Coventry City Council

Briefing note

To: Health and Social Care Scrutiny Board (5) **Date:** 10th December 2014

Subject: Discharging Responsibilities for Winterbourne View

1 Purpose of the Note

1.1 To provide Health and Social Care Scrutiny Board (5) with an overview of action taken within Coventry and Warwickshire as a response to Winterbourne.

2 Summary

2.1 Following the events that took place at Winterbourne View Hospital, *Transforming Care* and the *Winterbourne Concordat* placed a number of requirements on local areas including the development of a joint plan for high quality care and support services.

2.2 This paper describes progress to date in respect of national requirements and outlines the responsibilities held by different agencies with regard to Winterbourne, along with how assurance is provided that these responsibilities are both understood and being complied with.

2.3 The Adult Social Care Peer Review completed in March 2014 concluded that there was a lack of clarity over responsibilities for Winterbourne. This report seeks to provide this clarity.

3 Recommendations

3.1 Health and Social Care Scrutiny Board (5) are requested to:

- Note and comment on the arrangements in place to ensure the requirements of Winterbourne are being appropriately discharged.

4 Background

4.1 In December 2012, the Government published *Transforming Care* and the *Winterbourne Concordat* as a response to the abuse of adults with a learning disability at Winterbourne View hospital in South Gloucestershire which had been exposed in a BBC Panorama investigation broadcast in 2011.

4.2 Key components of the Concordat included: the requirement to establish, by April 2013, a local register of patients living in Assessment and Treatment units; a duty on local areas to review all hospital placements (by 30 June 2013) and move everyone inappropriately placed to community based support by 1 June 2014. In addition, every area was to develop a locally agreed joint plan for high quality care and support

services for people of all ages with challenging behaviour by 1 April 2014. Tightening of regulation and inspection by the Care Quality Commission was also a requirement.

5 Progress to date with National Requirements

5.1 Requirement to establish a register, review patients and arrange most appropriate support

A local register of Coventry and Warwickshire patients was in place prior to the April 2013 deadline. All patients were reviewed within the timescale set of 30 June 2013.

5.2 The table at Appendix 1 indicates the position as at September 2014 regarding each individual patient identified as being as part of Coventry's Winterbourne cohort. The table shows the status of patients remaining in inpatient settings, patients already discharged and new admissions to assessment and treatment units.

5.3 There were originally seven Coventry residents placed by Coventry and Rugby Clinical Commissioning Group (CRCCG) in Assessment and Treatment units. Four have subsequently been discharged. Three remain in hospital settings. An additional two people have subsequently been admitted following determination by a multidisciplinary panel that the particular circumstances of the individuals mean that a limited stay is appropriate. A further three Coventry citizens were, and continue to be, the responsibility of NHS England and are therefore not part of the original cohort. These patients are however included on our local register so we have a comprehensive overview of all Coventry citizens.

6 Delivering a Co-ordinated Response to Winterbourne

6.1 The responsibility for assuring the quality of care for Coventry citizens accommodated in assessment and treatment units and those discharged to other provision is the responsibility of a number of agencies. These responsibilities are as follows:

6.2 Care Quality Commission

The Care Quality Commission (CQC) is the independent regulator of health and social care responsible for monitoring adherence to national standards. CRCCG (or Arden Commissioning Support Unit on CCG's behalf) has regular discussions with CQC representatives in respect of the quality of health provision including assessment and treatment units.

6.3 NHS England Specialised Commissioning

NHS England's specialist commissioning remit includes commissioning secure hospital provision. NHS England has dedicated case managers whose role includes quarterly attendance at providers' premises. This is usually in the form of ward rounds and there is scrutiny of care plans and potential to discuss care with patients. The Birmingham, Solihull and Black Country Area Team, which covers Coventry, have recently appointed an additional worker which has enabled one case manager to be released to work solely with the Winterbourne cohort. A register is kept and there is 100% compliance in terms of review and care planning.

NHS England continues to liaise with CCGs on a regular basis to support discharge planning. A key aim is to ensure that patients placed outside of the West Midlands area are repatriated. The City Council is informed of any quality issues through, for example, regular clinical review meetings.

6.4 Coventry and Warwickshire Partnership Trust

The main provider of assessment and treatment services for Coventry patients is Coventry and Warwickshire Partnership Trust at their Brooklands Hospital site. These services were inspected by the Care Quality Commission in 2013 and 2014. The 2014 inspection found that issues raised in 2013 had been addressed and that all staff had received training in safeguarding vulnerable adults and processes were in place to ensure that people were safe. People were treated with dignity and respect and their physical health care needs were being met. Some issues were raised, for example, in respect of restrictions placed on patients and there not being a comprehensive range of meaningful activities. CQC has confirmed that the issues were not significant and that good progress is being made in addressing them.

6.5 Coventry City Council

The City Council is responsible for ensuring the quality of care and support services that it provides or commissions for Coventry citizens within the city or elsewhere. It also has broader safeguarding duties in relation to all health and care provision within Coventry and duties in relation to the provision of Approved Mental Health Professionals (AMHPs). The City Council does not have the remit to place citizens in assessment and treatment units but works closely with health colleagues to ensure that the care and support requirements of people placed are met within these settings.

In circumstances where the Council commissions or provides care and support either singly or jointly with CRCCG, the Council's own Quality Assurance process is applied in partnership with health colleagues. This is important in the context of both people returning "Winterbourne" residents and Coventry citizens per se whether accommodated within the city or elsewhere.

6.6 Coventry and Rugby Clinical Commissioning Group

The Coventry and Rugby Clinical Commissioning Group commissions assessment and treatment places for Coventry and Rugby citizens not requiring secure provision. CRCCG responsibilities include establishing outcome based contracts for its patients in assessment and treatment units and ensuring the quality of this provision. Quality assurance support is provided to all Coventry and Warwickshire CCGs through arrangements with Arden Commissioning Support Unit (ACS).

ACS's contracts management approach is based on an assurance framework that has been agreed with CCG's. The approach is risk based and targets poor performance using performance information from the providers, service user feedback, CQC engagement and multi-agency performance review.

CRCCG have no current concerns about the quality of care patients are receiving in assessment and treatment units.

7 Discharging Responsibilities for Winterbourne View

7.1 In order to ensure an integrated approach to the review of care and appropriate commissioning a Clinical Review Group was established which has implemented a successful model across Coventry and Warwickshire to review all adults meeting the Winterbourne criteria, and move them closer to home and into less restrictive settings, where appropriate. This work is continuing and is being extended to encompass all adults with learning disabilities and autism placed out of area, and those living in hospital and residential care within Coventry and Warwickshire.

7.2 As part of the on-going role of the Winterbourne Clinical Review Group, the current register of people has been expanded to include children and young people to provide

assurance that the system is meeting the needs of children and young people with learning disabilities and autism are also being considered.

Whilst the City Council is a full partner in the sub-regional work, there are additional supplementary arrangements in place to ensure a robust local management. This includes the maintenance of a register that monitors clinical reviews, informs commissioning and provides an auditable trail to placement decisions, quality assurance and joint commissioning of preventative services to reduce the need for intensive placements.

7.3 The City Council has also developed a programme of training for social workers and other customer facing staff which focusses on ensuring that the principles of treating people with dignity and respect and positive behaviour management and risk taking is embedded in practice .

8 Coventry and Warwickshire's Joint Winterbourne Plan

8.1 The document "Coventry and Warwickshire's Local Response to Winterbourne: A Work Programme for 2014-16" (see Appendix 2) describes the activities that are being undertaken alongside the review of people currently living in hospital, to prevent the need for admissions, and where people are admitted, to reduce the length of hospital stay.

8.2 The Winterbourne Review focused on people with challenging behaviour. However, the plan also includes people with learning disabilities and autism who have high support needs and who may be at risk of being admitted to hospital, developing challenging behaviour, or being accommodated out of area.

9 Governance

9.1 Progress on the sub-regional and local plans will be reported through Adult Joint Commissioning Boards to Coventry's Health and Wellbeing Board.

9.2 Service user, family carer and broader stakeholder engagement will continue to be managed through the Learning Disability Partnership Board.

List of appendices included

Appendix 1: Current Status of Coventry Winterbourne Cohort

Appendix 2: Coventry and Warwickshire's Local Response to Winterbourne: A Work Programme for 2014-2016.

Other useful background papers

None

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Appendix 1

Current Status of Coventry Winterbourne Cohort

Person	Current status	Provision
Original Winterbourne Cohort		
A	Discharged from assessment and treatment with Joint s117 aftercare funding	Moved to Residential accommodation
B	Discharged from assessment and treatment with Joint s117 aftercare funding	Moved to Residential accommodation
C	Discharged from assessment and treatment with Joint s117 aftercare funding	Moved to Residential accommodation
D	Discharged from assessment and treatment with Joint s117 aftercare funding	Moved to Residential accommodation
E	Recent Care Programme Approach and Tribunal held	Remains in assessment and treatment unit
F	s37/41 - Recent Care Programme Approach and Tribunal held	Remains in assessment and treatment unit
G	Recent Care Programme Approach and Tribunal held	Remains in hospital
Subsequent Admissions to Assessment and Treatment Units		
H	s3. CPA reviews 6 weekly. Tribunal held. Responsibility transferred from CRCCG to NHS England	Remains in assessment and treatment unit
I	S3. Recent Care Programme Approach and Tribunal held. Under 18 – AHMP working with children social worker.	Remains in assessment and treatment unit
People not on the original cohort as funded by NHS England		
J	s37 - Recent Care Programme Approach and Tribunal held regular	Remains in assessment and treatment unit
K	s3 - Recent Care Programme Approach and Tribunal held.	Remains in assessment and treatment unit
L	S37 - Recent Care Programme Approach and Tribunal held.	Remains in assessment and treatment unit

NHS Coventry and Rugby Clinical Commissioning Group
NHS South Warwickshire Clinical Commissioning Group
NHS Warwickshire North Clinical Commissioning Group

Coventry City Council
Warwickshire County Council

Coventry and Warwickshire's local response to Winterbourne View Hospital

A work programme for 2014-2016

This is Coventry and Warwickshire's joint strategic plan for people with learning disabilities or autism who also have mental health conditions or behaviours viewed as challenging

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Forward

In response to the findings of the national Winterbourne View Report, the three NHS Clinical Commissioning Groups (CCGs) and two local authorities in Coventry and Warwickshire have developed a joint plan for services for people with learning disabilities and autism; specifically those who also have mental health issues or challenging behaviour.
The plan, which is backed by the Coventry and Warwickshire Health and Wellbeing Boards, describes how local services will be transformed so that people no longer have to live in hospitals when they could live somewhere more appropriate or at home – and that they feel supported to do this successfully. Outlined in the plan is the CCGs' and local authorities' commitment to working with individuals and families to put patients at the centre of care services.
The main principles of the plan are that people with a learning disability and autism will;

- be treated as individuals and have personalised care plans that reflect this;
- have more choice, control and influence over their care;
- be cared for in the most appropriate setting
- have the support to lead full and meaningful lives and play an active role in their community;
- feel safe and be free from abuse.

This plan has been developed with service users, carers and providers of learning disability services across Coventry and Warwickshire.

The Warwickshire (and Coventry) Learning Disability Partnership Boards have endorsed this plan. Regular updates will be provided to both Learning Disability Partnership Boards about progress with implementation of the plan.

Executive Summary

This plan describes how we will transform health and care services in Coventry and Warwickshire for all people with learning disabilities or autism who have high support needs or challenging behaviour. We want to stop people being placed in hospital inappropriately, provide the right model of care, and drive up the quality of care and support.

While many people with learning disabilities live at home and access universal services, the people to whom this plan refers often need more personalised support from health and social care services in order to maintain independent living arrangements. This plan complements existing strategies for people with learning disabilities and autism and highlights the actions required to ensure that the specific requirements of people with high support needs or challenging behaviour are recognised and supported by local services.

A clinical review group has been established and has implemented a successful model across Coventry and Warwickshire to review all adults meeting the Winterbourne criteria, and repatriate individuals where appropriate. This work is continuing and is being extended to review all people placed with learning disabilities and autism placed out of area, and those in hospital and residential care within Coventry and Warwickshire.

This plan describes the strategic activities that need to be undertaken alongside the review of people currently living in hospital, to prevent the need for people to be admitted to hospital in the first place, and where people are admitted, to reduce the length of time spent in hospital.

A period of engagement about this plan with service users and carers was undertaken between May and July 2014. The development of local "I" statements was a focus of these engagement activities, describing what service users and carers want from care and support services. The following are the "I" statements which service users and carers in Coventry and Warwickshire agreed to:

- ***I am safe.***
- ***I am helped to keep in touch with my family and friends.***
- ***I have regular care reviews to assess if I should be moving on.***
- ***I am involved in decisions about my care***
- ***I am supported to make choices in my daily life.***
- ***I am supported to live safely & take an active part within the local community.***
- ***I get good quality general healthcare.***
- ***I get the additional support I need in the most appropriate setting.***
- ***I get the right treatment and medication to keep me well***
- ***I am protected from avoidable harm, but also have my own freedom to take risks***
- ***I am treated with compassion, dignity and respect.***
- ***I have a choice about living near to my family and friends.***
- ***I am cared for by people who are well supported***

The above statements could describe the desired outcomes for any user of health and care services. What was highlighted by the Winterbourne Review is that we need to transform our health and care services so that people with learning disabilities and autism with high support needs or challenging behaviour can expect the same outcomes as the rest of the local population.

In order to achieve this ambition, our aim is to commission appropriate safe high quality services for all children, young people and adults with high support needs or challenging behaviour, in order to deliver care and support that promotes prevention and early intervention and that is:

- closer to home;
- in line with best practice models of care;
- personalised and responsive to individual needs over time;
- based on individuals' and families wishes; and
- value for money.

We will share our information and work together to develop measures which we can use to demonstrate progress towards our aim and the achievement of the above outcomes.

Health and social care commissioners in Coventry and Warwickshire are committed to a range of interventions which are required to achieve our aim. These are expressed through a number of strategic objectives to which all partners to this plan are committed. These objectives are underpinned by the following principles:

- ***Service users and their families will be at the heart of decisions about their care***
- ***Services will be commissioned which promote prevention and early intervention to support people of all ages who are at risk of developing challenging behaviours and minimise inappropriate admissions to hospital***
- ***Commissioners and providers of care and support will collaborate to achieve the best outcomes for service users, including collaborating regionally across West Midlands and with NHS England specialised commissioners where appropriate***
- ***People involved in implementing the plan will use a problem solving, 'can do' approach***

The following diagram shows how our agreed objectives relate to our desired outcomes.

Outcomes, aims and objectives

Desired Outcomes	Strategic aim	Key drivers	Strategic objectives
Our outcomes need to reflect what our service users and carers want from health and care services. Developing localised "I" statements will be a focus of our engagement with service users and carers. The following are examples of "I" statements: • *I am safe.* • *I am helped to keep in touch with my family and friends.* • *I have regular care reviews to assess if I should be moving on.* • *I am involved in decisions about my care* • *I am supported to make choices in my daily life.* • *I am supported to live safely & take an active part within the local community.* • *I get good quality general healthcare.* • *I get the additional support I need in the most appropriate setting.* • *I get the right treatment and medication to keep me well* • *I am protected from avoidable harm, but also have my own freedom to take risks* • *I am treated with compassion, dignity and respect.* • *I have a choice about living near to my family and friends.* • *I am cared for by people who are well supported* These statements could be used to describe what any user of services might expect from health and care services. We need to work harder to ensure that people wth learning disabilities and autism with high support needs or challenging behaviour have an equitable experience with others in the population.	To commission appropriate safe high quality services for all children, young people and adults with learning disabilities or autism who have high support needs or challenging behaviour, in order to deliver care and support that promotes prevention and early intervention and that is: • closer to home; • in line with best practice models of care; • Personalised and responsive to individual needs over time; • based on their own and families wishes; and • Value for money.	Develop enablers for change	Understand the current and future health and socialcare needs of this population
			Ensure that individuals have a voice and the opportunity to contribute to the design, monitoring and evaluation of services
			Introduce commissioning arrangements which support the model of care
			Promote a culture of positive risk management and accountability, not blame
			Develop and maintain a good collective understanding of how people's needs are being met through joint contracting and monitoring arrangements and learnmg lessons from what has and has not worked well.
		Provide a seamless health and social care service	Explore the use of pooled budgets to support the provision of joined up care for people
			Ensure individuals receive a personalised assessment by a competent and appropriate professional which is shared with others across health and social care, and which is regularly reviewed.
		Reduce length of stay and reliance on out of area placements, inpatient care and assessment and treatment services	Agree and implement a jointly owned model of care that reflects best practice, promotes prevention and early intervention and maintains people in their community
			Move all service users closer to home
		Provide personalised services based on individual need that promote positive outcomes, enable choice and control and are safe for service users and their carers	Offer personalised packages of care and support, including use of personal health budgets and self-directed support
			Commission effective community services by developing the local market to meet the needs of the local population and provide informed choices for service users

Background

In 2012 following an investigation into criminal abuse at Winterbourne View Hospital, the Department of Health published a review of the care and support experienced by all children, young people and adults with learning disabilities or autism who also have mental health conditions or behave in ways that are often described as challenging. For the purposes of this plan, we describe this vulnerable group of people as "people with challenging behaviour".

The Department of Health review highlighted a widespread failure to design, commission and provide services which give people with challenging behaviour the support they need close to home and which are in line with well-established best practice. A national programme of action was produced to transform services so that people with challenging behaviour no longer live inappropriately in hospitals. The national programme aims to ensure that people with challenging behaviour are cared for in line with best practice, based on their individual needs, and that their wishes and those of their families are listened to and are at the heart of planning and delivering their care.

> *"We should no more tolerate people with learning disabilities or autism being given the wrong care than we would accept the wrong treatment being given for cancer."*
>
> **Transforming care: A national response to Winterbourne View Hospital**
>
> **(Department of Health)**

In order to transform services in line with the national programme, a local response is required from health and care commissioners. This document describes the way that Warwickshire County Council, Coventry City Council, NHS South Warwickshire Clinical Commissioning Group, NHS Warwickshire North Clinical Commissioning Group and NHS Coventry and Rugby Clinical Commissioning group will work together to deliver the changes required.

The following statement from the national programme of action describes the responsibility of local commissioners in developing and implementing this document.

> *"Every area will put in place a locally agreed joint plan for high quality care and support services for people of all ages with challenging behaviour, that accords with the model of good care. These plans should ensure that a new generation of inpatients does not take the place of people currently in hospital.*
>
> - *This joint plan could potentially be undertaken through the health and wellbeing board and considered alongside the local Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy processes.*
> - *The strong presumption will be in favour of supporting this with pooled budget arrangements with local commissioners offering justification where this is not done."*
>
> **Winterbourne Concordat: Programme of Action**
> **(Department of Health)**

The Winterbourne Review focused on people with challenging behaviour. In Coventry and Warwickshire, commissioners have chosen to broaden the scope of this plan to include people with learning disabilities and autism who have high support needs. For the purposes of this document, people with high support needs are those who have multiple interlocking needs that span health and social issues, that lead to limited participation within society and which require a personalised response from services. This could be linked to:

- behaviour that is challenging
- specific personal care needs
- safeguarding issues
- mental health needs

People with high support needs may be at increased risk of:

- being admitted to hospital,
- developing challenging behaviour, or
- being accommodated out of area.

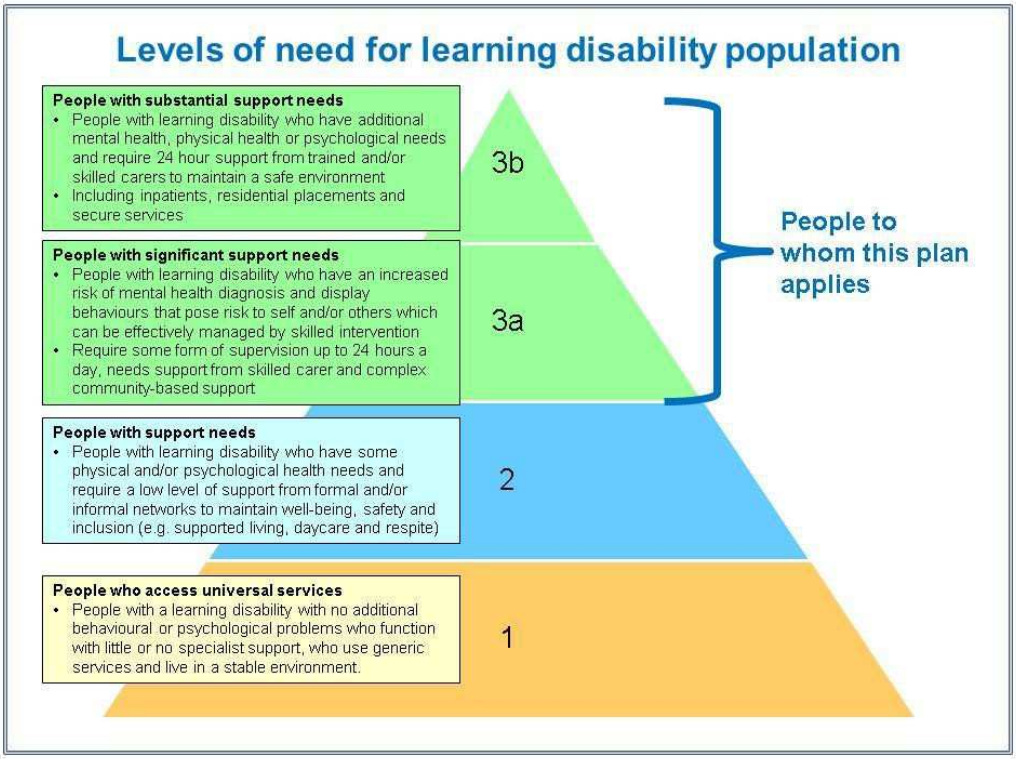
It is therefore appropriate to consider people with high support needs alongside those of people with challenging behaviour to ensure that strategies exist to minimise the number of people who are admitted to hospital, to reduce the length of stay for people in hospital and to ensure local services meet the needs of the local population.

Local strategies exist which describe the range of services available to support people in Coventry and Warwickshire with learning disabilities and autism. Further information about local learning disability services can be found at http://coventry.ldpb.info/ and https://www.warwickshire.gov.uk/ldpb. This plan will be implemented while appropriately considering the Care Act 2014 and Children and Families Act 2014.

While many people with learning disabilities live at home and access universal services, the people to whom this plan refers often need more personalised support and may require periods of residential, nursing or inpatient care. **This plan complements existing strategies for people with learning disabilities and autism and highlights the actions required to ensure that the specific requirements of people with high support needs or challenging behaviour are recognised and supported by local services.**

Diagram 1 represents the levels of support required by people in the learning disability population. This plan focuses on people in levels 3a and 3b of this diagram, those who require significant or substantial support from health and care services.

Diagram 1



Due to the small numbers of people with high support needs and challenging behaviour in levels 3a and 3b of the diagram, some of the actions described in this plan will be achieved through working with Solihull to create economies of scale.
While this plan is owned and will be delivered by health and social care commissioners in Coventry and Warwickshire, activities will be carried out in partnership across Coventry, Warwickshire and Solihull, or regionally across West Midlands where appropriate and in line with the West Midlands Winterbourne Joint Improvement Programme Regional Action Plan.

What do we know about our current services?

In Coventry and Warwickshire, learning disability services for people with high support needs or challenging behaviour are commissioned by three clinical commissioning groups and two local authorities. Forensic and secure services are commissioned by NHS England.

Coventry and Warwickshire Partnership Trust are commissioned to provide the following services:

- Specialist assessment and treatment services for adults and adolescents
- Respite and day services
- Residential and domiciliary care, including home-based support services and registered care homes
- Community learning disability teams
- Secure services (commissioned by NHS England specialist commissioning)

Additional services for people with high support needs or challenging behaviour are commissioned locally through the independent sector for specialist wrap around packages of support, for supported living or for nursing and specialist placements.

To give an indication of scale, a snapshot from April 2014 indicates that **Coventry and Warwickshire provide care and support for 65 adults with significant support needs and 132 adults with substantial support needs** (levels 3a and 3b in diagram 1).

10.1 People currently living outside Coventry and Warwickshire
The needs of some people with learning disability or autism are not currently met locally, so some specialist placements are commissioned outside Coventry and Warwickshire.

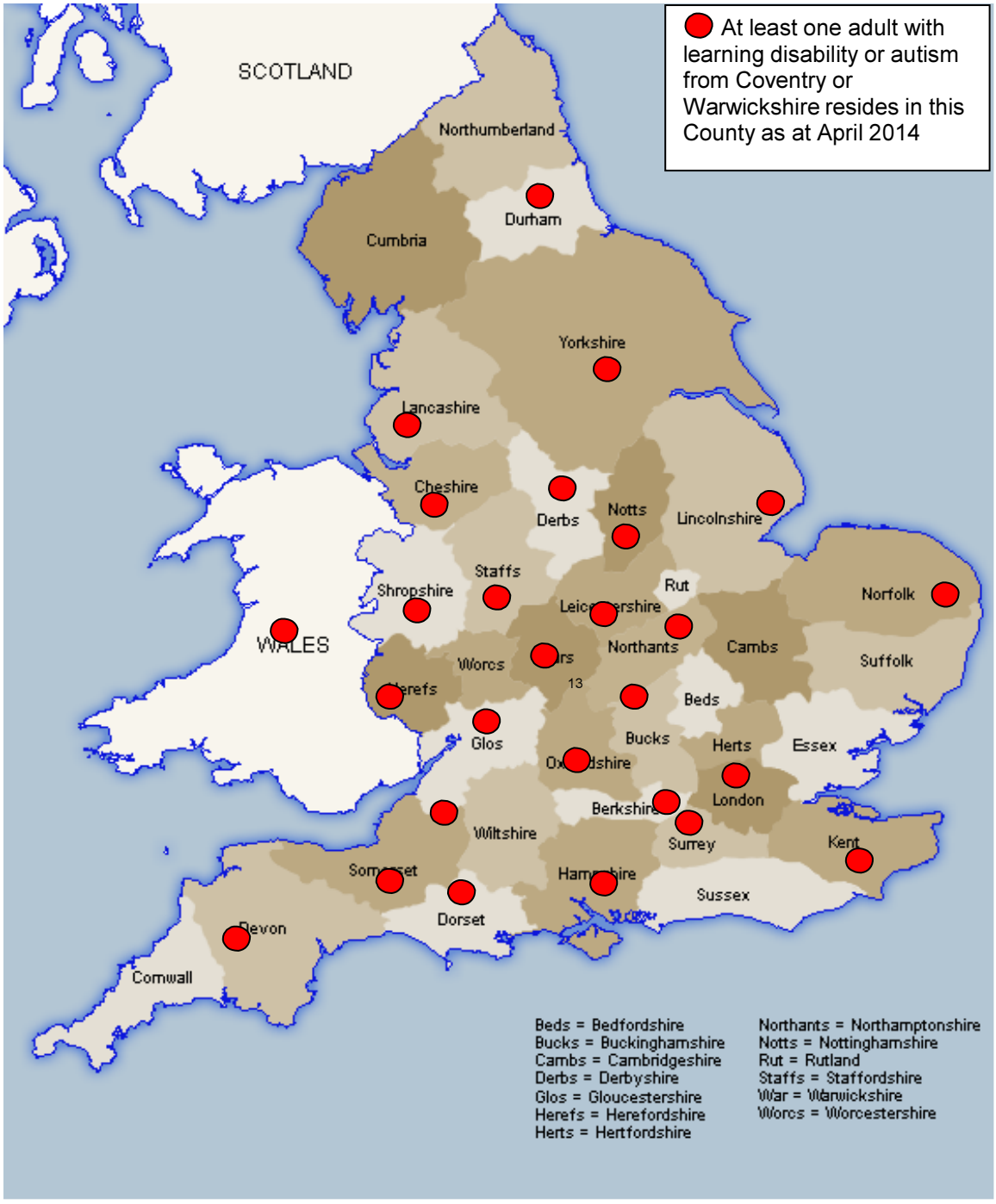
A snapshot from April 2014 indicates for Coventry and Warwickshire there are 164 adults accommodated out of area (of whom less than 10 meet the original Winterbourne criteria).

The Winterbourne review highlighted the negative impact on individuals and their families when people are placed away from their home. In Coventry and Warwickshire, following the review of people living out of area who meet the Winterbourne criteria, commissioners have agreed that all people who are placed out of area will be reviewed, and where appropriate either repatriated to Coventry and Warwickshire, or transferred to local services where they currently reside. Repatriating individuals to Coventry and Warwickshire will require the commissioning of different local services to meet individuals' needs and this is addressed through this plan.

While no children or young people from Coventry and Warwickshire were identified as meeting the Winterbourne criteria, we know there are children and young people with learning disabilities and autism who are accommodated out of area in residential schools or collages. As part of a phased approach, the current register of people is in the process of being expanded to include children and young people.

This map illustrates the geographical spread of services currently commissioned by Coventry and Warwickshire. This snapshot shows in which Counties adults from Coventry and Warwickshire are located as at April 2014. This includes all people with learning disabilities and autism who are placed out of area, not just those who meet the Winterbourne definition.

Diagram 2


At least one adult with learning disability or autism from Coventry or Warwickshire resides in this County as at April 2014
SCOTLAND
Northumberland
Durham
Cumbria
Yorkshire
Lancashire
Cheshire
Derbs
Notts
Lincolnshire
Staffs
Shropshire
Rut
Norfolk
WALES
Worcs
Northants
Cambs
Suffolk
Beds
Glos
Bucks
Herts
Essex
London
Berkshire
Surrey
Wiltshire
Kent
Sussex
Dorset
Devon
Cornwall
Beds = Bedfordshire
Bucks = Buckinghamshire
Cambs = Cambridgeshire
Derbs = Derbyshire
Glos = Gloucestershire
Herefs = Herefordshire
Herts = Hertfordshire
Northants = Northamptonshire
Notts = Nottinghamshire
Rut = Rutland
Staffs = Staffordshire
War = Warwickshire
Worcs = Worcestershire

What we have changed since April 2013
A clinical review group has been established and has implemented a successful model across Coventry and Warwickshire to review all adults meeting the Winterbourne criteria, and move them closer to home and into less restrictive settings where appropriate. This work is continuing and is being extended to encompass all adults with learning disabilities and autism placed out of area, and those living in hospital and residential care within Coventry and Warwickshire.

Children and young people in residential care are regularly reviewed through existing safeguarding processes. As part of the on-going role of the Winterbourne Clinical Review Group, the current register of people is in the process of being expanded to include children and young people to provide complete assurance to the Winterbourne Programme Board that the system is meeting the needs of children and young people with learning disabilities and autism.

Our plan to transform services
What do we want to achieve?
Our outcomes need to reflect what our service users and carers want from health and care services. The following "I" statements have been developed through engagement with service users and carers.

- ***I am safe.***
- ***I am helped to keep in touch with my family and friends.***
- ***I have regular care reviews to assess if I should be moving on.***
- ***I am involved in decisions about my care***
- ***I am supported to make choices in my daily life.***
- ***I am supported to live safely & take an active part within the local community.***
- ***I get good quality general healthcare.***
- ***I get the additional support I need in the most appropriate setting.***
- ***I get the right treatment and medication to keep me well***
- ***I am protected from avoidable harm, but also have my own freedom to take risks***
- ***I am treated with compassion, dignity and respect.***
- ***I have a choice about living near to my family and friends.***
- ***I am cared for by people who are well supported***

These statements could be used to describe what any user of services might expect from health and care services. We need to work harder to ensure that people with learning disabilities and autism with high support needs or challenging behaviour have an equitable experience with others in the population.

In order to achieve this ambition, our aim is to commission appropriate safe high quality services for all children, young people and adults with high support needs or challenging behaviour, in order to deliver care and support that promotes prevention and early intervention and that is:

- closer to home;
- in line with best practice models of care;
- personalised and responsive to individual needs over time;
- based on individuals' and families wishes; and
- value for money.

A key principle of the transformation of services is that people should be supported to live as independently as possible. It is recognised that people's needs change over time and that people with learning disabilities and autism may need additional support at particular times to maintain their current living arrangements. This might be due to a change in their own physical or mental health or a change in their social care needs, or it might be due to a change in the existing carer arrangements. This is particularly relevant to people with high support needs and challenging behaviour, who are more likely to require additional support at particular times to avoid hospital admissions.

Another important theme is that of early identification of children and young people who are at risk of developing challenging behaviours. The way that challenging behaviour is managed for children and young people has crucial implications. Difficulties arising in childhood that are not addressed properly or sensitively can have enormous repercussions for individuals and their families later in life. Where the needs of children and young people are managed well and in an integrated way, individuals and their families will be more likely to cope well with the transition to adult services.

How will we know we have achieved our aim?

Outcome measures in national health and social care outcomes frameworks relate to this plan as detailed in Appendix B. However, it is not currently possible to drill down into this nationally collected data to identify the particular population to whom this plan applies. There is therefore an action included in the plan to develop a set of measures, sharing data between organisations where necessary, which will more accurately demonstrate an improvement in outcomes for people with challenging behaviour or high support needs.

The following measures are being considered as potential ways to demonstrate progress. Person and system level measures will be developed and used to create a Winterbourne dashboard with data collected over time to demonstrate a change in outcomes:

- Number of patients maintained in or moving to lower levels of care
- Length of stay (inpatients, residential, nursing homes)
- Number of patients in out of area placements
- Number of patients in inpatient / assessment and treatment
- Expenditure against budget and historical data
- Number of people receiving personal health budgets
- Satisfaction of individuals and families regarding service provision
- Positive increases in quality of life for individuals and families
- Reduction in health inequalities for individuals
- Population level changes in prevalence of behaviour that challenges
- Reduced number of individuals with learning disabilities and / or autism in residential school / out of area placemen
- The Green Light Toolkit has been identified as a tool to measure access for people with learning disabilities to mental health services.

- The Health Equalities Framework is currently being trialled by Coventry and Warwickshire Partnership Trust and could be used to demonstrate a reduction in health inequalities for individuals.

What changes can we make that will deliver the desired outcomes?

A range of interventions are required to achieve this aim and these are expressed through a number of strategic objectives to which all partners to this plan are committed. Diagram 3 shows how the strategic objectives detailed relate to the overall aim. These objectives are underpinned by the following principles:

Principles which underpin this plan

- *Service users will be at the heart of decisions about their care*
- *Services will be commissioned which promote prevention and early help to avoid people developing challenging behaviours and avoid people requiring hospital admission*
- *Commissioners and providers of care and support will collaborate to achieve the best outcomes for service users*
- *People involved in implementing the plan will use a problem solving, 'can do' approach*

The actions in this plan will be delivered through exploring ways to deliver services differently in a way which optimises the use of existing health and social care budgets, without the use of substantial additional funds.

Diagram 3 Outcomes, Aim and Objective

Desired Outcomes	Strategic aim	Key drivers	Strategic objectives
Our outcomes need to reflect what our service users and carers want from health and care services. Developing localised "I" statements will be a focus of our engagement with service users and carers. The following are examples of "I" statements: • *I am safe.* • *I am helped to keep in touch with my family and friends.* • *I have regular care reviews to assess if I should be moving on.* • *I am involved in decisions about my care* • *I am supported to make choices in my daily life.* • *I am supported to live safely & take an active part within the local community.* • *I get good quality general healthcare.* • *I get the additional support I need in the most appropriate setting.* • *1 get the right treatment and medication to keep me well* • *I am protected from avoidable harm, but also have my own freedom to take risks* • *I am treated with compassion, dignity and respect.* • *I have a choice about living near to my family and friends.* • *I am cared for by people who are :veil supported* These statements could be used to describe what any user of services might expect from health and care services. We need to work harder to ensure that people with learning disabilities and autism with high support needs or challenging behaviour have an equitable experience with others in the population.	To commission appropriate safe high quality services for all children, young people and adults with learning disabilities or autism who have high support needs or challenging behaviour, in order to deliver care and support that promotes prevention and early intervention and that is: • closer to home; • in line with best practice models of care; • Personalised and responsive to individual needs over time; • based on their own and families wishes; and • Value for money.	Develop enablers for change	Understand the current and future health and social care needs of this population Ensure that individuals have a voice and the opportunity to contribute to the design, monitoring and evaluation of services Introduce commissioning arrangements which support the model of care Promote a culture of positive risk management and accountability, not blame Develop and maintain a good collective understanding of how people's needs are being met through joint contracting and monitoring arrangements and learning lessons from what has and has not worked well.
		Provide a seamless health and social care service	Explore the use of pooled budgets to support the provision of joined up care for people Ensure individuals receive a personalised assessment by a competent and appropriate professional which is shared with others across health and social care, and which is regularly reviewed.
		Reduce length of stay and reliance on out of area placements, inpatient care and assessment and treatment services	Agree and implement a jointly owned model of care that reflects best practice, promotes prevention and early intervention and maintains people in their community Move all service users closer to home
		Provide personalised services based on individual need that promote positive outcomes, enable choice and control and are safe for service users and their carers	Offer personalised packages of care and support, including use of personal health budgets and self-directed support Commission effective community services by developing the local market to meet the needs of the local population and provide informed choices for service users

Key actions to achieve objectives

Key Driver – Develop enablers for change		
The objectives described under this key driver are those activities that we need to undertake to ensure that we have the right conditions for change. These activities will provide supporting structures and processes to enable us to make changes to services.		
Objective	**Rationale**	**In order to do this we will**
Understand the current and future health and social care needs of this population	Wherever possible, local services must be available to meet the needs of our local population. In order to understand what services are required, we need to understand the needs of the local population of children young people and adults with learning disabilities and autism who have high support needs or challenging behaviour.	• Co-ordinate available data from NHS Arden Commissioning Support, Clinical Commissioning Groups, Local Authorities, education services and specialist commissioners at NHS England to ensure that we have a central record of all people in this population including children and young people • Under-take and document a joint strategic needs assessment for this population which identifies the services required to meet the needs of our population. This needs assessment will include the housing, care and support, education and employment needs of individuals. • Work in partnership to forecast the future needs of our population, in particular considering the needs of children and young people as they reach transition and the needs of people who are due to return from specialist commissioning.
Ensure that individuals within this population have a voice and the opportunity to contribute to the design, monitoring and evaluation of services	We must ensure that opportunities exist for people with learning disability or autism who have high support needs or challenging behaviour to provide their views about services which they access. This is equally relevant for people who are currently living out of area. As this is a minority group within the wider learning disability and autism population, we must be confident that we have made every effort to engage these individuals and their carers in a way which enables them to communicate their needs and wishes.	• Ensure that terms of reference of both Learning Disability Partnership Boards and carer forums in Coventry and Warwickshire describe how people of all ages with high support needs and challenging behaviour are represented • Ensure that meaningful consultation and engagement activities, which focus on people with high support needs and challenging behaviour, are built into the action plans for all objectives in this plan as appropriate • Ensure that any consultation and engagement plans describe how people who are currently living out of area will be given opportunities to contribute • Explore access to advocacy services for people with high support needs and challenging behaviour / people who live out of area • Develop information that is accessible for people with high support needs and challenging behaviour • Ensure we meet the requirements of the Mental Capacity Act and Deprivation of Liberty Safeguards

Objective	Rationale	In order to do this we will
Have commissioning arrangements in place which reinforce the model of care	An important objective for this plan is to implement a model of care which provides additional support to people with high support needs and challenging behaviour to maintain independent living arrangements wherever possible. Where people do require a period of residential, nursing or inpatient care, they should be accommodated locally and supported to return to more independent living as soon as is appropriate. In order to achieve this, our commissioning arrangements and payment mechanisms need to reinforce our desired model of care. We want to think innovatively about how we can do this.	• Undertake a research project which will explore the incentives that can be used by commissioners to support the model of care. This project will look at examples of best practice and seek input from of service users, carers and providers and will produce an options appraisal for commissioners which will propose potential mechanisms to reinforce the model of care. • Depending on the outcome of this project, commissioning arrangements will be altered across health and social care.
Promote a culture of positive risk management and accountability, not blame	A culture of positive risk management supports the provision of care and support that is personalised and maintains the independence of service users. We want to enable our service users to have the freedom to take make choices and to take some risks in their day to day lives in a supported and safe manner. In order to do this, the culture needs to span the health and social care system, including commissioners, providers and front line carers and support workers.	• Reinforce positive risk management through existing and new strategies and service specifications • Equip and upskill health and social care practitioners to adopt a positive risk management approach via a programme of awareness raising and development sessions • Engage with the wider market and ensure that service specifications reflect the core principles of positive behaviour support. • Implement a risk stratification process which will enable organisations to identify, understand and mitigate risks to individuals and organisations (including financial, risk to self and others, safeguarding, quality assurance and contract monitoring)

Objective	Rationale	In order to do this we will
Develop and maintain a good collective understanding of how people's needs are being met through joint contracting and monitoring arrangements and learning lessons from what has and has not worked well	We need to be confident that the services that we commission provide high quality care and support which meets the needs of individuals in line with our model of care. It is important that we are transparent about our outcomes so that service users and carers can hold us to account. We want to do more of what works well, and intervene early where services are not delivering the outcomes we want to see.	• Develop joint contracting and monitoring arrangements to monitor cost, location and quality of services • Develop a Winterbourne dashboard of outcome measures for this population which will be measured over time to demonstrate progress towards our aim • Develop a process for tracking individuals through the system to ensure that the model of care is meeting the needs of individuals and successfully keeping people out of hospital wherever possible • Determine what information can be shared between organisations under existing information sharing agreements and modify agreements if necessary to enable joint monitoring of individuals • Work with service users and carers to provide them with information which enables them to hold commissioners and providers to account for the quality of local services. • Support a culture of accountability by convening a joint forum for learning lessons from what has worked well and what needs improvement.

Key Driver – Provide a seamless health and social care service		
Many people with high support needs and challenging behaviour will require care and support from services which have traditionally been commissioned by health or social care. In order to provide comprehensive and personalised care and support for individuals, care and support needs to be more closely integrated between health and social care commissioners and providers. These objectives describe how we will work together more effectively to do this.		
Objective	**Rationale**	**In order to do this we will**
Explore the use of pooled budgets to support the provision of joined up care for people	The existence of separate budgets for health and care services can present a barrier to the provision of personalised packages of care and support for individuals, particularly where there is disagreement about which organisation funds which eligible needs and services. We are committed to working together to find ways to streamline funding of packages of care and support which fit the model of care. Strategic benefits would include a move to lead commissioning arrangements.	• All three clinical commissioning groups and both local authorities are already working together to combine funding under the better care fund. The individuals meeting the criteria of this plan will be considered as part of wider work in this area • Form a small working party with representation from all partners to this plan who will identify opportunities for pooled budgets. We will start small by testing the use of pooled budgets, with two pilots (one each in Coventry and Warwickshire). • Following the pilot we will explore formal arrangements for pooled budgets.
Ensure individuals receive a personalised assessment by a competent and appropriate professional which is shared with others across health and social care	The provision of personalised packages of care and support begins with an assessment which provides a complete picture of individuals' needs. Undertaking an integrated assessment which captures all of an individual's needs will provide a more positive experience for service users. Integrated assessments may also represent greater value for money by reducing repetition of effort for professionals undertaking assessment.	• Explore existing models for assessment including a holistic functional assessment tool that could be used by a wide range of professions. • Produce competency based role description for single point of contact / care coordinator and trusted assessor as part of the model of care. • In all service specifications, include requirement for providers to deliver personalised assessments which are shared with others and to undertake reviews at least annually or more often as appropriate.

Key Driver – Reduce length of stay and reliance on out of area placements, inpatient care and assessment and treatment services.		
A key principle of the transformation of services is that people should be supported to live as independently as possible and we want to reduce the time that people spend in hospital or residential facilities. This is particularly relevant to people with high support needs and challenging behaviour, who are more likely to require additional support at particular times to avoid hospital admissions.		
Objective	**Rationale**	**In order to do this we will**
Agree and implement a jointly owned pathway and model of care that reflects best practice, promotes prevention and early intervention and maintains people in their community	We need a model of care which is responsive to individuals' needs. We recognise that people's needs change over time. This might be due to a change in their own physical or mental health or a change in their social care needs, or it might be due to a change in existing carer arrangements. People with learning disabilities and autism may need additional support at particular times to maintain their current living arrangements.	• Work jointly to develop and test a pathway and model of care with the engagement of service users, carers and staff • Once the pathway is tested and signed off by all organisations, the pathway will be embedded into all governance structures and services will be jointly commissioned which comply with the model of care • Explore commissioning of early intervention services to provide 24 hour supported living outreach to people wherever they reside across Coventry, Warwickshire and Solihull • Improve pre-crisis responsiveness through development of an early warning score and escalation protocol for learning disabilities • Insert something about
Move all service users closer to home	We want to provide services which keep people in our local population as close to home and to their families, friends and communities as possible. Good progress has already been made to review the needs of people who fit the Winterbourne criteria and to move them closer to home where possible. We want to build on this good practice by expanding this programme of work to all people currently placed out of area.	• Collaborate to build on existing good practice in order to establish a joint clinical review team across Coventry and Warwickshire funded by all partners. This team will review all people currently placed out of area and where appropriate commission or coordinate packages of care and support which enable them to move closer to home. • Commission the clinical review team to provide care coordination to support the model of care and reduce the length of time people spend in hospital in Coventry and Warwickshire. • Link into existing processes to review children and young people placed out of area or living in residential care to give complete assurance to the Winterbourne Programme Board that the needs of children and young people are being met.

Key Driver – Provide personalised services based on individual need that promote positive outcomes, enable choice and control and are safe for service users and their carers		
The individuals to whom this plan applies have a wide range of different care and support needs. We want to personalise services to individuals to enable people with high support needs or challenging behaviour to live as independently as possible and to support the families and carers of our service users.		
Objective	**Rationale**	**In order to do this we will**
Offer personalised packages of care, including use of personal health budgets and self-directed support	The different needs of individuals are best met through packages of care and support that are personalised, rather than fitting people into existing services. Personal health budgets and direct payments are a good way of providing flexible financial arrangements to enable personalised packages of care and support. Direct payments are already quite widely used and we will work to increase the opportunities for people to access personal health budgets.	• Ensure personalisation is a key theme that runs through all strategic plans and communication and workforce plans. • Use the relevant markers of the Think Local Act Personal's Making It Real checklist to promote personalisation and community support • Link into wider work to introduce personal health budgets to ensure that consideration is given to how these can be used to provide care and support for people with high support needs or challenging behaviour • Engage clinicians and win hearts and minds to support the pro-active use of personal health budgets.
Commission effective community services by developing the local community market to meet the needs of the local population and provide informed choices for service users	In order to deliver our model of care through local care and support that is personalised to the needs of our service users, there need to be providers in our local market who can deliver the care and support we want to commission. This will require us to work pro-actively to develop the market locally, through working with existing and potential new providers of community services. As the market develops, we need to ensure that service users, families and carers are supported to make informed and safe choices about their care and support.	• Understand and map the local market and compare this to our needs assessment and the needs of individuals in our local area • Develop a procurement strategy to meet our local needs and engage with existing and potential new providers to help them understand what is expected • Revise all service specifications across health and social care to reflect our model of care and positive behavioural support core principles • Develop a communication strategy to help service users and families understand the care and support that is available

Monitoring progress and reviewing our plan

The Winterbourne Strategy Group will have overall responsibility for delivering the actions in this plan and will report on progress to the Joint Commissioning Boards in Coventry and Warwickshire via the Transforming Care for People with Learning Disabilities Board. All three CCGs and two local authorities will be represented on the Winterbourne Strategy Group and will share responsibility for implementation of the plan.

A diagram of the Winterbourne governance structure is attached at Appendix C.

Progress with the plan will be reviewed at monthly meetings of the Winterbourne Strategy Group. Outcome measures once developed will be reviewed regularly as appropriate.

This plan describes the work programme for 2014 to 2016. The plan will be reviewed in 2016 to determine whether a separate Winterbourne plan is still required, or whether the work can be incorporated with wider learning disability strategies.

Appendix A Helping you understand the words we use.

Appendix B National outcome measures which relate to this plan

Strategic Objective	Adult Social Care Outcomes Framework 2014/15	CCG Outcome Indicator Set and NHS Outcomes Framework 2014/15	Public Health Outcomes Framework 2014/15
Agree and implement a jointly owned pathway / model of care that reflects best practice and maintains people in their community • Move all service users closer to home • Commission early intervention services to provide 24 hours supported living outreach to people wherever they reside • Improve pre-crisis responsiveness through development of an early warning score and escalation protocol for learning disabilities	1E Proportion of adults with a learning disability in paid employment 1G Proportion of adults with a learning disability who live in their own home or with their family 1I Proportion of people who use services and their carers, who reported that they had as much social contact as they would like*	<u>Domain 1</u> • Reducing premature deaths in people with learning disabilities (measure in development for future years) <u>Domain 2</u> • Health related quality of life for people with a long term mental health condition <u>Domain 4</u> • Responsiveness to in-patients' personal needs NHSOF4.1 • Patient experience of community mental health services NHSOF 4.7 • Improving people's experience of integrated care (measure in development for future years) <u>Domain 5</u> • Patient safety incidents reported NHS OF 5a	<u>Improving the wider determination of health</u> 1.6 Adults with a learning disability / in contact with secondary mental health services who live in stable and appropriate accommodation 1.8 Employment for those with long term health conditions 1.18 Social isolation

Strategic Objective	Adult Social Care Outcomes Framework 2014/15	CCG Outcome Indicator Set and NHS Outcomes Framework 2014/15	Public Health Outcomes Framework 2014/15
Offer individualised packages of care, including use of personal health budgets and self-directed support	1B Proportion of people who use services who have control over their daily life * 1C Proportion of people using social care who receive self-directed support, and those receiving direct payments 3C The proportion of carers who report that they have been included or consulted in decisions about the person they care for		
Introduce a single assessment of needs and ensure needs are regularly reviewed	3E Improving people's experience of integrated care (TBC)		
Develop funding models which support the provision of joined up care for people			
Develop the local community market to meet the needs of the local population and provide informed choice for service users, including good quality housing and building based services	3A Overall satisfaction of people who use services with their care and support 3B Overall satisfaction of carers with social services 3D The proportion of people who use service and carers who find it easy to find information about support		

Appendix C Winterbourne governance structure

Governance Structure for WinterbourneActivities