disagree	Don't know	Agree	Strongly agree
C14:5 People with learning disabilities and family carers are at the centre of, and participate in, standard setting, performance monitoring and service evaluation.				
Strongly disagree	Disagree	Don't know	Agree	Strongly agree
C14:6 Quality is 'everyone's business' and all staff are encouraged to look at the way they 'measure what matters' in their work and make best use of information in person centred plans and health action plans to assess outcomes.				
Strongly disagree	Disagree	Don't know	Agree	Strongly agree
C14:7 Strategies are in place to safeguard vulnerable adults.				
Strongly disagree	Disagree	Don't know	Agree	Strongly agree
C14:8 There is an identified lead within the team for clinical governance.				
Strongly disagree	Disagree	Don't know	Agree	Strongly agree

Debra Moore Associates

Confirm & Challenge (CLDT) Self Assessment Tool (V2)

Outcome C1. Centredness

I feel I am in control of the services I receive from the community team.

Family carers and others who know and care for me are active partners.

Strongly disagree	Disagree	Don't know	Agree	Strongly agree

Outcome C2. Community

I get support from the team that helps me to stay close to my family and within my community.

Strongly disagree	Disagree	Don't know	Agree	Strongly agree

Outcome C3. Citizenship

I get support from the team to understand and uphold my human rights.

I am treated with dignity and respect.

Strongly disagree	Disagree	Don't know	Agree	Strongly agree

Outcome C4. Commissioning

The team works well with other professionals to help me and my family to get the services and supports that we need.

Strongly disagree	Disagree	Don't know	Agree	Strongly agree

C5: Competence

I have confidence in the services provided by the team.

Support is provided to keep healthy, safe and well.

My family carers feel valued and supported.

Strongly disagree	Disagree	Don't know	Agree	Strongly agree

C6. Checking

I am involved in deciding if services provided by the team are good and what needs to be improved.

Strongly disagree	Disagree	Don't know	Agree	Strongly agree