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

Version History

Version Date	Summary of Changes	Author	Circulated to
V0.1 14/01/14	First draft circulated to stakeholders	Ali Cole	Winterbourne strategy group
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V0.4 8/4/14	Incorporating more detailed feedback from stakeholders	Ali Cole	Winterbourne strategy group
V0.5 23/4/14	Incorporating feedback from meeting 8/4/14, comments from Zandrea, further data on numbers of people living out of area, separation of operational action plan	Ali Cole Sally Eason Jon Reading	Service users and carers, CCGs, local authorities, learning disability partnership boards
V0.6	Incorporating feedback from service users, carers and members of commissioning organisations	Ali Cole	Winterbourne Strategy Group
V0.7	Minor changes to wording, updated governance structure, incorporating further feedback from CWPT	Ali Cole	Coventry and Warwickshire Health and Wellbeing Boards for approval

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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.

Service users, carers and providers of learning disability services across Coventry and Warwickshire have been engaged as part of the development of this plan, and their feedback has been used to inform the local response to Winterbourne.

The Coventry and Warwickshire 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 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 with all stakeholders 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, early intervention and well-being 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. The following 'I statements' were developed through engaging 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	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 in line with their wishes
		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)**

Scope of this plan

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.

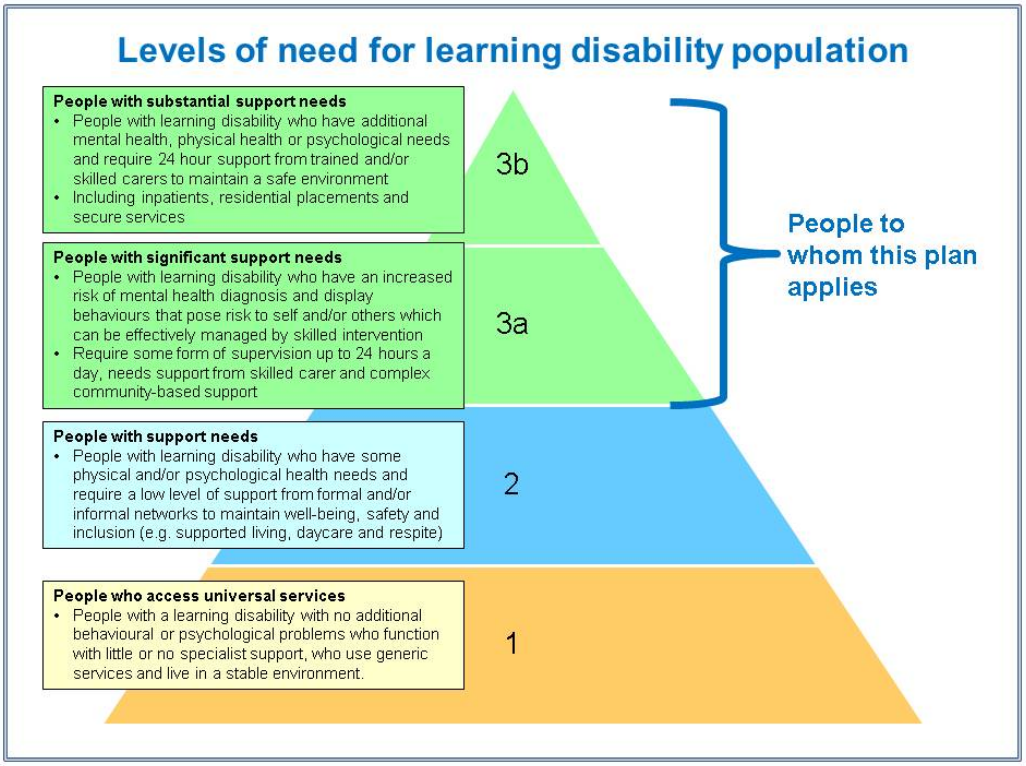
It is therefore appropriate to consider people with high support needs alongside those of people with challenging behaviour to ensure that strategies exist to minimise the number of people who are admitted to hospital, to reduce the length of stay for people in hospital and to ensure local services meet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

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.

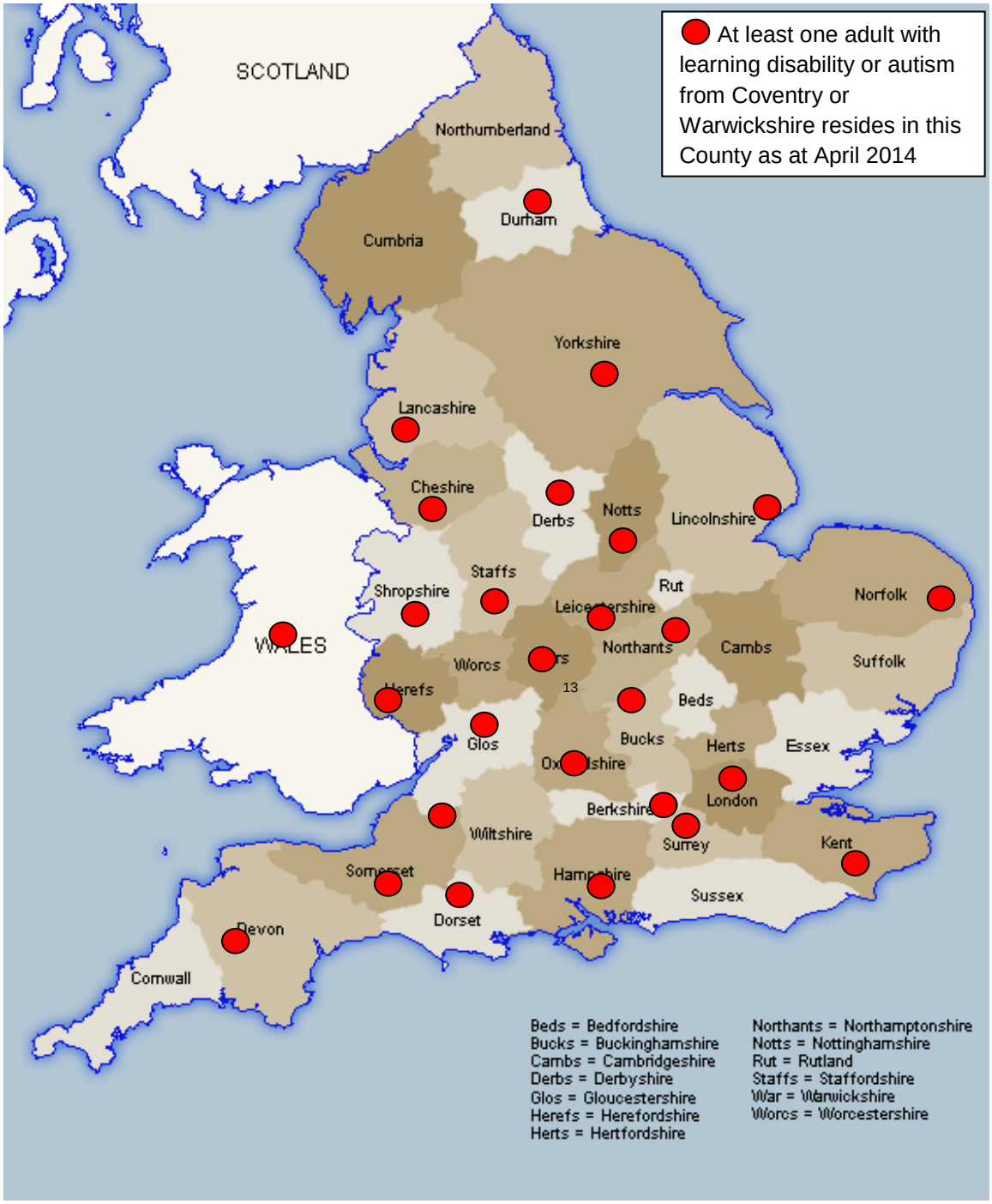
A snapshot from April 2014 indicates for Coventry and Warwickshire there are 164 adults accommodated out of area (of whom less than 10 meet the original Winterbourne criteria of being in hospital placements).

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 being addressed and will be further enhanced 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 colleges. 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



What we have changed since April 2013

A multi-agency 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?

We will continue to review individuals to ensure that care and support is appropriate to their needs and is enabling them to achieve a range of personalised outcomes. We will also continue to strengthen how we monitor contracts and services at a strategic level with a focus on outcomes. In addition to self-assessment and contract monitoring processes we will further develop peer review to provide a fresh perspective on service quality.

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 less restrictive care settings

- Length of stay (inpatients, residential, nursing homes)
- Number of patients in out of area placements due to lack of local provision
- 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 placement
- 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.

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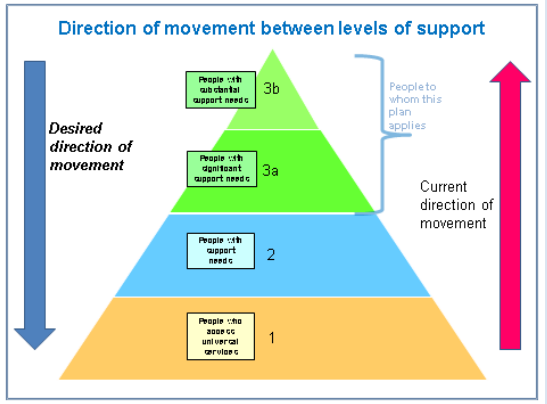
Diagram 3 Outcomes, Aim and Objectives

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. The following 'I statements' were developed through engaging 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	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 in line with their wishes
		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 and engage in co-production. 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 co-production, 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 co-production, 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 and monitor outcomes. • 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, providers and commissioners. • 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 enhanced support service to provide early intervention support to people in crisis or risk of admission to hospital 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
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 market facilitation 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, personalised commissioning approaches 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 Coventry and Warwickshire Learning Disabilities and Autism Commissioners' Group will incorporate the Winterbourne Programme Board and will have overall responsibility for delivering the actions in this plan. Progress with delivery of the plan will be regularly reviewed at the Learning Disabilities and Autism Commissioners Group. Outcome measures once developed will be reviewed and reported on regularly as appropriate.

This group will also have responsibility for aligning the implementation of this plan with other local joint strategies, for example the implementation of recommendations from the joint health and social care learning disability and autism self-assessment frameworks (SAF) and the confidential enquiry into premature deaths of people with learning disabilities (CIPOLD).

The Group will report on progress with delivering the local response to Winterbourne to Health and Wellbeing Boards in Coventry and Warwickshire via the Joint Commissioning Boards in Coventry and Warwickshire. All three CCGs and two local authorities will be represented on the Learning Disabilities and Autism Commissioners Group and will share responsibility for implementation of the plan.

Regular updates will be provided to both Learning Disability Partnership Boards about progress with implementation of the plan.

A diagram is attached at Appendix C, which depicts the local governance structure and the roles of each group in relation to the local response to Winterbourne.

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 more closely incorporated with wider learning disability and autism strategies.

Appendix A Helping you understand the words we use.

This appendix will be completed as part of the translation of the document into an easy read version, which will be undertaken once the plan is approved by Health and Wellbeing Boards.

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