

**A Health Strategy  
for people with a  
Learning Disability.**

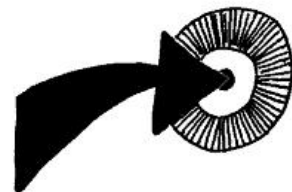
**1. Introduction**

The Health and Wellbeing Strategy developed by Southampton PCT and Southampton City Council focuses on the needs of all individuals living in the area. Southampton City Learning Disability Partnership Board has responsibility to ensure that people with a learning disability are included and share the outcomes aimed to improve people's quality of life.



**2. Purpose**

This paper aims to set out the strategic direction for learning disability health services for the coming 3 - 5 years. The paper reflects on the work already achieved by commissioners and services in delivering the aims and objectives of Valuing People 2001. The paper outlines proposals to take forward the proposed integration of commissioning and provision of learning disability services.



**3. Valuing People**

In 2001 the government published the document "Valuing People" (Department of Health, 2001), which set out Key principles for services to follow to modernize services for people with a learning disability.

The 4 themes are:

- Rights
- Independence
- Choice
- Inclusion



#### 4. How Many People have a learning disability?

It is not clear how many people living in Southampton have a learning disability. Southampton at present does not have a learning disability register of peoples needs. National research undertaken by Emerson and Hatton suggest the following

- Just under 3% of population has LD
  - 1% known to specialist services  
(social services or specialist health team)

It is predicted that the number of adults with Learning Disabilities in England in 2001 and 2011 will be as follows, (assuming no change in prevalence).

<b>Age Group</b>	<b>2001</b>	<b>2011</b>	<b>% Change from 2001</b>
Number of people with learning disabilities known to services			
Aged 20-59	146,089	151,694	3.8 %
Aged 60 or over	26,615	31,975	20.1 %
<b>Total</b>	<b>172,704</b>	<b>183,669</b>	<b>6.3 %</b>
Actual number of people with learning disabilities			
Aged 20-59	625,199	647,688	3.6 %
Aged 60 or over	174,631	206,999	18.5 %
<b>Total</b>	<b>799,830</b>	<b>854,687</b>	<b>6.9 %</b>

This table shows the change in population of adults with learning disabilities in England during the decade 2001-2011. It does not take account of any variations other than age. The number of adults known to services in 2001 was 172,704 and by 2011 will be 183,669. This modest increase of 6.3% hides a significant change among people over 60 of 20.1%.

Adjusted for other factors these predictions suggest modest but sustained growth of 8.4% over the 10 years from 2001/2011 of people with learning disabilities known to services and an increase of 11.9% of the true number of people with learning disabilities.

## **5. What are the health needs of people with a learning disability?**

5.1 The recording of learning disability in primary care is poor. Practices use a range of different codes to identify learning disability. Some are not exclusively associated with learning disability (as in the case of dyslexia), while terms for general educational or learning problems (eg special educational needs) that should capture learning disabilities also include a wide range of people with other needs. In addition, the proportion of people with learning disabilities who are known to services is estimated to be around one quarter of actual prevalence. For these reasons, it is difficult to be confident that any data will fully capture the needs of all people with learning disabilities.

5.2 With these provisos, it is possible to attempt to identify specific issues from the available evidence, it shows that:

- People with learning disabilities had higher rates of respiratory disease at 19.8% than the remaining population (15.5%).
- People with learning disabilities were more likely to be obese. The rate of obesity in all those with recorded body mass index (BMI) was 28.3% in people with a learning disability, as compared to 20.4% for the remaining population.

5.3 For other health conditions such as diabetes, stroke and heart disease, rates were lower amongst people with learning disabilities than in the remaining population. However, the figures in the analysis may be under-estimates: it is known that diabetes, for instance, is often under-diagnosed, primary care records may not accurately reflect the extent of health problems, and the health needs of people with learning disabilities often remain unidentified.

5.4 People with learning disabilities die younger than other citizens. They also have high rates of unmet health needs, which may contribute to early death.

5.5 Improved recording of learning disabilities in primary care is essential to achieving a better understanding of health status and outcomes; and in order to track progress over time.

## **6. Children's Learning Disability Services**

6.1 Children's Learning Disability Services in Southampton are changing.

We have 4 teams at the moment:

- The Team for Disabled Children – which is a team of social workers
- The Intensive Intervention Team – which is a team that helps families cope better with difficult behaviour
- The Specialist Healthcare Team – which is a team of nurses, doctors and other health professionals who work in schools and in people's homes
- Westwood Bungalow – which is a house that children have short breaks in when they need time away from their families

6.2 We are joining these teams together to make one whole team called "Jigsaw", which will hopefully start to run in January 2007. Jigsaw will do all of the same jobs of the old teams but we think that it will be easier for workers to work together and this will then make the service that children and their families get much better.

6.3 We are also wanting to add more tasks to what we do, so that we can help families much earlier and quicker than we do at the moment, this is called "early intervention". We are hoping that working in this way will mean that we are able to stop problems before they become too big to deal with.

6.4 We are also planning to have a worker for each child with a disability and their families in Southampton who they can talk to when they have a problem, so that we know when we need to offer help to the family. This person is called "a lead professional".

6.5 We are also setting up ways of working that give parents the information they need to help them look after their child, this is called "preventative work", and we hope that this way of working will help parents feel more in control.

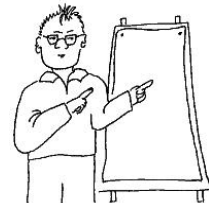
6.6 We are collecting information together so that we can have one document that we all share. This will be called "a foundation assessment", and means that families will not have to answer the same questions over and over again to lots of different workers. This will also help professionals work together when they are making plans with children and their families.

## 7. Community Specialist Health Care Team

7.0 “Valuing People” has set out the strategic aims for services, for the coming 10 – 20 years. Community teams need to facilitate, train, educate, enable, support and demonstrate to services what is achievable for people with a learning disability. The structure of services therefore needs to be flexible and focused on delivering these objectives. The community team will continue to provide support and advice to users and their carers on a referral basis, in addition to providing leadership to achieve strategic priorities.



7.1 The Southampton City Community Specialist Health Care Team is a well established team, which plays a key role in supporting adults with a learning disability.



7.2 New performance measures need to be developed, to help Community Teams to focus on priorities and deliver permanent changes for people with a learning disability and their family. Work has started, some of the outcome measures include:

- Supporting Person Centred Planning
- Helping people to develop Health Action Plans
- Provide training for family carers and local services
- Helping people with complex needs gain employment.

7.3 The plan is for the Community Specialist Health Care Team to work much more closely with Southampton Adult Social Care, Learning Disability Care Management Team. The teams will merge to provide a single point of access, assessment, and improve the service that is provided to the community. The new team will be lead by adult social care.

## 8. Primary Care

8.0 It is well recognized that the health of people with a learning disability and their families is significantly poorer that the general population. It is also recognized that the wider health services offer a poor service to people with a learning disability. With the Primary Care Trust reacting to “Commissioning a Patient-led NHS” it is going to become increasing problematic for learning disability services to support and achieve strategic improvements in the delivery of primary and secondary health care for people with a learning disability.



8.1 Primary care and acute health services are currently not in a position respond to the specific needs of people with a learning disability and their carers. Generic health services will need ongoing systematic support to raise awareness,

improve the skills and knowledge of the needs of people with a learning disability. There needs to be a specific service solution to address the health inequalities.

8.2 A local survey of the level of awareness and competency within primary care on learning disabilities revealed the need for education and support. This is backed up by national evidence i.e. "Once a Day, DOH 1999", and "Valuing People, DOH 2001".



8.3 The appointment of a Professional with Special Interest will be to help develop primary care services to meet the needs of existing patients with a learning disability and for those being discharged from long stay hospital units.

Their Objectives will be to:

- Improve the health outcomes for people with a learning disability currently in long stay hospital units in Southampton City.
- To improve access and quality of provision to primary, community, secondary and specialist health services
- To ensure that the design of care pathways (patient journeys) achieves the best use of resources and outcome for patients
- To establish a basic level of competencies and confidence within primary care.

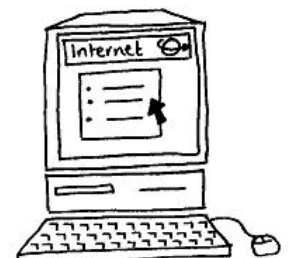


8.4 The Government has asked that everyone with a learning disability be offered the opportunity to develop a Health Action Plan that would show the actions needed to keep a person healthy. It is a way of linking the person to a variety of services and supports, which will help them to have better health. Health Action Plans are part of a person's Person Centred Plan and will be one of the things that help the person enjoy life. The Plan is for the person who has a learning disability and wherever possible that person will help to develop it.



8.5 Health Facilitators are the people who help support a person with their day-to-day health. They will know the person well and be able to help them stay healthy. Most people will have several health facilitators who will be people like relatives, carers, friends and support staff. Health Facilitators will need training and support. The Community Learning Disability Team in partnership with Primary Care will enable this to happen.

8.6 The exact numbers of people with a learning disability in the city are not known so it is difficult to make an assessment of the



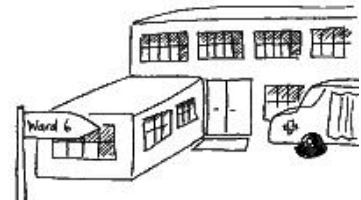
populations health needs. The Government is also asking that we record everyone who has been offered a Health Action Plan. The PCT will work with GP Practices to develop Practice Learning Disability Registers. The Register will record information about the person's health to enable Primary Care and the PCT to provide better health services to people with a learning disability and their carers.



8.7 With the support of Choices Advocacy Service the PCT has established a service user group focused around on health. The group will act as a source of information and advice about how services should be developed. The group will also be undertaking an adapted Expert Patient Programme course. The individuals from the group will provide a user view during training of generic health care staff.

## 9. Acute and Secondary Care

9.0 It is well known that service from acute and secondary care do not meet the needs of people with a learning disability and their carers well. Awareness needs to be raised and staff require training about learning disability issues.



9.1 A common adapted care pathway will be developed for people being admitted and discharged from hospital to ensure that the individual's needs are being met and planned for. Acute and secondary care should ensure that an individual is well supported whilst in hospital and should not expect that families and social carers provide this support on an ongoing basis. Standards that a person with a learning disability should expect in the form of an enhanced service will be identified

9.2 Southampton University Hospital Trust has identified a senior nurse to take forward these issues and be the champion within the Trust for learning disability issues.

9.3 Good work has been undertaken around cancer. Central South Coast Cancer Network with the support of local learning disability services have developed strategies to improve the outcomes for people with a learning disability. Learning disability services need to work in similar ways with other disease networks to help them improve their service to people with a learning disability.

## 10. Long Term Conditions

10.0 One third of people with a learning disability have an associated physical disability most often cerebral palsy. This puts people at risk of postural deformities, hip dislocation, chest infections, eating and swallowing problems, gastro-oesophageal reflux, constipation and incontinence. Certain conditions such as Downs Syndrome carry an increased risk of certain health complications, such as cardiac disorders, respiratory problems, thyroid disorders and hearing. Epilepsy occurs in about one third of people with a learning disability and the likelihood of seizures increasing with the severity of learning disability. Often seizures are complex and difficult to control.

10.1 The PCT is developing a strategy for the City to improve the service for people with long term conditions. These conditions include:

- Coronary Heart Disease
- Diabetes
- Renal Care
- Stroke
- Dementia
- Epilepsy
- Other Neurological Conditions



10.2 Many of the services to be developed and improved will be accessed by people who have a learning disability and these developments must address their specific needs. The PCT is planning to develop a patient accessible care plan for people with a long term condition. It is planned that patients who have a learning disability will have the opportunity to link into this scheme. This will record information from the individuals Health Action Plan and can be accessed by any health professional to ensure that the individual gets the right support and their information taken into account.

Each Long Term condition area will need to develop a range of patient focused information this will need to take into account the needs of people with a learning disability.

## 11. Healthy Fulfilled Lifestyles



11.0 A central plank of the governments Valuing People strategy is Person Centred Planning & Health Action Planning. Person Centred planning is a set of tools to help people with a learning disability decide how they want to live, to make dreams happen and aspire to a better life. It is common for people with a learning disability and their families to have very low expectations. With support and the back up of services many of an individual's desire can be achieved. Common wishes that individuals want to achieve are a home of their own, to work, to learn a new skill, to visit a new place, or to meet someone famous. The principle of person

centred planning is to use natural networks and to have a circle of support to help. Services will be developed to respond in a person centred way to peoples aspirations.

11.1 Southampton City Adult Social Care is in the process of modernising the day services it provides. It is closing the large day service based at Brookside and investing in small neighbourhood community centres. The investment has meant that the resources can be used in a more flexible way and improve access for all people in the community. The Community Centres will act as a meeting place so individuals and groups before they go off to undertake activities in the wider community. This means that individuals attending these day services can be supported to live healthier lifestyles, increasing levels of exercise and engagement with the community.



11.2 There are a number of people complex health needs, challenging behaviour or autism who find using services in a group situation difficult. These individuals also have difficulty accessing respite care. At present many of these individuals receive a patchy and fragmented service, often travelling outside the City. Plans are being developed to enable individuals to be supported in the City. It is hoped that individuals will be able to access an ordinary house during the day from which to undertake activities, plugging into the activities organised through the main day service. The house could also be used for periods of respite care. The PCT with other partners funds East Southampton Day Service. This service is in need of modernisation.

11.3 Southampton Adult Social Care has been successful in supporting people with a learning disability to gain employment. Many individuals who previously attended day services are now in paid employment. Local services have not been as successful in supporting people with complex needs into employment. The support for those with complex needs could be redirected to assist people into work. It has been found that the health of people in work develop dramatically, improving posture, communication skills, and self-esteem. The Community Learning Disability Team will play a key role in working with individuals and local employment services to enable people to gain work. The PCT and the City Council has a relatively poor record at present in employing people with a learning disability. The recruitment practices of the PCT will need to be revised to increase the numbers of people with a learning disability employed. The PCT will set a target for the numbers of people with a learning disability it employs.

## 12. Mental Health

12.0 People with learning disabilities can experience the full range of mental health problems as those in the general population without learning disabilities. People with learning disabilities are more at risk of mental ill-health than the general population and require innovative approaches from support services for assessment and treatment.

12.1 “Valuing People” placed emphasis on partnership working to meet the mental health needs of people with learning disabilities, and the rights of people with learning disabilities to benefit from the same standards of mental health treatment as the general population. Green Light for mental health is a service improvement toolkit that was developed for the Department of Health by the Valuing People Support Team and the National Institute for Mental Health in England. The toolkit provides a framework for evaluating services on the question: ‘how good are your mental health services for people with learning disabilities?’ and focuses on delivering the Mental Health National Service Framework (Department of Health, 1999) for people who have learning disabilities.



12.2 Southampton City Mental Health Local Implementation Team sponsored the review of mental health services for people with a learning disability using the Green Light Toolkit. The review took place during the summer and autumn of 2005 and gained the views of a wide range of users, carers and related support agencies. A workshop was held in January 2006 at which the following priority work areas were agreed.



### 4 Priority Areas

- Agreement of clinical interface protocol between Adult Mental Health and Learning Disabilities services
- Development of a protocol for referrals from Primary Care to Adult Mental Health and/or Learning Disabilities services
- Formal implementation of the Care Programme Approach to National Service Framework standards by Learning Disability services for people with mental health and learning disability needs
- Form a ‘virtual team’ of professionals from mental health and learning disability services who will work together with mental health and learning disability needs

12.3 A review of the progress of these objectives is required as well as identifying further priority areas to address ongoing service improvement. A well established user group made up of people with a learning disability who have a mental health problem continues to assist these developments.

### **13. Modernization of Assessment & Treatment/Inpatient Services**

13.0 Southampton City Council, Southampton City Primary Care Trust and Hampshire Partnership Trust have been working in partnership to develop a service response for individual's learning disability who are experiencing periods of crisis. Individuals' relationships with their carers have often reached breaking point. These difficulties are often due to levels of challenging behaviour or periods of mental illness which result in family or support breakdown. In addition a small number of individuals are given notice to leave residential care services at very short notice due to the above reasons.



13.1 Individuals who are in crisis have very limited choices open to them. The main option available to them is to move into residential care. These placements are often expensive, are far away from their families and social networks. Services being offered to individual do not address fundamental issues of appropriate housing and support that resulted in a crisis. Services are not person centred and do not support the individual to access the range of services available to them. Local services often become disengaged with the person due to the distances involved in maintaining regular contact.

13.2 It is proposed to establish a small dedicated team to support a small number of individuals who can be identified as being at risk of needing to be re-housed in an emergency or be in a crisis situation. The team would have the capacity to work with the individual on an out reach basis to facilitate the person to remain in their preferred housing solution. If this was not possible the team would support the individual to move into the emergency housing on a temporary basis until a more permanent solution to their housing and support needs could be identified. In addition the team would provide a crisis resolution, home treatment style of support for those with acute mental illness in an attempt to avoid admission to hospital. If a hospital admission was required than the team would provide an in-reach support service for the period of admission.

13.3 The PCT would wish to see the current service provide by Hampshire Partnership Trust on the Tatchbury site develop into a regional service to support people with a learning disability who have come into contact with the police or the courts.

## 14. Re provision of Locally Based Hospital Units

14.0 There are 38 people with learning disability currently living in 3 Locally Based Hospital Units in the City. There are well developed plans to re-house these individuals in ordinary housing across the City. The PCT has been working with 3 Housing Associations to develop suitable accommodation for people to move into. People will be discharged from NHS care and their on going support will be commissioned through a pooled budget with Southampton City Council.



## 15. Continuing Care

15.0 It has been well documented recently that the cost of supporting people with a learning disability is likely to increase significantly. In a recent report published by the Association of Directors of Social Services showed that these increases were likely due to:

- Improvements in post-natal care
- Increased life expectancy
- Increase in number with complex disability

15.1 Last year the PCT invested in a post to case manage a number of individuals whose support cost is high. The aim was to develop a local service on an individualised basis using person centred approaches to service design. This strategy has resulted in a number of individuals receiving improved quality of life and made significant savings for the PCT.



15.2 Other strategies need to be developed to manage this need, these include:

- Improved Transition Planning
- Developing Extra Care Housing
- Developing Dementia Care Services
- Improved access to housing to support the development individualised services.
- Regular review of placements jointly with Adult Social Care partners.
- Continued joint procurement with the City Council for domiciliary care & residential care services.

## 16. Commissioning & Partnership Working

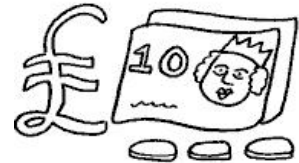
16.0 It is the PCT's intention to enter into a detailed partnership arrangement with Southampton City Council Adult Health & Social Care Directorate using Health Act Flexibilities. This will involve using the following Section 31 powers:



- LA Lead Commissioning
- Pooled Budget
- Integrated Provision

16.1 This will build on the current partnership work focused around the implementation of the Valuing People agenda.

16.2 Work will continue to develop shared procurement strategies such as the current Domiciliary Care tendering exercise. Through this partnership arrangement it will be possible to achieve best value for both the PCT and Local Authority.

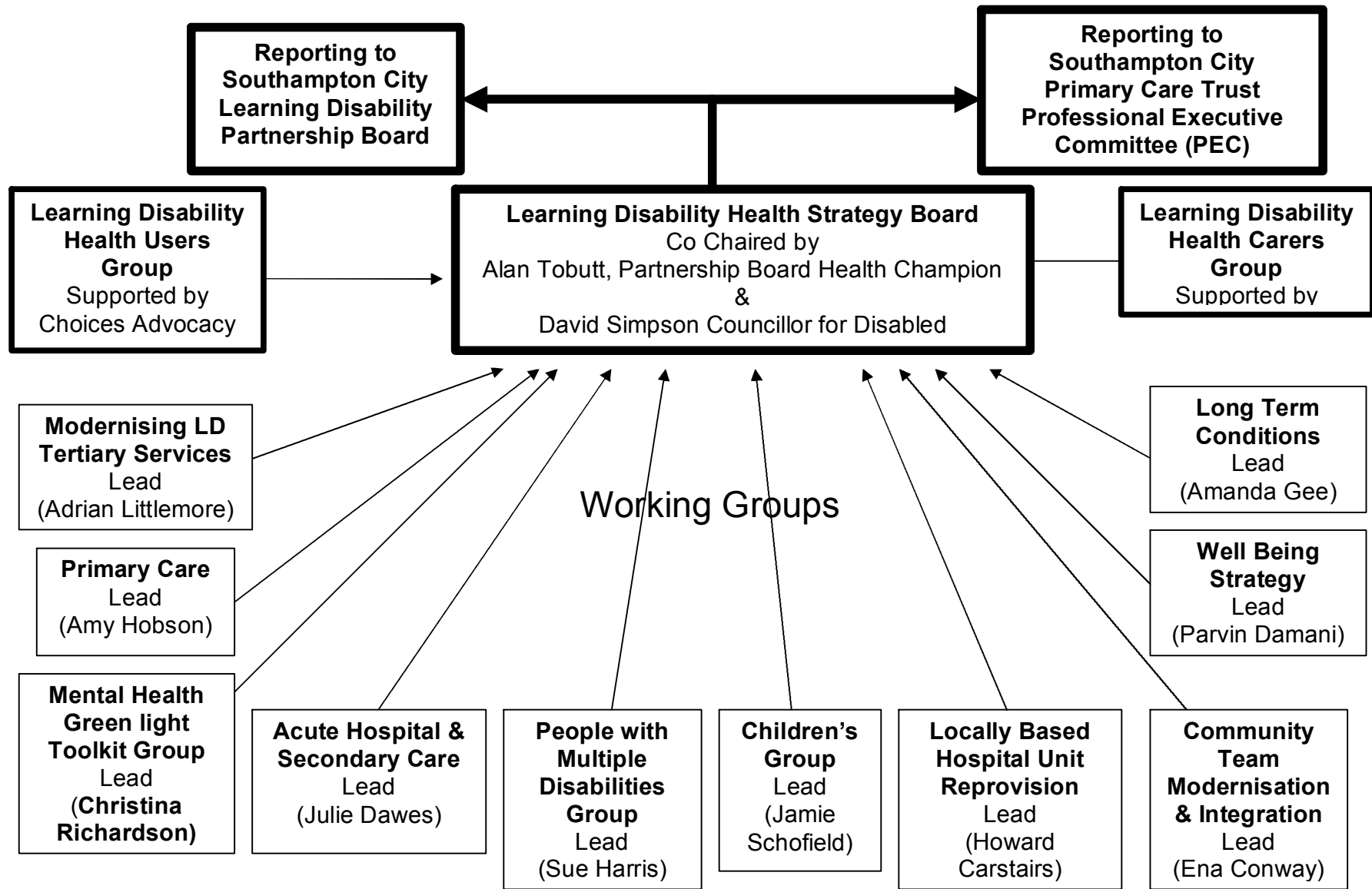


## **17. Implementation of the Health Strategy**

17.0 A new Learning Disability Health Strategy Board is to be established to coordinate and monitor progress on the implementation plans. The Board will report to the Southampton City Learning Disability Partnership Board through the LIG and to the Southampton City Primary Care Trust Professional Executive Committee. The Board will be co-chaired by Southampton City Councillor with the lead for disability and by the Learning Disability Partnership Board Health Champion.

17.1 The structure of the Board and sub groups will be as follows:

17.2 Each Lead is responsible for developing an accessible detailed implementation plan and providing reports to the Learning Disability Health Strategy Board.



Adrian Littlemore  
Commissioning Manager  
Learning Disabilities  
23<sup>rd</sup> May 2006

## Implementation Plan for Southampton City Learning Disability Health Strategy

Each Lead is responsible for developing an accessible detailed implementation plan and providing reports to the Learning Disability Health Strategy Board.

	<b>Tasks</b>	<b>Lead</b>	<b>To Be completed By</b>	<b>Progress to Date</b>
<b>Children's Services</b>	<ol style="list-style-type: none"> <li>1. Establish a single team for children with a learning disability called Jigsaw.</li> <li>2. Develop a system to identify children who would benefit from early intervention strategies.</li> <li>3. Develop a system where every child with a learning disability has a lead professional supporting and coordinating their care.</li> <li>4. Develop an information strategy to inform parents and carers about their child's need.</li> <li>5. Develop a single Foundation Assessment to be completed for all children with a learning disability.</li> </ol>	Jamie Schofield		
<b>Transition into Adulthood</b>	<ol style="list-style-type: none"> <li>1. Develop improve planning for young people entering adult provision from children's services.</li> <li>2. Develop specific service plans for emerging health needs being identified.</li> <li>3. Agree an eligibility criteria for access to a managed transition process</li> <li>4. Agree minimum standards for transition</li> <li>5. Review and implement transition protocols</li> <li>6. Establish a Transition Register held by Adult Services</li> <li>7. Develop performance measure and system to manage multi agency performance.</li> </ol>	Adrian Littlemore		

	<b>Tasks</b>	<b>Lead</b>	<b>To Be completed By</b>	<b>Progress to Date</b>
<b>Adult Community Team</b>	<ol style="list-style-type: none"> <li>1. Develop a single Community Team with management structures with the ability to deliver Valuing People objectives.</li> <li>2. Identify with the community Team key strategic priorities which they will work towards.</li> <li>3. Develop new performance measures which take into account the strategic priorities.</li> <li>4. Develop a single referral and assessment process.</li> </ol>	Ena Conway		

	<b>Tasks</b>	<b>Lead</b>	<b>To Be completed By</b>	<b>Progress to Date</b>
<b>Primary Care</b>	<ol style="list-style-type: none"> <li>1. Appoint a Learning Disability Professional with Special Interest (PwSI) to support Primary Care Patients.</li> <li>2. Undertake a training needs analysis for Primary Care staff.</li> <li>3. Improve the health outcomes for people with a learning disability currently in long stay hospital units in Southampton City.</li> </ol>	Amy Hobson		

	<ol style="list-style-type: none"> <li>4. To improve access and quality of provision to primary, community, secondary and specialist health services</li> <li>5. To ensure that the design of care pathways (patient journeys) achieves the best use of resources and outcome for patients</li> <li>6. To establish a basic level of competencies and confidence within primary care.</li> <li>7. All individuals with a learning disability to be offered the opportunity to develop a Health Action Plan, linked to their Person Centred Plan.</li> <li>8. Health Facilitators to be offered training and ongoing support.</li> <li>9. All GP practises to develop a Learning Disability Register, initially identifying all individuals known to specialist services.</li> <li>10. All GP practises to develop a patient accessible care plan which records information from the persons Health Action Plan.</li> <li>11. A learning disability patient users group to be established supported through Choices Advocacy and the PCT.</li> <li>12. The Expert Patient Programme to be adapted to enable access for patients with a learning disability.</li> <li>13. To develop an accessible and higher profile complaints process linking into the PAL's service.</li> </ol>			
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	<b>Tasks</b>	<b>Lead</b>	<b>To Be completed By</b>	<b>Progress to Date</b>
<b>Acute Care</b>	<ol style="list-style-type: none"> <li>1. Raise the awareness of the needs of patients with a learning disability in hospital staff.</li> <li>2. Undertake a training needs analysis for Hospital staff.</li> <li>3. Develop an adapted care pathway for patients with a learning disability focusing on admission and discharge from hospital.</li> <li>4. Develop care standards for an enhanced service which patients with a learning disability can expect.</li> <li>5. Identify a lead professional structure across the hospital to champion learning disability issues.</li> <li>6. Identify partnership opportunities with other disease areas to improve the health outcomes for patients with a learning disability.</li> </ol>	Julie Dawes		

	<b>Tasks</b>	<b>Lead</b>	<b>To Be completed By</b>	<b>Progress to Date</b>
<b>Long Term Conditions</b>	<ol style="list-style-type: none"> <li>1. GP registers to record long term condition health information for people with a learning disability.</li> <li>2. Information from GP registers to inform Practise Based Commissioning Strategies.</li> <li>3. All Long Term Condition areas to take into account the specific needs of patient with a learning disability in their strategy development.</li> <li>4. Learning Disability Services to support the Long Term Conditions Strategy to develop an accessible health care plan for by all.</li> <li>5. Each Long Term Conditions area to produce a range of patient information some of which needs to be accessible to patients who have a learning disability.</li> </ol>	Amanda Gee		

	<b>Tasks</b>	<b>Lead</b>	<b>To Be completed By</b>	<b>Progress to Date</b>
<b>Healthy Lifestyles</b>	<ol style="list-style-type: none"> <li>1. Undertake a needs analysis identifying the service requirements for people with complex health needs including people who present challenges and those requiring intrusive health interventions.</li> <li>2. Develop a health &amp; social care service strategy for people with complex health needs.</li> <li>3. Modernise East Southampton Day Service in line with Adult Social Care modernisation.</li> <li>4. Increase the numbers of individuals with complex health needs gaining employment.</li> <li>5. The PCT and other Healthcare providers to develop targets to employ more people with a learning disability.</li> </ol>	Sue Harris		

	<b>Tasks</b>	<b>Lead</b>	<b>To Be completed By</b>	<b>Progress to Date</b>
<b>Mental Health</b>	<ol style="list-style-type: none"> <li>1. Agreement of clinical interface protocol between Adult Mental Health and Learning Disabilities services.</li> <li>2. Development of a protocol for referrals from Primary Care to Adult Mental Health and/or Learning Disabilities services.</li> <li>3. Formal implementation of the Care Programme Approach to National Service Framework standards by Learning Disability services for people with mental health and learning disability needs</li> <li>4. Form a ' virtual team' of professionals from mental health and learning disability services who will work together with mental health and learning disability needs</li> <li>5. Continue to support and develop the mental health user support group</li> </ol>	Christina Richardson		

	<b>Tasks</b>	<b>Lead</b>	<b>To Be completed By</b>	<b>Progress to Date</b>
<b>Assessment &amp; Treatment Services</b>	<ol style="list-style-type: none"> <li>1. To develop a service system which support people in crisis due to their behaviour, mental health or social circumstances breaking down.</li> <li>2. Support the development a specialist forensic inpatient and community service.</li> <li>3. To develop a detailed project plan.</li> <li>4. To appoint a Project Worker to take forward the project.</li> </ol>	Adrian Littlemore		

	<b>Tasks</b>	<b>Lead</b>	<b>To Be completed By</b>	<b>Progress to Date</b>
<b>Locally Based Hospital Unit Reprovision</b>	<ol style="list-style-type: none"> <li>1. To re-house all residents currently living in Locally Based Hospital Units</li> <li>2. To establish person centred support services through a tendering process.</li> <li>3. To support Southampton City Council take on lead commissioning and establish a pooled budget for the new service provision.</li> <li>4. For all individuals to be supported to develop a person centred plan and health action plan.</li> </ol>	Howard Carstairs/ Adrian Littlemore		

	<b>Tasks</b>	<b>Lead</b>	<b>To Be completed By</b>	<b>Progress to Date</b>
<b>Continuing Care</b>	<ol style="list-style-type: none"> <li>1. Improved Transition Planning</li> <li>2. Develop Extra Care Housing</li> <li>3. Develop Dementia Care Services</li> <li>4. Improved assess to housing to support the development individualised services.</li> <li>5. Explore the appointment of a Housing Enabling officer for people with a learning disability.</li> <li>6. Regular review of placements jointly with Adult Social Care partners.</li> <li>7. Continued joint procurement with the City Council for domiciliary care &amp; residential care services.</li> </ol>	Adrian Littlemore		

	<b>Tasks</b>	<b>Lead</b>	<b>To Be completed By</b>	<b>Progress to Date</b>
<b>Commissioning &amp; Partnership</b>	<p>1. Continue to develop detailed partnership arrangement with Southampton City Council Adult Health &amp; Social Care Directorate using Health Act Flexibilities. Involving the use of the following Section 31 powers:</p> <ul style="list-style-type: none"> <li>• LA Lead Commissioning</li> <li>• Pooled Budget</li> <li>• Integrated Provision</li> </ul> <p>2. Continue to develop shared procurement strategies such as the current Domiciliary Care tendering exercise.</p>	Carol Valentine/ Amy Hobson		

