Enclosure A

audit 2001/2002

Review of Services for Adults with Learning Disabilities (Final draft version)

London Borough of Harrow

INSIDE THIS FINAL DRAFT SUMMARY REPORT

DISTRICT AUDIT

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Introduction

Services for people with learning disabilities are high on the national agenda, with the publication in March 2001 of the White Paper *Valuing People – A New Strategy for Learning Disability in the 21st Century*. This describes a new vision for this client group and the services which support them. It is based on four principles: Rights, Independence, Choice and Inclusion.

At the same time, the *London Learning Disability Strategic Framework* (Department of Health and Social Services Inspectorate 2001) is a regional strategic plan echoing the White Paper. It sets out a framework with a five-year implementation timescale.

Background

Against this background, the Harrow Learning Disabilities Joint Investment Plan for 2001-04 was produced in April 2001. This sets out the interagency vision and values for the learning disabilities service and an action plan for achieving them. The Council fully subscribes to this document.

The greatest challenge Harrow faces is providing a wide enough range of services to users within the resources available. First, the total number of clients is increasing. Second, service users present increasingly complex needs. For example, officers estimate there are now 180 children and 100 adults in Harrow with autistic spectrum disorder (ASD). The White Paper expects authorities to respond to individual user need in a flexible and tailored way. This implies that a complex range of services, many of them expensive, must be provided at a time of resource constraint for the Council.

A Best Value Review (BVR) of day care has already taken place. A similar BVR of residential care is in the process of completion, having been rescoped.

A Private Finance Initiative (PFI) project is underway which includes plans to reprovide residential and day care for users with learning disabilities.

Against this background, and the reality of budget pressures in the Council, Harrow Social Services Department (SSD) has commissioned District Audit to review services for users with learning disabilities.

Scope and objectives

District Audit's work focused on services for adults with learning disabilities (including those with diagnoses of ASD), while recognising the crucial overlaps with services for young people with learning disabilities. It primarily involved a 'health check' of management arrangements in the following aspects:

- clarity of the joint planning for the client group, including:
  - objectives and priorities
  - the joint approach to service planning and commissioning within the context of the mixed economy
  - the interagency context and the role of the Social Services Department and the Council within it.

The audit also considered:

- effectiveness of care management arrangements
- cost of provision.

Audit approach

The fieldwork involved the following:

- review of key documentation
- interviews with managers and other stakeholders concerned with planning, supporting and providing the service
- questionnaires and a workshop
- review of financial and activity data.

Main conclusions

Shared strategic approach to service planning

The joint approach to services for adults with learning disabilities presents a mixed picture. Relationships between the statutory agencies in particular are good, and relationships between the statutory agencies and voluntary organisations also tend to be satisfactory. However the joint approach has lacked effectiveness in implementing the action plans that were signed up to in the Joint Investment Plan (the JIP). These include two crucial areas that still need resolution:

- services for people with ASD, and
- a plan for the future of the Harrow Learning Disability Team (HLDT).

The lack of costings, task allocation and specific, measurable, achievable, reasonable and time-limited (SMART) targets in the JIP have contributed to a lack of effectiveness in some areas.

The establishment of the new Learning Disabilities Partnership Board (LDPB) represents a positive way forward, as well as providing compliance with guidance. The agreement to appoint the joint commissioning manager is positive but, of itself, the new Board is no guarantee of greater effectiveness in planning or in services. It will also have to ensure that:

- its functioning takes account of the objectives and priorities of the statutory organisations,
- there is ownership of its processes, both by the statutory (that is the major funding) agencies, and by the organisations representing users and carers,
- there is clarity about the fact its role is purely to monitor advise and propose, rather than make decisions,
- members have the appropriate level of delegated authority.

It will have to oversee and drive a comprehensive review of the pattern of service provision in the context of the modernisation agenda, the pressing issues identified (ASD services, and the future of the HLDT), and the work already under way on the Path. This is a development plan for learning disability services in Harrow, facilitated by the National Development Team (NDT). Finally, it will have to take account of resource availability, explore the possibilities for bringing in new resources, and ensure that there is a match between service provision, resources and need (if not demand).

The LDPB constitution, adopted in December 2001, is helpful in setting out the formal framework within which these issues may be taken forward.

The operational framework for the HLDT

The work focussed on the HLDT, which provides assessment and services itself, and is also the way to further services for users. Relationships between SSD and health staff in the HLDT are generally good, and there is a very genuine appreciation of the benefits of co-location and of working in a multi-disciplinary team. However joint working paints a confused picture, with unclear decision-making and planning, and unclear communication at managerial level. There are tensions, pressures and contradictions in the team – changing roles, the poor accommodation, issues about the offering of ASD assessments without service, resources pressures, social work vacancies. There is no current operational policy, and no current agreed plan on the way forward for the HLDT, which at times appears to be operating as two teams – a multi-disciplinary health team working (at times closely) with a team of social workers on the basis of co-location and good informal relationships. There is no performance management framework for the team, and the eligibility criteria need to be updated. It lacks useful targets and guidance on its priorities. There is no common model of caseworking between health and SSD staff.

With the difficult budget situation, and lacking the support of a clear operating framework, staff are working under pressure. The strengths of the team are its co-location (except for psychiatry), and the communication between team members. It has a single point of entry, a single assessment process, and coherent allocation processes. However the HLDT does not have the formal framework it needs to promote or assess performance improvement, as it is expected to do through Best Value.

Care management arrangements

Eligibility criteria for the service are underdeveloped, inconsistent with practice and unsustainable. The out-of-date eligibility criteria:

- mask major issues for the future of the service that are unresolved
- deprive staff of guidance to make well-founded judgements on what work to prioritise or turn away
- leave the team in no position to rebut claims that it is overly focused on assessment, and that service provision decisions lack transparency and consistency.

Consequently services are fragmented, which is a source of considerable frustration to all concerned, and adds to the stresses and pressures on staff.

There are two areas where there are particular concerns.

- The HLDT works in areas of potentially high risk – child protection, challenging behaviour and self-harm, assessments and compulsory admissions under the Mental Health Act. There are increasing levels of formal complaints. However there is no coherent risk assessment or management strategy. This is urgently needed.
- Transition planning is a crucial area. It refers to planning services for young people between the ages of 14 and 19 who are becoming adults. These services may be life-long, and involve major decisions about life chances and resources. Transition planning is unsatisfactory for all those involved. It is not functioning effectively as part of the process for maximising the independence of young people with learning disabilities. It is the source of great anxiety and frustration for parents and carers. There is no continuous

- process of transition planning over the period available, and social workers are becoming involved in detailed transition planning, involving complex and expensive care packages, far too late in the process. This must severely undermine their capacity to manage the transition process and the SSD's relationship with young people and carers at a very difficult time.

At the same time there are a number of strengths in this area that can be drawn on – the joint panel on residential placements between Social Services, Education and the Health Authority, good interagency relations, and the potential availability of information held on the learning disability planning register in the HLDT.

Cost of provision

In the context of the challenges facing the interagency approach and the HLDT, the issues around information and financial systems on costs for the Council are lower priority. The SSD centralisation of budget controls has not proved effective in containing costs. New software systems are being introduced in SSD which are anticipated to give better information. This offers the prospect of developing information systems to monitor the work of the HLDT, and review how far the new framework recommended is succeeding in providing a cost-effective service that meets strategic and operational priorities within the resources available. The Learning Disability Planning Register has the potential to add more value to the HLDT.

The Way Forward

The audit on services for adults with learning disabilities has been commissioned by the Harrow Social Services Department. The draft report was made available to officers in March 2002 and has been revised in light of the comments received. This final draft report will be finalised when the attached action plan is completed.

Detailed report

Issue	Findings	Conclusion	Recommendations
Is there a shared strategic approach to planning for services for adults with learning disabilities?			
Is there a joint approach to service planning, commissioning and provision?	The Harrow Best Value Performance Plan (BVPP) has as a key service priority to "improve services for disabled people" and there is a recent history of joint planning in Harrow. A Joint Strategy was produced by the Learning Disability Strategy Group in November 2000. This group comprised representatives of the statutory and voluntary agencies, users and carers. The report was picked up in the Joint Improvement Plan (JIP), April 2001. In line with good practice, it includes a vision, objectives, key issues, needs analysis, development priorities and an action plan. The changing legal context for and guidance on service provision is highlighted, along with the significant implications for service development.	The joint approach presents a mixed picture. Relationships between the statutory agencies in particular are good, and relationships between the statutory agencies and voluntary organisations tend to be quite good. However the joint approach has lacked effectiveness in implementing the action plans that are signed up to in the JIP. These include the key areas of services for people with ASD, and the plan for the future of the HLDT – two crucial areas that need resolution. The lack of costings, task allocation and specific, measurable, achievable, reasonable and time-limited (SMART) targets may be another reason for the lack of effectiveness.	R1 Review the effectiveness of the Partnership Board after 12 months.
	Relationships are good between the agencies, and questionnaires and interviews confirm this. However the Partnership Board questionnaire reveals a considerable range of views on the overall effectiveness of the interagency approach – 60% thought it strong or very strong, 30% thought it weak. The more critical view tended to come from voluntary sector representatives. Harrow Learning Disability Team (HLDT) staff were very positive about the overall interagency approach and their management, although they were more critical of the extent to which stakeholders had been involved in policy development.	Harrow Social Services Department is in the process of completing its BVR on residential services for adults, having already completed its BVR on adult day care. The former has resulted in concrete and costed plans for a fundamental shift in service provision in line with modern thinking on models of service provision. The latter seems less likely to do so because of the narrow terms of reference. There is a pressing need to review and modernise services for adults with learning disability across the range of service provision, for a number of reasons: • the modernisation agenda expressed in central government guidance	R2 Review through the Partnership Board the pattern of service provision. This should be a whole-systems approach, taking account of the work done on the Path. R3 Produce a costed and prioritised action plan with SMART targets to address the issues identified in the service provision review. R4 Prepare and submit a business case for Adult Learning Disability Services to be a priority call on the Council's capacity to bid for and bring in additional and

Issue	Findings	Conclusion	Recommendations
			external funding.

Issue	Findings	Conclusion	Recommendations
	The opposite view is that stakeholders – user and carer groups – have been powerful in setting the agenda. For example, the recent pressures on services to extend to meet the needs of people with Autistic Spectrum Disorders (ASD) is seen as in part a result of the articulate presentation of needs. They were also seen as influential in the Joint Strategy, and in the JIP. This may be in part why there is in key areas a considerable discrepancy between JIP plans and what has happened over the past year. For example, the JIP recommendation on ASD that "resources be identified to address the shortfalls in the 1998 needs analysis", and "ensure a range of suitable provision". Also the recommendation that "strategic management arrangements need to be developed to integrate health and social care work via pooled budgets, lead commissioning and/or integrated provision". A more fundamental debate about the future direction of joint service development is under way, including discussions between Social Services and Health managers on the future direction of the HLDT (see below). On a positive note, Health and Social Services (SSD) have reached an agreement to fund jointly a commissioning manager post.	• increased demand and service and budget pressures • changes in Health structures The establishment of the new Learning Disabilities Partnership Board represents a positive way forward, as well as providing compliance with guidance. The agreement to appoint the commissioning manager is positive but, of itself, the new body is no guarantee of greater effectiveness on the ground. It will also have to ensure that its functioning takes account of the objectives and priorities of the statutory organisations (and vice versa) and that there is ownership of its processes, both by the statutory (that is, the major funding) agencies, and by the organisations representing users and carers. There will have to be clarity about its role as a purely advisory body or forum rather than a decision-making body. Members will need to have the appropriate level of delegated authority. It will have to oversee and drive a comprehensive review of the pattern of service provision in the context of the modernisation agenda, the pressing issues identified (ASD services, and the future of the HLDT), and the work already under way on the Path. Finally, it will have to take account of resource availability, explore the possibilities for bringing in new resources, and ensure that there is a match between service provision, resources and need (if not demand).	R5 Ensure the Partnership Board has the information necessary on budgets and activities as well as need.

Issue	Findings	Conclusion	Recommendations
	There is an agreed view that learning disability services need to be modernised. A Best Value Review (BVR) of day care has already been undertaken, resulting in a Private Finance Initiative that will transform services. Difficulties remain; the BVR proposed no interim service improvement plan, and it focuses on capital resources rather than revenue and service delivery issues. A BVR on residential services is also reporting back, although the terms of reference are now viewed as too narrow. Part of the modernisation process is the establishment of the Partnership Board in October 2001, in accordance with the requirements of the 'Valuing People' white paper. The constitution for the LDPB sets out its terms of reference, objectives and functions. Its role is purely to advise, oversee, propose and recommend on relevant issues.	The LDPB constitution is helpful in setting out the formal framework within which these issues may be taken forward.	

Issue	Findings	Conclusion	Recommendations
	Education does not have a high profile in the joint strategy arena, but relationships again are cordial, without an obvious positive impact on service improvement (see section on transition planning). The context of this joint work is the fact that the statutory agencies are all 'strapped for cash' as one officer put it – if not actually facing considerable overspends. At the same time, demands on services – and challenges to the pattern of service provision – are increasing. The analyses of need already undertaken indicate that this trend will continue. At the same time, there is a general view that service provision has become outdated, and requires modernisation. The Path developed by the NDT indicates a way forward that operational staff are signed up to. However the Path does not seem to have been taken directly into account in the JIP or the Joint Strategy. A final, significant factor is the change to health structures in April 2002, with the inauguration of the new Primary Care Trusts (PCTs) and the Strategic Health Authority (SHA). The JIP points out that a number of areas of guidance are supported by funding availability, and there are also other external resources for which application can be made, such as European funding. However there is limited capacity evident to take forward external bids, given the demands of the PFI process.		
	Overall, the Partnership Board questionnaires show a picture of a positive valuing of joint working, especially leadership, and individual's contributions. The only factors to score negatively were culture and information.		

Issue	Findings	Conclusion	Recommendations
How well does the Partnership Board use information on community needs and service performance to decide joint priorities?	In line with good practice, there has been extensive work on needs analysis, mainly demographic, and work to establish joint priority areas. This includes background research to inform the Joint Strategy and the JIP, and work to establish the joint priority areas, taking account of stakeholder views. The information has informed the development of joint priorities as expressed in the JIP. However there is no specific mention of the Learning Disability Planning Register in terms of the strategic use of client information, and, as stated above, there are concerns about the information available to the JIP. This includes both service activity and financial information.		

Issue	Findings	Conclusion	Recommendations
What is the operational framework for the HLDT?			
Are plans and policies in place?	The HLDT has been operating since before 1990. It was a very early example of a joint team, initially mainly nurses and social workers. Since then the team has grown considerably, incorporating a range of professional groups (e.g psychiatrists and psychologists) involving changes in roles and structures. With the growth in size and complexity of the team, pressure on management arrangements has increased (see section below on team systems and structure) and uncertainties have arisen over the future development of the team. Health staff had concerns over the differences in funding and service provision (see section on eligibility criteria). There are some significant issues facing the team. The environment – the top floor of the civic centre, with complex and difficult access – is unsuitable, and psychiatry remains at the previous base. Consequently the team is split. Staff would very much like to move out of the current accommodation to somewhere more user-friendly. Another source of pressure has been the freezing of posts by the SSD as part of the measures to address budget pressures. There are in any case normally vacancies, particularly among social work staff. Partly as a consequence, staff see themselves as under siege. This is exacerbated by the ASD social worker post, which carries out assessments but has no services to offer. There was also recognition that skills are difficult to retain, and health staff expressed concerns about joining the SSD which might give them further difficulties in recruitment and retention. There is a year wait for an assessment.	Like the situation with interagency working, relationships between SSD and health staff are generally good, and there is a very genuine appreciation of the benefits of co-location and of working in a multi-disciplinary team. However the history of joint working demonstrates a confused picture, with unclear decision-making, planning led from the workfront, and unclear communication. There are tensions, pressures and contradictions in the team – changing roles, the accommodation, views of social services from health, issues about the offering of ASD assessments without service, resources etc. There is no current operational policy, and no agreed plan on the way forward for the team, which at times appears to be operating as two teams – a multi-disciplinary health team working (at times closely) with a team of social workers on the basis of co-location and good informal relationships. This is demonstrated by the combination of positive regard amongst the staff and appreciation of each other's skills, with pessimism about the possibilities of improving the service. The NDT Plan goes some way towards indicating a way forward for the team, but their pessimism and concern about financial and staffing resource shortfalls and about the challenges ahead does not portray an optimistic team.	R6 Resolve the uncertainty over the future of the HLDT by developing an integration plan for a single service, or an alternative way forward. R7 Resolve the environmental issues by moving the team to a more user-friendly location, subject to the outcome of R6.

Issue	Findings	Conclusion	Recommendations
	Formal complaints are a significant factor for the SSD managers of the team. These take up a considerable amount of managerial time – several hours each – and there is a concern about the risk of Judicial Review of decisions made in the service.		
	Social Services managers had planned to develop the HLDT as a single service with one management structure and pooled budgets. Health managers have been considering the possibility of developing the HLDT as a Social Care Trust, with lead responsibility with the new PCT. The uncertainty about the future direction of the team needs to be resolved between the two agencies involved.		
	Despite the pressures, relationships in the HLDT are good. Staff believe the most positive factors taking the team forward are the skills of staff and interagency working, followed by leadership of the partnership, internal communication, partnerships and stakeholders. Co-location and the multi-disciplinary nature of the team are seen as a huge benefit. They are most negative about the effects of political issues and then financial and staffing issues, and external changes, including the pace of change.		

Issue	Findings	Conclusion	Recommendations
	Neither the HLDT staff group nor the Partnership Board report strong views on the policies in place – although the HLDT staff were rather more critical of the process of policy development in terms of its openness and involvement of stakeholders. An operational policy was agreed within the HLDT about 1994. It has been revisited several times since, but never fully revised – the team have lacked the resources and guidelines to do it. The policy is now out-of-date and of no practical use. The HLDT has a statement of aims and objectives, although not in a format or document that promotes the team positively. Social workers have produced work plans in 1999 and 2000. These were oriented to internal projects and not clearly related to priorities outside the team, although the 2001 work plan was subsumed into the SSD business plan. The Health and SSD staff share their plans, and there is an overarching team workplan, but it does not fully integrate performance indicators or individual work plans. At the same time, the Area Manager has the expectation that the HLDT will be moving towards greater integration in the short term.	The HLDT effectively has no internal policy framework, and the statement of aims and objectives needs review, particularly as to its format, but also its content. The conclusion is that plans and policies are not in place for service improvement and the future development of the HLDT. Good relationships and communication within the team have allowed it to maintain a certain level of functioning without these key supports in place. There is little prospect of service improvement without a clear mandate and sense of direction from senior managers and a supportive internal framework for the team.	See R6 above and R9 below
	As already stated, the NDT-facilitated Plan is a significant element in the way HLDT team member see services developing – they feel they have a way forward. However it is not clear that the two agencies have each formally signed up to the document – senior managers have made little mention of it.		

Issue	Findings	Conclusion	Recommendations
	Staff report they are very confident in their skills, and that they are good in providing the services agreed. However it is noteworthy that only 40% agreed the service was achieving more and more as time went on.		
Are there clear objectives priorities and targets, linked to strategic plans and priorities?	Staff believe fairly strongly that the objectives of the service are well defined and that they produce clear action plans. They reported neutral views on whether action plans are relevant and up-to-date. The Partnership Board was rather more skeptical on these issues, and viewed systems in general as a hindrance to service provision. Action planning is done mainly through the work plans mentioned above. They are not linked directly into wider priorities, apart from the inclusion of a work plan in the SSD business plan for 2000-01. There is no process to relate the work plans and objectives of the subgroups to overall objectives for the team, and the staff report no great awareness of team objectives, and were unclear whether they even exist. They think of the NDT Path as synonymous with the team objectives. Health culture within the team includes a bottom up planning process "Glue comes up from the bottom". These are then aggregated into a contribution to the Trust's plan.	There is no performance management culture or framework in the HLDT – indeed, the health part of the team and Health managers do not seem to consider this important, and promote a bottom-up approach. This contributes to the fragmentation within the team. The lack of clear priorities contributes to the picture of a team facing very considerable pressures and unable to see a way forward. There is a real risk that the team will feel under siege. The NDT Path is a valuable contribution to establishing a shared way forward within the team and in its wider context of stakeholders in learning disability services. By itself, however, the Plan is insufficient. There should be a more formal process where each agency decides to commit themselves to the Plan, or to elements within it.	R8 Consider the Path at the new Partnership Board and integrate it explicitly into the next JIP, and the operational framework of the HLDT. R9 Establish (subject to the outcome of R6) action planning within the HLDT to: • link team activities to strategic and interagency priorities • contribute to SSD and Trust plans • establish SMART targets for planning.

Issue	Findings	Conclusion	Recommendations
How does the HLDT relate its objectives and work plans to individuals' work plans?	Each sub-group in the team has meetings, normally weekly. Nursing staff have monthly supervision and annual appraisal with a 6-monthly review. Social workers have professional supervision, but not appraisal. No staff have a system for linking supervision of their work with the team or sub-group work plans. Clinical and casework matters appear to be the main priority.	There is no formal matching between individual's work and HLDT objectives and work plans.	R10 Implement a performance management framework in the HLDT, subject to the outcome of R6.
How effective are team systems and the team structure?	The team structure consists of nurses, answerable to the senior nurse in the HLDT, a psychiatric subgroup, answerable directly to the Trust, psychology, answerable directly to a psychology manager, and other workers with their own reporting structures. A Trust manager commented that nurses "practice as experienced autonomous professionals", and this is a similar model to psychiatry and psychology. Each subgroup holds its own files, with the social work files most easily accessed by other staff. However the psychology group do not make their files available. The team is effectively on split sites, with psychiatry having remained at Orme Lodge when the rest of the team moved to the Civic Centre. The SSD Area Manager has no current formal remit for the HLDT health staff, although she is seen (at least within the HLDT) as having a leadership role for the HLDT on a day-to-day basis. This is valued by team members but the informal arrangement has also been the source of confusion in the past.	Structurally the HLDT is fragmented, oriented to specialist and clinical priorities, particularly for Health staff. Some team systems are working reasonably well – the single referral system, efficient allocation processes – but others bear little examination. The team is held together functionally by good communication, both formally through meetings and informally through colleagues. However there is an over-reliance on informal communication – for example, in the lack of consistent openness regarding client files. Experience of child protection review findings elsewhere suggests this must potentially be an area of risk for the HLDT. The Area Manager role is not supposed to involve responsibility for the whole team. Despite the personal regard in which the Area Manager is held by staff, her position is more that of a co-ordinator and her responsibilities and position have appeared confused. The issue is likely to be resolved by the actions suggested in R6 above.	See R6 above.

Issue	Findings	Conclusion	Recommendations
	Duty and assessment functions are carried out by the social workers, who operate a single point of entry into the HLDT. Referrals are then passed out through the duty senior social worker to the sub-groups who then take responsibility for the referral. Assessments can be slow to complete – a year on occasions. Cases will be reallocated if a second professional group needs to work with the same client. From the Area Manager's viewpoint, the team has a single point of referral, a single allocation process (which may involve reallocation between the different staff groups), joint eligibility criteria (but see below) and an agreed operational policy (but see above). The team see their co-location (except psychiatry) as a huge advantage, and the main reason for the high quality of their internal communication and good work relationships. There is a regular meeting of 'heads of service', as well as team meetings quarterly, and subgroup meetings, often weekly. They also felt that transition planning issues (for young people becoming adults) are more effectively handled in a team that deals with all ages (see section below). At the same time they reported that they find it 'impossible' to keep up with the changing expectations across the all age user group. This pressure may in part be the reason HLDT staff are so strongly of the view that the main hindrances to their work (apart from financial and staffing resources) are external changes and political issues. The view that the team is set in its ways and could be more flexible and creative has already been noted. Staff do believe they have a good understanding of the needs of their service users, and are good at providing services – although the Partnership Board is more neutral.		

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How does the HLDT monitor and review its services?	To an extent, the work plan process involves review of previous plans and the services provided. Nursing has made use of clinical audit for specific purposes. However the team overall acknowledge that they do not have good arrangements for monitoring and reviewing the HLDT's performance. They believe they do not have useful activity information, and believe strongly they do not have good financial information. The Partnership Board concur with these views, but are rather more critical of the arrangements for performance monitoring and review across services. The Learning Disability Planning Register does not seem to be considered as a resource in this context.	The general focus of the HLDT on individual casework results in little performance monitoring or review. See R 10 and the section below on activity and financial information.	See R10 above

Issue	Findings	Conclusion	Recommendations
How effective are care management arrangements?			
Are there clear eligibility criteria in the HLDT, that inform access to assessment and to services?	The service is dealing with a difficult context for its decision-making on how to use its staff. The funding from the health side of the HLDT comes through the Health Authority, and the commissioning contract stipulates that the funding is for adults with an IQ of 69 or below. Health services for children with disabilities are, formally, commissioned elsewhere. In practice, Health staff report this service is more nominal than real, and HLDT health staff do work with some children – if only to support their SSD colleagues. This is frowned on by Trust managers because it lies outside the contract with the Health Authority, so it is unfunded. SSD staff work with adults and children with learning disabilities. For eligibility criteria, they have a guideline drawing on the IQ level and significant social impairment. However, while Trust staff work with users formerly resident in the large mental handicap hospitals now resident in Harrow, the SSD staff do not. The position with regard to children, young people and adults with Autistic Spectrum Disorder (ASD) is particularly complex and challenging because of eligibility issues, the considerable rise in demand recently, and the articulate nature of the advocacy by family and carers on behalf of people with ASD. In 1998 an interagency group signed up to a report on ASD provided through the National Autistic Society Harrow (NASH). SSD subsequently provided funding for a social work post dedicated to the assessment of children and adults with ASD, but a parallel health bid was unsuccessful. Consequently there is now a single social work post in the team dedicated to assessment of adults with ASD, irrespective of their degree of	Eligibility criteria for the service are underdeveloped inconsistent and unsustainable. They mask major issues for the future of the service that have been considered by senior managers at different times, but that are unresolved. Consequently services are fragmented which is a source of considerable frustration to all concerned, and adds to the stresses and pressures on staff. In addition, the absence of eligibility criteria again deprives staff of guidance to make well-founded judgements on what work to prioritise or turn away. Without written eligibility criteria guidance on the role of assessment, an operational policy, or service provision priorities, the team is in no position to rebut the claims that it is overly focused on assessment, and that service provision decisions lack transparency and consistency. The HLDT is operating in areas of high risk, including child protection, challenging behaviour, and assessments and compulsory admissions under the Mental Health Act. Without a clear and reasonable framework to support its decision-making, the SSD and the Trust are at risk from work going wrong, and challenge from users carers and others. This needs to be addressed as a high priority, drawing on appropriate legal advice and systemic risk assessment skills.	R11 Produce a written operational policy for the team that provides clear guidance on how the HLDT should operate, including the relative weighting of the assessment and service provision functions, and transparent decision making on service provision. R12 Establish and implement eligibility criteria that reflect strategic joint priorities and the priorities and objectives established for the team, subject to the outcome of R6. R13 Undertake a risk assessment of the work in which the HLDT is involved. R14 Establish a framework for responding to high-risk areas identified in the risk assessment that includes protocols for cross-boundary working.

Issue	Findings	Conclusion	Recommendations
	disability (if any). Services are only available to people with ASD who meet the eligibility criteria, and specifically the requirement that they should be disabled. This leaves people with a diagnosis of Asperger's syndrome (characterised by features of autism without significant disability) in a position of having a written assessment of need, but with little in the way of services to meet those needs. This contradiction is leaving the social worker, the HLDT, the SSD and Trust, and people with Aspergers and their families all in a most difficult and unsatisfactory situations – expectations are raised with no prospect of meeting them (despite the fat this is an action point for the last JIP report). The team's external boundaries have been suggested as another source of impediment to the provision of a seamless service. Specifically, the arrangements with SSD children and families fieldwork teams for the investigation of child protections concerns, but also the joint working arrangements with the Harrow Unified Mental Health Service (HUMHS), and also to a lesser extent with the physical disability team. It was pointed out that people with ASD may display challenging behaviour, and are at particular risk of self-harm and compulsory admission to hospital. The lack of clarity is itself a source of general concern, but the boundaries with fieldwork teams and with HUMHS cover areas of high risk, and anything less than clear formal and written protocols must raise the levels of risk further.		

Issue	Findings	Conclusion	Recommendations
	The SSD managers with line responsibility for the HLDT social work team have all remarked on the rising incidence and formality of the challenge to the service's criteria and service provision, particularly in the context of formal complaints, which are difficult and time-consuming to finalise. There is also a concern that the SSD may be at risk of judicial review of its decisions. Originally, the eligibility criteria agreed for the team by the Trust and SSD were more or less the WHO definition of mental impairment (including the identification of an IQ of 69 or below as the cut off point). These have been discussed periodically since, but there has been no updating of the criteria. Comments have been made by NASH and a senior staff member that the HLDT and particularly the social work service are overly focused on assessment rather than service provision, and also that there is little transparency in the decisions on what services will be provided following assessment.		

Issue	Findings	Conclusion	Recommendations
Is there a joint model for case working?	There is no joint model for case working. Social workers use care management, nurses have developed their own model, and psychiatry is advocating the care programme approach. This must add to the complexity and lack of seamlessness in team working. It is worth noting that HUMHS' recent review by the Social Services Inspectorate resulted in a number of relevant recommendations: • develop Care Programme Approach (CPA) guidance and systems including consolidated single file, • clarity on the roles of care co-ordinators in leading care planning • "Clarity about multi-disciplinary roles and functions leading to a single model of joint working" • a CPA database, • regular audit • "The SSD and Trust should develop a clear description of the model of joint working required both in CMHT and for the wider linkages within HUMHS". • "The SSD & Trust should establish updated and joint systems for staff supervision and case audit". HUMHS is evidently much further down the path of integration that HLDT, but it is worth noting the sorts of issues that need to be taken forward to achieve integration, if that is the objective, whether within the SSD or as a Social Care Trust, in conjunction with the PCT.	One element of the fragmentation in the HLDT is the lack of a single model of case working. If or when decisions are made as to future of the HLDT, this issue will need to be grasped. HUMHS is a parallel service that is already committed to an integrated team model, and a recent SSI inspection report supports this and makes recommendations for further implementation of the model.	R15 Consider the recommendations of the SSI inspection report on HUMHS in terms of any value they can add for the HLDT, subject to the outcome of R6.

Issue	Findings	Conclusion	Recommendations
What are the transition planning arrangements?	Transition planning arrangements are not satisfactory from the point of view of the Education Department, the SSD, parents, or voluntary organisations. Transition planning is a responsibility of the Local Education Authority (LEA). For those young people with a statement of special educational need (SEN), it has a statutory responsibility to review their position with regard to becoming adult, at the first annual review of the statement after the young person turns 14. The review should be inter-agency and multi-disciplinary wherever necessary. For young people with complex needs, including many with learning disabilities who have been accommodated by the local authority, or placed in residential schools, these '14+ reviews' can allow up to about 5 years to make appropriate arrangements for when the young person leaves school. Harrow LEA retains little direct education provision for young people over 16. Although many of the young people of interest to HLDT will have places in the remaining provision – a mild learning disability (mld) and a severe learning disability (sld) school - the normal Harrow LEA arrangements still apply.	Transition planning is unsatisfactory for all those involved. It is not functioning effectively as part of the process for maximising the independence of young people with statements. It is the source of great anxiety and frustration for parents and carers. There is no continuous planned process of transition planning over the period available, and social workers are often involved in detailed transition planning, involving complex and expensive care packages, far too late in the process. This must severely undermine their capacity to manage the transition process and the SSD's relationship with young people and carers. Transition planning is a critical area to get right in terms of long-term relations with users and carers, and in terms of resource implications. It can be inferred that last minute and rushed planning will not be as cost-effective or efficient as planned work. However there are also a number of strengths in this area. The planning register contains good information, which could be used as a fail-safe system for identifying young people entering the transition planning window. The joint panel is	R16 In the context of R6 and the decision-making about the establishment of a specialist children's disability service, establish the clear objective to improve the transition planning service to young people with learning disabilities and their carers: • establish a joint LEA/SSD protocol to identify young people with learning disabilities who are approaching their 14+ review • develop a system for prioritising work with those young people most at risk. The system for prioritising should reflect wider HLDT and interagency priorities • ensure those with the highest priority are allocated a social worker for the transition planning period.

Issue	Findings	Conclusion	Recommendations
	Consequently the responsibility for this annual review is devolved to the schools, with the LEA holding a monitoring but not an initiating role. For young people in residential placements there is a joint panel (LEA, SSD and the Health Authority/SHA) which meets monthly. It agrees placements and funding arrangements. At the end of the calendar year, it reviews the leaver group for the following Summer. When young people leave the LEA provision, their statement of special educational need automatically lapses. Post –transition arrangements then become the responsibility of the SSD and the Learning and Skills Council although the LEA traditionally continues to provide transport where needed. The transition planning for young people in the local special schools does not appear as problematic as that for young people placed away. The LEA express some frustration at the lack of engagement by the SSD in transition planning. They cite the fact that young people with learning disabilities placed away from home may not have an allocated social worker, and may not attend annual reviews, particularly if it involves travel (the case of one young person placed in Aberdeen was mentioned as an example). From their point of view – and that of at least some parents – the SSD was doing too little too late. This view was shared by a number of Health colleagues. For their part, the LEA also acknowledge that 14+ reviews do not tend to be active exercises in planning for adulthood, nor is the intervening period used to focus on the opportunities to maximise independence in the context of approaching adulthood. From the SSD point of view, the HLDT felt at times that no effective interagency transition planning took place before the young person actually left school, and on occasions	proving effective in agreeing placements, and an extension to its functions could be considered. Finally, relations between SSD and Education appear solid. The area of transition planning is in need of a quick review to establish protocols to ensure that all young people with learning disabilities entering transition planning are clearly identified and the list is communicated regularly to the HDLT and/or any team for children with disabilities. The team or teams should establish a system for prioritising those young people most at risk of requiring residential and other expensive care packages, and ensuring the allocation of a social worker who can monitor and participate in an active transition planning process. This process should seek to establish positive relations and reassurance with young people and their carers, to ensure that important life decisions are made in a joint and planned way.	

Issue	Findings	Conclusion	Recommendations
	they knew little about the timing of young people's return home. The learning disability planning register (see below) does not seem to have been used to track need in this context. These issues apply to the situation of all young people with moderate or severe learning disabilities (who will ipso facto have statements of SEN) whatever their educational setting, although they apply most directly to young people in residential placements. The issues test the assertion by members of the HLDT that the issues of transition from child care to adulthood are better handled in their seamless service dealing with all ages. This feedback may have influenced the SSD in the decision it has now taken in principle to establish a dedicated service for children with disabilities. Other aspects of the context are the comment that the HLDT has no resources for transition planning (but the suggestion that the team could be more creative has already been noted) and the team's experience of the increasing complexity of young people's needs and the corresponding high costs of care and support packages. One senior Trust staff member thought that the HLDT needed to become more oriented towards prevention and the transparent allocation of resources, and place less emphasis on assessment – views also expressed by NASH. This may be an area in point. Despite these difficulties, there was a general view that relations between the SSD and Education staff are good.		

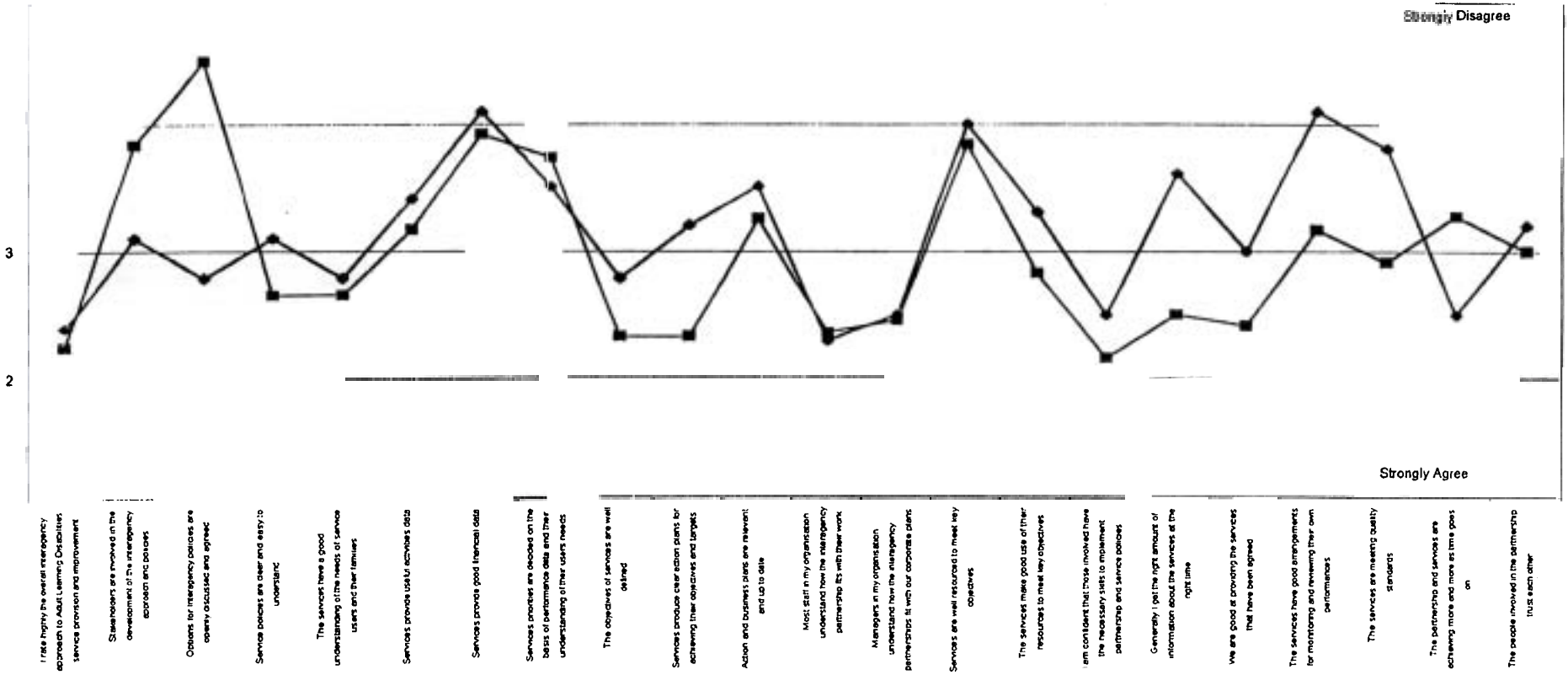
Issue	Findings	Conclusion	Recommendations
Cost of provision			
What financial data and reports are produced? Does the data include unit costs?	The BVPP notes, with regard to residential services for people with learning disabilities, "there is insufficient confidence in financial systems to know if performance can be improved". Both the Partnership Board and HLDT staff feel that the quality of information on activity and costs is a hindrance to the service. Budget reports are made available to the area manager monthly, but the formal budget holder is the third tier officer to whom she is accountable. The finance section go through the reports with the managers. Summarised reports go to the SSD Departmental Management Team 6-weekly. The SSD is spending 100% over its SSA allocation for the line including learning disability services. In the view of the finance officer, the budget was set lower than what was needed, but there is a projected overspend for the end of the year greater than either amount - £729k against a budget of £4.545m on spot and block contracts. Unit costs are not routinely provided, and the pattern - small numbers of highly expensive placements – does raise the question of how valuable this might be. However the Trojan database is being adopted and this has a capacity to include information on financial assessments and care packages. It will be able to make information directly available to managers under standard reports. It has been suggested that one consequence of the tight central control of the budget high up in the organisation results in staff lower down not feeling personal responsibility or the need to economise.	The quality of financial information is not seen to be good, but regular reports are made to operational and strategic managers, and a new financial system is being implemented. The level of overspend indicates that centralisation of budgetary responsibility has not proved effective in matching service demand to resources available. The new Trojan database will give increased capacity to provide financial information. Taken together with the recommendation to reconsider the model of working, the team objectives etc, and to implement performance management, this gives the opportunity to explore possibilities of better integration of resource management into the way the social workers and the HLDT operate. This will entail a review of the scheme of delegation, and the way that financial information is made available.	R17 Review the scheme of delegation in the light of the recommendations above to explore how authority and ownership over spending decisions can be extended together.

Issue	Findings	Conclusion	Recommendations
Are unit costs compared with those of other authorities?	The BVR on residential care has undertaken some basic cost comparisons, but has not found it easy to get benchmarking information from other Boroughs. Most information available from public databases is several years old. Harrow is involved in pan-London meetings on contracts for learning disability services. The meetings are attempting to apply the development work on standard contracts and costs for children's residential services across London to learning disability services. There are a number of particular issues around residential places. Demand exceeds supply, so the costs are increasing. Also, places for ASD service users are very expensive – one recent placement cost £124k p.a.	Benchmarking is an important continuous activity under Best Value, and work has been done in the SSD on this area, both in terms of the BVRs and in terms of linking into standing fora. Activity in this area will need to be reviewed once the HLDT is in a position to provide a clearer access route to services.	
What activity data and reports are produced? How far does the information available meet planning and operational needs?	Both the Partnership Board and the HLDT staff group scored information slightly on the hindrance side of neutral. SSD uses CARES client index system, which collates personal details of clients and allocation details. It has nothing on care packages, and little on service delivery. Care plans tend to be hand-written, and RAP information is collected in paper-based form. Referrals are taken on paper then admin input them onto the system. Any staff member can run an activity report, and it can provide 300 standard reports. Reports are set up in response to demand – associated with planning, committee reports etc. Social work managers can run some reports. However, in the view of the information manager, "the system is not working. It is not clear who should input information".	Overall, electronic activity and financial recording systems are drawn on periodically to monitor the HLDT, and particularly the day care and residential services located in a different section of the division. They have been utilised in the BVRs. There is less evidence that the information is used systematically to inform HLDT planning monitoring and reviewing. Financial information is made available in the form of regular budget reports, and activity reports are available, but it is unclear how far they are used. The learning disability planning register is seen as valuable, but again it is unclear how far it is used as an active planning tool. With the establishment of the new framework recommended for the HLDT, information and financial systems will have an important role in	R18 Develop financial and activity reports that facilitate monitoring of the HLDT's recommended eligibility criteria, operational policy, priorities and targets. R19 Consider how to develop the contribution that the Learning Disability Planning Register makes to service planning and delivery.

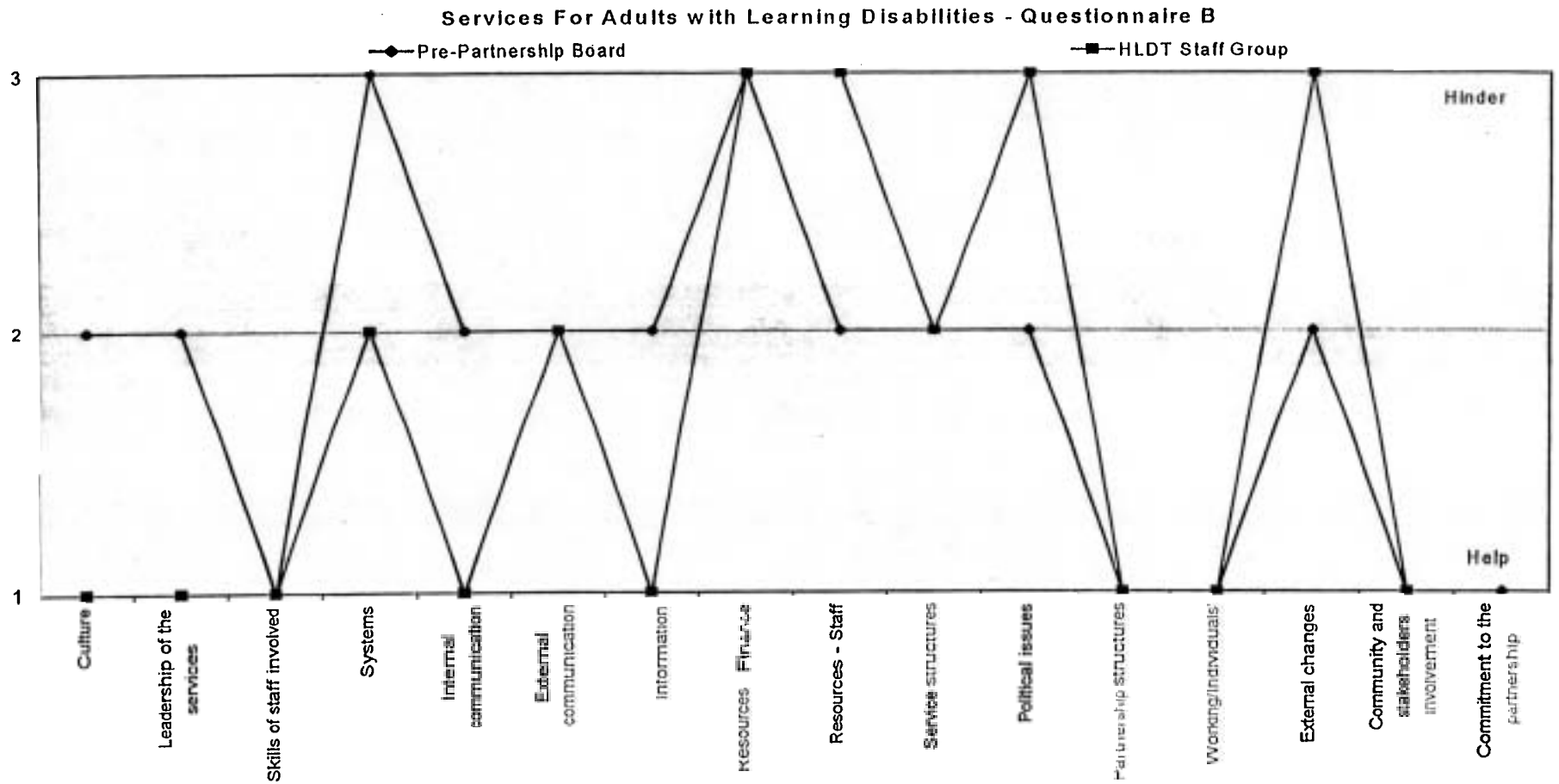
Issue	Findings	Conclusion	Recommendations
	The aim is to develop a workflow process to give social workers the benefits of the windows-based system. The current strategy is to tie everything into an electronic process from referral to resolution, and to run with the single assessment process. A windows-based system should be in place by 31.3.02. At the same time SSD IT strategy is being reviewed, with procurement decisions due June/July 2002. There is also the learning disability planning register, run by a Health staff member, with a separate health database. The staff member completes a 15-page questionnaire with the family. The register includes sections on assessment and services enormous amount of information, mainly on children. The register provides management information, mainly to the Trust. It is widely seen as a valuable tool, although there is little evidence of its effective use to aggregate data for interagency planning purposes. HUMHS have put in a bid under the Council's Invest to Save Bid (ISB) process. This bid involves a common desktop across all professionals, tracking professional contacts. It is due to go live in June 2002. One view would like to see the same in HLDT. However it is worth noting that some staff members are skeptical, feeling that this has already been tried, without a great deal of success.	providing the data to monitor the way the new framework is operating in practice The learning disability planning register is a real asset, but it is under-utilised in terms of the contribution it could make to the service.	

APPENDIX 1

Amalgamated Questionnaire A



Amalgamated Questionnaire B



Notes to the graphs

1. The two questionnaires were administered to the HLDT staff who attended the workshop on 6.12.01, and to an interagency group who were involved in the establishment of the Partnership Board, before its first meeting.
2. 12 staff members completed the questionnaire and 9 members of the 'Pre-Partnership Board'.
3. Questionnaire A required an evaluation of interagency working in Harrow by rating 22 positive statements according to whether the respondent agreed with them very strongly or strongly, neither agreed nor disagreed, or disagreed strongly or very strongly.
4. Questionnaire B listed 16 factors associated with interagency working, and asked respondents to rate them as helping or hindering interagency working and service improvement.