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Community and Wellbeing Scrutiny Committee

Wednesday 17 April 2019 at 6.00 pm
Boardrooms 3-5 - Brent Civic Centre, Engineers Way, Wembley, HA9 0FJ

Membership:

Members	**Substitute Members**
Councillors:	Councillors:
Ketan Sheth (Chair) Colwill (Vice-Chair) Afzal Conneely Hector Knight Shahzad Thakkar	S Butt, Gbajumo, Gill, Kabir, Kelcher, Mashari and Nerva Councillors: Kansagra and Maurice

Co-opted Members
Helen Askwith, Church of England Schools
Simon Goulden, Jewish Faith Schools
Sayed Jaffar Milani, Muslim Faith Schools
Iram Yaqub, Parent Governor Representative (Primary)
Alloysius Frederick, Roman Catholic Diocese Schools

Observers
Ms Sotira Michael, Brent Teachers' Association
Lesley Gouldbourne, Brent Teachers' Association
Jean Roberts, Brent Teachers' Association
Brent Youth Parliament, Brent Youth Parliament

For further information contact: Bryony Gibbs, Governance Officer
Tel: 020 8937 1355; Email: bryony.gibbs@brent.gov.uk

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The press and public are welcome to attend this meeting

Notes for Members - Declarations of Interest:

If a Member is aware they have a Disclosable Pecuniary Interest* in an item of business, they must declare its existence and nature at the start of the meeting or when it becomes apparent and must leave the room without participating in discussion of the item.

If a Member is aware they have a Personal Interest** in an item of business, they must declare its existence and nature at the start of the meeting or when it becomes apparent.

If the Personal Interest is also significant enough to affect your judgement of a public interest and either it affects a financial position or relates to a regulatory matter then after disclosing the interest to the meeting the Member must leave the room without participating in discussion of the item, except that they may first make representations, answer questions or give evidence relating to the matter, provided that the public are allowed to attend the meeting for those purposes.

***Disclosable Pecuniary Interests:**

(a) **Employment, etc. -** Any employment, office, trade, profession or vocation carried on for profit gain.
(b) **Sponsorship -** Any payment or other financial benefit in respect of expenses in carrying out duties as a member, or of election; including from a trade union.
(c) **Contracts -** Any current contract for goods, services or works, between the Councillors or their partner (or a body in which one has a beneficial interest) and the council.
(d) **Land -** Any beneficial interest in land which is within the council's area.
(e) **Licences-** Any licence to occupy land in the council's area for a month or longer.
(f) **Corporate tenancies -** Any tenancy between the council and a body in which the Councillor or their partner have a beneficial interest.
(g) **Securities -** Any beneficial interest in securities of a body which has a place of business or land in the council's area, if the total nominal value of the securities exceeds £25,000 or one hundredth of the total issued share capital of that body or of any one class of its issued share capital.

****Personal Interests:**

The business relates to or affects:

(a) Anybody of which you are a member or in a position of general control or management, and:
- To which you are appointed by the council;
- which exercises functions of a public nature;
- which is directed is to charitable purposes;
- whose principal purposes include the influence of public opinion or policy (including a political party of trade union).

(b) The interests a of a person from whom you have received gifts or hospitality of at least £50 as a member in the municipal year;

or

A decision in relation to that business might reasonably be regarded as affecting the well-being or financial position of:

- You yourself;

a member of your family or your friend or any person with whom you have a close association or any person or body who is the subject of a registrable personal interest

Agenda

Introductions, if appropriate.

Item		Page
1	**Apologies for absence and clarification of alternate members** Notice of items to be raised under this heading must be given in writing to the Head of Executive and Member Services or his representative before the meeting in accordance with Standing Order 64.	
2	**Declarations of interests** Members are invited to declare at this stage of the meeting, the nature and existence of any relevant disclosable pecuniary or personal interests in the items on this agenda and to specify the item(s) to which they relate.	
3	**Deputations (if any)** To hear any deputations received from members of the public in accordance with Standing Order 67.	
4	**Minutes of the previous meeting** To approve the minutes of the previous meeting held on 18 March 2019 as a correct record.	**To follow**
5	**Matters arising (if any)**	
6	**Update on Transforming Care Programme: Learning Disabilities** This report provides the background to why the Transforming Care programme was developed and an update on Brent's progress against national and regional requirements and/or priorities, and confirms the priorities for this year agreed at the Health and Wellbeing Board in January 2019.	1 - 132
7	**Community and Wellbeing Scrutiny Committee Work Plan 2018 - 2019 Update** The report updates Members on the Committee's Work Programme for 2018/19 and captures scrutiny activity which has taken place outside of its formal meetings.	133 - 146

8 Any other urgent business

Notice of items to be raised under this heading must be given in writing to the Head of Executive and Member Services or his representative before the meeting in accordance with Standing Order 60.

Date of the next meeting: To be confirmed following the Annual Council Meeting in May 2019

Please remember to ***SWITCH OFF*** your mobile phone during the meeting.

- The meeting room is accessible by lift and seats will be provided for members of the public.

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Brent	**Community and Wellbeing Scrutiny Committee** 17 April 2019
	Report from the Strategic Director of Community Wellbeing

Update on Transforming Care: Learning Disabilities

Wards Affected:	All
Key or Non-Key Decision: **(only applicable for Cabinet, Cabinet Sub Committee and officer decisions)**	N/A
Open or Part/Fully Exempt: (If exempt, please highlight relevant paragraph of Part 1, Schedule 12A of 1972 Local Government Act)	Open
No. of Appendices:	Two appendices: Appendix 1 – Building the Right Support, October 2015. Appendix 2 – A national response to Winterbourne View Hospital, December 2012.
Background Papers:	N/A
Contact Officer(s): (Name, Title, Contact Details)	Helen Duncan-Turnbull Head of Service, Complex Care helen.duncan-turnbull@brent.gov.uk 0208 937 6169 Sarah Nyandoro Head of LD and MH CCG sarah.nyandoro@nhs.net 020 8900 5391

1.0 Purpose of the Report

1.1 Following on from the Winterbourne View scandal in 2012, and subsequent investigation and report, the CCG and Local Authority are required to report to NHS England all patients with a learning disability they have a duty of care for, who are in treatment units and their plans for discharge. Additionally, the Winterbourne View report identified a number of actions that needed completing relating to the total learning disability population in order to ensure that, in

the future, support for people with a learning disability reduces the likelihood of individuals needing to be admitted to an in-patient unit or be placed in an institutional setting.

1.2 This report provides the background to why the Transforming Care programme was developed and an update on Brent's progress against national and regional requirements and/or priorities, and confirms the priorities for this year agreed at the Health and Wellbeing Board in January 2019.

2.0 Recommendation(s)

2.1 The committee to note measures already in place to support the TCP cohort in the borough and the further actions planned as part of the TCP programme.

2.2 The committee to note progress against key milestones and the areas that require further development.

3.0 Background and National Context

3.1 Winterbourne View was a hospital in South Gloucestershire for people with learning disabilities and autism whose behaviour sometimes made their families and professionals worry and could present significant risks to themselves or others. It was meant to help by assessing and treating patients so that they could have ordinary lives in their own homes. An undercover investigation exposed appalling and systemic abuse at Winterbourne View, and led to a review that identified a number of measures that should be taken to ensure that such abuse did not occur again and that, crucially, the majority of people with autism, learning disabilities and mental health conditions should be supported in a community setting, and not a hospital whenever possible.

3.2 The review sets out the government's final response to the events at Winterbourne View hospital. It sets out a programme of action to transform services for people with learning disabilities or autism and mental health conditions or behaviours described as challenging.

3.3 The main focus is on ensuring that people with a learning disability and/or autism in hospital who could be supported in the community are discharged into a community setting as soon as possible, and do not spend long periods of time in institutional care.

3.4 The identified priorities are: developing appropriate accommodation, community care and support services, and building capacity in the community so that people only go into hospital when they need treatment and not because their support in the community has broken down.

3.5 This work ensures that services make the necessary improvements to current and future care planning as well as ensuring the needs of this cohort are considered in commissioning intentions.

3.6 In October 2015, the paper 'Building the Right Support' (BRS) was published, which set out the vision and plan for the programme duration, from April 2016 to April 2019. The scope of the national programme, and all work under the Transforming Care Agenda includes people with learning disabilities and/or autism that have or are at risk of developing a mental health condition or behaviours described as challenging, that could lead to contact with the justice system. This is an all ages programme.

3.7 The aims of the national programme are:

- reduced reliance on inpatient services (by closing hospital services and strengthening support in the community)
- improved quality of life for people in inpatient and community settings

- improved quality of care for people in inpatient and community settings
- the transformation of specialist and mainstream services to minimise future admissions.

3.8 The focus of the national programme is to consider and plan for the enhanced/intensive support that needs to be delivered in the community in order to provide effective interventions for children, young people and adults with a learning disability and/or autism who present with behaviours that challenge which place themselves or others at risk of serious harm; or for whom the nature or degree of risk might otherwise lead to exclusion, placement breakdown, and admission to inpatient services.

4.0 Regional Context – North West London

4.1 The North West London Board oversees progression for the region and is also the lead for service development required at a regional level. Brent has a joint local TCP Steering Group which ensures that local priorities are progressed and escalate issues that require regional consideration to the NWL Board. The NWL Partnership between CCGs and LAs was established in early 2016 and the Partnership collectively developed a vision and published its plan in April 2016 which sets out how the Partnership vision will be achieved. Five priority work streams were agreed for the board:

- Workforce Development
- Accommodation and Estates
- Support and Specialist Services
- Crisis and Prevention
- Finance

4.2 Workforce development - An extensive Positive Behaviour Support (PBS) training programme has been developed to reduce challenging behaviour in people who have learning disabilities and/or autism. This training has been delivered to parent/carers, over 400 frontline staff and the final phase of train-the-trainer programme was completed in April 2018, to 80 CLDT health and social care staff; this has included providers and staff in Brent.

4.3 Treat Me Right Autism and Learning Disability Awareness training programmes are being delivered across 6 NWL Hospital Trusts, to empower health and social care staff to be competent and also feel confident when working with, and making reasonable adjustments for, people with learning disabilities and autism who attend their services.

4.4 Accommodation and Estates - A NW London Housing and Accommodation Strategy was commissioned, to ensure that people who have been discharged from an inpatient setting or are at risk of admission, have access to accommodation and support that is appropriate to their needs. This strategy included a review of the range and scope of existing NWL services, specifically for people with complex and challenging behaviour across residential care and supported living housing options and identifying local providers that are trained to meet the housing and support needs of people who have behaviour that challenges. It was recognised at the NWL Board that Brent's New Accommodation for Independent Living (NAIL) project would meet the local needs and that Brent were ahead of most other boroughs in this area.

4.5 Support and Specialist Services – the focus of this work stream is to ensure that across the TCP footprint there are a comprehensive range of support services and providers that are appropriately skilled and configured to meet the on-going support needs of people with LD/Autism who have behaviour that can challenge.

4.6 West London Forensic Service (WLFS) were commissioned to scope the availability of existing mainstream community forensic and diversion services across NW London to determine what

forensic expertise is available within local CLDTs, review anticipated demand should patients be brought back to their home boroughs, and appraise potential future service configurations based on the findings of the assessments.

4.7 The preferred option following this review, which is still in the early stages of development, is to expand the criteria for existing Mental Health Forensic Diversion services to include people with LD / autism at borough /sub regional level. The team would be managed within Forensic services.

4.8 There are still on-going discussions around capability, capacity, expertise and experience to determine preferred provider. Brent CCG is fully involved in these discussions.

4.9 Crisis and Prevention – the focus of this is to ensure that people in crisis and those identified at risk of admission are able to access universal and specialist services when they need them, to enable them to continue to live independently within the community, and prevent the need for an unnecessary admission.

4.10 Finance - the NWL Board has a function to ensure that NWL TCP maintains effective financial oversight and leadership of the delivery of the transforming care programme, so that the best possible outcomes are achieved within the available resources. The Board has undertaken detailed financial modelling enabling an understanding of NWL inpatient, community placement costs and requirements. Systems are in the process of being developed to enable the tracking and reporting of funding as individuals move through the system and across commissioning boundaries.

5.0 Commissioning Context

5.1 *Commissioning arrangements for health services*

5.2 *Specialised Commissioning (Specs Comms)*

NHS England directly commissions 'specialised' services for Learning Disabilities and/or Autism, supporting individuals who have the most complex needs and pose the highest risk either to themselves or others, and will include individuals who if they did not have a learning disability may have received a prison sentence as an outcome of the risks they presented.
The key inpatient bed provisions commissioned by Specs Comms are secure beds which means that the wards are locked and individuals are under close supervision:

- Low, Medium and High secure provision for Adults
- Children and Young People's secure in-patient beds

5.3 *Clinical Commissioning Groups (CCGs)*

Clinical Commissioning groups are responsible for commissioning acute inpatient, primary care and community services for children and young people with LD and autism.

They also commission community forensic services (services that support people with an offending/criminal history), however, there isn't a specialist LD community forensic service in Brent currently.
The key services for adults with LD and autism commissioned by the CCG in Brent are:

- Community Learning Disability Team (CLDT) provided by Central and North West London NHS Foundation Trust
- London North West Hospital Trust
- Autism Diagnostic Services for children and adults

- Mainstream community mental health services for children and adults with mental health needs which will accept patients with autism and mild LD
- Mainstream mental health beds for adults with mental health needs which will accept patients with autism or a mild LD who don't need a specialist service
- Specialist assessment and treatment (A&T) and open / locked rehabilitation provision for adults with LD and autism. These are spot purchased and include out of area placements.

5.4 The local specialist inpatient services are:

- Kingswood Centre -Specialist Assessment and Treatment service for adults with LD, provided by CNWL
- Cygnet, Harrow - Specialist open and locked rehabilitation service for adults with autism (including those with a mild LD, and with or without a forensic history)

5.5 NHS Brent CCG has a number of block contracts with bordering CCGs i.e. West London Mental Health Trust, Camden and Islington and Barnet Enfield and Haringey Mental Health Trust. They also commission specialist Psychological/Psychotherapy services with the Tavistock and Portman NHS Foundation Trust.

5.6 These contracts support individuals who are registered with a Brent GP but who live in those areas. These are Block contracts that provide both community and in-patient beds. These arrangements also support individuals with Learning Disabilities. The values of these contracts range from £60k to £800k.

5.7 NHS Brent CCG has a contract with CNWL for Learning Disabilities in-patient beds which is again managed on a Block contract basis and the spend on that ranges from £400k to £600k per year.

5.8 They commission a number of specialist Learning Disabilities open and locked rehabilitation beds out of area on a spot purchase basis. A number of these are step down from forensic beds that are managed by NHS England and on average we fund these at circa £650 a day.

5.9 Brent CCG also commissions community support for people with learning disabilities and the value of the current community service element is £1,279,386

5.10 ***Commissioning arrangements for Social Care Services***

Under the Care Act, Local Authorities are required to ensure that people who live in their areas:

- Receive services that prevent their care needs from becoming more serious, or delay the impact of their needs
- Can get the information and advice they need to make good decisions about care and support
- Have a range of provision of high quality, appropriate services to choose from

5.11 Local Authorities are responsible for commissioning and providing a wide range of social care services in the community for the transforming care cohort. Services are provided by multiple private and voluntary organisations as well as some in-house provision and these include:

- Provision of Social Workers and Education Health and Care Plan Coordinators
- Residential, nursing, supported living and housing related support
- Homecare and Day opportunities including supported employment
- Short breaks and respite for people living at home with their families

- Residential schools and colleges
- Advocacy
- Information and advice

5.12 Current LD Support Commissioned by Local Authority

LA service type	Number of People	Cost
Nursing	11	£520,024
Residential	152	£9,666,222
Extra care	1	£12,628
Supported living	155	£7,162,032
Shared lives	15	£264,692
Direct payments	220	£3,315,407
Home care	57	£764,642
Day care	233	£3,207,160
Respite/short term or stepdown	96	£803,842
Reablement	2	£1,583
Accommodation/Bed & Breakfast	2	£38,480
Foster carer/care	2	£44,408
Transport	27	£165,376
Out Reach	16	£116,999
Total	989	£26,083,495

5.13 Out of Borough provision

5.14 There are 84 people currently in residential/nursing provision out of borough of which there are plans to move 13 back into borough during 19/20.

5.15 There are 36 people currently in supported living out of borough, of which there are plans to move 11 people back into borough during 19/20.

5.16 7 people have been moved back into borough during 18/19

6.0 Local Context

6.1 Achieving an effective model of integrated community and inpatient services and support is key to the delivery of the Transforming Care Plan (TCP). Within Brent we have a diverse transforming care cohort supported by a mix of community and inpatient providers with varying levels of capacity and expertise. The aim of the TCP is to support people closer to home and in the least restrictive setting; and ensuring patients get discharged to the community at the earliest opportunity when it is clinically safe to do so.

6.2 Within Brent, in order to achieve the national TCP aims there are four work streams, each with a project plan, aimed at reducing the risk of admission and ensuring the community infrastructure can meet the needs of the local learning disability population The work streams are:

- Reduction in the number of NHSE and CCG in-patients
- Integration of the health and social care learning disability teams
- Market Development
- Transitions

6.3 People with learning disabilities and/or autism who are placed in or are at risk of admission to an inpatient setting are a highly heterogeneous group and the integrated model of care and support needs to reflect that diversity. The needs of the inpatient cohort from NWL fall broadly into these categories:

- Mild LD with a diagnosed mental health need
- Moderate or severe LD and autism with challenging behaviour including self-injurious behaviour
- Mild LD and/or autism with a forensic history, with /without a mental health diagnosis

6.4 The complex commissioning and provider landscape for health and social care represents a challenge when developing the integrated services needed to support the transforming care cohort in the community and in hospital.

6.5 Financial pressures faced by all partners, and the lack of clarity regarding the transfer of funding from NHS Specialised Commissioning in regards to inpatient provision have added to the challenges.

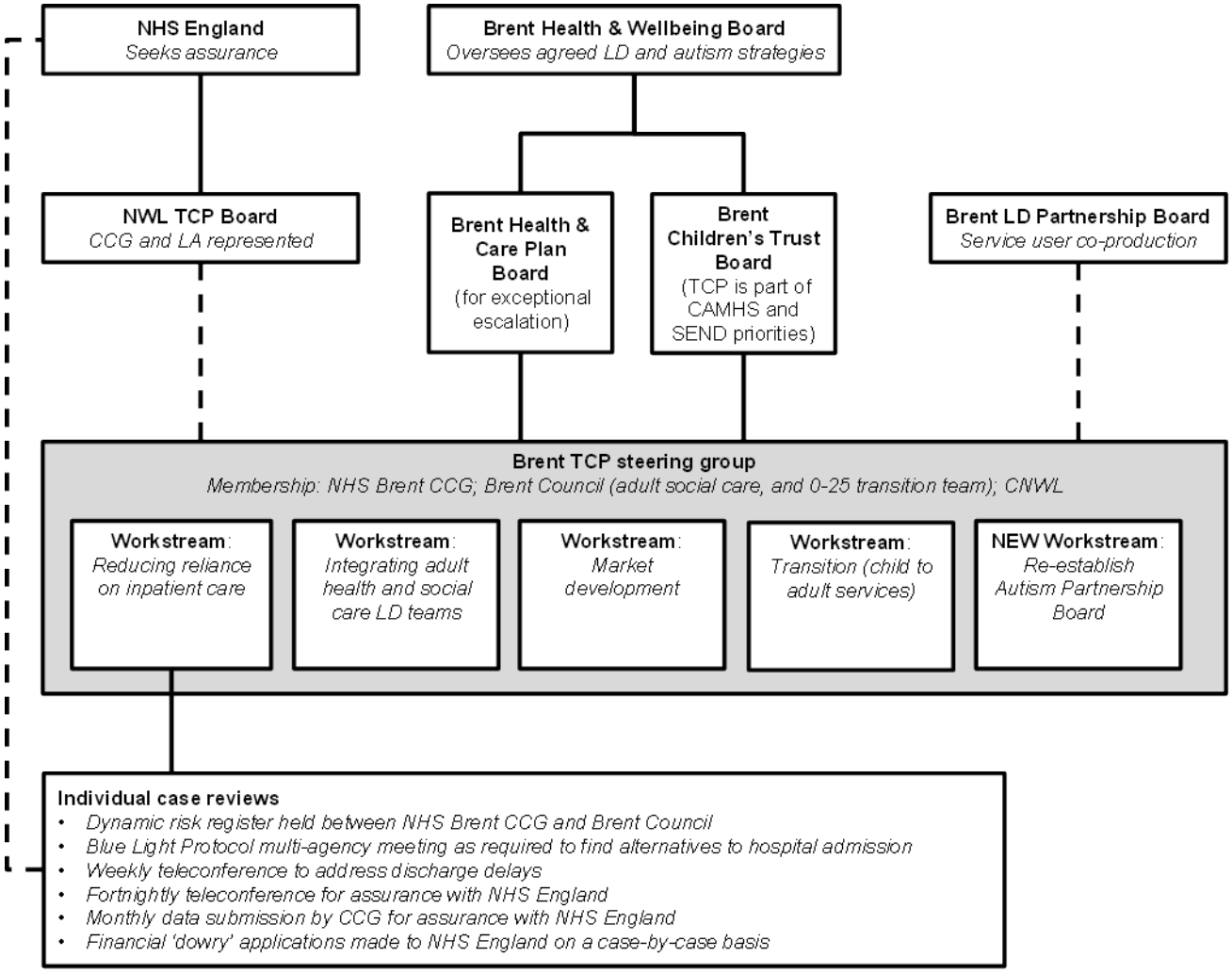
6.6 **Governance arrangements**

6.7 Governance arrangements between Brent Council, NHS Brent CCG, and NHS England are shown in the diagram below.

6.8 NHS England seeks strategic assurance through the NWL TCP Board, and operational assurance through case-level teleconferences and data submissions.

6.9 There are parallel lines of accountability for children and adults to the Brent Health and Wellbeing Board.

6.10 The current LD Partnership Board receives regular updates on progress; we intend to re-establish the Brent Autism Partnership Board in 2019/20 to ensure delivery of the joint Autism Strategy.



7.0 Brent work stream update

7.1 Reduction in the number of NHSE and CCG in-patients and readmission

7.2 Our weekly TCP monitoring teleconferences show that in the past year there have been no new admissions to inpatient units, but four readmissions (including two outside Brent). A requirement off the TCP programme is that all areas establish a Dynamic Risk Register and a protocol (Blue Light) to enable rapid multi-disciplinary discussion and action when an individual is identified as at risk of admission; in order to try and prevent an admission being needed. In addition, whilst not specific to the TCP programme, all CCGs are required to have in place a process to review the deaths of all people with a learning disability to determine whether poor access to, or support from, health care or support services could have contributed to the death. This is as a result of a report published in March 2007 by Mencap, 'Death by Indifference' which reported the deaths of six people with a learning disability – deaths that the six families involved and Mencap believe were the result of failings in the NHS and the subsequent report '74 Lives and Counting' progress report in 2012.

7.3 Dynamic Risk Register

7.4 A requirement off the TCP programme is that all areas establish a Dynamic Risk Register and a protocol (Blue Light) to enable rapid multi-disciplinary discussion and action when an individual is identified as at risk of admission.

7.5 A dynamic register is a list of individuals who are currently, or who are at risk of, developing behaviour that challenges (including those at risk of hospital admission). The Transforming Care Plan guidance requires all local CCG/LAs to have a Dynamic Risk Register to gather data on adults and children with learning disabilities. The National Dynamic Risk Register template has been designed to include a banding criteria divided into red, amber and green categories.

- **Red level**: Is for those individuals who are the most at risk of deteriorating very rapidly and are receiving direct intervention, potentially from a number of disciplines and organisations.
- **Amber level**: Is for those people who are at a secondary prevention level; have the potential to require tertiary support but do not need that support right now.
- **Green level**: Is for those with underlying well managed vulnerabilities, who require no current input.

7.6 Brent CCG in partnership with the Local Authority and NHS Trust Partners has developed a local risk register which is systematically updated, monitored and reviewed. This has been further developed in the last quarter of 2018 to include children and young people with learning disabilities and/or special needs and disabilities as well as adults with Learning Disabilities and/or autism. This enables health and social care services to ensure individuals have multi-disciplinary involvement to either prevent admission or plan robust support upon discharge and also enables monitoring at a macro level the efficacy of local provision in preventing admissions and providing adequate community support.

7.7 A recommendation from the Health and Wellbeing Board in January 2019 was that when someone is placed on the risk register their GP should be informed, to enable them to have oversight and engagement with any clinical decisions and/or discussions that may be required; this has been implemented.

7.8 Blue Light Protocol

7.9 Brent, as required, developed a robust Blue Light Protocol in 2017 to support individuals assessed and considered to be at risk of inpatient admission.

This protocol: -

- Ensures that we have arrangements in place to provide urgent interventions to support individuals with learning disabilities stay in the community and prevent admissions to acute in-patient settings.
- Is used as an early identification and intervention protocol designed to support individuals experiencing deterioration in their presentations to enable them to stay in their own home environments.
- Provides commissioners with a set of prompts and questions to prevent people with learning disabilities being admitted unnecessarily into inpatient learning disability and mental health hospital beds.
- This protocol has had a positive response since it was first introduced. It helps to identify barriers to supporting individual/s to remain in the community and to make clear and constructive recommendations as to how these barriers could be overcome by working together and using resources effectively and creatively.

7.10 The protocol works in conjunction with the Care and Treatment Reviews (CTR) and a Care Programme Approach (CPA) to escalate those cases where an individual with a learning disability is at risk of inpatient admission. It facilitates arrangements to put in place a support plan that allows the individual to receive the required support to enable them to remain in the

community. Evidence to date shows that responses to individual need are much quicker and that in around 60% of cases admission is prevented. Work is continuing to monitor the effectiveness of this protocol and to utilise the aggregated individual needs information to inform market shaping and workforce development requirements.

7.11 TCP patients as of March 2019

- Total Number of patients in treatment: 14
- Number of Specialised Commissioning patients: 10 (7 adults and 3 children)
- Number of CCG patients: 4 (all adults)
- Number of '>5 years' dowry patients: 3 (of 11 specialised commissioning patients)

In the past 3 months there have been two children where a Blue Light Protocol meeting successfully offered a community alternative to inpatient admission.

8.0 Update on milestones

8.1 Key milestones for reducing admissions

In the previous TCP paper, October 2017, to HWB a number of key milestones were agreed for each work stream. The milestones for 'Reduction in the number of NHSE and CCG in-patients' were as follows:

- Incorporation of children and individuals with Autism on the Dynamic Risk Register – *complete*
- Discharge of 2 individuals during the next quarter (plans in place) *complete*
- Confirmation of proposed discharge dates from in-patient units for the remaining individuals *there are plans in place for 6 of the adults to be discharged this year and all 4 of the children. 4 individuals continue to present significant challenges and require specialist secure provision and are not deemed ready for discharge.*
- Confirmation from NHSE regarding Brent's Specialised Commissioning Funding for eligible in-patients – *funding transfer arrangements confirmed. The CCG must apply for funding as discharge plans are agreed.*

8.2 Integration of the health and social care learning disability teams

8.3 From the middle of September 2018 the health and social care learning disability teams became integrated, with a single manager and the local authority as the operational lead. The team's role is to support people with a learning disability and their carers, with a focus on; enabling people to live as independently lives as possible within their communities and providing specialist interventions and commissioned support to individuals and their carers.

8.4 Work is currently underway to consider the most appropriate governance structure, probably through the use of an alliance contract.

8.5 The joint Service Manager (between the LA and CNWL) will oversee the implementation of a revised operational and administrative structure and devise and implement a team development plan.

8.6 Key milestones LD Team integration

- Commissioning plan to be developed that sets out future commissioning arrangements for the LD team e.g. S75 – *complete*

- Outcomes based learning disability team service specification to be ratified – NWL have devised a specification framework which is being used by each CCG to contract locally
- Operational delivery model identified and agreed – *complete*
- Integrated team operating in shadow form – *complete*
- Integrated team fully operational – *complete*

9.0 Market Development

9.1 In order to effectively manage Brent's market for people with learning disabilities, including those with complex needs and behaviour that challenges, to ensure we have suitable provision that can meet the range of needs presented, now and in the future, we need to first understand the profile of the LD population's needs; and our current market capacity and capability.

9.2 The focus of the market shaping work stream is to gather the local population based commissioning intelligence for people with a LD and/or autism and to establish a flow of data regarding the Brent LD population. The outcome of this will be a population based report regarding the Brent LD population that informs both the CLDT improvement plan and the Market management plan. This will provide an evidence base to inform and stimulate the market and commission appropriate increased capacity from community providers.

9.3 By understanding our supply and demand for service provision locally, and using client data it will be possible to anticipate trends and be proactive in developing the market to respond; this will ensure that the local market is sustainable now and in the future.

9.4 As part of the New Accommodation for Independent Living programme the primary focus is on developing supported living schemes that can support individuals with complex needs, in particular behaviours that challenge; the challenge will be identifying/attracting providers that have a workforce with the skills required to manage individuals with complex needs, particularly supported housing for people with LD and autism who have forensic histories.

9.5 A number of schemes have already been developed and further schemes are planned for the coming year that will meet the needs of people with a learning disability with complex needs.

Delivered	
Salmon Street	6
Manor Drive	4
Total	10
Planned	
127 and 129 Harrowdene Road	6
Preston Road	6
Fairlight Avenue	6
Ruby Street	6
Woodhill Crescent	6
Oxgate Gardens	6
Gladstone Park Gardens	6
Total	42

9.6 There are also a total of 40 beds that have been achieved via de-registration or spot purchase. We are currently looking at some of the very high cost placements and those individuals currently in hospital to see who may be suitable to move but would require a very bespoke environment; this would include those individuals currently still in hospital.

9.7 Brent is also currently in the process of designing a home care re-procurement and a subsequent review of day care provision across the borough. It has been agreed that, rather than undertaking a separate piece of work, the development of LD specific support will be undertaken as part of this activity; informed by the population based report.

9.8 Key Milestones Market Development

- LD and Autism strategy to be formally signed off by LA and CCG – *draft complete and will be signed off at May Learning Disability Partnership Board*
- Market management priorities and action plan with timescales to be finalised – *draft complete and will be signed off at May Learning Disability Partnership Board*
- Autism Board to be established – *CCG leading and aim to establish by April 19*

10.0 Transitions

10.1 The Transitions work stream has progressed well with a particular focus on the 'Preparing for Adulthood Pathway' and the development of a 0-25 disabilities team.

10.2 The pathway has been co-produced with parents and key stakeholders and signed off by the Strategic Inclusion Board, chaired by an Operational Director in the Children and Young People's department; and is currently going through partner agency governance processes. It identifies and provides clarity around what is available through the Local Offer and the professional support that can be expected at each stage of a young person's life from the point of commencing secondary education; utilising the Education, Health and Care Plan as the planning vehicle.

10.3 A 0-25 Disabilities Team has been developed by integrating the Children with Disabilities and Transitions Teams to form a single team. This provides greater continuity for the child or young person and their family and enables a much earlier focus on maximising independence; the team is operationally managed by Children's services who are in the process, in partnership with Adult services, of developing a team development plan.

10.4 The purchasing budget will remain, in the first instance, with Adult Social Care, as this a significant area of risk, and a joint panel process established to enable shared oversight. This will provide time for staff unfamiliar with adult services to develop their knowledge and skills and provide assurance that expenditure reflects the application of a 'maximising independence' approach.

10.5 Key Milestones Transitions

- Develop options appraisal for team changes – *complete*
- 0-25 team operational - *complete*
- Develop Preparing for Adulthood pathway – *complete*

11.0 Autism

11.1 Following the completion of the Transition work stream, the Brent TCP Steering Group has adopted a new priority to re-establish the Brent Autism Partnership Board in 2019/20. This will ensure co-production with service users in delivering the joint Autism Strategy (for people with autism but not a learning disability).

12.0 **Finance**

12.1 NHSE believe that by reducing the numbers of inpatients in NHS England's commissioned beds this will enable the release of the associated funding which can then be used to pay for packages of care in the community, to support discharges and prevent admissions. The premise is that funding should flow with the patient and this is supported by the national arrangements around Building the Right Support.

12.2 The model that has been agreed by NHSE to facilitate the flow of funds to local TCPs is through CCGs and is called the Funding Transfer Agreements (FTA). This funding is only available to 5+ year patients discharged after April 2017 and will be treated as a dowry payment.

12.3 NHSE has estimated that the average cost of a bed for the London region is £180,000. This is the full year effect that NHSE will release for each 5 years plus patient successfully moved back to local TCP areas. Brent currently has 3 patients who have been in treatment beds for over 5 years who are likely to meet the requirements of the FTA.

12.4 This presents a significant cost pressure risk to the Local Authority as there are currently 10 individuals (3 children) in NHSE beds but only 3 of these are dowry eligible, with no guarantee of health funding for the remaining 7.

13.0 Next Steps/Priorities

13.1 The priorities, which will be monitored via the Brent TCP steering group on a monthly basis, for the coming year are as follows:

- Establishment of an Autism Board (April 2019) - CCG
- Further development of specialist accommodation via NAIL project (on-going) - LA
- Development of a forensic support service (NWL priority)
- Homecare and Day Care review and re-procurement (Sept 2019) - LA
- Transfer of Transitions Team budget to Children's Services (May 2019) - LA
- Community Learning Disability Team Service review (Sept 2019) LA/CCG/CNWL

14.0 Financial Implications

14.1 Financial implications are addressed in the body of this report.

15.0 Legal Implications

15.1 There are no legal implications arising from this report.

16.0 Equality Implications

16.1 There are no equality implications arising from this report.

17.0 Consultation with Ward Members and Stakeholders

17.1 Ward members who are members of the scrutiny committee will be involved in scrutinising this report at committee.

REPORT SIGN-OFF

Phil Porter
Strategic Director of Community Wellbeing

Local Government Association

directors of adass adult social services

NHS England

Building the right support

A national plan to develop community services and close inpatient facilities for people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition

October 2015

Building the right support

A national plan to develop community services and close inpatient facilities for people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition

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Contents

Foreword

Children, young people and adults with a learning disability and/or autism have the right to the same opportunities as anyone else to live satisfying and valued lives, and to be treated with dignity and respect. They should have a home within their community, be able to develop and maintain relationships, and get the support they need to live healthy, safe and rewarding lives.

As a society, we are on a long journey to make that simple vision a reality. We have made enormous strides over several decades. But for a minority of children, young people and adults with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition[1], we remain too reliant on inpatient care - as they and their families have been telling us loud and clear.

It is for that reason that, in February 2015, NHS England publicly committed to a programme of closing inappropriate and outmoded inpatient facilities and establishing stronger support in the community, and promised that further details would follow later in the year. This plan meets that commitment.

We know it comes at a time when many people with a learning disability and/or autism, as well as their families/carers are frustrated - that change has been limited and slow, particularly following the appalling scandal at Winterbourne View. We know too that thousands of frontline carers, clinicians, providers and commissioners want to make progress.

This plan sets out how we will do so: supporting local leadership and making available new investment to kick-start change. It means that we now have an opportunity – to make real the rights of people with a learning disability and/or autism, and to help thousands of people lead happier lives.

We know that this challenge is achievable because many parts of the country are already successfully doing it. There is good practice across the country to replicate, and the skills and expertise of thousands of families and front-line staff to build on. 'Fast track' areas across England are starting to show what kind of transformational change is possible with strong local leadership building a new generation of community-based services.

Now it is time to deliver across the whole country. This plan sets out how we intend to do so – working with people with a learning disability and/or autism, families, staff, clinicians, providers, and commissioners.

Jane Cummings,
Chief Nursing Officer, England

Ray James, President, Association of Directors of Adult Social Services

Sarah Pickup, Deputy Chief Executive, Local Government Association

Dominic Slowie, National Clinical Director for Learning Disability, NHS England

[1] Hereafter people with a learning disability and/or autism

1. Executive summary

The journey to date

1.1 Over many decades, as a society we have significantly reduced our reliance on institutional care to support people with a learning disability and/or autism, closing asylums, campuses and long-stay hospitals. For a minority of people however, there is still an over reliance on inpatient treatment for people who could, given the right support, be at home and close to their loved ones.

1.2 Over the last few years hundreds of people from hospital have been supported to leave hospital – but others are admitted in their place, often to inappropriate care settings, so the number of inpatients remains steady. We have not made enough progress when it comes to changing some of the fundamentals of care and support.

1.3 To make this permanent we need a change in culture, a shift in power to individuals and a change in services. We need to see people with a learning disability and/or autism as citizens with rights, who should expect to lead active lives in the community and live in their own homes just as other citizens expect to. And we need to build the right community based services to support them to lead those lives, thereby enabling us to close all but the essential inpatient provision.

1.4 To speed up this process and to help shape a national approach to supporting change, six 'fast track' areas[2] drew up plans over the summer of 2015 and are already making a difference on the ground. Together they envisage shifting money into community services in order to reduce their usage of inpatient provision by approximately 50% over the coming three years. Their plans will result in the development of a range of new community services and the closure of hospital units, including the last standalone learning disability hospital in England.

1.5 This document describes how we intend to build on our experience with fast tracks to implement change across the rest of the country.

The new services we need

1.6 People with a learning disability and/or autism who display behaviour that challenges are a highly heterogeneous group. Some will have a mental health problem which may result in them displaying behaviour that challenges. Some, often with severe learning disabilities, will display self-injurious or aggressive behaviour unrelated to any mental health condition. Some will display behaviour which can lead to contact with the criminal justice system. Some will have been in hospital for many years, not having been discharged when NHS campuses or long-stay hospitals were closed. The new services and support we put in place to support them in the community will need to reflect that diversity.

[2] Greater Manchester; Lancashire; North East and Cumbria; Arden, Herefordshire and Worcestershire; Nottinghamshire; Hertfordshire

1.7 A national service model, developed with the help of people with lived experience, clinicians, providers and commissioners, outlined in this document and published in full alongside it, sets out the range of support that should be in place no later than March 2019. It should be read in tandem with this plan.

1.8 Implementing this model, and giving people greater power over the services they use, will result in a significantly reduced need for inpatient care. We expect that as a minimum, in three years' time no area will need capacity for more than 10-15 inpatients per million population in clinical commissioning group (CCG) commissioned beds (such as assessment and treatment units), and 20-25 inpatients per million population in NHS England-commissioned beds (such as low-, medium- or high-secure services).

1.9 These planning assumptions will mean that, at a minimum, 45 – 65% of CCG-commissioned inpatient capacity will be closed, and 25 – 40% of NHS England-commissioned capacity will close, with the bulk of change in secure care expected to occur in low-secure provision. Overall, 35% - 50% of inpatient provision will be closing nationally with alternative care provided in the community. The change will be even more significant in those areas of the country currently more reliant on inpatient care. In three years we would expect to need hospital care for only 1,300-1,700 people where now we cater for 2,600. This will free up money which can then be reinvested into community services, following upfront investment.

1.10 These planning assumptions should be seen as the starting point. Commissioners should, working with people with a learning disability and/or autism, be ambitious in thinking about how much further they can go, starting not from the point of what services they have currently but what support people need to live the best possible life.

1.11 Just like the rest of the population, people with a learning disability and/or autism must and will still be able to access inpatient hospital support if they need it. What we expect however is that the need for these services will reduce significantly. The limited number of beds still needed should be of higher quality and closer to people's homes.

1.12 For those that do need this more specialist support in hospital, their length of stay should be as short as possible. We will work with providers, commissioners and clinicians to reduce length of stay overall and ensure areas learn from best practice – for instance one 'fast track' area aims to reduce length of stay in assessment and treatment services to an average of 85 days.

Delivering change

1.13 To achieve this systemic change, 49 transforming care partnerships (commissioning collaborations of CCGs, NHS England's specialised commissioners and local authorities) are mobilising now. They will work with people who have lived experience of these services, their families and carers, as well as key stakeholders to agree robust implementation plans by April 2016 and then deliver on them over three years.

1.14 An alliance of national organisations will support these transforming care partnerships to deliver on this ambitious agenda, including NHS England, Local Government Association (LGA), Association of Directors of Adult Social Services (ADASS), Health Education England (HEE), Skills for Health, Skills for Care, the Care Quality Commission (CQC), NHS Trust Development Authority (TDA), Monitor, and provider representative organisations, working closely with people with a learning disability and/or autism as well as their families/carers.

1.15 In every part of the country there are people with the skills and experience to deliver effective care and support. These people can be found within health and social care services, and amongst the families and carers who support individuals in their own homes. Successful delivery will depend on them. Their insight will be key to designing, developing and launching new services in the community, and their skills and experience will be central to delivering them.

1.16 As part of this alliance for delivery, and working alongside local commissioners, we will work with provider organisations to mobilise innovative housing, care and support solutions in the community. Our collaboration will focus on supporting commissioners to redesign services, scaling up community-based services, developing the workforce, accessing investment to expand community services, and securing the capital to deliver the new housing needed.

1.17 A new financial framework will underpin delivery of the new care model:

- Local transforming care partnerships will be asked to use the total sum of money they spend as a whole system on people with a learning disability and/or autism to deliver care in a different way that achieves better results
- To enable that to happen, NHS England's specialised commissioning budget for learning disability and autism services will be aligned with the new transforming care partnerships
- CCGs will be encouraged to pool their budgets with local authorities whilst recognising their continued responsibility for NHS Continuing Healthcare.
- For people who have been in hospital the longest, the NHS will provide a 'dowry' – money to help with moving people home
- During a phase of transition, commissioners will need to invest in new community support before closing inpatient provision. To support them to do this NHS England will make available up to £30 million of transformation funding, to be matched by CCGs, over and above the £10 million already made available to fast track areas

- In addition to this, £15 million capital funding over three years will be made available and NHS England will explore making further capital funding available following the Spending Review
- From November 2015, *'Who Pays'* guidance will be reformed to reduce financial barriers to swift discharge

1.18 Before the end of 2018, having built up community support and closed hundreds of beds, we will take stock and look at going further.

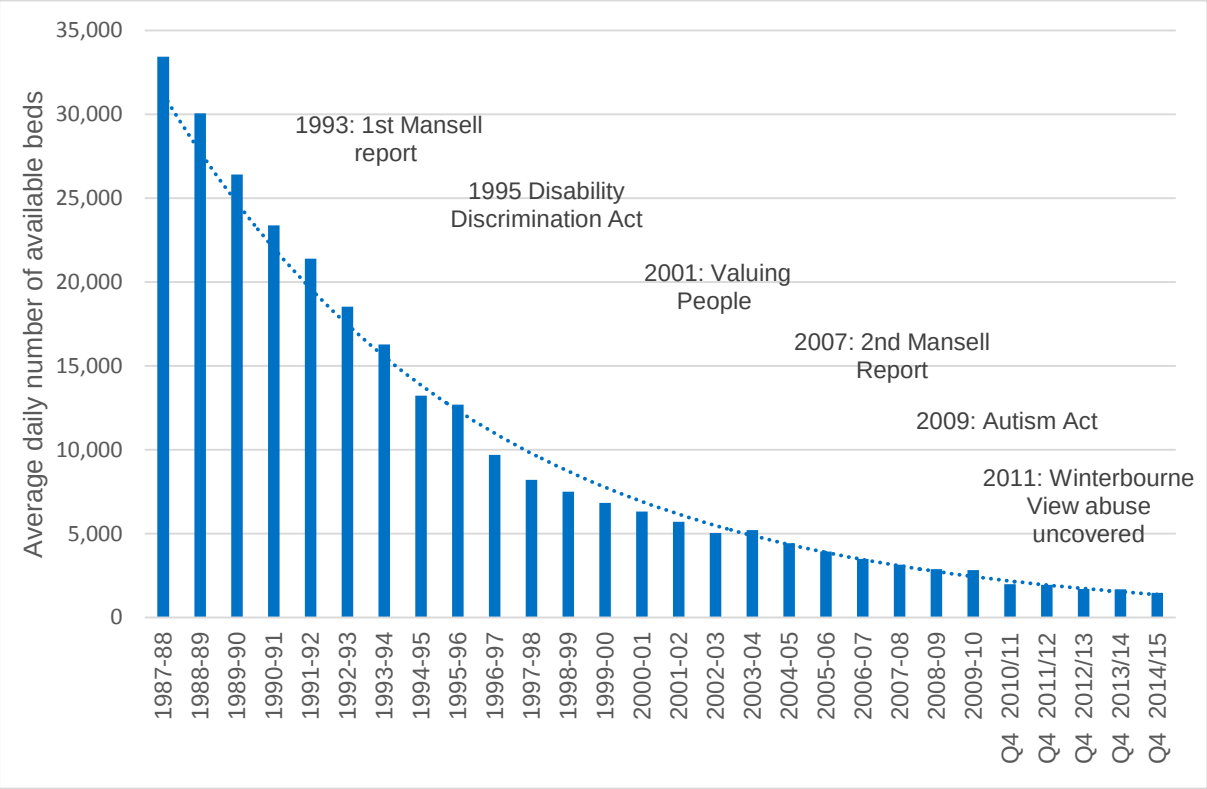
2. The journey to date

Background

2.1 Historically, from the asylum to the long stay hospital, too often people have been routinely placed in institutions away from their homes and communities.

2.2 Rightly, most of these institutions were closed and now the majority of people with a learning disability and/or autism will never come into contact with the types of hospitals – including assessment and treatment services – that are discussed in this document.

Figure 1: NHS learning disability beds since 1987[3]



2.3 The scandal at Winterbourne View, however, was not just an individual episode of appalling abuse. It also highlighted the fact that despite the progress we have made as a society in recent decades, for a small number of people we remain too reliant on hospital care, particularly in some parts of the country (see figure 2 and figure 3).

[3] Data taken from KH03 collection from all NHS organisations that operate consultant-led beds open overnight or day only. Changes to the way data is collected mean only Q4 data provided from 2010/11. More information: http://www.england.nhs.uk/statistics/statistical-work-areas/bed-availability-and-occupancy/

Figure 2: Geographical variation in reliance on *CCG-commissioned* inpatient services (as at 31 July 2015)[4]

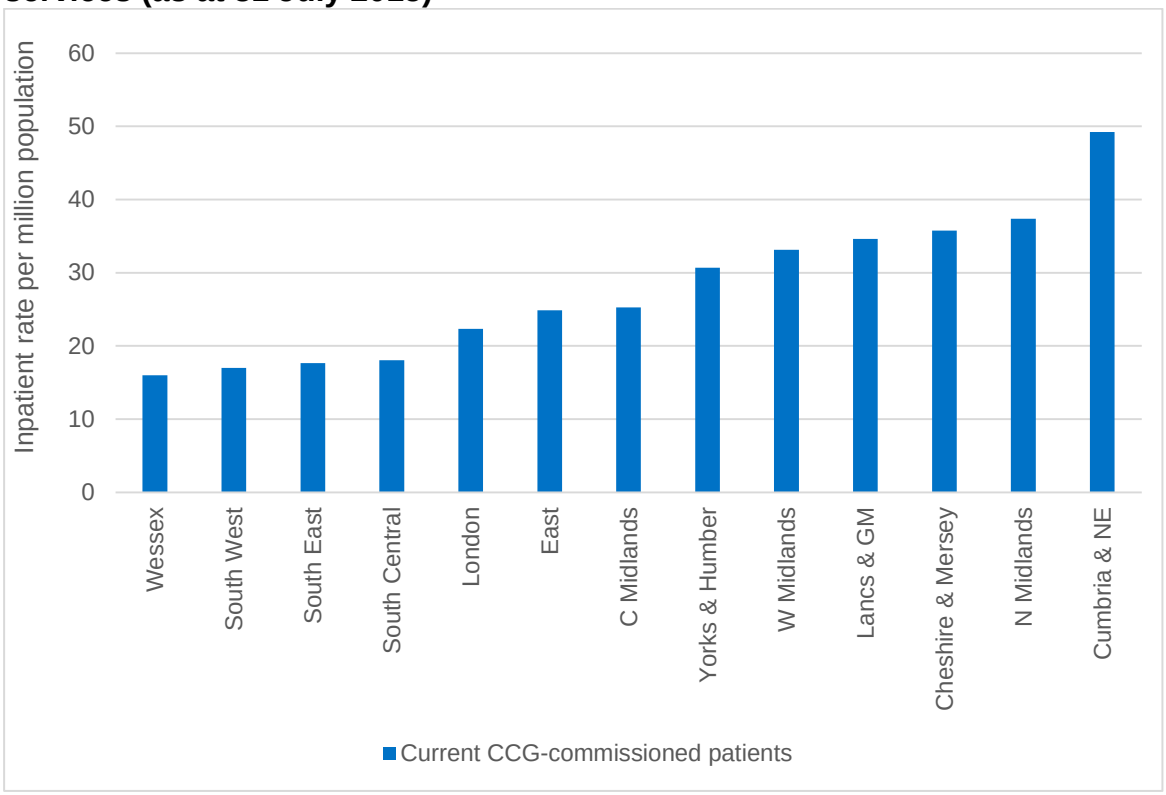
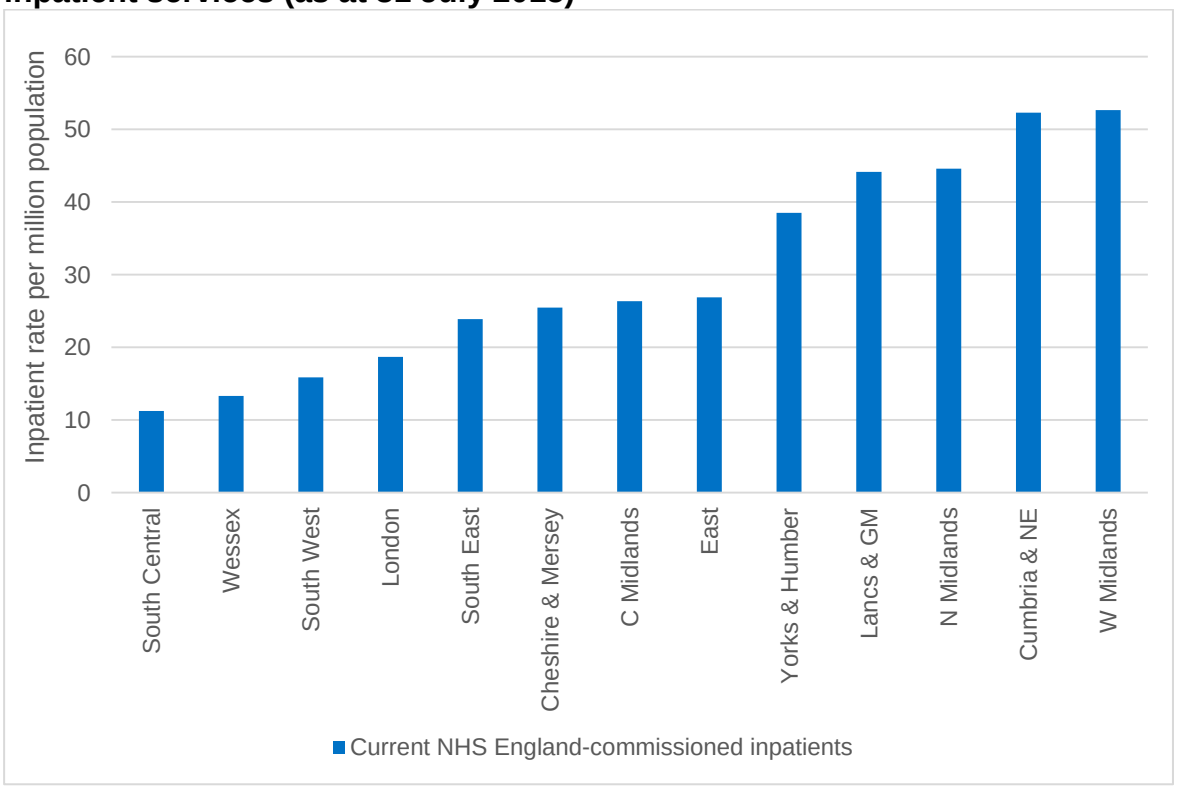


Figure 3: Geographical variation in reliance on *NHS England-commissioned* inpatient services (as at 31 July 2015) [5]



[4] See Annex C for further notes on the data used in these charts
[5] See Annex C for further notes on the data used in these charts

2.4 To address this longstanding problem recently there has been a renewed push to address these issues with, for instance:

- The CQC introducing a new approach to inspecting learning disability hospitals and the care of people with a learning disability and/or autism in acute hospitals
- New data systems put in place to track the care people are receiving
- The Department of Health's consultation *No Voice Unheard, No Right Ignored: a consultation for people with learning disabilities, autism and mental health conditions* looked at how to strengthen rights, incentives and duties in the wider system, focusing on how people can be supported to live independently in their communities and make choices in their lives. Views were sought on a range of ideas intended to strengthen or build upon existing policies, including possible changes to legislation. The Government will shortly set out the actions it proposes in response to the consultation

2.5 In addition to this, NHS England has rolled out a programme of Care and Treatment Reviews (CTRs) - reviews of individual patients' care to prevent unnecessary admissions and avoid lengthy stays in hospital. These CTRs bring together:

- People with a learning disability and/or autism and their families/carers
- Independent expert advisors – one clinical and one expert by experience
- The responsible commissioner and others involved in the persons care and treatment

These reviews look to see if someone's care is safe, effective and whether they need to be in hospital as well as whether there is a plan in place for the future. By mid-September 2015 over 2,020 CTRs had been completed since their introduction in October 2014. Between March and August 2015, over 750 people in hospital were discharged or transferred.

2.6 Progress has been made. Hundreds of people previously in hospital are now living in their own homes, and the foundations for future progress have been laid.

2.7 Despite this, we know the most significant changes needed lie ahead. For all the progress discharging individuals from hospital, the number of people not living at home remains similar to what it was when CTRs were introduced. Admissions remain high, and some people are in hospital when they are ready to be discharged because the right support is not available.

2.8 As Sir Stephen Bubb highlighted in his report for NHS England[7], we need to change the mix of services available on the ground - shifting our investment into better support in the community and closing some inpatient services. To do this "we need both more 'top-down' leadership...and from the 'bottom up'

[7] http://www.england.nhs.uk/wp-content/uploads/2014/11/transforming-commissioning-services.pdf

more empowerment for people with learning disabilities and/or autism and their families."

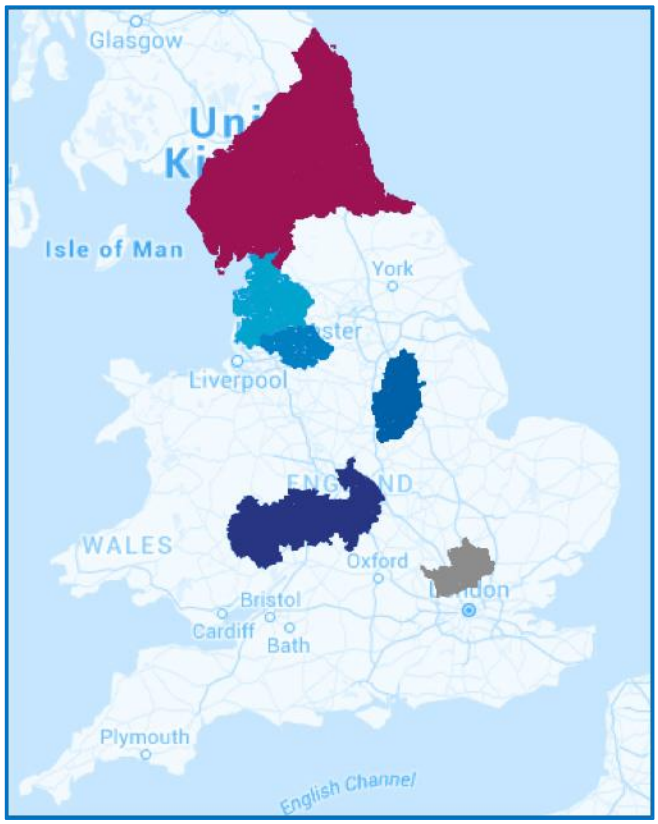
2.9 Six 'fast track' areas have begun that process, and this plan sets out how we will now support the rest of the country to follow suit.

Fast tracks

2.10 Over the summer of 2015, NHS England, LGA and ADASS supported six 'fast track areas'[8] (collaborations of CCGs, local authorities and NHS England specialised commissioners) to draw up plans for service transformation. A £10 million fund was made available to these areas to help fund transitional costs and speed up implementation.[9]

2.11 These areas are highly diverse – in terms of demography, patient flows, provider landscapes, deprivation, urban and rural communities – allowing NHS England, LGA and ADASS to test our approach to a range of different challenges that different communities in England will face as they seek to transform services – from developing the local workforce to designing new community health services to ensuring that funding flows enable change.

Figure 4: Fast track areas



[8] Greater Manchester; Lancashire; Cumbria and the North East; Arden, Herefordshire and Worcestershire; Nottinghamshire; Hertfordshire

[9] The NHS and local government in these areas spend many millions on care for people with a learning disability and/or autism. The £10 million is not intended to fund all the costs in that new service model

2.12 Each fast track has published its plan and fast track areas are now engaging with local communities and providers to help shape delivery.

2.13 Taken together, fast track plans envisage that bed usage across all six areas will reduce by approximately 50% over the coming three years, freeing up tens of millions of pounds which will be invested in community-based support to prevent hospital admissions.

2.14 Below is a summary of some of the actions that each of the fast track areas are implementing.

Greater Manchester

2.15 The devolution deal for Greater Manchester has resulted in new powers and responsibilities for local leaders. In describing their joint ambition for change, they have prioritised the improvement of services for people with a learning disability and/or autism.

2.16 In terms of bed usage, the Greater Manchester Fast Track uses a range of hospital providers but has a significant number of inpatients in Calderstones Partnership Foundation Trust, which is also used to a large degree to provide care to patients from Lancashire. As such their plans are being jointly developed with the Lancashire Fast Track.

2.17 Their ambition is to reduce their use of 130 inpatient beds by 50%: from 77 non-secure beds to 30 (a 60% reduction) and from 53 secure beds to 35 (a 34% reduction) by 2018/19. To re-provide this care they are creating intensive community support services with robust case management and discharge coordination across the area to enable individuals to receive care at home and improve their care experience.

2.18 Recognising that occasionally the needs of individuals can increase, they are also investing, this year, in six local crisis beds and an in-reach/outreach team providing safe short intensive support when needed.

2.19 Furthermore they are in the process of creating an innovative housing scheme that will ensure round-the-clock care for people with a learning disability and/or autism from early next year.

2.20 A cornerstone of the plan is their intention to retain and build the confidence of the staff, as well as families/carers, to improve quality of care in the community. To do this they intend to deliver a three year family and staff development programme.

2.21 In addition, to monitor the impact of the plan by March 2017 - as part of the wider Greater Manchester Public Sector Reform Programme - there will a formal evaluation assessing its impact over an 18 month period.

Lancashire

2.22 Similarly to Greater Manchester Fast Track, Lancashire uses a range of hospital providers but has a significant number of inpatients in Calderstones Partnership Foundation Trust.

2.23 Lancashire intends to reduce their reliance on non-secure beds by 70% and substantially reduce the numbers of people who come into contact with secure services. This high ambition will be achieved by focussing on putting in place high-quality individual packages of care and creating a hub and spoke community support model (expected to be fully operational by March 2018). They will develop:

- An integrated community learning disability team across the whole of Lancashire
- Crisis intervention and support services across the area
- A small number of community-based assessment and treatment services to prevent unnecessary out of area placements

2.24 To help with developing these services, Lancashire is rolling out a local engagement plan to ensure people impacted by these changes are fully involved in the building up of community capacity and shaping the services they use.

2.25 Their intention to retain staff to work in new models of care is a vital part of the plan. A comprehensive development programme will be rolled out this year, with two CCGs implementing Positive Behavioural Support (PBS) training and a scheme designed to offer rights-based training to improve access to mainstream health and social care services for people with a learning disability and/or autism.

2.26 Finally, in line with the national service model, they expect from April 2017 to reshape advocacy services across the region and develop a more robust model for delivering short break services.

- **Calderstones Partnership NHS Foundation Trust**

2.27 A key plank of the plans being developed in Lancashire and Greater Manchester will be to close and re-provide services offered by Calderstones Partnership NHS Foundation Trust.

2.28 Calderstones Partnership NHS Foundation Trust is the only remaining standalone learning disability hospital trust in England with 223 beds. They have initiated a collaboration with Mersey Care NHS Trust driven by an ambition to develop person-centred care, and sustainable services that stand the test of time, underpinned by a strong quality, clinical and financial case for fundamental changes in local secure mental health and learning disabilities care.

2.29 The plan is for Mersey Care NHS Trust to take over Calderstones Partnership NHS Foundation Trust, which from July 2016 will cease to exist.

2.30 The plans developed by Greater Manchester and Lancashire Fast Tracks with NHS England Specialised Commissioners, subject to consultation, will implement a new service model resulting in a substantial reduction of beds (>60% fewer than currently).

2.31 NHS England will also cease commissioning secure services on the Calderstones site.

2.32 All hospital beds on the current Calderstones site will therefore, subject to consultation, close and be re-provided over the next three years on a case by case basis for each patient, in the community or in new state of the art units elsewhere in the North West, and the Calderstones site will close.

2.33 Ongoing consultation and engagement with people with learning disabilities, their families and carers will be central to the process of change and the commissioners and providers involved are committed to ensuring that patients and families are always involved in decisions about their care and support.

2.34 Calderstones Partnership NHS Foundation Trust and Mersey Care NHS Trust have appointed a joint Medical Director to provide clinical leadership in the process of bringing these two organisations together. The post holder will help sustain and build world class leaders and staff, enabling them to be part of the future.

2.35 The trusts are already focussing on a range of joint quality initiatives with staff to improve quality and increase efficiency - for instance, they have initiated an international collaboration with Stanford Risk Authority (Stanford University) to manage risk and learn lessons in a way that has never been undertaken in the NHS.

Cumbria and the North East

2.36 Compared to the rest of the country, Cumbria and the North East have more individuals with a learning disability registered on GP registers and a higher usage of inpatient services (255 inpatient beds) mainly making use of two key hospital trusts – Northumberland, Tyne and Wear Foundation Trust and Tees Esk and Wear Valleys Foundation Trust.

2.37 These beds are a collection of secure and non-secure beds and are occupied not only by people from the area, but from across the country. Cumbria and North East aim to deliver a 52% reduction (76 beds) in non-secure beds and a 43% reduction (47 beds) in low secure beds. Commissioning action is already underway to facilitate this reduction, with 40 beds being empty at time of publication.

2.38 Building on service improvements in physical health, Cumbria and the North East are creating a single set of standards to incorporate into contracts used locally. Each local authority and CCG is developing and building community capacity, including in 2015/16 new investment in:

- Services to support people with attention deficit hyperactivity disorder and autism across Northumberland, and Tyne and Wear
- Advocacy services
- Carers support

2.39 Localities are also testing new approaches to improving quality. For example, in Newcastle an innovative housing initiative, developed through collaboration between social care providers and an NHS provider, is providing preventative care and treatment to improve the quality of support people with a learning disability and/or autism experience and to avoid unnecessary admissions.

2.40 A central plank to the plan is to retain staff to work in new models of care, and develop and up skill the workforce. For instance, working with Northumbria University and local clinicians they intend to implement a National Vocational Qualification (NVQ) based on PBS training for staff.

Hertfordshire

2.41 For several years Hertfordshire CCGs have been working with Hertfordshire Partnership Trust, Hertfordshire County Council and others to modernise services for people with a learning disability and/or autism, and they have already successfully closed many assessment and treatment beds across the area. But they believe they should go further.

2.42 Their ambition is now to bring adult and children's services together into a dedicated integrated service. This will include a single point of access that will empower service users of all ages to access help, support and appropriate treatment in the community. This model will be consulted on before the end of the year.

2.43 By 2018/19 they expect to reduce their usage of low-secure beds by over 30%, and to reduce length of stay in assessment and treatment beds to an average of 85 days.

2.44 Furthermore, they are establishing an evaluation partnership with Hertfordshire University to test a number of prevention and early discharge services for individuals who have been in contact with the criminal justice system. This includes a strengthened community forensic team to enable faster supported discharge and greater use of community restriction orders, and a Circles Project to deliver community support to people with a learning disability and/or autism who are deemed to be at high risk of sexual offending.

2.45 Recognising that individuals' needs can increase, a number of innovative crisis intervention pilots will be commissioned and evaluated from 2015/16, namely:

- A hosted family crisis support pilot which will provide intensive home support during crisis periods
- A 'crash pad' pilot providing short term accommodation for people who need crisis intervention in situations where there has been a placement breakdown or termination of tenancy

2.46 Finally, Hertfordshire has already begun work to pilot the implementation of integrated personal health budgets, which will start to be introduced from April 2016.

Nottinghamshire

2.47 Nottinghamshire intends to reduce its reliance on non-secure services from 40 occupied beds to 15 (a 63% reduction) and almost halve its usage of low and medium secure beds from 34 to 16 (a 56% reduction). Nottinghamshire now has 65 people in inpatient care in NHS trusts and the independent sector.

2.48 Nottinghamshire's plan has individual rights at its centre and an immediate priority is to commission an increase in advocacy for people during care and treatment reviews. Early plans also include strengthening their existing community learning disability and intensive care and treatment teams, as well as risk registers, so they can confidently support individuals who are at risk of coming into contact with the criminal justice system and subsequent admission to hospital.

2.49 Recognising that confidence of staff and families is paramount to helping individuals stay at home, families will be offered evidence-based parenting training as well as practical and emotional support locally. In addition, to retain and up skill staff to deliver the new care model workforce training will be undertaken to ensure staff have a consistent understanding and approach to working with people who display behaviour that challenges which enables individuals to remain in the least restrictive setting.

2.50 Next year, they will expand their personal health budget offer and tackle gaps in the accessibility of mainstream services. As the needs of individuals can increase, new crisis accommodation will be established as well as new pioneering housing options for people with complex behaviours and those in contact with the criminal justice system as they are discharged from hospital.

2.51 Nottinghamshire will start to pool budgets for crisis care from April 2016 and work towards further alignment and pooling arrangements from April 2017.

2.52 Finally, across Nottinghamshire there are a high number of local inpatient beds (199), many of which are not used by local commissioners. The Fast Track has recognised that the longer term plan of this economy will require strong partnerships with other commissioners across the country.

Arden, Herefordshire and Worcestershire

2.53 Commissioners in Arden, Herefordshire and Worcestershire have been driving forward improvements in learning disabilities for several years and have agreed strategies for improving both physical and mental health and been steadily reducing reliance on hospital beds. They now have 47 people in inpatient care, mainly in Coventry and Warwickshire NHS Trust.

2.54 It is expected that across the area they will reduce the number of beds used by inpatients to 14. This means reducing their usage of non-secure beds from 19 to 3 (an 85% reduction), and of secure beds from 21 to 11 (a 48% reduction). They also intend to reduce their usage of child and adolescent mental health service (CAMHS) beds by children with a learning disability and/or autism by seven.

2.55 These closures are expected to start this year, with a nine-bed assessment and treatment ward shutting (subject to appropriate local consultation).

2.56 Their intention is to redeploy staff working in that unit to new community services, and having learnt from the experience and undertaken appropriate consultation, to apply the learning to other sites.

2.57 In addition, the area plans to develop by November 2015:

- An admission avoidance scheme in Coventry and Warwickshire NHS Trust
- A short-term accommodation for people who need support when a placement breaks down or, for example, if a tenancy breaks down

2.58 Throughout the rest of the year, across Arden, Herefordshire and Worcestershire the aim is to create intensive community support teams which will work with existing mental health crisis teams to provide comprehensive crisis care 24/7. To facilitate this they plan to have a liaison nurse who will work to improve support and the interface between learning disability and wider mental health services.

2.59 From April 2016 a community forensic service will be commissioned to support people to be discharged who are currently out of area and enhance the support locally to avoid future admissions. The aim is to then review the coverage and plan for further closures in 2017/18.

2.60 Finally, Coventry and Warwick Partnership Trust are commissioned by other West Midlands commissioners. The Arden, Hereford and Worcestershire Fast Track is exploring strategic alliances with them to spread learning and support change.

Figure 5: Projected bed usage rates across fast track sites (inpatients per million population)[10]

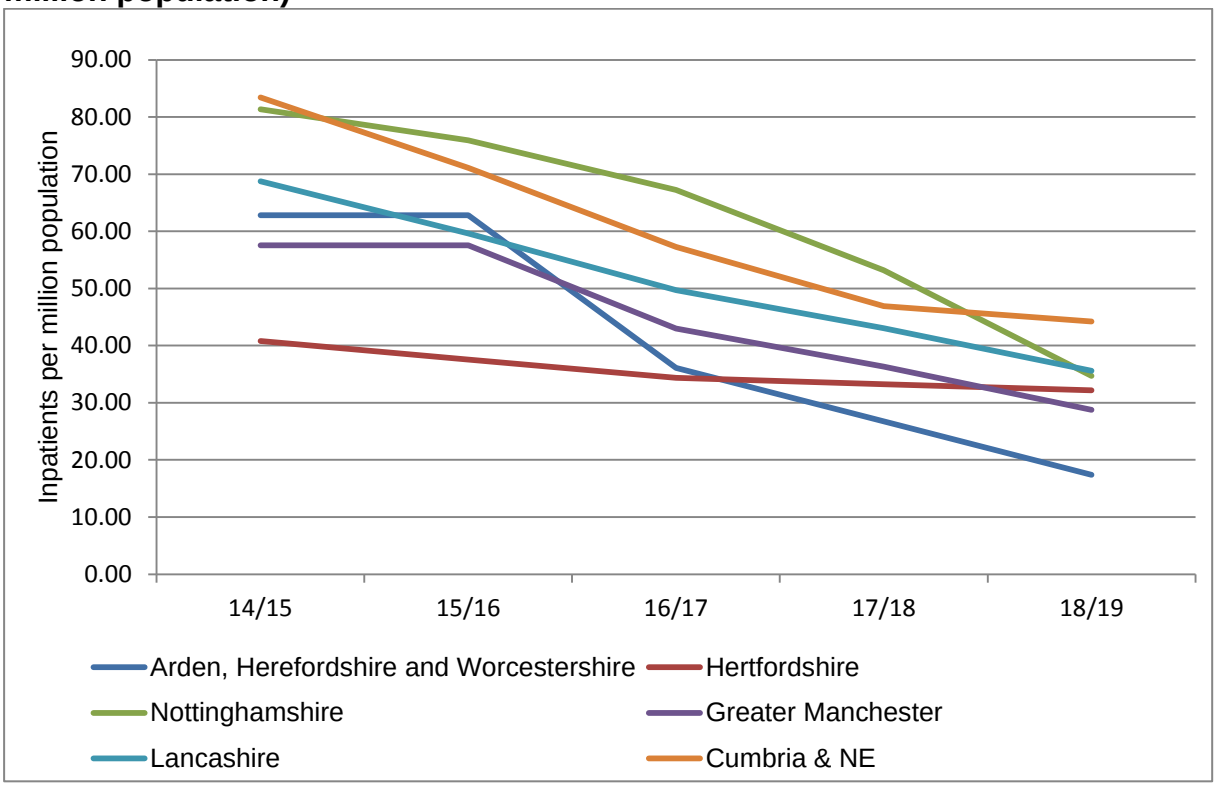
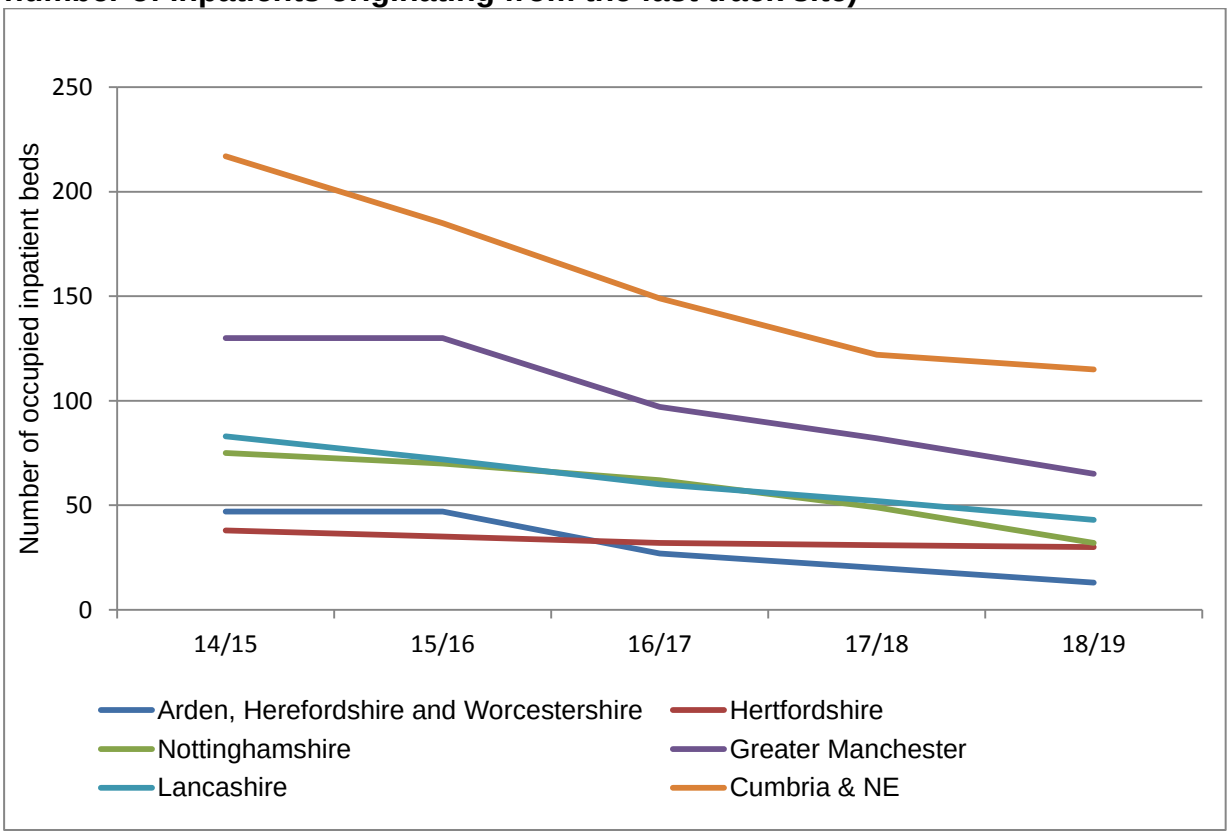


Figure 6: Projected *total* bed usage across fast tracks (chart shows projected number of inpatients originating from the fast track site)[11]



[10] See Annex C for further notes on the data used in these charts
[11] See Annex C for further notes on the data used in these charts

Figure 7: Projected usage of *NHS England*-commissioned beds across fast tracks (chart shows projected number of inpatients originating from the fast track site)[12]

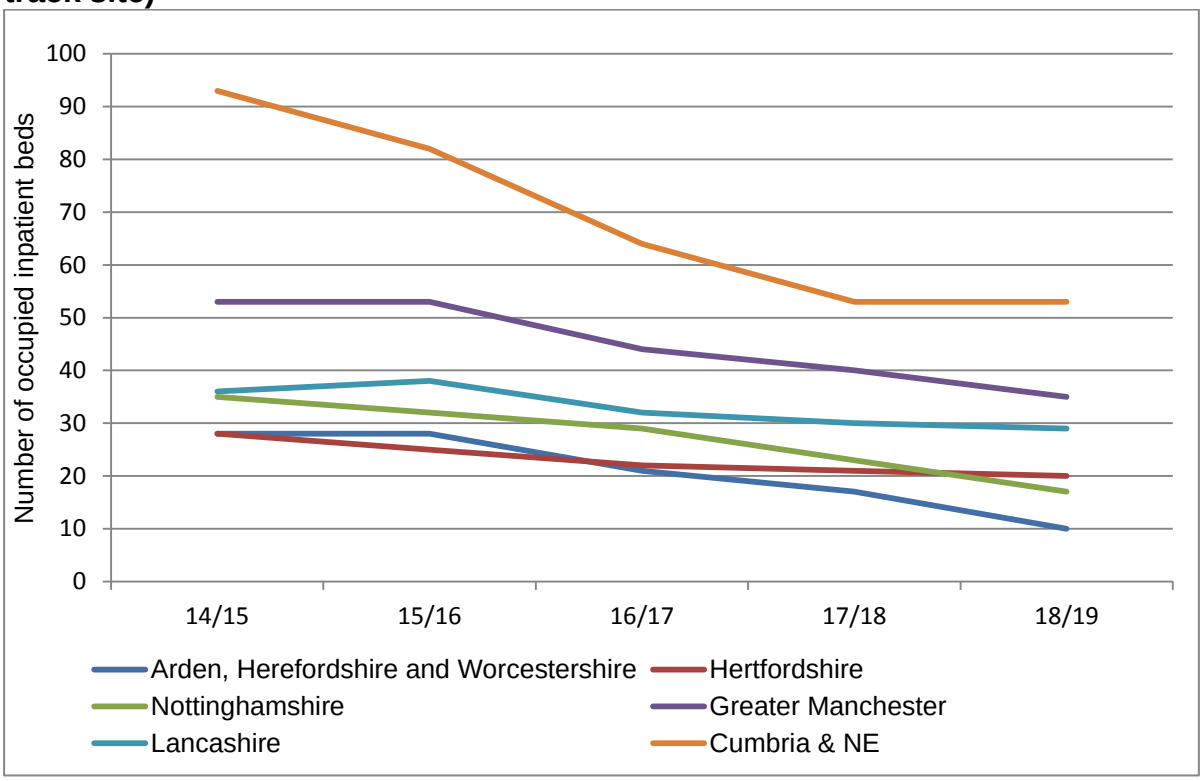
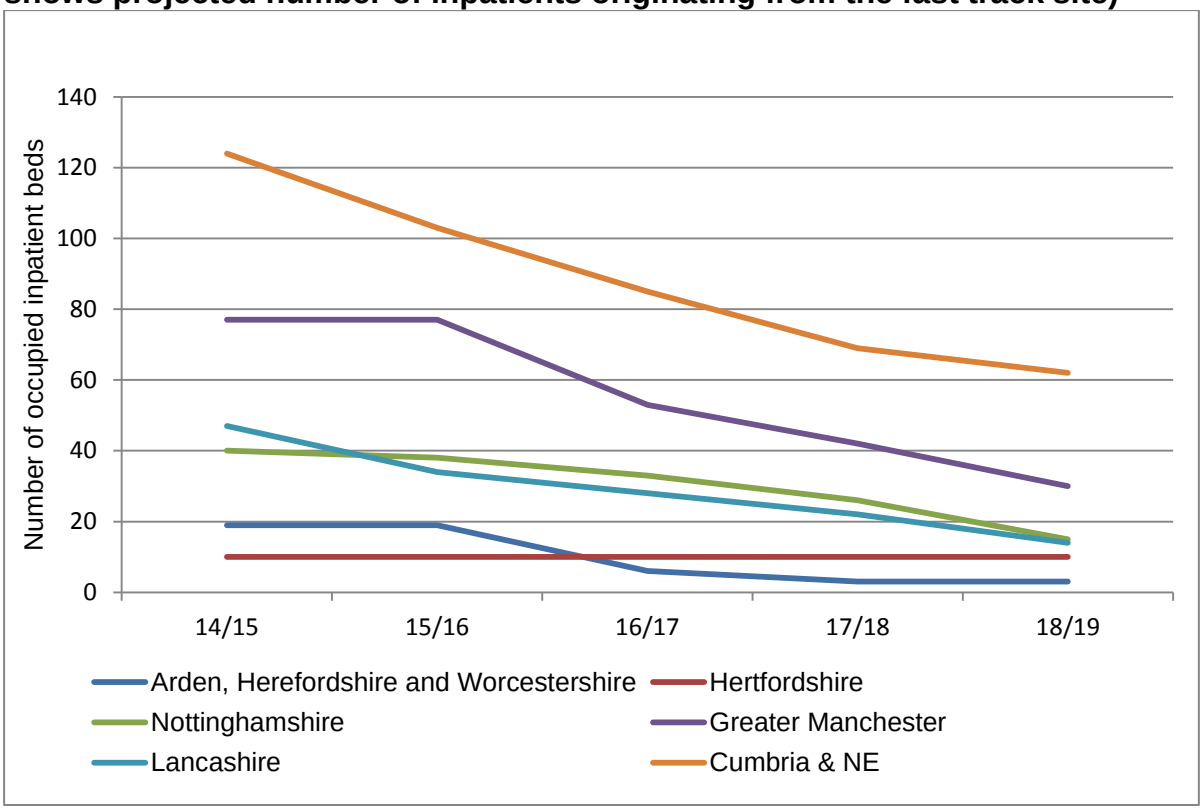


Figure 8: Projected usage of *CCG-commissioned* beds across fast tracks (chart shows projected number of inpatients originating from the fast track site)[13]



[12] See Annex C for further notes on the data used in these charts
[13] See Annex C for further notes on the data used in these charts

2.61 The action outlined above represent just the start of what the fast tracks will do, and as their plans develop and community services mature we expect the bed reduction trajectories set out in their plans to translate into further closure of individual wards and units. As the fast track areas start to implement their ambitious plans for change, NHS England, LGA and ADASS will draw on our experience of working with them to support the rest of the country to build new community services and close inpatient provision that is no longer needed. The rest of this plan sets out how these new services should look, and how we plan to work together to deliver them.

3. The new services we need

3.1 People with a learning disability and/or autism have the right to the same opportunities as anyone else to live satisfying and valued lives and to be treated with dignity and respect. They should expect, as people without a learning disability or autism expect, to live in their own homes, to develop and maintain positive relationships and to get the support they need to be healthy, safe and an active part of society.

3.2 As Professor Jim Mansell highlighted in 1993 and in 2007, however, too rarely do people receive this type of personalised support across their whole life. In turn, many of the behaviours services label as challenging could be prevented from developing if the right support were made available to people and their families or carers when they needed it.

3.3 The changes to services we plan to make are intended to put that right.

Improving services for a heterogeneous group

3.4 People with a learning disability and/or autism who display behaviour that challenges are a highly heterogeneous group. The task of reshaping services will reflect that diversity.

3.5 For people who have been in inpatient settings for a very long period of time, the task facing commissioners will be to resettle those individuals into the community and close the hospital beds behind them. This will include a number of people who will have been in hospital for many years, in some cases having not been discharged when NHS campuses or long-stay hospitals were closed. It is the group of people for whom hospital has effectively become a permanent home, and for whom the task now is to find them a more appropriate home in the community, with the right package of health and care support around them. This is the group who will likely be eligible for NHS-funded dowries when they are ready to be discharged, to help fund their new package of care in the community (see chapter 4 for more detail on how these ‘dowries’ will work).

3.6 Approximately a third of the people currently in hospital have been in inpatient settings for five years or longer. Whilst hospital may be the right place for some of this group (for clinical reasons often combined with Ministry of Justice restrictions), Care and Treatment Reviews have already identified transfer/discharge dates over the coming three years for just under 40% of the individuals concerned, and we would expect that number to rise as we build the right set of services in the community.

3.7 In the main, however, the challenge facing commissioners is as much about preventing new admissions and reducing the time people spend in inpatient care by providing alternative care and support, as it is about discharging those individuals currently in hospital. The task requires: advocacy, early intervention, prevention, ensuring the right set of services are available in the community.

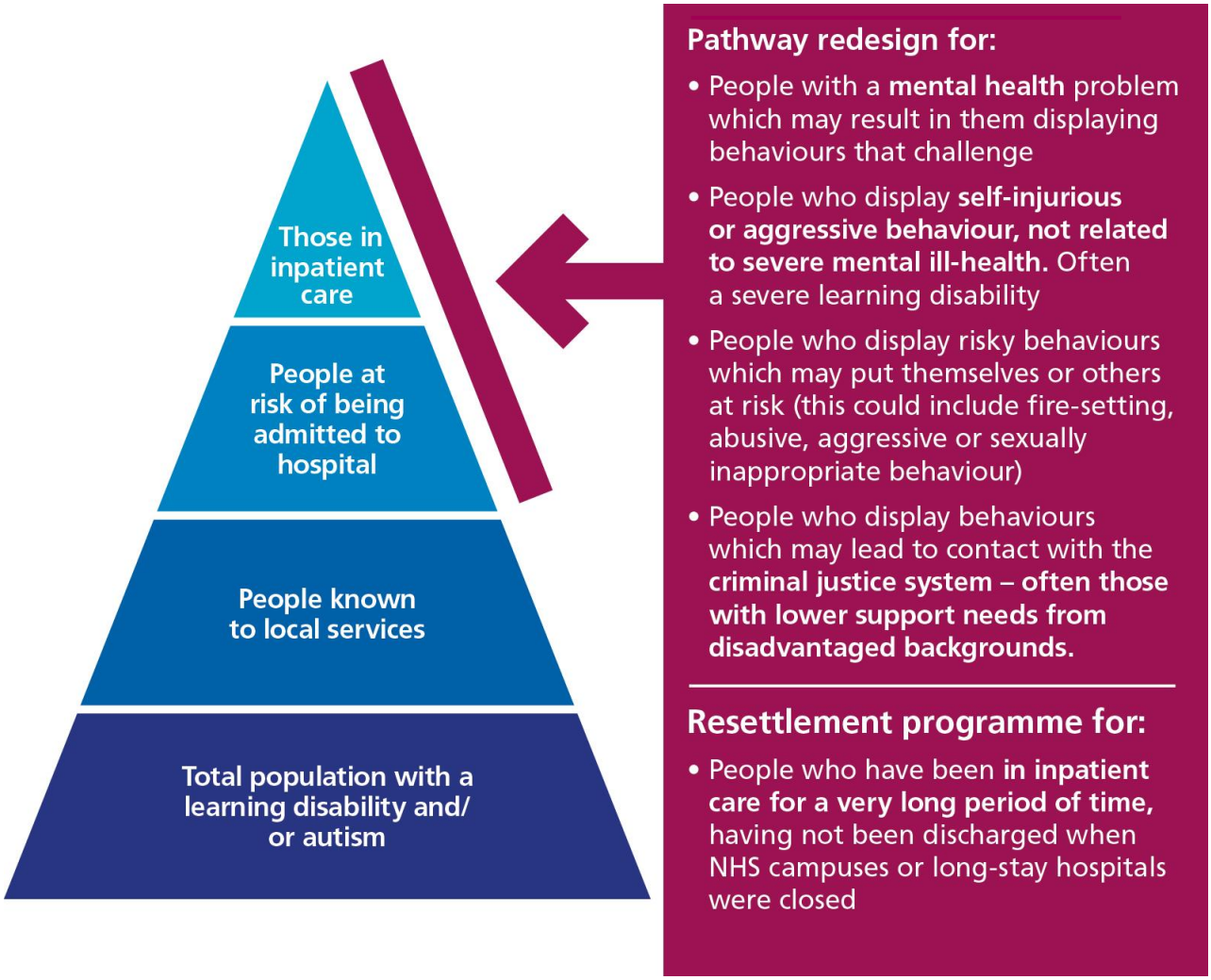
3.8 In many cases, it will involve close collaboration not just between the NHS and social care, but also with parts of the criminal justice system, building on recent joint work between NHS England and the Ministry of Justice to facilitate discharges of patients subject to restriction orders - currently more than one in five of the people in hospital settings have been detained on part III of the Mental Health Act with a Ministry of Justice restriction.

3.9 Transformation will mean redesigning services to better meet a range of common sets of needs. For instance, it will mean better serving children, young people or adults with a learning disability and/or autism who:

- Have a mental health condition such as severe anxiety, depression, or a psychotic illness, and those people with personality disorders, which may result in them displaying behaviour that challenges
- Display self-injurious or aggressive behaviour (not related to severe mental ill health), some of whom will have a specific neuro-developmental syndrome where there may be an increased likelihood of developing behaviour that challenges
- Display risky behaviours which may put themselves or others at risk and which could lead to contact with the criminal justice system (this could include things like fire-setting, abusive or aggressive or sexually inappropriate behaviour)
- Often have lower level support needs and who may not traditionally be known to health and social care services, from disadvantaged backgrounds (e.g. social disadvantage, substance abuse, troubled family backgrounds) who display behaviour that challenges, including behaviours which may lead to contact with the criminal justice system

3.10 The different kinds of shift in service response required to better meet these different needs are set out in more detail in a national service model for commissioners of health and social care services, developed with the support of a group of independent experts, including people with lived experience of services, and published alongside this document.

Figure 9: People for whom we need new services



The service model

3.11 Each local area is different. Local populations have different needs, and their range of providers have different strengths and weaknesses. The mix of services they put in place will need to reflect that diversity. However, there does need to be some national consistency in what services look like across local areas, based on established best practice.

3.12 The national service model, developed with the support of people with learning disability and/or autism, as well as families/carers, and a group of independent experts and published alongside this document, sets out how services should support people with a learning disability and/or autism who display behaviour that challenges.

The National Service Model

1. People should be supported to have a **good and meaningful everyday life** - through access to activities and services such as early years services, education, employment, social and sports/leisure; and support to develop and maintain good relationships.

2. Care and support should be **person-centred, planned, proactive and coordinated** – with early intervention and preventative support based on sophisticated risk stratification of the local population, person-centred care and support plans, and local care and support navigators/keyworkers to coordinate services set out in the care and support plan.

3. People should have **choice and control** over how their health and care needs are met – with information about care and support in formats people can understand, the expansion of personal budgets, personal health budgets and integrated personal budgets, and strong independent advocacy.

4. People with a learning disability and/or autism should be supported to live in the community with **support from and for their families/carers as well as paid support and care staff** – with training made available for families/carers, support and respite for families/carers, alternative short term accommodation for people to use briefly in a time of crisis, and paid care and support staff trained and experienced in supporting people who display behaviour that challenges.

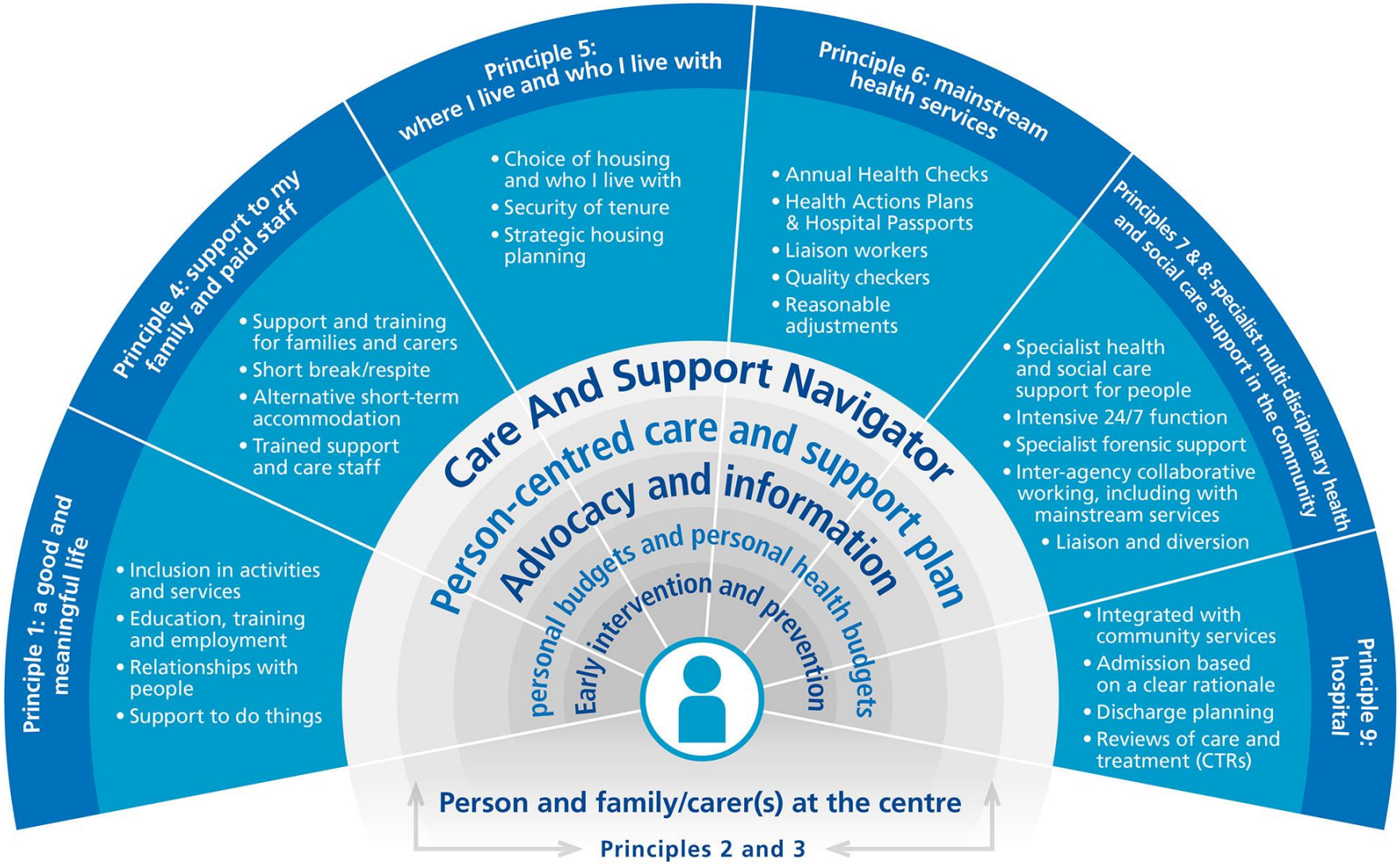
5. People should have a choice about where and with whom they live – with a choice of **housing** including small-scale supported living, and the offer of settled accommodation.

6. People should get good care and support from **mainstream NHS services,** using NICE guidelines and quality standards – with Annual Health Checks for all those over the age of 14, Health Action Plans, Hospital Passports where appropriate, liaison workers in universal services to help them meet the needs of patients with a learning disability and/or autism, and schemes to ensure universal services are meeting the needs of people with a learning disability and/or autism (such as quality checker schemes and use of the Green Light Toolkit).

7. People with a learning disability and/or autism should be able to access **specialist health and social care support in the community** – via integrated specialist multi-disciplinary health and social care teams, with that support available on an intensive 24/7 basis when necessary.

8. When necessary, people should be able to get **support to stay out of trouble** – with reasonable adjustments made to universal services aimed at reducing or preventing anti-social or 'offending' behaviour, liaison and diversion schemes in the criminal justice system, and a community forensic health and care function to support people who may pose a risk to others in the community.

9. When necessary, when their health needs cannot be met in the community, they should be able to access high-quality assessment and treatment in a **hospital** setting, staying no longer than they need to, with pre-admission checks to ensure hospital care is the right solution and discharge planning starting from the point of admission or before.



Service Model

Commissioners understand their local population now and in the future

Reduced need for inpatient services

3.13 With the right set of services in place in the community, the need for inpatient care will significantly reduce, and commissioners will need to have in place far less hospital capacity.

3.14 We will support local commissioners to plan exactly what inpatient capacity they do need, starting with a set of national planning assumptions. Those planning assumptions are that by March 2019, no area should need more inpatient capacity than is necessary at any one time to cater to:

- 10-15 inpatients in CCG-commissioned beds (such as those in assessment and treatment units) per million population
- 20-25 inpatients in NHS England-commissioned beds (such as those in low-, medium- or high-secure units) per million population

3.15 In some local areas, use of beds will be lower than these planning assumptions, and we will encourage those local areas to see if they can go still further in supporting people out of hospital settings above and beyond the these initial planning assumptions.

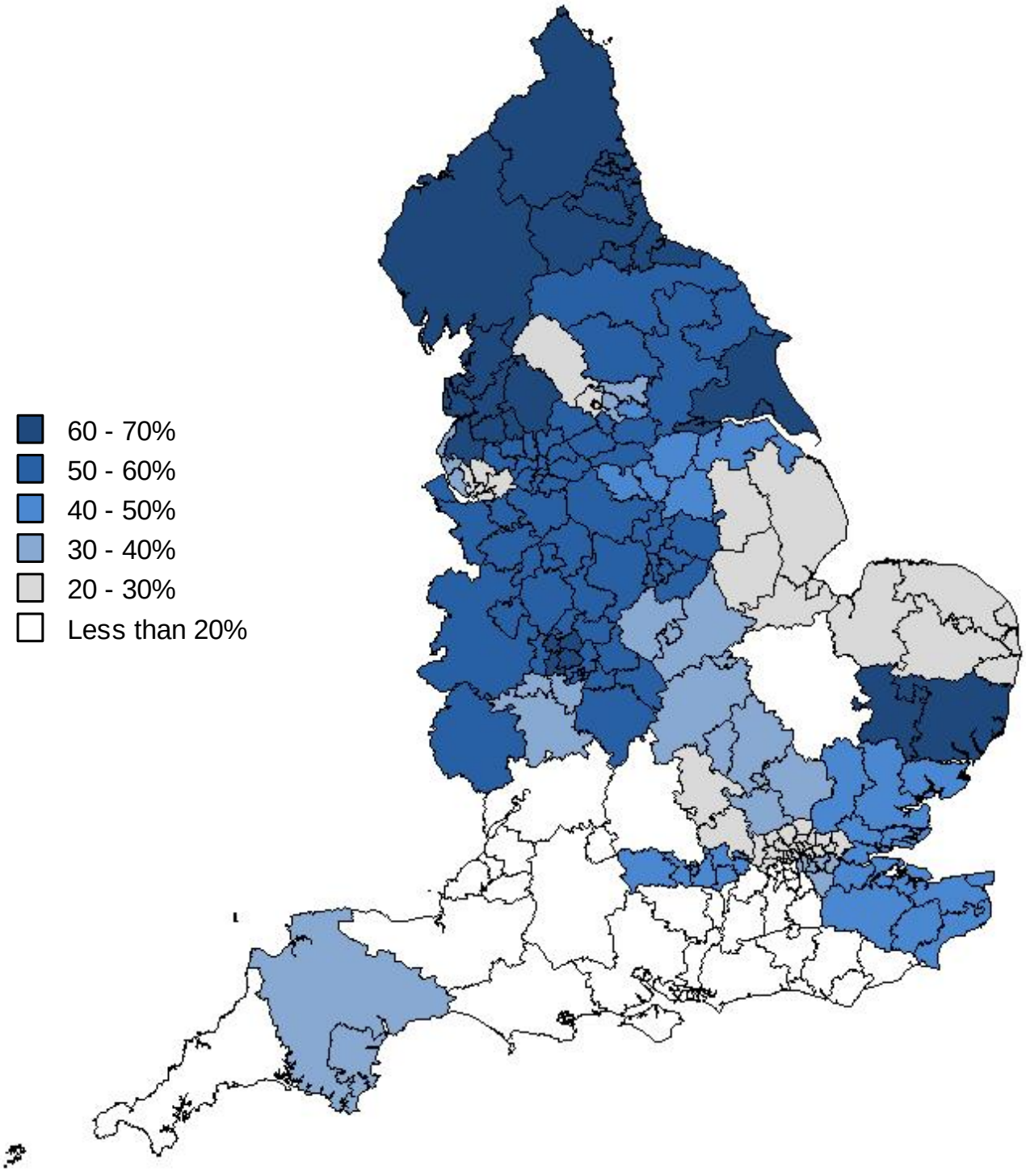
3.16 These planning assumptions are based on what fast track areas have told us they believe is possible, 'sense-checked' against current geographical variation in usage of inpatient services (see figures 2 and 3 below).

3.17 These planning assumptions (10-15 inpatients in CCG-commissioned beds per million population; 20-25 inpatients in NHS England-commissioned beds per million population) would translate to closing, at a minimum:

- 45-65% of CCG-commissioned inpatient capacity (such as assessment and treatment units)
- 25-40% of NHS-England- commissioned inpatient capacity (such as secure services, where we expect the bulk of change to occur in low-secure provision)

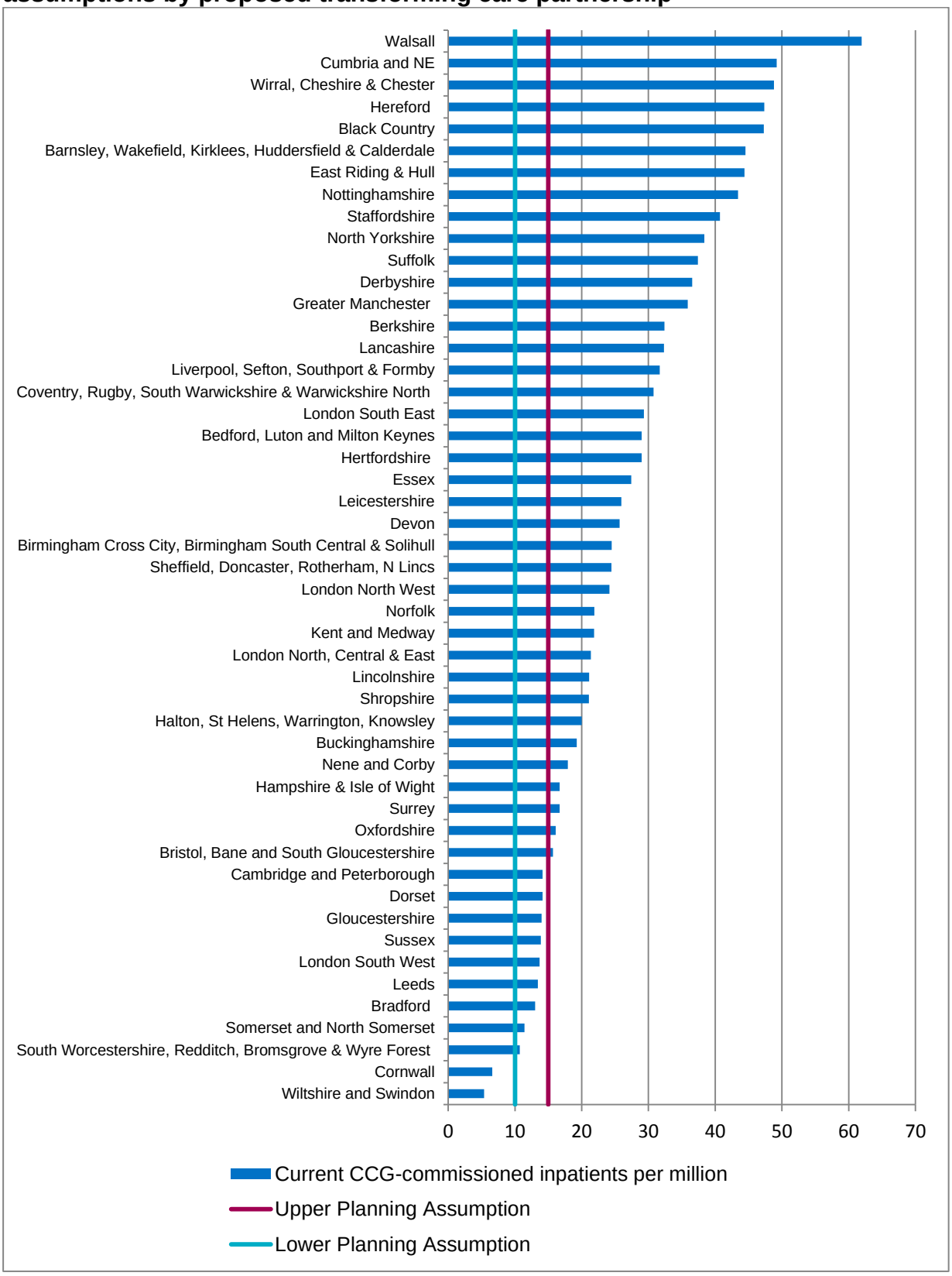
3.18 Taken together, that means closing, at a minimum, between 35% - 50% of inpatient provision nationally. In some areas more reliant on hospital care the change will be even more significant, as the following map and charts illustrate.

Figure 10: Reduction in bed usage (%) implied by national planning assumptions, by proposed transforming care partnerships[14]



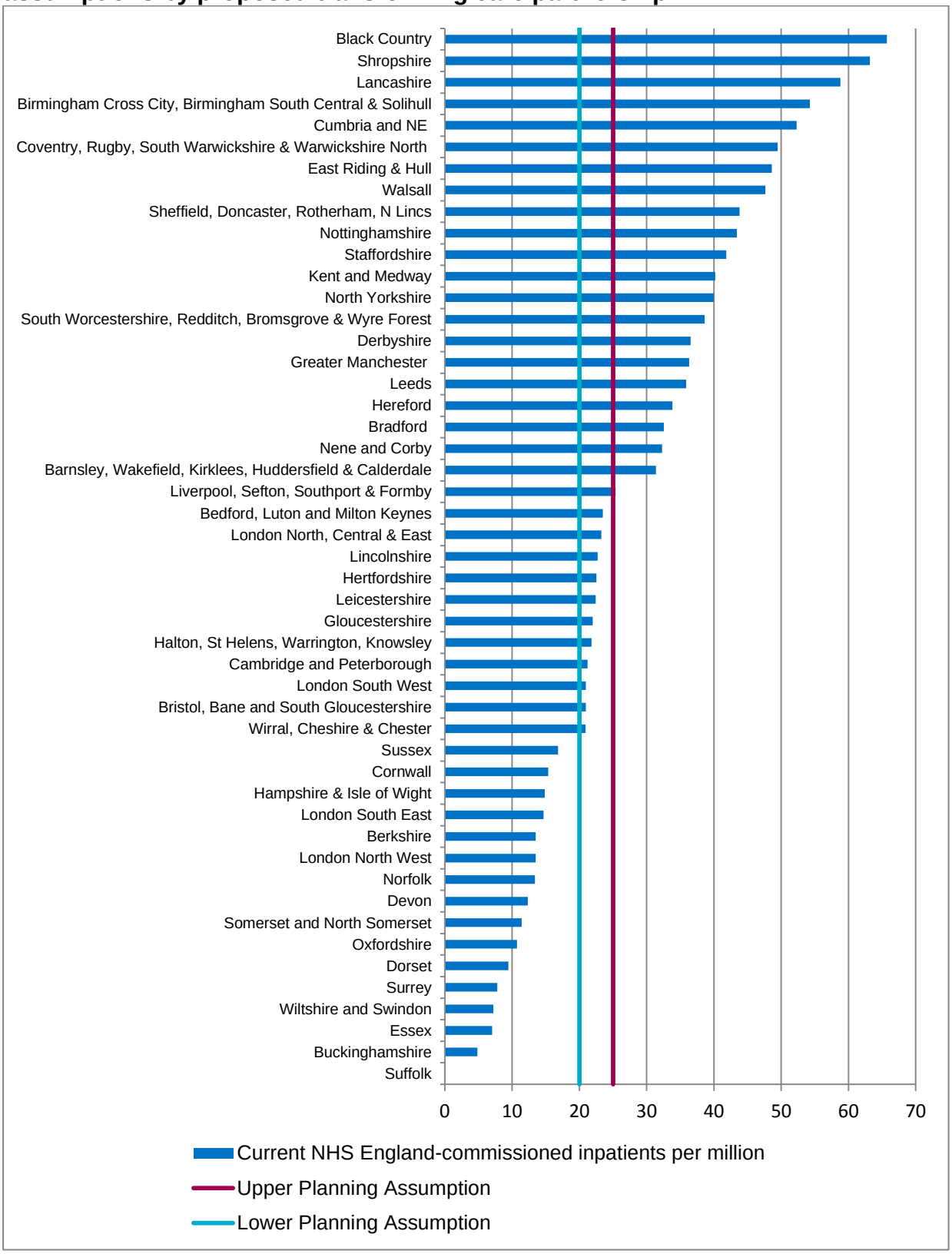
[14] Upper and lower planning assumptions have been applied to current inpatient rates at a transforming care partnership level. The map shows the % reduction in inpatient numbers represented by the midpoint between the projected upper and lower rates for each partnership. See Annex C for further notes on the data used in these charts

Figure 11: Geographical variation in reliance on *CCG-commissioned* inpatient services (as at 31 July 2015), shown against new national planning assumptions by proposed transforming care partnership[15]



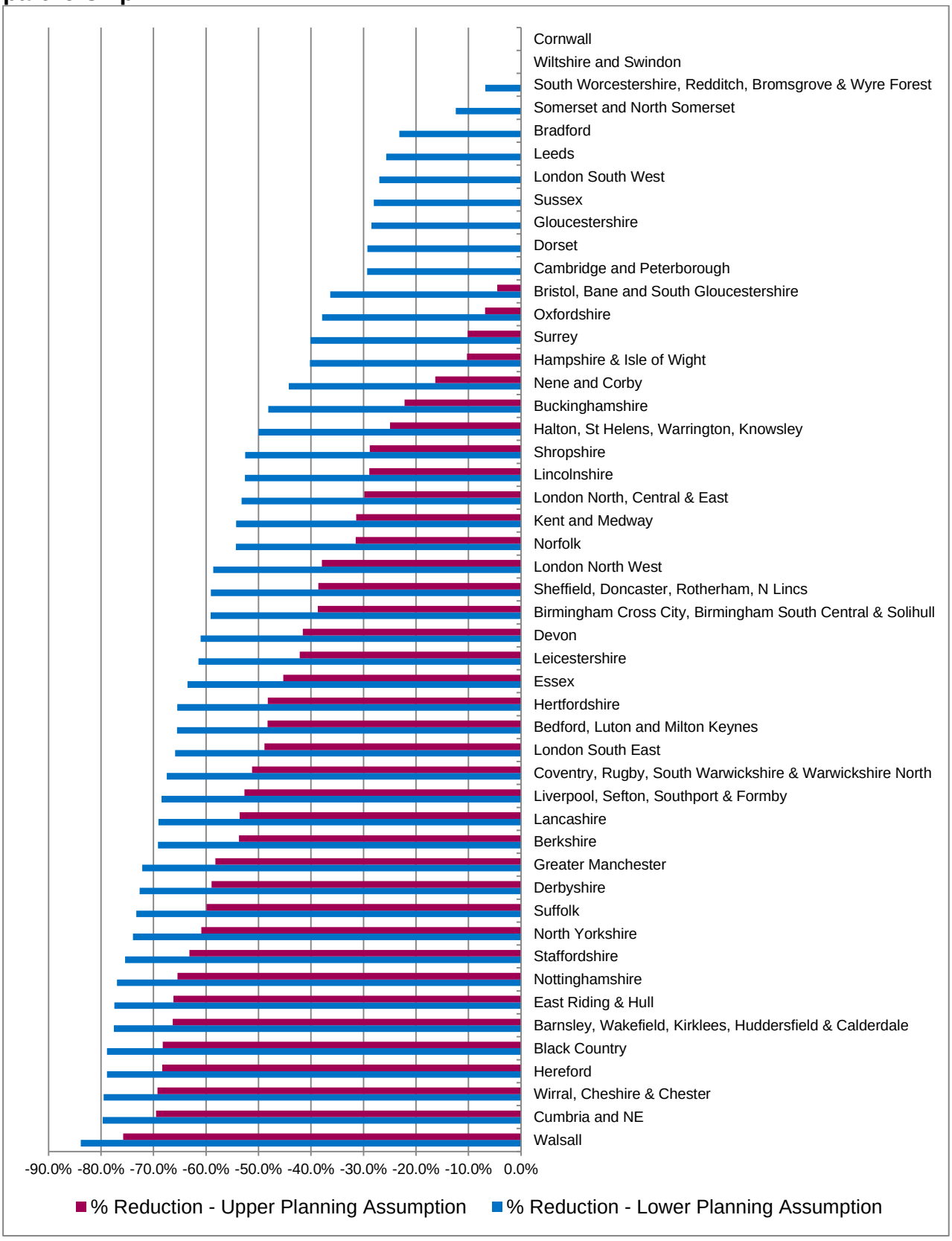
[15] See Annex C for further notes on the data used in these charts

Figure 12: Geographical variation in reliance on *NHS England-commissioned* inpatient services (as at 31 July 2015), shown against new national planning assumptions by proposed transforming care partnership[16]



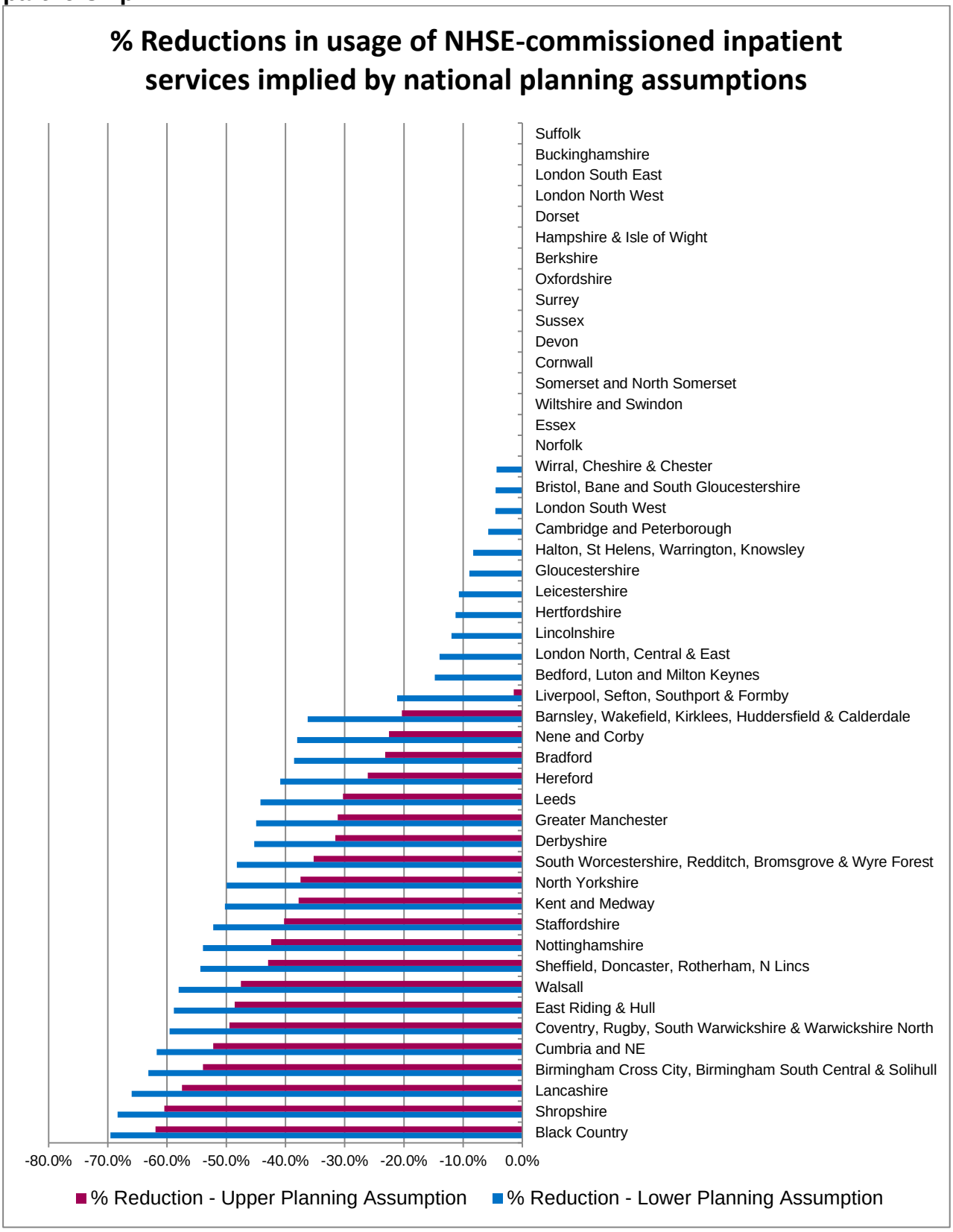
[16] See Annex C for further notes on the data used in these charts

Figure 13: Reductions in usage (%) of *CCG-commissioned* inpatient services implied by national planning assumptions by proposed transforming care partnership[17]



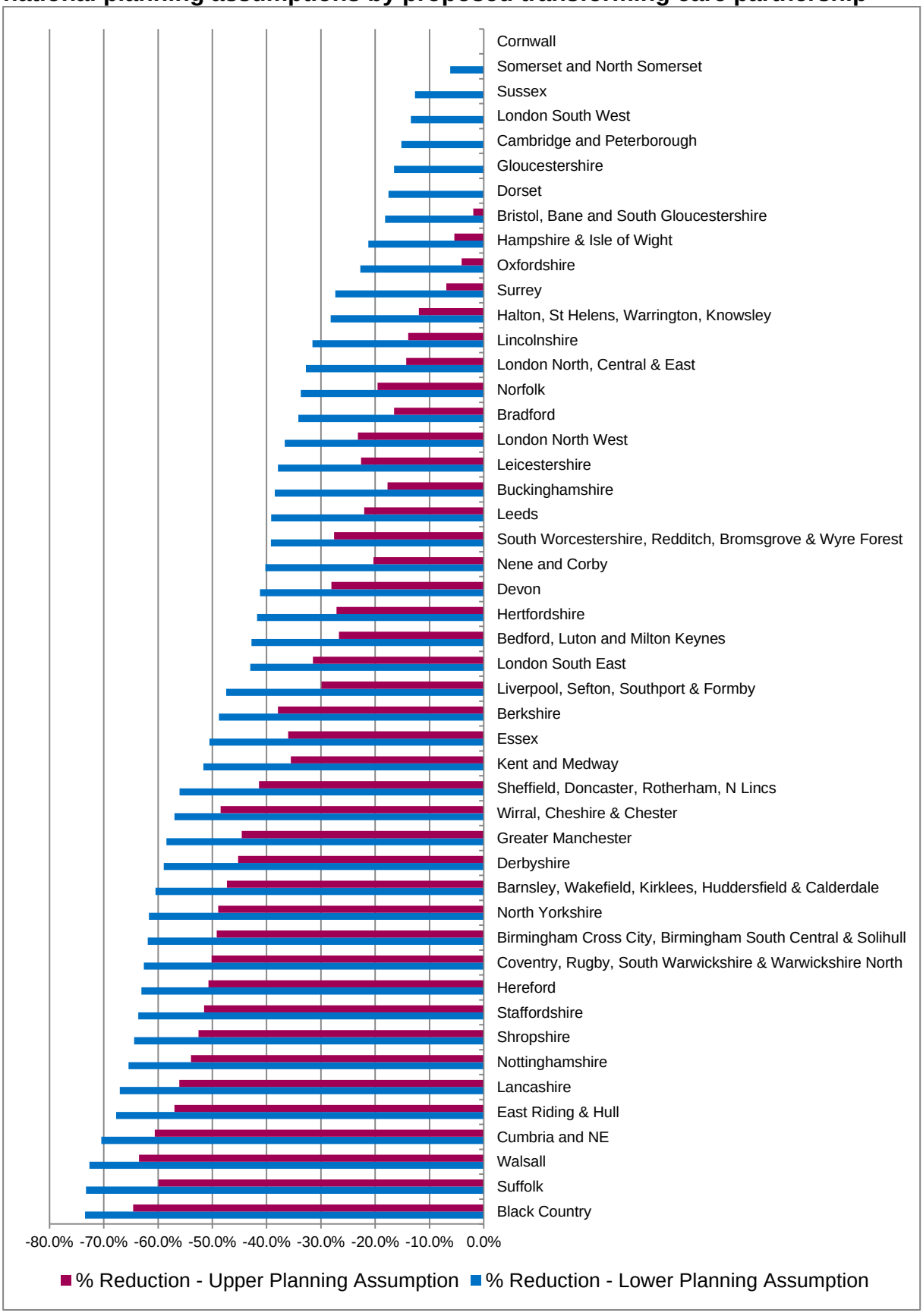
[17] See Annex C for further notes on the data used in these charts

Figure 14: Reductions in usage (%) of *NHS England-commissioned* inpatient services implied by national planning assumptions by transforming care partnership[18]



[18] See Annex C for further notes on the data used in these charts

Figure 15: Reductions in *total* usage (%) of inpatient services implied by national planning assumptions by proposed transforming care partnership[19]



[19] See Annex C for further notes on the data used in these charts

3.19 These national planning assumptions should be seen as articulating a minimum ambition for the coming three years - not a target that, once met, renders the task complete.

3.20 These assumptions are exactly what the term implies – assumptions for local commissioners to use as they enter into a detailed process of planning. Local planning needs to be creative and ambitious based on a strong understanding of the needs and aspirations of people with a learning disability and/or autism, their families and carers, and on expert advice from clinicians, providers and others. The starting point for service planning should be to think creatively about what support would help people to live the best possible life, as opposed to making marginal change to the set of services we have currently – and we will support people with lived experience, clinicians, providers and other experts to work with commissioners and help them think ambitiously and creatively in that way.

3.21 In parallel to these planning assumptions, for the inpatient provision that remains we will work with clinicians, providers and commissioners to reduce the period of time that people spend in hospital, building on and spreading best practice – for instance, Hertfordshire's fast track plan aims to help reduce length of stay in assessment and treatment services to an average of 85 days. We will also use Care and Treatment Reviews (CTRs) to this end: if someone is still in hospital after six months a mandatory CTR will take place, and people in hospital will also have a right to request a CTR.

3.22 The planning assumptions articulated here should not be seen as describing an 'end state' after which services can be set in aspic. We will always want to improve the services and support we make available to people with a learning disability and/or autism. So before the end of 2018, having built up community support and closed hundreds of beds, we will take stock and look at going further with the development of community support and the closure of inpatient services.

3.23 The immediate task now, however, is to start delivering the ambitious changes set out above. What follows is our plan for doing that.

4. Working together to provide new services

Transforming care partnerships

4.1 To deliver the change outlined in the previous chapter, and following what we have learned from the fast tracks, NHS commissioners, in discussion with local government, are mobilising transforming care partnerships – collaborations of CCGs, local authorities and NHS England specialised commissioners.

4.2 Currently the approach to commissioning services for people with a learning disability and/or autism is fractured, with responsibility split between local authorities, CCGs and NHS England. It can be difficult to move funding from one agency to another, to enable the commissioning of less inpatient care and more preventative, community-based services and support. Furthermore, many CCGs will be commissioning for a small number of people with a learning disability and/or autism, making it difficult to take a strategic approach to changing services across the system. Hospitals caring for this group of patients will often be commissioned by a large number of CCGs and NHS England, so that it is difficult for one commissioner to work with those providers to change the services they offer.

4.3 The new transforming care partnerships, currently mobilising, are intended to help address these weaknesses in commissioning arrangements. They will bring together the commissioners responsible for funding health and social care for people with a learning disability and/or autism (CCGs, local authorities with their responsibilities for care and housing, NHS England specialised commissioning), with their budgets aligned or pooled as appropriate. Figure 16 below and Annex A set out further details on how CCGs propose to cluster together in order to work with local authorities and NHS England specialised commissioning hubs in these new partnerships. We expect all CCGs in England to have finished these arrangements by December 2015.

4.4 Transforming care partnerships will be supported to work alongside people who have experience using these services, as well as their families/carers, clinicians, providers and other stakeholders to formulate and implement **joint transformation plans** – closing some inpatient provision and shifting investment into support in the community.

4.5 They will bring commissioners together at a scale larger than most CCGs and many local authorities, with their geographical footprint based on:

- Building where possible on existing collaborative commissioning arrangements (e.g. joint purchasing arrangements amongst CCGs, joint commissioning arrangements between CCGs and local authorities)
- Local health economies of services for people with a learning disability and/or autism (e.g. patient flows, the provider landscape, and relationships between commissioners and providers). Where, for instance, a number of CCGs tend to use the same hospital provider for inpatient services for

people with a learning disability and/or autism, it makes sense for those CCGs to implement change collaboratively
- Commissioning at sufficient scale to manage risk, develop commissioning expertise and commission strategically for a relatively small number of individuals whose packages of care can be very expensive

The challenge

4.6 Each Transforming Care Partnership will be supported to improve outcomes for people with a learning disability and/or autism – both those currently in inpatient services (of whom there are approximately 2,600 nationally) and those in the community at risk of being admitted to hospital without the right support (of whom there are an estimated 24,000 nationally[20]).

4.7 We will support local transforming care partnerships to make progress on three outcomes:

- Reduced reliance on inpatient services (closing hospital services and strengthening support in the community)
- Improved quality of life for people in inpatient and community settings
- Improved quality of care for people in inpatient and community settings

4.8 People with a learning disability and/or autism as well as their families/carers should be supported to co-produce these plans. The change we need to see is as much about a shift in power as it is about service reconfiguration, and that should be reflected not just in the new services and support put in place (where for instance the national service model calls for the expansion of personal health budgets and high-quality independent advocacy), but in the way service changes are planned and delivered.

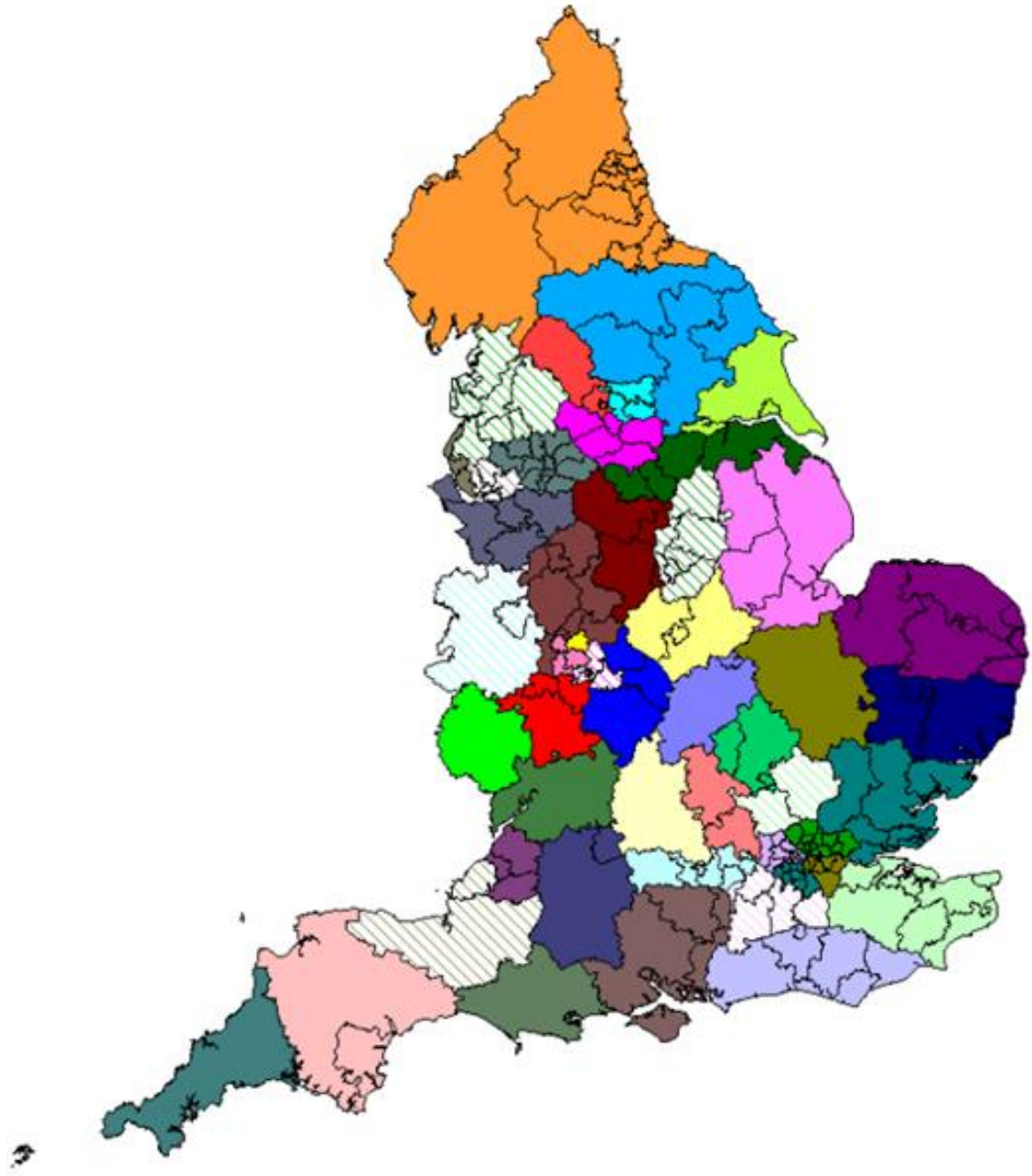
4.9 We will expect transforming care partnerships to tailor their approach based on local context, but in a way that is consistent with national parameters - in particular, the national service model and minimum planning assumptions on inpatient capacity outlined in chapter 3.

4.10 This work will also need to align with a number of other national priorities, such as:

- Local Transformation Plans for Children and Young People's Health and Wellbeing
- Local action plans under the Mental Health Crisis Concordat
- The 'local offer' for personal health budgets, and Integrated Personal Commissioning (combining health and social care)
- Work to implement the Autism Act 2009 and recently refreshed statutory guidance
- The roll out of education, health and care plans

[20] K. Lowe et al, Challenging Behaviours: prevalence and topographies. Journal of Intellectual Disability Research, 51, 625–636 (2007).

Figure 16 – Proposed transforming care partnerships



Transforming Care Partnerships

- South Worcestershire, Redditch, Bromsgrove & Wyre Forest (Fast Track)
- Hereford (Fast Track)
- Coventry, Rugby, South Warwickshire & Warwickshire North (Fast Track)
- Birmingham Cross City, Birmingham South Central & Solihull
- Walsall
- Black Country
- Derbyshire
- Nottinghamshire (Fast Track)
- Suffolk
- Norfolk
- Cambridge and Peterborough
- Essex
- Bedford, Luton and Milton Keynes
- Hertfordshire (Fast Track)
- Nene and Corby
- Lincolnshire
- Leicestershire
- Shropshire
- Staffordshire
- Gloucestershire
- Wiltshire and Swindon
- Bristol, Bane and South Gloucestershire
- Somerset and North Somerset
- Cornwall
- Devon
- Kent and Medway
- Sussex
- Surrey
- Oxfordshire
- Buckinghamshire
- Berkshire
- Hampshire & Isle of Wight
- Dorset
- Wirral, Cheshire & Chester
- Halton, St Helens, Warrington, Knowsley
- Liverpool, Sefton, Southport & Formby
- Greater Manchester (Fast Track)
- Lancashire (Fast Track)
- Cumbria and NE (Fast Track)
- North Yorkshire
- Barnsley, Wakefield, Kirklees, Huddersfield & Calderdale
- Bradford
- Leeds
- Sheffield, Doncaster, Rotherham, N Lincs
- East Riding & Hull
- London North West
- London North, Central & East
- London South East
- London South West

Supporting local areas

4.11 NHS England, LGA and ADASS will support transforming care partnerships through the different stages of their journey in planning for and implementing change.

Mobilisation

4.12 Local areas will need to have a solid foundation upon which to base transformation, including strong leadership and sound governance, engagement and commitment to joint working amongst a complex range of stakeholders.

4.13 As with the fast track areas, we envisage all transforming care partnerships having a single Senior Responsible Officer (SRO) responsible for the development and delivery of this work.

4.14 Transforming care partnerships will need to engage with and involve a broad range of people, including: all the CCGs; NHS England specialised commissioners; local authorities, including those commissioners responsible for adult and children's social care, education, housing and safeguarding; people with a learning disability and/or autism, their families/carers; clinicians; third-sector organisations; the police and those responsible for the criminal justice system; and relevant Local Education and Training Boards.

4.15 We will support local commissioners in this phase to mobilise the necessary project management resource, governance arrangements and partnership working across the range of organisations who need to be involved.

Understanding the starting point

4.16 Transforming care partnerships will need to base their plans on a strong understanding of: the population they are seeking to achieve better outcomes for (both current inpatients and those in the community at risk of admission without the right support); how much money CCGs, local authorities and NHS England specialised commissioners are currently spending on health and care for that population; which providers are delivering what services for that spend; and how the system is currently performing, its strengths and weaknesses.

4.17 In addition to the above areas will need to understand the estate and housing requirements to implement their plans, and establish whether there are

available capital receipts which could be recycled as part of this programme – including those relating to the estimated 2,000 properties used by councils or social landlords to provide housing or care to people with a learning disability but under an NHS charge.

4.18 NHS England, LGA and ADASS will provide data and access to subject matter experts to support local commissioners to understand the strengths and weaknesses of existing local services.

Developing a vision for the future and designing a future model of care

4.19 We will support local commissioners to develop a shared vision of how services will change, in line with the national service model.

4.20 NHS England, LGA and ADASS will support local areas with independent facilitation to bring local stakeholders together to design a jointly-owned future model of care. We will also support commissioners to access a range of experts, such as people with a learning disability and/or autism and their family carers who are 'experts by experience', clinicians, people with experience of person-centred planning - and integrated personal budgets - and providers of innovative community care and support.

Implementation planning

4.21 Local commissioners will need to draw up a road map for implementation, covering issues such as finance, workforce development, market development, or changes to estates.

4.22 NHS England, LGA and ADASS will provide technical expertise to support local areas with implementation planning. Building on the review process developed for assuring fast track plans and in alignment with the process for assuring CCGs' annual plans, local implementation plans will be reviewed and challenged by a range of stakeholders including people with a learning disability and/or autism, their families/carers, clinicians and commissioners from other areas.

Delivery

4.23 We expect local transforming care partnerships to have drawn up robust implementation plans and be delivering against them from 1 April 2016.

4.24 A cross-sector alliance of organisations will support these transforming care partnerships to deliver on this ambitious agenda.

4.25 Working alongside local commissioners, NHS England, LGA and ADASS will work with providers and their representative bodies to rapidly mobilise new housing and care services in the community. This work will focus on supporting providers to:

- Support commissioners to redesign services, including through advice on commissioning plans and market development, expertise on legal frameworks (such as the Mental Capacity Act and Deprivation of Liberty

Safeguards [DoLS]), and supporting individuals and families to design person-centred packages of support
- Deliver appropriate community-based services at scale, including through joint work between social care providers and providers of clinical services, and developing local responses to emergencies
- Train the local workforce within and beyond their organisations (e.g. through PBS training)
- Access the investment needed to expand and improve their offer at pace, including potentially through social investors
- Secure the capital required to deliver high-quality housing in community settings, including through potential social investment solutions such as charity bond issues (see case study below)

Case study – Retail Charity Bonds

In 2014, the first charity bond to be listed on the London Stock Exchange's Order Book for Retail Bonds was launched.

The bond, which raised £11 million to fund accommodation for people with a learning disability, was so oversubscribed it closed its offer period two and half weeks early.

The bond was launched by Retail Charity Bond plc and the funds have been used by Golden Lane Housing, the national charity which provides housing for people with a learning disability, to invest in buying and adapting much-needed community based housing across the country for over 100 people with a learning disability.

4.26 Alongside this work with providers to mobilise new services and housing in the community, we will explore the establishment of a national collaborative improvement programme (co-ordinating peer-learning and shared problem-solving between local areas), and a national accelerated support team able to work intensively with local areas with the biggest challenges and/or struggling to make progress.

4.27 HEE, Skills for Health and Skills for Care will collaborate to support the development of an appropriately skilled workforce to build the capacity to support people in the community. As far as possible, this will include working to support current inpatient staff to develop skills to work in the community. Every transforming care partnership will have a lead HEE contact to support them with planning and delivering workforce change. That lead contact will help them access relevant tools (such as competency frameworks), funding streams and training (for example leadership development or training to support staff in mainstream services to understand the needs of people with a learning disability and/or autism). Annex B sets out some of these resources in more detail.

4.28 NHS England, Monitor and the TDA will work together to support hospitals proactively to shift their business models, increasingly offering NHS assessment and treatment services in the community.

4.29 We will work with the CQC, Monitor, the TDA and local commissioners to ensure that inpatient units are only closed when people living in those units are supported to move in an appropriate and timely way to high quality services that can meet their needs. The CQC is also undertaking work to review their fundamental standards against the service model. When regulating active services (or those seeking registration) these fundamental standards will be used and robust action taken if services are not compatible with these and therefore the new service model.

4.30 We will review governance arrangements for the Transforming Care programme at a national level to ensure it reflects this alliance of organisations supporting local areas to deliver.

Monitoring progress

4.31 Nationally, we will monitor progress on delivery against the overarching outcomes we expect transformation to achieve, namely:

- Reduced reliance on inpatient services (closing hospital services and strengthening support in the community)
- Improved quality of life for people in inpatient and community settings
- Improved quality of care for people in inpatient and community settings

4.32 Reduced reliance on inpatient services will be monitored using Assuring Transformation data,[21] and from January 2016 the Mental Health Services Single Data Set[22] (MHSDS), incorporating data from the Learning Disabilities Census and Assuring Transformation dataset.

4.33 We will explore with transforming care partnerships an appropriate way to monitor improvements in quality of life, but are minded to support areas to roll-out use of the Health Equality Framework tool[23] to monitor quality of life. In particular, we are considering how to support the use of this tool to understand changes to quality of life as people are supported to move out of inpatient services.

4.34 We will support the development of a basket of indicators to monitor improvements in quality of care, aligned with the newly developed service model. This basket of indicators will, as far as possible, be based on existing data sources currently collected in the NHS and social care.

4.35 Furthermore, as part of the role out of the CTRs across the NHS, NHS England will work with system partners on introducing a metric for measuring the outcomes of this process. This may involve introducing a Patient Reported Outcome Measure (PROM) and/or a Patient Reported Experience Measure

[21] http://www.hscic.gov.uk/article/6328/Reports-from-Assuring-Transformation-Collection
[22] This is replacing the Mental Health and Learning Disabilities dataset
[23] http://www.ndti.org.uk/publications/other-publications/the-health-equality-framework-and-commissioning-guide1/

(PREM). Development of this CTR outcome measure will have to involve people with a learning disability and/or autism, as well as their families/carers, clinicians, providers and commissioners to ensure it is robust and can be used at a national level to assess progress.

4.36 We will also revise the Learning Disability Self-Assessment Framework (SAF) and the Autism Self-Assessment Framework so that they reflect how well local areas are doing in building up support in the community and closing inpatient services.

4.37 With all the measures outlined above, it is important that people are supported to understand who will see their information, how their information will be used and make decisions about sharing their information. People should be given help to do this. For those people who lack capacity, they should still be involved as much as possible in any decisions made in their best interests.

4.38 NHS England will also support people with a learning disability to check the quality of services themselves, through a programme of work to establish a centralised system for NHS Quality Checking by people with a learning disability. Quality checker services train and support experts by experience to audit service quality. Quality checkers use their own experiences to make assessment on the quality of care and support, and to give a view that can be often missing from other forms of quality review. This entails using indicators of quality which people with a learning disability themselves consider to be relevant and important and which may therefore differ from those which have historically been used. Quality checkers with a learning disability will themselves carry out the evaluation, part of which will involve talking to service users about their experiences and views of the service in question. Evaluation of quality checking programmes show them to be an effective and efficient use of resources and to be associated with increases in quality and improved outcomes.

4.39 In addition, pilot work supported by NHS England has also demonstrated the potential of ‘Always Events’ to strengthen the voices of people with a learning disability and/or autism in the quality assurance of services.

4.40 Lancashire Care NHS Foundation Trust - in partnership with the Institute for Healthcare Improvement (IHI), the Picker Institute Europe and NHS England - has co-produced with people with a learning disability a set of ‘Always Events’ to improve the quality and consistency of transitions within and between services. NHS England will expand its work on ‘Always Events’, share the case study from Lancashire and produce a toolkit with IHI to support the further use of this tool in order to improve the responsiveness and accountability of services.

Financial underpinnings

4.41 A new financial framework will underpin and enable transformation.

4.42 Local transforming care partnerships (CCGs, local authorities and NHS England specialised commissioning) will be asked to use the total sum of money they spend as a whole system on people with a learning disability and/or autism to deliver care in a different way to achieve better results. This includes shifting money from some services (such as inpatient care) into others (such as community health services or packages of support). The costs of the future model of care will therefore be met from the total current envelope of spend on health and social care services for people with a learning disability and/or autism. We estimate that the closure of inpatient services of the scale set out in chapter 3 will release hundreds of millions of pounds for investment in better support in the community.

4.43 To enable that to happen, NHS England's specialised commissioning budget for secure learning disability and autism services will be aligned with the new transforming care partnerships, and CCGs will be encouraged to pool their budgets with local authorities whilst recognising their continued responsibility for NHS Continuing Healthcare. CCGs, NHS England specialised commissioning and local authorities will be supported to, where appropriate, put in place governance and financial mechanisms to align or pool resources and manage financial risk. The degree of change and financial risk will inevitably vary across localities, and we will support local commissioners to base decisions on transparent, open-book discussions, focussed on achieving the best outcomes for the people they serve.

4.44 For people who have been an inpatient for five years or more (approximately one third of the total inpatient population) and who are ready for discharge, we expect the transformational change required to be one of 'resettlement' out of hospital and into a more suitable home, as opposed to redesigning services to reduce the 'revolving door' of admissions and discharges. For this group, money will 'follow the individual' through dowries.

4.45 Dowries will be paid by the NHS to local authorities for people leaving hospital after continuous spells in inpatient care of five years or more at the point of discharge. We expect that NHS England will pay for dowries when the inpatient is being discharged from NHS England-commissioned care, and that CCGs will pay for dowries when the individual is being discharged from CCG-commissioned care. Dowries will be recurrent, will be linked to individual patients, and will cease on the death of the individual. An annual confirmation of dowry-qualifying individuals should be undertaken by local authorities and CCGs. Dowries are to be prospective only, and so should not be applied to any patients that have already been discharged. They should apply to those patients discharged on or after 1 April 2016, and only to those patients who have been in inpatient care for five years or more on 1 April 2016 (not any patient who reaches five years in hospital subsequent to that date). They should apply pro rata in the start and finish year. To ensure that the costs of the future model of care fit within the existing funding envelope, it is important

that dowries are set at a level which is consistent with this principle. The absolute level of the dowry is not expected to be set nationally, but is to be left to local discussions which should be subject to the principles set out here. In addition to paying for these dowries, the NHS will continue to fund continuing healthcare (CHC) and relevant Section 117 aftercare.

4.46 In addition, from November 2015 *Who Pays* guidance - determining responsibility for payment to providers - will be revised to facilitate swifter discharge from hospital of patients originating from one CCG but being discharged into a different local area. This will ensure continuity of care with responsibility remaining with one CCG rather than being passed from commissioner to commissioner.

4.47 Transformation of this scale will entail significant transition costs, including the temporary double running of services as inpatient facilities continue to be funded whilst new community services are established. The extent of the transition costs will depend on the efficiency of the bed closure programme, and the timing and extent of required new community investment. We will work with commissioners and providers to support the closure of inpatient capacity and development of new community services as efficiently as possible, but we recognise that non-recurrent investment will still be necessary. To support local areas with these transitional costs and building on the approach tested with fast track areas, NHS England will make available up to £30 million of transformation funding over three years, with national funding conditional on match-funding from local commissioners.

4.48 In addition to this, £15 million capital funding over three years will be made available, and NHS England will explore making further capital funding available following the Spending Review.

4.49 As set out in the national service model, alongside these new financial underpinnings to enable transformation we expect to see a significant growth in personalised funding approaches (personal budgets, personal health budgets, and integrated personal budgets as well as education, health and care plans). Local transformation should, for instance, be aligned with existing requirements for CCGs to set out a ‘local offer’ on personal health budgets.

4.50 In some parts of the country, local transformation plans will also need to align with Integrated Personal Commissioning (IPC) pilots. IPC sites are currently testing approaches to enable people to purchase their care (including clinical services currently commissioned using NHS standard contracts) through personal budgets, combining resources from health, social care and other funding sources where applicable. The work these sites are undertaking includes linking cost and activity data across services and trialling new contracting and payment approaches that enable the money to be used differently. As IPC sites progress their work, we will support local transforming care partnerships to learn from them and apply the lessons to their own local areas.

Conclusion

This document started with a simple vision that people with learning disability and/or autism have the right to the same opportunities as anyone else to live satisfying valued lives and to be treated with dignity and respect. They should have a home, be able to develop and maintain relationships, and get the support they need to live healthy, safe and fulfilling lives in the community.

For all the frustration of recent years, it is a vision that we can make real. Thousands of people with a learning disability and/or autism are today supported in the community who would years ago have lived in hospitals. There is good practice across the country. There are thousands of people with the expertise and commitment to make this shift happen, from people with a learning disability and/or autism themselves, families/carers as well as frontline clinicians and staff. We have local leaders across social care, the NHS and criminal justice system ready and willing to take up the challenge. At a national level there is an alliance of organisations committed to breaking down the barriers to change, supporting local leaders to make a difference.

Together we have an opportunity to transform thousands of lives. Together we must seize the day and deliver.

Annex A – Proposed CCG clusters for transforming care partnerships

This table shows how CCGs currently propose to cluster together to work with local authorities and NHS England specialised commissioning to build up community services and close inpatient provision that is no longer needed.

Transforming Care Partnership	Clinical Commissioning Group (CCG)
South Worcestershire, Redditch, Bromsgrove & Wyre Forest	NHS South Worcestershire CCG
	NHS Wyre Forest CCG
	NHS Redditch and Bromsgrove CCG
Hereford	NHS Herefordshire CCG
Coventry, Rugby, South Warwickshire & Warwickshire North	NHS Coventry and Rugby CCG
	NHS South Warwickshire CCG
	NHS Warwickshire North CCG
Birmingham CrossCity, Birmingham South Central & Solihull	NHS Birmingham CrossCity CCG
	NHS Birmingham South and Central CCG
	NHS Solihull CCG
Walsall	NHS Walsall CCG
Black Country	NHS Dudley CCG
	NHS Sandwell and West Birmingham CCG
	NHS Wolverhampton CCG
Derbyshire	NHS Erewash CCG
	NHS Southern Derbyshire CCG
	NHS Hardwick CCG
	NHS North Derbyshire CCG
Nottinghamshire	NHS Mansfield and Ashfield CCG
	NHS Bassetlaw CCG
	NHS Newark and Sherwood CCG
	NHS Nottingham City CCG
	NHS Nottingham North and East CCG
	NHS Nottingham West CCG
	NHS Rushcliffe CCG
Suffolk	NHS Ipswich and East Suffolk CCG
	NHS West Suffolk CCG
Norfolk	NHS North Norfolk CCG
	NHS Norwich CCG

	NHS South Norfolk CCG
	NHS West Norfolk CCG
	NHS Great Yarmouth and Waveney CCG
Cambridge and Peterborough	NHS Cambridgeshire and Peterborough CCG
Essex	NHS Basildon and Brentwood CCG
	NHS Castle Point and Rochford CCG
	NHS Mid Essex CCG
	NHS North East Essex CCG
	NHS Southend CCG
	NHS Thurrock CCG
	NHS West Essex CCG
Bedford, Luton and Milton Keynes	NHS Bedfordshire CCG
	NHS Luton CCG
	NHS Milton Keynes CCG
Hertfordshire	NHS East and North Hertfordshire CCG
	NHS Herts Valleys CCG
Nene and Corby	NHS Nene CCG
	NHS Corby CCG
Lincolnshire	NHS Lincolnshire East CCG
	NHS Lincolnshire West CCG
	NHS South Lincolnshire CCG
	NHS South West Lincolnshire CCG
Leicestershire	NHS East Leicestershire and Rutland CCG
	NHS Leicester City CCG
	NHS West Leicestershire CCG
Shropshire	NHS Shropshire CCG
	NHS Telford and Wrekin CCG
Staffordshire	NHS East Staffordshire CCG
	NHS North Staffordshire CCG
	NHS South East Staffordshire and Seisdon Peninsular CCG
	NHS Stafford and Surrounds CCG
	NHS Cannock Chase CCG
	NHS Stoke-on-Trent CCG
Gloucestershire	NHS Gloucestershire CCG
Wiltshire and Swindon	NHS Swindon CCG
	NHS Wiltshire CCG
Bristol, Bane and South	NHS Bristol CCG

Gloucestershire	NHS South Gloucestershire CCG
	NHS Bath and North East Somerset CCG
Somerset and North Somerset	NHS North Somerset CCG
	NHS Somerset CCG
Cornwall	NHS Kernow CCG
Devon	NHS North, East, West Devon CCG
	NHS South Devon and Torbay CCG
Kent and Medway	NHS Ashford CCG
	NHS Canterbury and Coastal CCG
	NHS Dartford, Gravesham and Swanley CCG
	NHS Medway CCG
	NHS South Kent Coast CCG
	NHS Swale CCG
	NHS Thanet CCG
	NHS West Kent CCG
Sussex	NHS Brighton and Hove CCG
	NHS High Weald Lewes Havens CCG
	NHS Eastbourne, Hailsham and Seaford CCG
	NHS Hastings and Rother CCG
	NHS Coastal West Sussex CCG
	NHS Crawley CCG
	NHS Horsham and Mid Sussex CCG
Surrey	NHS Guildford and Waverley CCG
	NHS North West Surrey CCG
	NHS Surrey Downs CCG
	NHS East Surrey CCG
	NHS Surrey Heath CCG
Buckinghamshire	NHS Aylesbury Vale CCG
	NHS Chiltern CCG
Berkshire	NHS Bracknell and Ascot CCG
	NHS Slough CCG
	NHS Windsor Ascot and Maidenhead CCG
	NHS Newbury and District CCG
	NHS North and West Reading CCG
	NHS South Reading CCG
	NHS Wokingham CCG
Hampshire & Isle of Wight	NHS North East Hampshire and Farnham CCG
	NHS North Hampshire CCG

	NHS Portsmouth CCG
	NHS South Eastern Hampshire CCG
	NHS Southampton CCG
	NHS West Hampshire CCG
	NHS Fareham and Gosport CCG
	NHS Isle of Wight CCG
Dorset	NHS Dorset CCG
Wirral, Cheshire & Chester	NHS Wirral CCG
	NHS West Cheshire CCG
	NHS Eastern Cheshire CCG
	NHS South Cheshire CCG
	NHS Vale Royal CCG
Halton, St Helens, Warrington, Knowsley	NHS Halton CCG
	NHS St Helens CCG
	NHS Warrington CCG
	NHS Knowsley CCG
Liverpool, Sefton, Southport & Formby	NHS South Sefton CCG
	NHS Southport and Formby CCG
	NHS Liverpool CCG
Greater Manchester	NHS Bolton CCG
	NHS Bury CCG
	NHS Central Manchester CCG
	NHS Heywood, Middleton and Rochdale CCG
	NHS North Manchester CCG
	NHS Oldham CCG
	NHS Salford CCG
	NHS South Manchester CCG
	NHS Stockport CCG
	NHS Tameside and Glossop CCG
	NHS Trafford CCG
	NHS Wigan Borough CCG
Lancashire	NHS Blackburn with Darwen CCG
	NHS Blackpool CCG
	NHS Chorley and South Ribble CCG
	NHS East Lancashire CCG
	NHS Fylde and Wyre CCG
	NHS Greater Preston CCG
	NHS Lancashire North CCG

	NHS West Lancashire CCG
Cumbria and NE	NHS Cumbria CCG
	NHS Newcastle Gateshead CCG
	NHS North Tyneside CCG
	NHS Northumberland CCG
	NHS South Tyneside CCG
	NHS Sunderland CCG
	NHS Darlington CCG
	NHS Durham Dales, Easington and Sedgefield CCG
	NHS Hartlepool and Stockton-on-Tees CCG
	NHS North Durham CCG
	NHS South Tees CCG
North Yorkshire	NHS Hambleton, Richmondshire and Whitby CCG
	NHS Harrogate and Rural District CCG
	NHS Scarborough and Ryedale CCG
	NHS Vale of York CCG
Barnsley, Wakefield, Kirklees, Huddersfield & Calderdale	NHS Barnsley CCG
	NHS Wakefield CCG
	NHS North Kirklees CCG
	NHS Greater Huddersfield CCG
	NHS Calderdale CCG
Bradford	NHS Bradford Districts CCG
	NHS Bradford City CCG
	NHS Airedale, Wharfdale and Craven CCG
Leeds	NHS Leeds North CCG
	NHS Leeds South and East CCG
	NHS Leeds West CCG
Sheffield, Doncaster, Rotherham, North Lincolnshire	NHS Doncaster CCG
	NHS Rotherham CCG
	NHS North East Lincolnshire CCG
	NHS North Lincolnshire CCG
	NHS Sheffield CCG
East Riding & Hull	NHS East Riding of Yorkshire CCG
	NHS Hull CCG
London North West	NHS Brent CCG
	NHS Central London CCG

	NHS Ealing CCG
	NHS Hammersmith and Fulham CCG
	NHS Harrow CCG
	NHS Hillingdon CCG
	NHS Hounslow CCG
	NHS West London CCG
London North, Central & East	NHS Barking and Dagenham CCG
	NHS Barnet CCG
	NHS Camden CCG
	NHS City and Hackney CCG
	NHS Enfield CCG
	NHS Haringey CCG
	NHS Havering CCG
	NHS Islington CCG
	NHS Newham CCG
	NHS Redbridge CCG
	NHS Tower Hamlets CCG
	NHS Waltham Forest CCG
London South East	NHS Bexley CCG
	NHS Bromley CCG
	NHS Greenwich CCG
	NHS Lambeth CCG
	NHS Lewisham CCG
	NHS Southwark CCG
London South West	NHS Croydon CCG
	NHS Kingston CCG
	NHS Merton CCG
	NHS Richmond CCG
	NHS Sutton CCG
	NHS Wandsworth CCG
Oxfordshire	NHS Oxfordshire CCG

Annex B – Workforce development

i. In every part of the country there are people with the skills and experience to deliver effective care to people with a learning disability and/or autism. These people can be found within health and social care and amongst the people with a learning disability and/or autism themselves, as well as families/carers that support individuals in their own home.

ii. As such, an essential part of delivering each joint transformation plan relies on how areas can harness these skills.

iii. Areas need to develop, focus and refine the skills needed to enable them to work in a different way. They need to manage risk efficiently and have robust and effective ways of intervening in crisis situations that lead to the best possible solutions in the least restrictive environment.

iv. Each area needs to establish mechanisms to understand the skills and competencies that are required to support the specific needs of every individual. Only then will they be able to commission a service that is flexible enough to care for each person and their own specific circumstances. The development of new and innovative approaches to supporting people will be reliant upon the development of a flexible and skilled workforce equipped to adapt and adopt new practices. This may involve commissioning new roles from those traditionally employed within the current provision.[24] Those commissioned to provide such services will need to define competencies and skills required, assess the capability currently available within their workforce, and access appropriate training and development. This will include developing skills to deliver services across all ages in the areas of mental health, autism, managing behavioural problems and offending behaviour.

v. HEE alongside partner organisations Skills for Care and Skills for Health will offer practical support with the aim to:

- **Equip commissioners with the tools and confidence to commission for workforce skills and competencies.** Commissioners are an essential part of the workforce that needs development and support to deliver the new service model. This includes enhancing existing service provision, creating new service models and commissioning beyond the traditional service boundaries, for example placing learning disability nurses in primary and secondary care in order to support health and care professionals to make better decisions. Skills for Care have developed a workforce commissioning model that provides a systematic way of linking service commissioning with workforce commissioning and financial strategy. This can be found here

vi. There are several models for testing workforce assumptions and undertaking Strategic Workforce planning, including Integrated Workforce Planning

[24] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/309153/Strengthening_the_commitment_one_year_on_published.pdf

Solutions from Skills for Health, and Skills for Care's Workforce Capacity Planning guidance.

- **Work with existing service providers to review the skills and competencies within their existing workforce to identify education and training needs, and facilitate transition to a new way of working.** HEE in partnership with Skills for Health have developed a skills and competency framework which can be utilised to undertake a training needs analysis of the existing workforce, and to build a competency based team model against which new and existing roles can be mapped. The framework, alongside an illustrative animated video, can be found here: HEE Skills & Competency Framework

vii. We are in the process of developing an interactive tool to support the implementation and use of the competence framework.

viii. The Positive Behavioural Support (PBS) Coalition have published a PBS Competency Framework. For ease of use, the PBS competencies have been mapped into the HEE Skills and Competency Framework.

ix. Whilst this framework has been developed primarily for the health care workforce it can be utilised in a range of services. Skills for care have developed a strategy for the social care sector to support functional and employability skills (Core Skills), which impact directly on the quality of care and support services.

- **Ensure that education and training to enable the wider workforce is able to meet the needs of people with a learning disability in all care settings**. Recognising that most people with a learning disability have their health and care needs met by mainstream health care services, HEE commissioned the development of education and training resources 'Learning Disability Made Clear' that can be used by staff in a range of health and care settings to increase their knowledge and support how services can make adjustments to meet specific needs

x. A suite of existing resources developed to raise awareness of the needs of people with autism, have been reviewed and located in one place to enable individuals and organisations to select the most appropriate resource for their needs. A marketing and promotion strategy is underway to ensure these resources are widely accessed by employers, employees, volunteers and carers across the country. These can be found here.

xi. In addition to the above, work is being undertaken to develop specific learning disability and autism skills in the mainstream mental health workforce on whom we will become increasingly reliant as specialist services become more integrated.

- **Developing leadership capability across the system including commissioners, service providers and carers to promote innovation and change services to focus on people's needs.** HEE, Skills for Health and Skills for Care will coordinate access to the various provision and funding streams available across agencies to ensure that creative and innovative leadership activities are supported as part of the national transformation plan

Annex C – Notes on data used in this document

All modelling to produce planning assumptions and charts was based on calculating inpatient rates per million population. The following notes apply to all charts used in this document which describe projected reductions in fast track bed usage and current geographical variation in reliance on inpatient care across England.

- All inpatient rates are based on GP registered population aged 18 and over as at 2013/14
- Inpatient numbers include children under the age of 18 but these patients represent less than 5% of the total inpatient population
- High secure services have been excluded (65 patients[25])

Data on the current position and projections for fast track areas is taken from the fast track plans, but projections exclude Worcestershire (part of Arden, Herefordshire and Worcestershire Fast Track).

The data set used to calculate the current geographical variation as at 31 July 2015 combines information on CCG-commissioned patients from the Assuring Transformation collection and data on NHS England-commissioned patients from NHS England's Local Trackers (this includes information on the home CCG of NHS England-commissioned patients). This means that the presentation of inpatient data is based on where patients originally come from, not where their hospital is located.

Assuring Transformation data is collected and published by The Health and Social Care Information Centre (HSCIC). All rights reserved ©2015. Assuring Transformation data is presented in accordance with HSCIC rules on suppressed data for collections involving small numbers of records.

Not all NHS England-commissioned patients in the Local Tracker data could be matched to a CCG of origin, and these patients are therefore omitted from the analysis of geographical variance on a Transforming Care Partnership level. The geographical analysis presented in Figures 2 and 3 assigns these patients to the locality of their commissioner.

[25] Number of inpatients in high secure settings suppressed in accordance with HSCIC rules on suppressed data for collections involving small numbers of records. Figure correct as at 31st July 2015.

Transforming care:

A national response to Winterbourne View Hospital

Department of Health Review:
Final Report

DH INFORMATION READER BOX

Policy	Clinical	Estates
HR / Workforce	Commissioner Development	IM & T
Management	Provider Development	Finance
Planning / Performance	Improvement and Efficiency	Social Care / Partnership Working

Document Purpose	For Information
Gateway Reference	18348
Title	Transforming care: A national response to Winterbourne View Hospital: Department of Health Review Final Report
Author	Department of Health
Publication Date	**December 2012**
Target Audience	PCT Cluster CEs, NHS Trust CEs, SHA Cluster CEs, Care Trust CEs, Foundation Trust CEs , Medical Directors, Directors of PH, Directors of Nursing, Local Authority CEs, Directors of Adult SSs, GPs, Directors of Children's SSs
Circulation List	Medical Directors, PCT PEC Chairs, PCT Cluster Chairs, NHS Trust Board Chairs, Special HA CEs, Directors of HR, Directors of Finance, Allied Health Professionals, Communications Leads, Emergency Care Leads, Voluntary Organisations/NDPBs
Description	The report sets out the governments final response to the events at Winterbourne View hospital. It sets out a programme of action to transform services for people with learning disabilities or autism and mental health conditions or behaviours described as challenging.
Cross Ref	Department of Health Review: Winterbourne View Hospital: Interim Report Winterbourne View Review: Concordat: A Programme of Action
Superseded Docs	N/A
Action Required	N/A
Timing	**N/A**
Contact Details	Mental Health, Disability and Equality Department of Health Room 313A Richmond House 79 Whitehall SW1A 2NS
For Recipient's Use	

Transforming care:
A National response to Winterbourne View Hospital

Department of Health Review: Final Report

Contents

Ministerial Foreword

The scandal that unfolded at Winterbourne View is devastating.

Like many, I have felt shock, anger, dismay and deep regret that vulnerable people were able to be treated in such an unacceptable way, and that the serious concerns raised by their families were ignored by the authorities for so long.

This in-depth review, set up in the immediate aftermath of the Panorama programme in May 2011, is about the lessons we must learn and the actions we must take to prevent abuse from happening again.

It is also about promoting a culture and a way of working that actively challenges poor practice and promotes compassionate care across the system.

First and foremost, where serious abuse happens, there should be serious consequences for those responsible.

At Winterbourne View, the staff had committed criminal acts, and six were imprisoned as a result. However, the Serious Case Review showed a wider catalogue of failings at all levels, both from the operating company and across the wider system.

When failure occurs, repercussions should be felt at all levels of an organisation. Through proposed changes to the regulatory framework, we will send a clear message to owners, Directors and Board members: the care and welfare of residents is your active responsibility, so expect to be held to account if abuse or neglect takes place.

Yet Winterbourne View also exposed some wider issues in the care system.

There are far too many people with learning disabilities or autism staying too long in hospital or residential homes, and even though many are receiving good care in these settings, many should not be there and could lead happier lives elsewhere. This practice must end.

We should no more tolerate people being placed in inappropriate care settings than we would people receiving the wrong cancer treatment. That is why I am asking councils and clinical commissioning groups to put this right as a matter of urgency.

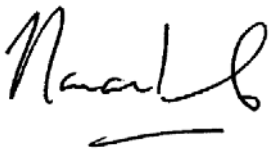
Equally, we should remember that not everything will be solved through action driven from the centre. Stories of poor care are a betrayal of the thousands of care workers doing extraordinary things to support and improve people's lives.

And while stronger regulation and inspection, quality information and clearer accountability are vital, so too is developing a supportive, open and positive culture in our care system.

I want staff to feel able to speak out when they see poor care taking place as well as getting the training and support they need to deal with the complex and challenging dilemmas they often face.

For me, this is the bigger leadership and cultural challenge that this scandal has exposed – and answering it will mean listening and involving people with learning disabilities and their families more than ever before.

As much as Winterbourne View fills us all with sorrow and anger, it should also fire us up to pursue real change and improvement in the future. It is a national imperative that there is a fundamental culture change so that those with learning disabilities or autism have exactly the same rights as anyone else to the best possible care and support. This Review is a key part of making that happen.



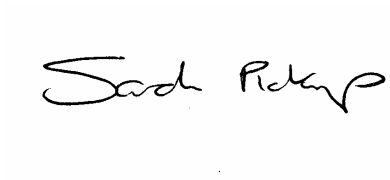
NORMAN LAMB
Minister of State for Care and Support

Joint Foreword

This report lays out clear, timetabled actions for health and local authority commissioners working together to transform care and support for people with learning disabilities or autism who also have mental health conditions or behaviours viewed as challenging. Our shared objective is to see the health and care system get to grips with past failings by listening to this very vulnerable group of people and their families, meeting their needs, and working together to commission the range of services and support which will enable them to lead fulfilling and safe lives in their communities.

The Concordat which accompanies this report sets out our commitment to work together, with individuals and families, and with the groups which represent them, to deliver real change, improve quality of care and ensure better outcomes. Together we will set the strategic direction and measure progress. This requires real system leadership across all sectors, including elected councillors as well as across health and care to reduce inequalities.

The new health and care system brings a greater opportunity for people to work together more creatively to develop local innovative solutions. We commit to doing this.



Sir David Nicholson KCB CBE

Chief Executive
NHS Commissioning Board

Sarah Pickup

President
Association of Directors of Adult Social Services

Councillor David Rogers

Chair, Community Wellbeing Board
Local Government Association

Executive summary

1. The abuse revealed at Winterbourne View hospital was criminal. Staff whose job was to care for and help people instead routinely mistreated and abused them. Its management allowed a culture of abuse to flourish. Warning signs were not picked up or acted on by health or local authorities, and concerns raised by a whistleblower went unheeded. The fact that it took a television documentary to raise the alarm was itself a mark of failings in the system.

2. This report sets out steps to respond to those failings, including tightening up the accountability of management and corporate boards for what goes on in their organisations. Though individual members of staff at Winterbourne View have been convicted, this case has revealed weaknesses in the system's ability to hold the leaders of care organisations to account. This is a gap in the care regulatory framework which the Government is committed to address.

3. The abuse in Winterbourne View is only part of the story. Many of the actions in this report cover the wider issue of how we care for children, young people and adults with learning disabilities or autism, who also have mental health conditions or behaviours described as challenging.

4. CQC's inspections of nearly 150 other hospitals and care homes have not found abuse and neglect like that at Winterbourne View. However, many of the people in Winterbourne View should not have been there in the first place, and in this regard the story is the same across England. Many people are in hospital who don't need to be there, and many stay there for far too long – sometimes for years.

5. The review has highlighted a widespread failure to design, commission and provide services which give people the support they need close to home, and which are in line with well established best practice. Equally, there was a failure to assess the quality of care or outcomes being delivered for the very high cost of places at Winterbourne View and other hospitals.

6. For many people however, even the best hospital care will not be appropriate care. People with learning disabilities or autism may sometimes need hospital care but hospitals are not where people should live. Too many people with learning disabilities or autism are doing just that.

7. This is the wider scandal that Winterbourne View revealed. 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.

8. Children, young people and adults with learning disabilities or autism, who also have mental health conditions or behaviours described as challenging can be, and have a right to be, given the support and care they need in a community-based setting, near to family and friends. Closed institutions, with people far from home and family, deny people the right care and present the risk of poor care and abuse.

9. The Department of Health review drew on:

- a criminal investigation with 11 individuals prosecuted and sentenced;
- the Care Quality Commission review of all services operated by Castlebeck Care, the owners of Winterbourne View, and the programme of inspections of 150 learning disability hospitals and homes;
- the NHS South of England reviews of serious untoward incident reports and the commissioning of places at Winterbourne View hospital;
- an independent Serious Case Review commissioned by the South Gloucestershire Safeguarding Adults Board, published on 7 August 2012; and
- the experiences and views of people with learning disabilities or autism and mental health conditions or behaviours described as challenging, their families and carers, care staff, commissioners and care providers.

10. An interim report was published on 25 June 2012. This final report of the review can be published now that the criminal proceedings have concluded.

Programme of Action

11. This report sets out a programme of action to transform services so that people no longer live inappropriately in hospitals but 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.

12. The Government's Mandate to the NHS Commissioning Board[1] says:

"The NHS Commissioning Board's **objective** is to ensure that CCGs work with local authorities to ensure that vulnerable people, particularly those with learning disabilities and autism, receive safe, appropriate, high quality care. The presumption should always be that services are local and that people remain in their communities; we expect to see a substantial reduction in reliance on inpatient care for these groups of people." (para 4.5)

13. We expect to see a fundamental change. This requires actions by many organisations including government. In summary, this means:

- all current placements will be reviewed by 1 June 2013, and everyone inappropriately in hospital will move to community-based support as quickly as possible, and no later than 1 June 2014;
- by April 2014 each area will have a locally agreed joint plan to ensure high quality care and support services for all children, young people and adults with learning

[1] http://www.dh.gov.uk/health/2012/11/nhs-mandate/

disabilities or autism and mental health conditions or behaviour described as challenging, in line with the model of good care set out at **Annex A**;

- as a consequence, there will be a dramatic reduction in hospital placements for this group of people and the closure of large hospitals;
- a new NHS and local government-led joint improvement team, with funding from the Department of Health, will be created to lead and support this transformation;
- we will strengthen accountability of Boards of Directors and Managers for the safety and quality of care which their organisations provide, setting out proposals during Spring 2013 to close this gap;
- CQC will strengthen inspections and regulation of hospitals and care homes for this group of people. This will include unannounced inspections involving people who use services and their families, and steps to ensure that services are in line with the agreed model of care; and
- with the improvement team we will monitor and report on progress nationally.

14. A full account of these actions, together with a range of further actions to support improvement of services – including, for instance, steps to improve workforce skills, and strengthening safeguarding arrangements – is set out in Parts 4-8. A timeline of the detailed actions is at **Annex B**.

15. Alongside this report, we are publishing a **Concordat** agreed with key external partners. It sets out a shared commitment to transform services, and specific actions which individual partners will deliver to make real change in the care and support for people with learning disabilities or autism with mental health conditions or behaviour that challenges.

16. This report focuses on the need for change, but there are places which already get this right. This shows that the change we intend to make is achievable. Alongside this report, we are publishing examples of good practice which demonstrate what can – and should be – done for all.

Part 1: Introduction

1.1 This Department of Health review responds to criminal abuse at Winterbourne View hospital revealed by the BBC Panorama programme in May 2011. It is equally concerned with 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 report, we describe this vulnerable group of people as "people with challenging behaviour".

1.2 There are currently an estimated 3,400 people in NHS-funded learning disability inpatient beds of which around 1,200 are in assessment and treatment units (usually known as A&T units)[2].

1.3 This report builds on the evidence and issues set out in the interim report published in June 2012[3].

1.4 The picture from investigations and reviews, and from people who use services, their families, and the groups which represent them[4] is of good services in some places, but too often they fall short. Too many people do not receive good quality care. The review found widespread poor service design, failure of commissioning, failure to transform services in line with established good practice[5], and failure to develop local services and expertise to provide a person-centred and multidisciplinary approach to care and support.

1.5 Starting now and by June 2014, we must – and we will – transform the way services are commissioned and delivered to stop people being placed in hospital inappropriately, provide the right model of care, and drive up the quality of care and support for all people with challenging behaviour.

1.6 This is not easy. Developing the right range of services locally to build up necessary expertise is a complex task – though that will be made easier with pooled budgets. But there is clear – and readily available – guidance and evidence for what works[6]. That guidance has been available for years. There are no excuses for local health and care

[2] There is poor quality data about the numbers of people with challenging behaviour. In the interim report we focused on the 1,200 beds in A&T units in the CQC Count me in Census 2010. In this report we have used the larger estimate of 3,400 people in NHS funded inpatient beds (from the same census). This is because some people may be in rehabilitation or other types of unit which provide A&T services and we also want to avoid inpatient services simply re-badging themselves.

[3] *Department of Health Review: Winterbourne View Hospital:Interim Report Interim Report:* (June 2012) http://www.dh.gov.uk/health/2012/06/interimwinterbourne/

[4] see summaries of engagement with people with learning disabilities and families published alongside this report at www.dh.gov.uk/learningdisabilities

[5] see *Services for People with Learning disability and challenging behaviour or mental health needs* 2007, Prof Jim Mansell. http://www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicandgudiance/dh_080129

[6] see http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_080129 Examples of good practice are published at http://www.dh.gov.uk/health/2012/06/interimwinterbourne/

commissioners failing to come together to commission and design the services which will enable most people to live safely with support in their communities and prevent unnecessary admissions to hospital. There are no excuses for continuing to commission the wrong model of care.

1.7 The programme for change described below draws on actions in the interim report[7] to which external delivery partners have already committed. A more detailed action plan will be agreed and monitored by the national Learning Disability Programme Board chaired by the Minister of State for Care and Support. The Board will measure progress against milestones, monitor risks to delivery, and challenge partners, to ensure all of these commitments are delivered.

1.8 In addition to this monitoring, the Department of Health will publish a progress report in one year, and again as soon as possible following 1 June 2014, to ensure that the steps set out in this report are achieved.

[7] http://www.dh.gov.uk/health/2012/06/interimwinterbourne/

Part 2: Winterbourne View hospital

2.1 When the interim report of this review was published in June, we were unable to comment on what happened in Winterbourne View hospital as criminal proceedings against former members of staff had not completed. Subsequently, all 11 individuals charged have pleaded guilty to all charges and have been sentenced (with custodial sentences for six former staff). The Crown Prosecution Service treated these offences as disability hate crimes, crimes based on ignorance, prejudice and hate, and brought this aggravating factor to the attention of the court in sentencing.

2.2 We now have a very detailed and compelling picture of the serious abuse suffered by patients at Winterbourne View hospital and the systematic way in which staff abused patients and misused restraint as punishment for what staff saw as bad behaviour.

2.3 The Serious Case Review (SCR) commissioned by South Gloucestershire Council Adult Safeguarding Board published on 7 August 2012 gives a compelling and comprehensive chronology of events at the hospital and we do not intend to duplicate that here.[8]

2.4 But now we have that picture, along with other reports shared as evidence to the SCR including reports from the police, the CQC, and the review by NHS South of England of commissioning of services at Winterbourne View hospital, we are able to draw firm conclusions about what went wrong.

2.5 Opened in December 2006, Winterbourne View was a private hospital owned and operated by Castlebeck Care Limited. It was designed to accommodate 24 patients in two separate wards and was registered as a hospital with the stated purpose of providing assessment and treatment and rehabilitation for people with learning disabilities. By the time the hospital was closed in June 2011, the majority of patients (73%) had been admitted to the hospital under Mental Health Act powers. Although thirteen were informal patients at admission, six of these were then detained under Mental Health Act powers after admission. On average, it cost £3,500 per week to place a patient in Winterbourne View.

2.6 Forty-eight patients had been referred to Winterbourne View by 14 different English NHS commissioners (there had also been a few placements from Wales); meaning that there was no one commissioner with a lead or strong relationship with the hospital. Similarly, South Gloucestershire Council, in whose area the hospital was located, was not party to the majority of referrals to Winterbourne View hospital.

[8] South Gloucestershire Safeguarding Adults Board *Winterbourne View Hospital: A Serious Case Review* by Margaret Flynn (2012) http://www.southglos.gov.uk/Pages/Article%20Pages/Community%20Care%20-%20Housing/Older%20and%20disabled%20people/Winterbourne-View-11204.aspx

2.7 This also meant that although a significant minority of patients were local to the hospital **almost half of the patients at Winterbourne View were placed far away from their homes**. Of 48 patients:

- 13 were referred by commissioners located within 20 miles;
- a further 12 patients were referred by commissioners between 20 and 40 miles away;
- 14 patients were referred by commissioners between 40 and 120 miles away; and
- 9 patients were referred by commissioners more than 120 miles away.

2.8 For just under half of the people in Winterbourne View, the main reason for referral was management of a crisis – suggesting a real lack of planning for crises or local responsive services for people with this type of support need.

2.9 **People were staying at Winterbourne View hospital for lengthy periods**. The average length of stay at Winterbourne View was around 19 months but some patients had been there more than three years when the hospital closed – and this in a hospital which was open for less than five years.

2.10 There is little evidence of urgency in considering discharge and move-on plans for Winterbourne View patients. It is worth noting for instance that 10 patients detained under Mental Health Act powers remained in Winterbourne View after their period of detention ended – in one case for a further 18 months.

2.11 One of the most striking issues is the **very high number of recorded physical interventions** at Winterbourne View (ie of patients being physically held to prevent danger to themselves or others). The Serious Case Review notes that Castlebeck Care Ltd recorded a total of 558 physical interventions between 2010 and the first quarter of 2011, an average of over 1.2 physical interventions per day. One family provided evidence that their son was restrained 45 times in 5 months, and on one occasion was restrained “on and off” all day. It is very difficult to see how such high numbers of interventions could possibly be seen as normal.

2.12 Opportunities to pick up poor quality of care were repeatedly missed by multiple agencies. For instance:

- Winterbourne View patients attended NHS Accident and Emergency services on 78 occasions while Winterbourne View was open but there was no process in place for linking these so that an overall picture emerged;
- Between January 2008 and May 2011 police were involved in 29 incidents concerning Winterbourne View patients;
- Between January 2008 and May 2011, 40 safeguarding alerts were made to South Gloucestershire Council but these were treated as separate incidents. 27 were allegations of staff to patient assaults, 10 were patient on patient assaults and three were family related incidents.

2.13 The Serious Case Review provides evidence **of poor quality healthcare**, with routine healthcare needs not being attended to – for instance there were widespread dental problems and "most patients were plagued by constipation". Many patients were being given anti-psychotic and anti-depressant drugs without a consistent prescribing policy.

2.14 The Serious Case Review also sets out very clearly that for a substantial portion of the time in which Winterbourne View operated, families and other visitors were not allowed access to the wards or individual patients' bedrooms. This meant there was very little opportunity for outsiders to observe daily living in the hospital and enabled a **closed and punitive culture to develop on the top floor of the hospital**. Patients had limited access to advocacy and complaints were not dealt with.

2.15 There is strong and compelling evidence of **real management failure at the hospital.** The Serious Case Review says that on paper Castlebeck's policies, procedures, operational practices and clinical governance were impressive. The reality was very different:

- for much of the period in which Winterbourne View operated, there was **no Registered Manager** (even though that is a registration requirement);
- approaches to staff recruitment and training did not demonstrate a strong focus on quality. For example, staff job descriptions did not highlight desirability of experience in working with people with learning disabilities or autism and challenging behaviour – nor did job descriptions make any reference to the stated purpose of the hospital;
- there is little evidence of staff training in anything other than in restraint practices;
- although structurally a learning disability nurse-led organisation, it is clear that Winterbourne View had, by the time of filming by Panorama, become dominated to all intents and purposes by support workers rather than nurses**;** and
- there was very high staff turnover and sickness absence among the staff employed at the hospital.

2.16 All this suggests **that managers at the hospital and the parent company, as well as commissioners, regulators and adult safeguarding, had a number of opportunities to pick up indications that there were real problems at Winterbourne View, but failed to do so.**

2.17 The very high number of recorded restraints, high staff turnover, low levels of training undertaken by staff, the high number of safeguarding incidents and allegations of abuse by staff – all could have been followed up by the **hospital itself or by Castlebeck Care Ltd,** but were not to any meaningful extent. This failure by the provider to focus on clinical governance or key quality markers is striking, and a sign of an unacceptable breakdown in management and oversight within the company.

2.18 Equally it is striking that **adult safeguarding** systems failed to link together the information. NHS South of England's review highlighted the absence of processes for commissioners to be told about safeguarding alerts – some commissioners were aware of concerns – and failures to follow up concerns when commissioners became aware of them.

2.19 Despite the high cost of places at Winterbourne View (on average £3,500 per week) **commissioners** do not seem to have focused much on quality, or on monitoring how the hospital was providing services in line with its registered purpose – ie. assessing the needs of individuals and promoting their rehabilitation back home. The lack of any substantial evidence that people had meaningful activity to do in the day, the way in which access by outsiders to wards was restricted, reports of safeguarding alerts (where

these were shared with commissioners) should have been followed up rigorously, but were not. **This amounts to a serious failure of commissioning**.

2.20 The **CQC** acknowledged that they did not respond to the Winterbourne View hospital whistleblower and that neither they nor their predecessor organisations followed up on the outcomes of statutory notifications – and clearly failed to enforce the requirement for there to be a registered manager.

2.21 The **Mental Health Act Commissioner** was notified on more than one occasion of incidents, and in its annual report in May 2008 referenced the need for action to improve – but it was not followed up.

2.22 The **Police** have acknowledged that they took explanations from staff at face value. Avon and Somerset Constabulary police were involved in 29 incidents concerning Winterbourne View patients. Eight of the reported incidents were associated with staff using physical restraint on patients. The Police secured the successful prosecution of one member of staff prior to the Panorama programme.

What happened to people at Winterbourne View

2.23 Patients at Winterbourne View hospital were subject to horrific and sustained abuse, ill-treatment and neglect. The Serious Case Review has thrown down a challenge to health and social care commissioners to ensure that the individual patients and their families get the support they need to recover from their experience. The Department of Health supports that challenge.

> *Out of Sight: Stopping the abuse of people with a learning disability pr*ovides an update on what happened to Simon, one of the patients at Winterbourne View.
>
> Simon's Mum said:
> *Simon is now back living near us, and he is loving every minute of his life. He is at the same residential care home he was in before he was sent away, but the service has been adapted so that it meets his needs. They have done this by developing a flat for him adjoining the care home, where he lives with his support team. It is his own space, an oasis of quiet and calm.*'
>
> *Simon's package of care now costs about half as much as it did for him to be in Winterbourne View. The staff he has now have been wonderful and are truly dedicated. I know that not only is Simon happy, he is safe."*

2.24 But we know that not every one who was at Winterbourne View has had the same experience as Simon. Indeed, the second Panorama programme broadcast on 29 October 2012 showed that some others who had suffered abuse have continued to be moved to hospitals far from home.

2.25 DH asked NHS South of England to coordinate follow up on what happened to the 48 English NHS patients who had been in Winterbourne View hospital. In March 2012:

- 26 former patients had moved into a range of social care supported arrangements and 22 patients were in various inpatient facilities;
- 19 had been subject to a safeguarding alert in their new location;

- 27 people had required support related to the trauma experienced at Winterbourne View hospital.

2.26 This exercise was repeated in September 2012. At that point:

- Additional hospital discharges had taken place with 32 former patients in a range of social care settings and 16 patients in inpatient setting.
- there were initial safeguarding alerts or active safeguarding procedures for six people at the time of the exercise.

2.27 Whilst one cannot generalise from such a small group of patients, the fact that two thirds of those in Winterbourne View are now in social care supported arrangements gives a strong indication of what is possible.

2.28 DH will continue to seek assurance about what has happened to this group of people.

Part 3: The picture beyond Winterbourne View

3.1 The events at Winterbourne View triggered a wider review of care across England for people with challenging behaviour. This included a programme of CQC inspections of nearly 150 learning disability services[9] together with engagement by the Department of Health to seek the experiences and views of people with learning disabilities and people with autism – some of whom had experienced care in hospital settings – as well as families, organisations who represent the interests of this group of people, professionals and providers.

3.2 The interim report of the Department of Health review published in June 2012[10] set out the findings:

- too many people were placed in hospitals for assessment and treatment and staying there for too long;
- they were experiencing a model of care which went against published Government guidance that people should have access to the support and services they need locally, near to family and friends;
- there was widespread poor quality of care, poor care planning, lack of meaningful activities to do in the day and too much reliance on restraining people; and
- all parts of the system have a part to play in driving up standards.

3.3 The interim report identified concerns about the quality of person centred planning, involvement of people and families in developing their care plan, and in ensuring personalised care and support.

3.4 In addition, the interim report summarised published good practice guidance including the 1993 Mansell report, updated and revised in 2007[11], which emphasise:

- the responsibility of commissioners to ensure that services meet the needs of individuals, their families and carers;
- a focus on personalisation and prevention in social care;
- that commissioners should ensure services can deliver a high level of support and care to people with complex needs or challenging behaviour; and
- that services/support should be provided locally where possible.

[9] The summary CQC report was published in June 2012. http://www.cqc.org.uk/public/reports-surveys-and-reviews/themed-inspections/review-learning-disability-services

[10] http://www.dh.gov.uk/health/2012/06/interimwinterbourne/

[11] *Services for people with learning disabilities and challenging behaviour or mental health needs* October 2007, Professor Jim Mansell – see http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_080129

3.5 Three examples of good practice – Salford, Tower Hamlets and Cambridgeshire – were published alongside the interim report.[12]

3.6 As a first step to driving redesign, the interim report set out the model of care which practice demonstrates will give the best quality of life and support and improve outcomes. This is summarised in here and set out in detail at **Annex A.**

3.7 In summary, the norm should always be that children, young people and adults live in their own homes with the support they need for independent living within a safe environment. Evidence shows that community-based housing enables greater independence, inclusion and choice, and that challenging behaviour lessens with the right support. People with challenging behaviour benefit from personalised care, not large congregate settings[13]. Best practice is for children, young people and adults to live in small local community-based settings.

3.8 Where children, young people and adults need specialist support the default position should be to put this support into the person's home through specialist community teams and services, including crisis support.

- the individual and her/his family must be at the centre of all support - services designed around them and with their involvement, highly individualised and person-centred across health and social care (including access to personal budgets and personal health budgets where appropriate);
- people's homes should be in the community, supported by local services;
- people need holistic care throughout their life, starting in childhood;
- when someone needs additional support it should be provided as locally as possible; and
- when someone needs to be in hospital for a short period, this should be in small inpatient settings as near to their home as possible.

3.9 This means that people with challenging behaviour should only go into specialist hospital settings exceptionally and where there is good evidence that a hospital is the best setting to enable necessary assessment and treatment - not the only available placement. From the beginning, the reason for admission must be clearly stated and families should be involved in decision making. Where an individual lacks capacity and does not have a family to support them, the procedures of the Mental Capacity Act 2005 should be followed to ensure that decisions made are in her/his best interest and, if appropriate, an Independent Mental Capacity Advocate appointed.

3.10 Where someone is admitted to hospital the priority from the start should be rehabilitation and returning home. This requires a strong and continuing relationship between local commissioners and service providers and the hospital, focused on the individual patient's care plan, and a real effort to maintain links with their family and the home community. It also means for example, maintaining the person's tenancy of their home where relevant unless and until a more appropriate home in the community is found. Most of all, it is vital that families are involved in decision-making.

[12] http://www.dh.gov.uk/health/2012/06/interimwinterbourne/

[13] NICE clinical guidelines for autism recommend that if residential care is needed for adults with autism it should usually be provided in small, local community-based units (of no more than six people and with well-supported single person accommodation).

3.11 Sending people out of area into hospital or large residential settings can cause real harm to individuals by weakening relationships with family and friends and taking them away from familiar places and community. It can damage continuity of care. It can also mean putting people into settings which they find stressful or frightening. This can damage mental health or increase the likelihood of challenging behaviour. There should always be clear and compelling reasons for sending any individual out of area. The individual and their family should always be involved and told these reasons. When this does happen, commissioners and the community team from the home area must keep in close contact with the individual and their family as well as the commissioner for the area where the individual is placed to assess progress and plan for their return to their own community.

Good Practice

The **Association of Supported Living** members contributed to a study on good commissioning in which they describe the ingredients to the successful outcomes they had achieved in moving people who at some point have been contained in institutions. Now everyone has a better life in community services which cost less. Prior to changes, costs ranged from £91,000 to £520,000 (for a private secure unit) per annum, following a move to supported living, high end costs reduced from £520,000 to £104,000 per annum.

3.12 The Government's Mandate to the NHS Commissioning Board makes clear that the presumption should always be that services are local and that people remain in their communities.

3.13 This model is achievable. It has been tried and tested and it works. The good practice examples published alongside the Interim Report are community-based and multidisciplinary. They can respond when someone presents with challenging behaviour, responding to that individual, their family, and care and support providers to seek explanations for the behaviour. That enables services working in partnership to develop interventions and support based on an understanding of the individual and their environment. Multidisciplinary approaches are essential because of the complexity of need and the way in which different perspectives contribute to agreeing appropriate interventions.

Part 4: The right care in the right place

4.1 A central part of our plan for action is to ensure that people with challenging behaviour only go into hospital if hospital care is genuinely the best option, and only stay in hospital for as long as it remains the best option. Our plan requires health and care partners to:

a. review all current placements, and support everyone inappropriately in hospital to move to community-based support;

b. in parallel, put in place a locally agreed joint plan to ensure high quality care and support services for all people with challenging behaviour that accord with the right model of care from childhood onwards; and

c. give national leadership and support for local change.

4.2 The patients at Winterbourne View were not listened to or believed when they told people about abuse. Their families were often not involved in decisions about where they were sent, parents and siblings found it increasingly difficult to visit and families' concerns and complaints often were not acted on. This failure to listen to people with challenging behaviour and their families is sadly a common experience and totally unacceptable. It leaves people feeling powerless.

4.3 We expect all actions in this programme to be appropriately informed by the views and needs of people with challenging behaviour and families in line with the NHS Constitution – which can mean providing appropriate advice, information and support. This will happen at all levels, locally and nationally:

- people with learning disabilities and families will be members of the Learning Disability Programme Board;
- CQC will involve self-advocates and families in inspections and in their stakeholder group;
- the NHSCB, LGA, and ADASS will involve them in planning and supporting changes in the way care is developed.

4.4 Changing attitudes to people with challenging behaviour is vital. Tackling disability hate crime is an issue the Department of Health takes very seriously. The Department is already taking steps to improve its understanding of disability hate crime and to deliver better outcomes for patients including those with learning disabilities.

4.a REVIEW ALL CURRENT PLACEMENTS AND SUPPORT EVERYONE INAPPROPRIATELY IN HOSPITAL TO MOVE TO COMMUNITY BASED SUPPORT

4.5 By 1 June 2014 we expect to see a rapid reduction in the number of people with challenging behaviour in hospitals or in large scale residential care - particularly those away from their home area. By that date, no-one should be inappropriately living in a hospital setting. This is a three stage process which involves:

- commissioners making sure they know who is in hospital and who is responsible for them;
- health and care commissioners working together and with partners to review the care people are receiving;
- commissioners working with individuals to agree personal care plans and bringing home or to appropriate community settings all those in hospital[14].

4.6 DH will closely monitor progress in bringing these numbers down. The Government's Mandate to the NHSCB emphasises the expectation for a substantial reduction in reliance on inpatient care for these groups of people.

4.7 Progress in this area will be dependent on developing the range of responsive local services which can prevent admissions to hospital or other large institutional settings and allow any existing patients to be moved to better settings, closer to home. This may involve better use of existing Mental Health services with the right reasonable adjustments, or the commissioning of new, smaller and more local inpatient units where they are needed. But the emphasis should be on designing community services in line with the best practice model. We would expect to see a dramatic and sustained reduction in the number of assessment and treatment units and beds as a result of this shift.

Agreeing who should be reviewed and who is responsible for them

4.8 Commissioners need to make sure they know who is in hospital and who is responsible for them.

Key Actions:

The NHS Commissioning Board will:

- **ensure by 1 April 2013 that all Primary Care Trusts develop local registers of all people with challenging behaviour in NHS-funded care;**

- **make clear to Clinical Commissioning Groups in their handover and legacy arrangements what is expected of them, including:**
    - **maintaining the local register from 1 April 2013; and**
    - **reviewing individuals' care with the Local Authority, including identifying who should be the first point of contact for each individual.**

[14] For a very small number of people with complex needs, this can be a lengthy process. However, we expect this process to be carried out as quickly as possible. If, by this time, there are a very small number of cases where plans are agreed but not yet fully implemented, progress will be closely monitored.

Reviewing care and agreeing personal care plans

4.9 People should have the right care and support package to meet their individual needs. The care plans of all inpatients with challenging behaviour will be reviewed individually. Commissioners will assess whether they can create a better, community-based support package tailored as far as possible to each individual's needs.

4.10 People with challenging behaviours and their families will have the support they need to ensure they can take an active part in these reviews - being provided with information, advice and independent advocacy, including peer advocacy.

4.11 Personal care plans should be enacted swiftly and safely. In many instances this will require the development of more personalised services in different settings so that individuals can be better supported at home or in the community. Although doing this can take time, the Department of Health expects it to be carried out with pace and a sense of urgency – whilst always putting the interest of the individual first.

4.12 Where responsibility transfers from the NHS to local government, councils should not be financially disadvantaged. The NHS should agree locally how any new burden on local authorities will be met, whether through a transfer of funding or as part of a pooled budget arrangement.

Key Actions

By 1 June 2013, health and care commissioners, working with service providers, people who use services and families will review the care of all people in learning disability or autism inpatient beds and agree a personal care plan for each individual based around their and their families' needs and agreed outcomes.

Plans should be put into action as soon as possible, and all individuals should be receiving personalised care and support in the appropriate community settings no later than 1 June 2014.

4b. LOCALLY AGREED PLANS TO ENSURE HIGH QUALITY CARE AND SUPPORT SERVICES WHICH ACCORD WITH THE MODEL OF GOOD CARE

4.13 In parallel with the actions for people currently in hospital, every local area will put in place a locally agreed joint plan to ensure high quality care and support services for all people 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.

Commissioning the right model of care and challenging poor practice

4.14 We expect commissioners to work together to drive the move from hospital care to good quality local, community-based services, and account for how they do this. This involves:

- better joint working between health and care; and
- using the evidence on good practice.

4.15 Health and care commissioners are accountable for commissioning services to meet identified needs. It is essential that they work together to develop specific plans for improving health and care services for this particular group of people. This goes wider than health and adult social care; in particular, a strategic plan must also include children's services and specialist housing.

Gloucestershire County Council and NHS Gloucestershire have a (joint) strategic commissioning plan which includes bringing people back into the county*. "For at least two years we have had a joint LA & NHS Learning Disability commissioning team (Gloucestershire CC and NHS Gloucestershire). We work from a common plan and as lead commissioner I head up the team of 8 people. We have commissioners from both health and social care. Health team members are directly engaged with complex people including people 100% funded by health and both LA and NHS colleagues work with people placed out of county*".

Referrals for anyone needing additional assessment or treatment also go through this team to a specialist Learning Disability NHS service whose aim is to prevent admission for assessment and treatment. Social care commissioning colleagues in the team also access the NHS A&T service this way. This also means that if anyone's current services need additional resources to avoid breakdown, before the resources are allocated, the specialist NHS Learning Disability service would ensure this is necessary and value for money.

4.16 Local health and care commissioners and services should be commissioning integrated care – care co-ordinated and personalised around the needs of individuals with a presumption that care should be local and that people should stay in their communities. This is more likely to happen if:

- Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWSs) take account of the health and care needs of people with challenging behaviour; and
- health and care commissioners pool budgets.

4.17 Pooled budgets with shared accountabilities are likely to facilitate the development of more integrated care. They may help overcome the lack of strong financial incentives on a single commissioner to invest in community services (eg where the cost of investment in supported living in local communities falls to councils while savings from reduced reliance on hospital services go to NHS commissioners). There should be a clear presumption that budgets should be pooled and that health and wellbeing boards should promote collaborative working and the use of pooled budgets.

4.18 Commissioners need to work with providers of specialist services to ensure that community learning disability teams have the additional, intensive support they need to keep people out of hospital – including in crises. They will also need to have access to local inpatient mental health services where these are genuinely required. This will reduce the need for hospital admissions out of area.

4.19 Finally, there is consensus that large hospital units are outdated and inappropriate and do not provide the care which people with challenging behaviour need. It is our clear expectation that commissioners should not place people in large hospitals. There may be a few people who need inpatient care, but this should be provided in smaller units and as close to home as possible. Any new, small specialist hospitals should only be built where JSNAs show a genuine unmet local need for such provision in a way which is consistent with good models of care. Local commissioners should have oversight of the services available in their areas and take the lead in discussing future need and what additional facilities are required. In addition, CQC will take account of the model of care in its revised guidance about compliance and in the registration and inspection of providers, as part of its new regulatory model.

Key Actions:

By April 2014, CCGs and local authorities will set out a joint strategic plan to commission the range of local health, housing and care support services to meet the needs of people with challenging behaviour in their area. This could potentially be undertaken through the health and wellbeing board and could be considered as part of the local Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy (JHWS) processes.

The strong presumption will be in favour of pooled budget arrangements with local commissioners offering justification where this is not done. The NHSCB, ADASS and ADCS will promote and facilitate joint commissioning arrangements.

Evidence on best practice

4.20 Commissioning needs to draw on the evidence of what is best practice in the care of people with challenging behaviour. The Model of Care set out in this report is based on well established evidence. To strengthen the evidence base, NICE is developing further standards and guidelines for this group of people, to go alongside the standards already published on autism clinical pathways.

Key Actions:

By Summer 2015 NICE will publish quality standards and clinical guidelines on challenging behaviour and learning disability.

By Summer 2016 NICE will publish quality standards and clinical guidelines on mental health and learning disability.

4.21 NICE will also develop new quality standards on child maltreatment. They will focus on the recognition and response to concerns about abuse and neglect and effective interventions. These will support the use of the Government's statutory guidance, *Working Together to Safeguard Children.*[15]

Prioritising children and young people's services

4.22 Children and young people with challenging behaviour can face particular difficulties and crises as they move from child to adult services. Integrating care and support around their needs and ensuring that they have access to the services identified in their agreed care plan is vital.

4.23 For children and young people with special educational needs or disabilities the Mandate to the NHS Commissioning Board sets out the expectation that children will have access to the services identified in their agreed care plan and that parents of children who could benefit will have the option of a personal budget based on a single assessment across health, social care and education. This means:

- integrated planning around the needs of individual children; and
- identifying best outcomes and measuring progress.

4.24 Local health and care commissioners need to plan strategically to develop local services that properly meet the needs of children and young people in the area where they live.

Good practice: Ealing services for children with additional needs set up "The Intensive Therapeutic & Short Break Service (ITSBS). The service provides a viable model for significantly reducing challenging behaviour and securing home placement stability for a small but significant number of children and young people whose challenging behaviour would otherwise most likely result in a

[15] https://www.education.gov.uk/publications/eOrderingDownload/00305-2010DOM-EN-v3.pdf

move to residential placements. Residential placement was avoided for all five young people who had been offered the service between 2008 and 2010. Residential placement has also been avoided for six out of the seven young people who were first offered the service between 2010 and 2011.

Key Actions:

The Department of Health will work with the Department of Education (DfE) to introduce from 2014 a new single assessment process and Education, Health and Care Plan to replace the current system of statements and learning difficulty assessments for children and young people with special educational needs; supported by joint commissioning between local partners (subject to parliamentary approval). The process will include young people up to the age of 25, to ensure they are supported in making the transition to adulthood.

Both Departments will work with the independent experts on the Children and Young People's Health Outcomes Forum to prioritise improvement outcomes for children and young people with challenging behaviour and agree how best to support young people with complex needs in making the transition to adulthood. This will report by June 2013.

4.25 Children and young people and their families need to be involved in this work.

4c. NATIONAL LEADERSHIP SUPPORTING LOCAL CHANGE

4.26 While changes to people's lives require action at a local level, with local commissioners and providers working together, change of this scale, ambition and pace requires **national leadership**. To provide leadership and support to the transformation of services locally, the LGA and the NHSCB will develop an improvement programme led by a senior sector manager. This will be in addition to the cross-government programme board.

Key Actions:

The Local Government Association and NHS Commissioning Board will establish a joint improvement programme to provide leadership and support to the transformation of services locally. They will involve key partners including DH, ADASS, ADCS and CQC in this work, as well as people with challenging behaviour and their families. The programme will be operating within three months and Board and leadership arrangements will be in place by the end of December 2012. DH will provide funding to support this work.

At a national level, from December 2012, the cross-government Learning Disability Programme Board chaired by the Minister of State for Care and Support will lead delivery of the programme of change by measuring progress against milestones, monitoring risks to delivery, and challenging external delivery partners to deliver to plan, regularly publishing updates.

4.27 Social care and health commissioners will be accountable to local populations and will be expected to demonstrate that they have involved users of care and their families in planning and commissioning appropriate local services to meet the needs of people with challenging behaviour. Families and self advocates have an important role to play in challenging local agencies to ensure that people have local services and the optimum model of care. There is a clear need both to challenge localities for failing to redesign services, and to provide practical support to help them do so.

Good Practice

There are many examples of good local practice in this area.

In **Salford,** in the last 5 years 16 people with a learning disability and behaviour that challenges living out of area have returned to their communities.

Beyond Limits have been commissioned by NHS Plymouth (now Devon CCG) to develop local personalised commissioning/provider processes and tailor-made services for people who have experienced long term, multiple placements and institutionalised living because their behaviours have challenged existing services. They are piloting this through facilitating planning for 20 people currently in out of area Specialist Assessment &Treatment Units and then providing support using personal Health Budgets.

4.28 Providers have a key role to play in redesigning service, working closely with commissioners, people who use services and families. The national market development forum within the Think Local Act Personal (TLAP) partnership will work with DH to identify barriers to reducing the need for specialist hospitals and by April 2013 will publish solutions for providing effective local services.

4.29 The Developing Care Markets for Quality and Choice programme will support local authorities to identify local needs for care services and produce market position statements, including for learning disability services.

4.30 The NHSCB will also work with ADASS to develop by April 2013 practical resources for commissioners of services for people with learning disabilities,[16] including:

- model service specifications;
- new NHS contract schedules for specialist learning disability services;
- models for rewarding best practice through the NHS Commissioning for Quality and Innovation (CQUIN) framework; and
- a joint health and social care self-assessment framework to support local agencies to measure and benchmark progress.

Key Action:

By March 2013 the NHSCB and ADASS will develop service specifications to support CCGs in commissioning specialist services for children, young people and adults with challenging behaviour built around the model of care in Annex A.

4.31 DH will ensure health and wellbeing boards have guidance and information to support them to understand the complex needs of people with challenging behaviour.

16 This will build on the guidance published in October 2012, *Improving the health and wellbeing of people with learning disabilities: an evidence-based commissioning guide for clinical commissioning groups.* http://www.improvinghealthandlives.org.uk/publications/1134/Improving_the_Health_and_Wellbeing_of_People_with_Learning_Disabilities:_An_Evidence-Based_Commissioning_Guide_for_Clinical_Commissioning_Groups
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Part 5: Strengthening accountability and corporate responsibility for quality of care

5.1 Although 11 former members of staff at Winterbourne View have been sentenced in connection with the abuse of patients, this review has identified weaknesses in the system of accountability where leaders of organisations are not fully held to account for poor quality or for creating a culture where neglect and even abuse can happen.

Quality of care

5.2 **The primary responsibility for the quality of care rests with the providers of that care. Owners, Boards of Directors and Senior managers of organisations which provide care must take responsibility for ensuring the quality and safety of their services**. The requirements set out in law include:

- safe recruitment practices which select people who are suitable for working with people with learning disabilities or autism and behaviour that challenges;
- providing appropriate training for staff on how to support people with challenging behaviour;
- providing good management and right supervision;
- providing leadership in developing the right values and cultures in the organisation;
- having good governance systems in place; and
- providing good information to support people making choices about care and support, including the views of people who use services about their experience.

5.3 We also expect boards to demonstrate good practice and comply with further legal requirements, which include:

- Directors, management and leaders of organisations providing NHS or local authority-funded services must ensure that systems and processes are in place to provide assurance to themselves, service users, families, local Healthwatch and the public that essential requirements are being met and that they deliver high quality and appropriate care;
- the Boards of care providers should understand the quality of the care and support services they deliver; and
- organisations must identify a senior manager or, where appropriate a Director, to ensure that the organisation pays proper regard to quality, safety, and clinical governance for that organisation.

Key Action:

We expect Directors, management and leaders of organisations providing NHS or local authority-funded services to ensure that systems and processes are in place to provide assurance that essential requirements are being met and that they have governance systems in place to ensure they deliver high quality and appropriate care.

Sanctions to hold Boards to account when the quality of care is unacceptable:

5.4 There must be robust consequences for senior managers or Boards of Directors of services where through neglect the organisations they lead provide poor quality of care or where people experience neglect or abuse.

CQC's enforcement powers

5.5 CQC will take steps to strengthen the way it uses its existing powers to hold organisations to account for failure to meet legal obligations to service users. CQC registers providers at an organisational level. However, its inspections take place at the level at which services are delivered. As a result CQC has not always held organisations to account at a corporate level, but rather at the level of the regulated service. This needs to be addressed.

5.6 While most organisations providing care put in place governance arrangements that support safety and quality, some do not pay sufficient attention to this area. Where the leadership of an organisation allows a culture to develop that does not foster safety and quality in care, the people providing that leadership have to be held to account for the service failings. In the words of the serious case review, "Castlebeck Ltd's appreciation of events… was limited, not least because they took the financial rewards without any apparent accountability."

5.7 This is an unacceptable situation and must change. CQC already has powers to take action:

- CQC is able to take tough enforcement action against organisations that do not meet the registration requirements, including stopping them from providing specific services or operating from specific locations. In the most extreme cases CQC can cancel a provider's registration, stopping it from providing any health or adult social care;
- it is already an offence under the Health and Social Care Act 2008 not to meet the essential levels of safety and quality. This would include, for example, not making suitable arrangements to ensure that service users are safeguarded against the risk of abuse. As well as prosecuting the corporate provider for a failure to meet the registration requirements, CQC can prosecute individual directors or managers where the offence can be proven to have been committed by, or with the consent or connivance of, or attributable to any neglect on the part of that individual.

5.8 It is important that CQC makes full use of its existing powers to hold the corporate body to account. CQC will meet with executives of provider organisations when there are serious concerns about quality and safety issues to discuss their plans to deliver safe

and effective care. Since summer 2012, CQC has appointed corporate compliance managers to assess the quality and safety of care of large providers who operate across a large area.

Key Action:

CQC will take steps now to strengthen the way it uses its existing powers to hold organisations to account for failures to provide quality care. It will report on changes to be made from Spring 2013.

Fit and proper person test

5.9 CQC will also consider whether it is able to use its existing powers to carry out a fit and proper person test of Board members as part of the registration of providers. One option for this could be to require providers to nominate an individual Board member with responsibility for quality who would be accountable to CQC for the quality of care. If this person did not meet the fit and proper person test, CQC could insist that another Board member is nominated. CQC could not use its existing powers to bar an individual from being a member of the Board, since Directors are not required to register with CQC.

5.10 DH will explore how a stronger fit and proper person test for board members of health and social care providers can be introduced to make it comparable to fit persons' tests in other sectors. This will include looking at:

- the tests applied by the Financial Services Authority, the Premier League and the Charity Commission, which look at an individual's past performance with regards to other regulatory systems;
- prior involvement with other companies which may have had their licences revoked, withdrawn or terminated; and
- if they or any business associated with them, has been suspended or criticised by a regulatory or professional body. Where individuals fail to meet these tests, regulators can deem them to be unsuitable to hold certain positions and organisations face regulatory action or risk being refused registration, where such persons are appointed. DH will examine if a similar approach could be applied to board members of health and social care providers.

Holding corporate bodies to account for poor care

5.11 There can be no excuse for Directors or managers allowing bullying or the sort of abusive culture seen in Winterbourne View. Individuals should not profit from others' misery.

5.12 DH will examine how corporate bodies, their Boards of Directors and financiers can currently be held to account under law for the provision of poor care and the harm experienced by people using those services.

5.13 There are a number of potential criminal offences for which a Board Director or Manager could be prosecuted:

- there are offences under general criminal law. For example, in cases where it is proved that an individual board member or manager has committed an offence against a person or aided and abetted the commission of any offence (such as an assault), then such individuals could also be prosecuted in accordance with general criminal law;
- organisations can be prosecuted for offences under the Corporate Manslaughter and Corporate Homicide Act 2007 if the service provider's organisation is managed in such a way that it caused a person's death. The track record of prosecution in such cases – despite new legislation being introduced expressly to address corporate failure – is thin.

Key Action:

The Department of Health will immediately examine how corporate bodies, their Boards of Directors and financiers can be held to account for the provision of poor care and harm, and set out proposals during Spring 2013 on strengthening the system where there are gaps.

We will consider both regulatory sanctions available to CQC and criminal sanctions. We will determine whether CQC's current regulatory powers and its primary legislative powers need to be strengthened to hold Boards to account and will assess whether a fit and proper persons test could be introduced for board members.

Developing leadership in Boards

5.14 Boards should ensure they have proper governance arrangements in place and take seriously their corporate responsibilities towards the people for whom they provide care. DH will explore with the National Skills Academy and the NHS Leadership Academy options to develop proposals on Board leadership development by March 2013.

Part 6: Tightening the regulation and inspection of providers

6.1 What happened at Winterbourne View raised profound questions about how regulation and inspection was working. As a result of Winterbourne View, and learning from their programme of inspecting nearly 150 learning disability hospitals, CQC is seeking to improve the way it regulates and inspects providers. In particular, CQC is committed to delivering on the recommendations set out in their Internal Management Review[17], the findings of the Serious Case Review, the evaluation of their inspection of nearly 150 learning disability services[18], and any relevant matters from the consultation on their strategy for 2013-16[19] to ensure that its regulation of providers is robust.

6.2 This means:

- checking how services fit with national guidance;
- improving inspection; and
- improving information sharing.

6.3 Providers are already required to have regard to national guidance, as one of the requirements of regulation monitored by CQC. The model of care at Annex A sets out an agreed framework for best practice in this area. CQC will take action to ensure this model of care is considered as part of inspection and registration of relevant services in their new regulatory model which will be implemented in 2013. CQC will also include reference to the model of care in their revised guidance about compliance, which will also be published in 2013. Where services are not provided in line with this model of care, CQC will seek assurance that the provider's approach still delivers care in line with national guidance and legal requirements.

Key Action:

CQC will use existing powers to seek assurance that providers have regard to national guidance and the good practice set out in the model of care at Annex A.

6.4 In addition, CQC will:

- share the information, data and details they have about prospective providers with the relevant CCGs and local authorities through their existing arrangements, who will, in turn, take account of the information and data shared by CQC when making decisions to commission care from the proposed service provider;

[17] CQC Internal Management Review of the regulation of Winterbourne View (October 2011) http://www.cqc.org.uk/sites/default/files/media/documents/20120730_wv_imr_final_report.pdf
[18] CQC Review of Learning Disability Services (June 2012) http://www.cqc.org.uk/search/apachesolr_search/evaluation%20of%20learning%20disability%20services
[19] CQC, The next phase: Our consultation on our strategy for 2013 to 2016 http://www.cqc.org.uk/sites/default/files/media/documents/cqc_strategy_consultation_2013-2016_tagged.pdf

- take steps now to strengthen the way we use existing powers to hold organisations to account for failures to provide quality care and report on changes to be made from Spring 2013;
- assess whether providers are delivering care consistent with the statement of purpose made at the time of registration, particularly in relation to length of stay and to whether treatment is being offered. Where it is not, CQC will take the necessary action (including, if necessary, enforcement action) to ensure that a provider addresses discrepancies either through changes to its services or changes to its statement of purpose;
- take tough enforcement action including prosecutions, restricting the provision of services, or closing providers down, where providers consistently fail to have a registered manager in place;
- take enforcement action against providers that do not operate effective recruitment procedures to ensure that their staff are suitably skilled, of good character and legally entitled to do the work in question. Operating effective recruitment procedures is a legal requirement and providers must be able to demonstrate to CQC that they have adequate procedures in place. Evidence of effective recruitment can include a provider showing it has requested criminal records checks for eligible employees (including any staff who regularly provide care or treatment) alongside checking references and qualifications. Where a provider has not requested criminal records checks on eligible employees, it will have to assure CQC that its recruitment procedures are still effective and that it can be evidenced that it is reasonable for the check not to have been made. Providers also commit an offence if they knowingly engage a person who is barred in activities such as providing healthcare or personal care. From 2014 the government will commence an explicit duty to check that a person is not barred before engaging them in these activities;
- continue to run the stakeholder group that helped to shape the inspection of 150 learning disability services. It will continue to meet twice yearly and will be chaired by the CQC Chief Executive. CQC will review the role and function of the group as part of that work programme to make sure it continues to provide advice and critique on CQC's inspection and monitoring of providers;
- continue to make unannounced inspections of providers of learning disability and mental health services employing people who use services and families as vital members of the team;
- take a differentiated approach to inspections between different sectors of care provision to ensure the inspections are appropriate to the vulnerability and risk for the different care user groups (subject to the outcome of consultation on its new strategy);
- review, as part of its new strategy, the delivery of its responsibilities under s120 of the Mental Health Act 1983 for the general protection of patients detained under the Act which include wide powers to review the way in which the Act's functions and safeguards are working and investigating complaints by any person detained under the Act.

Key Actions:

CQC will take action to ensure the model of care is included as part of inspection and registration of relevant services from 2013. CQC will set out the new operation of its regulatory model, in response to consultation, in Spring 2013.

CQC will also include reference to the model in their revised guidance about compliance. Their revised guidance about compliance will be linked to the Department of Health timetable of review of the quality and safety regulations in 2013. However, they will specifically update providers about the proposed changes to the registration process in respect of models of care for learning disability services in 2013.

6.5 From 2013 arrangements for checking criminal records will become quicker and simpler with the introduction of a new service that will make criminal records certificates more portable. When the new service is running, the Department of Health will review the regulatory requirements about criminal records checks and consider whether providers should routinely request a criminal record certificate on recruitment.

6.6 Monitor will begin licensing non-foundation trust providers of NHS funded services from April 2014. Monitor will consider strengthening Board-level governance by including internal reporting requirements in the licensing conditions. This is in line with the recommendations from the Serious Case Review. Monitor and CQC are required to co-operate with each other and share information.

6.7 In its recent consultation document on licence conditions, Monitor proposed two requirements for providers to meet before they could obtain a licence:

- a requirement for them to hold CQC registration; and
- to confirm that their governors and directors, or equivalent people, are fit and proper persons.

6.8 The proposal is that these requirements would also appear in the licence conditions, making them on-going obligations which providers would have to continue to meet in order to continue to hold a licence. Monitor and CQC will be under a legal duty to seek to ensure that the conditions are consistent.

6.9 Ofsted, CQC, Her Majesty's Inspectorate of Constabulary (HMIC), Her Majesty's Inspectorate of Probation and Her Majesty's Inspectorate of Prisons will introduce a new joint inspection of multi-agency arrangements for the protection of children in England from June 2013. This approach, which is currently being piloted, will focus on the effectiveness of local authority and partners' services for children who may be at risk of harm, including the effectiveness of early identification and early help. The inspectorates intend to publish the arrangements for the inspections by April 2013.

6.10 Ofsted is responsible for inspecting children's homes, as well as boarding and residential provision in schools. Under new inspection frameworks published in September 2012 they will make judgements on the overall effectiveness, outcomes for children and young people, quality of care, safeguarding as well as leadership and management. Under the framework inspectors are expected to consider residents views on the service, to observe interactions between staff and children and young people and to obtain the views of relevant parties including social workers and the authorities responsible for placements.

Part 7: Improving quality and safety

7.1 Ensuring that commissioners are commissioning the right services, that organisations are properly accountable, and that regulation is most effective will tackle many of the systemic problems revealed by Winterbourne View. However, the Serious Case Review and the other evidence we have received make it clear that the programme of change must go wider.

7.2 The actions we have described so far are primarily for the Department of Health, commissioners and regulators to lead. However, this wider programme lays much greater weight on the responsibility of providers, professional bodies and others to lead. It covers:

- making best practice normal;
- improving the capacity of the workforce;
- whistleblowing;
- the Mental Health Act and Mental Capacity Act;
- physical restraint;
- medication; and
- improving advocacy.

Making best practice normal

7.3 The fundamental responsibility for providing good quality care rests with providers. Representatives of provider organisations fully accept this. They have agreed to work together to develop options for improving quality, including bringing forward a pledge or code model based on shared principles along the lines of the TLAP Making it Real principles for learning disability providers.

7.4 Providers should involve people with learning disabilities and people with autism and their families in checking the quality of services.

Good Practice

Dimensions is a large social care provider that has made stringent efforts to monitor and improve quality and performance. It made a conscious decision to create a Compliance audit team separate from the operational management of services, believing that this tension would enable more objective and rigorous monitoring. The Dimensions Compliance team, together with a team of four Experts by Experience, work across each of the organisation's regions conducting service audits. The audits look at every aspect of the service from regulatory requirements, finance, health and safety and for evidence of better practice, including a two hour observation of staff interacting with the people they are supporting as well as on-going observation throughout the visit. The audit process gives a clear picture of what is happening in individual services and across the organisation, and forms part of the reporting of risk management up through its governance

structure, including the people it supports. The new systems are contributing to significant advances in quality and improved outcomes. Dimensions' intention is to promote best practice, ensure that it exceeds compliance requirements and demonstrate robust and rigorous processes of internal scrutiny in line with its vision and values.

7.5 Good practice guidance for the care of adults is well established[20]. And there will be new statutory guidance in relation to children in long-term residential care.

Key Action:

The Department of Health and the Department for Education will develop and issue statutory guidance on children in long-term residential care (s85 and s86 of the Children Act 1989) in 2013.

Improving the capability of the workforce

7.6 Recruiting, training and managing the workforce is the responsibility of providers. The events at Winterbourne View highlighted that there are too many front-line staff who have not had the right training and support to enable them to care properly for people with challenging behaviour. This is a theme which has been reinforced by many of the families we have heard from.

7.7 It is crucial that staff who work with people with challenging behaviour are properly trained in essential skills. CQC will take enforcement action against providers who do not operate effective processes to ensure they have sufficient numbers of properly trained staff. Better skills and training are an important part of raising standards overall and we expect providers to ensure the people they employ are properly trained. However, the Department of Health, commissioners and other organisations will play an important role in setting expectations, creating standards and offering advice.

7.8 We expect commissioners to assure themselves that providers are meeting proper training standards. Contracts with learning disability and autism hospitals should be dependent on assurances that staff are signed up to the proposed Code of Conduct which the Department of Health has commissioned from Skills for Health and Skills for care, and minimum induction and training standards for unregistered health and social care assistants are being met.

7.9 From April 2013 Health Education England (HEE) will have a duty to ensure we have an education and training system fit to supply a highly trained and high quality workforce. HEE will work with the Department of Health, providers, clinical leaders, and other partners to improve the skills and capability of the workforce to respond to the needs of people with challenging behaviour and will examine ways to ensure that skills include knowing when and how to raise concerns, (in other words 'whistleblow') including on disability hate crime.

[20] see *Services for People with Learning Disability and challenging behaviour or mental health needs* 2007, Prof. Jim Mansell, http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_080129

7.10 HEE will expect that all new entrants are tested for their values and interpersonal skills, and will reach out into schools and colleges to ensure that young people with the right values consider a career in healthcare. HEE will ensure the values set out in the NHS Constitution lie at the heart of all it does.

7.11 It is crucial that staff who work with people with challenging behaviour should be properly trained in essential skills. HEE are committed to ensuring that non-professional members of the workforce (ie bands 1-4) receive continuing development and training to provide a skilled and highly motivated workforce.

7.12 It is not sufficient to have a well-trained workforce. There also needs to be good clinical and managerial leadership. The National Skills Academy for Social Care, on behalf of the Department of Health, published a Leadership Qualities Framework for Adult Social Care in October 2012. This builds on the principle that leaders that demonstrate the right values and behaviours at every level of the sector provide the best foundation for transforming social care.

7.13 There will be concerted effort across the system over the next year to ensure health and care professionals understand and are guided in achieving minimum standards, and aspire to best practice.

Key Actions

CQC will take enforcement action against providers who do not operate effective processes to ensure they have sufficient numbers of properly trained staff.

By December 2012 the professional bodies that make up the Learning Disability Professional Senate will refresh *Challenging Behaviour: A Unified Approach*[21] to support clinicians in community learning disability teams to deliver actions that provide better integrated services.

By April 2013 the Academy of Medical Royal Colleges and the bodies that make up the Learning Disability Professional Senate will develop core principles on a statement of ethics to reflect wider responsibilities in the health and care system.

Skills for Care will develop by February 2013 a framework of guidance and support on commissioning workforce solutions to meet the needs of people with challenging behaviour.

Skills for Health and Skills for Care will develop by January 2013 national minimum training standards and a code of conduct for healthcare support workers and adult social care workers. These can be used as the basis for standards in the establishment of a voluntary register for healthcare support workers and adult social care workers in England.

[21] The Royal College of Psychiatrists and British Psychological Society and Royal College of Speech and Language Therapists: *A Unified Approach* (2007)

By end 2013 there will be a progress report on actions to implement the recommendations in *Strengthening the Commitment*, the report of the UK Modernising Learning Disability Nursing Review[22].

Confidence in Whistleblowing

7.14 When things go badly wrong, and local management is reluctant to change, members of staff must feel it is safe for them to raise their concerns more widely and that they will be listened to. The interim report of this review set out action already taken to encourage whistleblowing[23]. It also clarified roles within the system:

- **Government:** in ensuring that the legislative framework in the Public Interest Disclosure Act is adequate;
- **Employers**: in supporting staff to raise concerns by having a clear policy in place which makes it clear that staff who raise concerns will be supported and which provides ways to by-pass the immediate line management chain where necessary;
- **CQC**: in monitoring concerns about patient safety raised with it and ensuring that timely referrals are made to the professional regulators where necessary; and
- **Professionals and other health and care workers**: in raising concerns promptly.

7.15 CQC has strengthened its arrangements for responding to concerns that are raised with it by whistleblowers. Whistleblowing concerns are now monitored to ensure they are followed up and thoroughly investigated until completion and the information provided is included in regional risk registers, which list providers where 'major concerns' have been identified.

7.16 The Department of Health funds a free, confidential whistleblowing helpline for NHS and care staff and employers who need advice about raising concerns and for employers on best practice. The service, provided by Mencap, was extended for the first time to staff and employers in the social care sector. Mencap will shortly be announcing a campaign which aims to reduce the gap between those staff who know how to whistleblow and those who would feel comfortable in doing so.

7.17 In March 2012, we revised the NHS Constitution to include an expectation that staff will raise concerns, a pledge that concerns will be acted upon and an undertaking to give clarity around the existing legal rights to raise concerns. It is important that workers know to whom they can raise concerns and all employers should have a clear whistleblowing policy in place.

7.18 Where a doctor has good reason to think that patient safety is or may be seriously compromised by inadequate premises, equipment, or other resources, policies or systems, s/he has a duty to put the matter right if possible. Similar duties are laid on other professionals through their codes of conduct. In all cases, professionals must consider the wider implications of failing to report such concerns and the risks to patient safety.

7.19 The Department of Health has asked the LGA and NHSCB to take account of the recommendations of the Serious Case Review on whistleblowing**. Commissioners**

[22] *Strengthening the Commitment'*http://www.scotland.gov.uk/Publications/2012/04/6465/downloads
[23] http://www.dh.gov.uk/health/2012/06/interimwinterbourne/

should ensure that organisations contracting with the NHS or a local authority include a condition of employment on its workers to report concerns where:

- a criminal offence has been, is being or is likely to be committed;
- a person has failed, is failing or is likely to fail to comply with any legal obligation to which he is subject;
- a miscarriage of justice has occurred, is occurring or is likely to occur;
- the health or safety of any individual has been, is being or is likely to be endangered;
- the environment has been, is being or is likely to be damaged; or
- information tending to show any matter falling within any one of the preceding paragraphs has been, is being or is likely to be deliberately concealed.

Improving safeguarding

7.20 Following consultation, **DfE is revising *Working Together to Safeguard Children*, statutory guidance on how organisations, agencies and individuals working with children should work together to safeguard and promote their welfare**. The guidance will be published in due course.

7.21 Events at Winterbourne View flagged the need to prioritise strengthening adult safeguarding arrangements. The Serious Case Review shows that adult safeguarding systems failed to link information. NHS South of England's review highlighted the absence of processes for commissioners to be told about safeguarding alerts and failures to follow up concerns when commissioners became aware of them. The Department of Health has already announced its intention to put Safeguarding Adults Boards on a stronger, statutory footing, better equipped both to prevent abuse and to respond when it occurs. By strengthening the safeguarding adults boards arrangements and placing health, NHS and the police as core partners on the boards we will help ensure better accountability, information sharing and a framework for action by all partners to protect adults from abuse.

Key Action:

The Department of Health will revise statutory guidance and good practice guidance to reflect new legislation and address findings from Winterbourne View, to be completed in time for the implementation of the Care and Support Bill (subject to parliamentary approval). In particular:

- **Safeguarding Adults Boards will be put on a statutory footing, subject to parliamentary approval of the Care and Support Bill;**
- **local authorities will be empowered to make safeguarding enquiries, and Boards will have a responsibility to carry out safeguarding adults reviews;**
- **the Safeguarding Adults Board will publish an annual report on the exercise of its functions and its success in achieving its strategic plan; and**
- **the Safeguarding Adults Board core membership will consist of the LA, NHS and Police organisations, convened by the LA. Individual boards will be able to appoint other members in line with local need.**

7.22 Local authorities should ensure that everyone involved in safeguarding is clear about their roles and responsibilities. All local authorities and their local safeguarding partners should ensure they have robust safeguarding boards and arrangements and have the

right information-sharing processes in place across health and care to identify and deal with safeguarding alerts. This requires a multi-agency approach including all partners. In recognition of the critical role of information sharing and multi-agency working in delivering successful outcomes for adults and children at risk, the Home Office is working in partnership with the Association of Chief Police Officers (ACPO), the Department of Health and the Department for Education to improve our understanding of the different local multi-agency models in place to support information sharing around safeguarding responses for vulnerable people.

7.23 **Local areas need to work in partnership, including, where necessary with police and criminal justice agencies, to ensure that people returning to communities are supported adequately. This may include working with integrated offender management teams where appropriate**.

7.24 NHS Accident and Emergency (A&E) staff need to be alert to adult safeguarding issues and have a clear understanding of what to do with any safeguarding concerns. The Department of Health will highlight to A&E departments the importance of detecting incidences of re-attendance from the same location /individual in their annual review of Clinical Quality Indicators.

7.25 ACPO recognise the importance of working together with statutory agencies, local authorities and safeguarding partners to enhance the service provided to vulnerable adults. ACPO has reviewed the overall learning from Winterbourne View and will ensure the following:

- the one direct recommendation relating to the police regarding the early identification of trends and patterns of abuse has been fully recognised by Avon & Somerset Police. A specific workstream has been created by the force to identify a process to trigger early identification of abuse. The lessons learnt from the work undertaken will be disseminated nationally; and
- all associated learning from the review will be incorporated into training and practice, including Authorised Professional Practice.

Applying protections of the Mental Health Act and the Mental Capacity Act

7.26 Nearly three-quarters of people at Winterbourne View hospital (73%) were detained under the Mental Health Act 1983. But it is clear that the principles and safeguards of the Mental Health Act were not properly applied. This was also true for some of the people who were informal patients, who also had their freedom and movement constrained. Some of the people we met said they and their families were given little say in where they were sent. This does not fit with the principles of personalisation in the NHS Constitution or the principles of the Mental Health Act 1983 and Mental Capacity Act 2005.

Key Actions:

The Department of Health will work with CQC to agree how best to raise awareness of and ensure compliance with Deprivation of Liberty Safeguards (DOLS) provisions to protect individuals and their human rights and will report by Spring 2014.

During 2014 the Department of Health will update the Mental Health Act Code of Practice and this will take account of findings from this review.

Raising understanding of good practice and reducing the use of physical restraint

7.27 Physical restraint should only ever be used as a last resort and never used to punish or humiliate.

7.28 The CQC inspections revealed widespread uncertainty on the use of restraint, with some providers over-reliant on physical restraint rather than positive behaviour support and managing the environment to remove or contain the triggers which could cause someone to behave in a way which could be seen as challenging. In Winterbourne View, bullying, punishment and humiliation were disguised as restraint.

7.29 We need both to take enforcement action where restraint is used improperly or illegally and to clarify and spread better understanding on how to use restraint properly. Where CQC finds evidence of inappropriate or illegal use of restraint it will take enforcement action.

Key Actions:

The Department of Health will, together with CQC, consider what further action may be needed to check how providers record and monitor restraint.

With external partners, the Department of Health will publish by the end of 2013 guidance on best practice on positive behaviour support so that the physical restraint is only ever used as a last resort where the safety of individuals would otherwise be at risk and <u>never</u> to punish or humiliate.

7.30 This will include:

- a set of agreed values to promote change and raise standards to minimise the use of physical intervention;
- looking at different methods of restraint;
- a training framework for commissioners to enhance the skills of the workforce; and
- identification of information and data needs.

This work will look more widely than people with challenging behaviour and apply to anyone in the health and social care systems who may be subject to physical intervention.

Addressing the use of Medication

7.31 **We have heard deep concerns about over-use of antipsychotic and anti-depressant medicines**. Health professionals caring for people with learning disabilities should assess and keep under review the medicines requirements for each individual patient to determine the best course of action for that patient, taking into account the views of the person if possible and their family and/or carer. Services should have systems and policies in place to ensure that this is done safely and in a timely manner and should carry out regular audits of medication prescribing and management, involving pharmacists, doctors and nurses.

Key Actions:

The Royal College of Psychiatrists, the Royal Pharmaceutical Society and other professional leadership organisations will work with ADASS and ADCS to ensure medicines are used in a safe, appropriate and proportionate way and their use optimised in the treatment of children, young people and adults with challenging behaviour. This should include a focus on the safe and appropriate use of antipsychotics and anti-depressants.

The Department of Health will explore with the Royal College of Psychiatrists and others whether and how to commission an audit of use of medication for this group. As the first stage of this we will commission, by summer 2013, a wider review of the prescribing of antipsychotic and antidepressant medicines for people with challenging behaviour.

Improving information, advice and advocacy

7.32 Good information and advice, including advocacy, is important to help people with challenging behaviour and their families to understand the care available to them and make informed choices. But it is clear that there is a very wide variety in the quality and accessibility of information, advice and advocacy, including peer advocacy and support to self-advocate.

Good Practice

In Dudley the local authority is working with independent advocacy organisations and commissioners to develop a quality framework which we hope will be widely adopted.

Key Actions:

The Department of Health will work with independent advocacy organisations to:

- **identify the key factors to take account of in commissioning advocacy for people with learning disabilities in hospitals so that people in hospital get good access to information, advice and advocacy that supports their particular needs; and**
- **drive up the quality of independent advocacy, through strengthening the Action for Advocacy Quality Performance Mark and reviewing the Code of Practice for advocates to clarify their role.**

7.33 It is vital that people who make complaints about their care, or the care of a family member are listened to and are given the support (including advocacy as appropriate) and advice they need to make that complaint. This includes complaints about abuse and disability hate crime.

7.34 The Care and Support White Paper[24] states that all providers are required, by law, to have a clear and effective complaints system, and this is monitored by the CQC. If a provider or local authority does not resolve a complaint to the satisfaction of the user, that person can ask the Local Government Ombudsman to investigate. The Ombudsman will be clearly signposted through the new national information website for care and support.

7.35 The Department of Health accepted the recommendations made by the Equality and Human Rights Commission, which includes putting in place robust and accessible systems so that residents living in institutions can be confident of reporting harassment by staff or other residents.

7.36 The Department for Health is strengthening the ways in which people can give feedback on their care and support. This Government supports the development of websites which allow those who use services and their family or carers, to give feedback to providers and commissioners about any poor, or indeed good practice.

7.37 The Department of Health will work with the LGA and Healthwatch England on involving people with learning disabilities and their families in local Healthwatch organisations. A key way for local Healthwatch to benefit from the voice of people with learning disabilities and families is by engaging with existing local Learning Disability Partnership Boards, and, for children and young people, Parent Carer Forums. LINks (local involvement networks) and those preparing for Healthwatch can begin to build these relationships with their Boards in advance of local Healthwatch organisations starting up on 1 April 2013.

[24] *Caring for our Future: reforming care and support* , http://www.dh.gov.uk/health/2012/07/careandsupportwhitepaper/

Part 8: Monitoring and reporting on progress

8.1 How will government, the public, people with challenging behaviour and families know we are making progress? Transparency of information and robust monitoring are critical for delivering transformed care and support. This involves:

- auditing current provision;
- developing better information for the future; and
- national monitoring through the Learning Disability Programme Board, including service user and family representation.

Auditing current provision

8.2 In pursuing this review, it became clear that there is a lack of clarity on the number of people with challenging behaviour in hospital settings or who is responsible for them. There have been improvements, but much more needs to be done to establish a baseline.

Key Action:

By March 2013 the Department of Health will commission an audit of current services for people with challenging behaviour to take a snapshot of provision, numbers of out of area placements and lengths of stay. The audit will be repeated one year on to enable the learning disability programme board to assess what is happening.

Developing better information systems

8.3 The Department of Health intends to establish key performance indicators (on, for example, numbers of people in hospital, length of stay, incidents of restraint, and number of safeguarding alerts) which will enable the Learning Disability Programme Board and local services to monitor progress.

Action:
The Department of Health, the Information Centre for Health and Social Care and the NHSCB will develop measures and key performance indicators to support commissioners in monitoring their progress from April 2013.

The Department of Health will develop a new learning disability minimum data set to be collected through the Information Centre from 2014/15.

The NHSCB and ADASS will implement a joint health and social care self assessment framework to monitor progress of key health and social care inequalities from April 2013. The results of progress from local areas will be published.

Monitoring and transparency

8.4 We will monitor progress through the Learning Disability Programme Board. It will also be essential for the process to be transparent and open to scrutiny.

Key Actions:

The cross-government Learning Disability Programme Board will measure progress against milestones, monitor risks to delivery and challenge external delivery partners to deliver to the action plan of all commitments (Annex B). CQC, the NHSCB and the head of the LGA, ADASS, NHSCB development and improvement programme will, with other delivery partners, be members of the Programme Board, and report on progress.

Regular updates to the Programme Board will be published on the Department of Health website, with all other papers and minutes for that Board.

The Department of Health will work with the improvement team to monitor and report on progress nationally, including reporting comparative information on localities. We will publish a follow up report by December 2013 and repeat this by December 2014.

Part 9: Conclusion

9.1 For too long, people with challenging behaviour have – as highlighted by Mencap and the Challenging Behaviour Foundation – been too much out of sight. Although there is ample authoritative guidance across health and care, and examples of good practice around the country, in too many places the needs of this highly vulnerable group of people are not being addressed. It is easy to see why families and groups who support people with challenging behaviour are sceptical about what will happen this time to deliver the transformation of care which people deserve.

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9.2 But we believe that the package of timetabled actions set out in this report and the accompanying Concordat, together with the commitment by national and local leaders to monitor and report on delivery against these will deliver real change. And this will be enabled by the reforms to health and care systems which give greater power to individuals and local communities to develop services which genuinely respond to local needs.

Annex A: The model of care

There are too many people challenging behaviour living in inpatient services for assessment and treatment and they are staying there for too long.

The closure of most long-stay hospitals in the 1980s and 1990s, and the recent closure of NHS campuses, means most people with learning disabilities, including those with behaviours that challenge now live in the community with support. But some still live (for short or longer periods) in NHS funded settings. Assessment and treatment units emerged as the most likely solution to meeting the needs of people with learning disabilities and complex mental health/behavioural issues post-institutional closure. However, there were opposing views between 'building based' services and increasing support to people in their natural communities as the preferred option.

Good practice guidance on supporting people with learning disabilities, autism and those with behaviour which challenge includes the 1993 Mansell report, updated and revised in 2007. Both emphasise:

- the responsibility of commissioners to ensure that services meet the needs of individuals, their families and carers;
- a focus on personalisation and prevention in social care;
- that commissioners should ensure services can deliver a high level of support and care to people with complex needs/challenging behaviour; and
- that services/support should be provided locally where possible.

Evidence shows that community-based housing enables greater independence, inclusion and choice and that challenging behaviour lessens with the right support. The Association of Supported Living's report *There is an Alternative* describes how 10 people with learning disabilities and challenging behaviour moved from institutional settings to community services providing better lives and savings of around £900,000 a year in total.

The CQC *Count me in* 2010 census showed only 2 learning disabled patients on Community Treatment Orders compared to over 3,000 mental health patients – suggesting a greater reliance on inpatient solutions for people with learning disabilities than for other people needing mental health support.

CQC found some people were staying many years in assessment and treatment units. Annex B estimates that, in March 2010, at least 660 people were in A&T in Learning Disability wards for more than 6 months.

This report sets out how the model of care set out in the Mansell reports fits with the new health and care system architecture focusing on key principles, desired outcomes for individuals, and a description of how the model should work in practice.

Key principles

The key principles of high quality services for people with learning disabilities and behaviour which challenges are set out below:

For people:

1. I and my family are at the centre of all support – services designed around me, highly individualised and person-centred;
2. My home is in the community – the aim is 100% of people living in the community, supported by local services;
3. I am treated as a whole person;
4. Where I need additional support, this is provided as locally as possible.

For services:

5. Services are for all, including those individuals presenting the greatest level of challenge;
6. Services follow a life-course approach i.e. planning and intervening early, starting from childhood and including crisis planning;
7. Services are provided locally;
8. Services focus on improving quality of care and quality of life;
9. Services focus on individual dignity and human rights;
10. Services are provided by skilled workers;
11. Services are integrated including good access to physical and mental health services as well as social care;
12. Services provide good value for money;
13. Where inpatient services are needed, planning to move back to community services starts from day one of admission.

Outcomes

A high quality service means that people with learning disabilities or autism and behaviour which challenges will be able to say:

1. I am safe;
2. I am treated with compassion, dignity and respect;
3. I am involved in decisions about my care;
4. I am protected from avoidable harm, but also have my own freedom to take risks;
5. I am helped to keep in touch with my family and friends;
6. Those around me and looking after me are well supported;
7. I am supported to make choices in my daily life;
8. I get the right treatment and medication for my condition;
9. I get good quality general healthcare;
10. I am supported to live safely in the community;
11. Where I have additional care needs, I get the support I need in the most appropriate setting;
12. My care is regularly reviewed to see if I should be moving on.

This is about personalisation, starting with the individual at the centre, living in the community. The first level of support for that individual includes the people, activities and support all people need in their every day lives – family, friends, circles of support, housing, employment and leisure.

Most people with learning disabilities or autism will need more support from a range of sources: their GP or other primary care services, advocacy, a care manager or support worker and could include short breaks. That support may change as needs change, and this will involve assessments of physical or mental health needs or environmental needs (such as loss of a parent, a relationship breakdown, unemployment) to identify what support should be provided.

For people who need further support – including where they have behaviour which challenges – the intensity of support should increase to match need. That should include intensive support services in the community, assessment and treatment services (which could be provided in a safe community setting), and, where appropriate, secure services. But the aim should always be to look to improvement, recovery, and returning a person to their home setting wherever possible.

Responsibility for safety and quality of care depends on all parts of the system working together:

i. **providers** have a duty of care to each individual they are responsible for, ensuring that services meet their individual needs and putting systems and processes in place to provide effective, efficient and high quality care;
ii. **commissioners** (NHS and local authorities) are responsible for planning for local needs, purchasing care that meets people's needs and building into contracts clear requirements about the quality and effectiveness of that care;
iii. **workforce,** including health and care professional and staff who have a duty of care to each individual they are responsible for; and
iv. **system and professional regulators** who are responsible for assuring the quality of care through the discharge of their duties and functions.

To achieve these outcomes a revised model of care as set out below needs to be delivered.

Roles and responsibilities

Good services meeting the needs of everybody must include:

<u>Information</u>

- **Councils, elected councillors, health bodies and all care providers, whether from the public, for-profit or not-for-profit sectors** should provide good quality, transparent, information, advice and advocacy support for individuals, families and carers.

<u>Community based support</u>

- **Councils and health commissioners** should ensure that general services (GPs, hospitals, libraries, leisure centres etc) are user-friendly and accessible to people with learning disabilities/autism so they can access what everyone else can access.

- **Community based mental health services** for this group should offer assertive outreach, 24-hour crisis resolution, a temporary place to go in crisis and general support to deal with the majority of additional support needs at home.
- **Housing** authorities should include a wide range of community housing options - shared, individual, extra care, shared lives scheme, domiciliary care, keyring, respite.
- **Social care commissioners** should ensure the availability of small-scale residential care for those who would benefit from it (eg because they have profound and multiple disabilities).
- **Councils and employment services** should offer support into employment.
- **Councils and providers of services** should enable a range of daytime activities.
- **Councils** should roll out personal budgets for all those who are eligible for care and support including those with profound and multiple disabilities and/or behaviours seen as challenging.
- Where appropriate, **health commissioners** should fund continuing health care.
- **Health and social care commissioners** should focus on early intervention and preventive support to seek to avoid crises (eg behavioural strategies). Where crises occur, they should have rapid response and crisis support on which they can call quickly.

Commissioning, assessment and care planning

- **Health and social care commissioners** should develop personalised services that meet people's needs. Key factors include;
- involving individuals - with support where needed - and families at all stages;
- planning for the whole life course, from birth to old age, starting with children's services;
- developing expertise in challenging behaviour;
- developing partnerships and pooling resources to work together on joint planning and support with integrated services – including:
    - multi-disciplinary teams to perform assessments, care planning, care assessment, care management and review,
    - joint commissioning – ideally with pooled budgets, and
    - shared risk management;
- **Health and social care commissioners** should use all available information from joint strategic needs assessments (JSNAs) and local health and wellbeing strategies to commission strategically **for innovation** and to develop person-centred community based services;
- **Health and social care commissioners** should commission personalised services tailored to the needs of individuals, ensuring a focus on improving that individual's health and well-being and agreed outcomes. Progress towards delivering outcomes should be regularly reviewed;
- **Health and social care commissioners** should start to plan from day one of admission to inpatient services for the move back to community;
- **Health and social care commissioners** should ensure close coordination between the commissioning of specialised services including secure services, and other health and care services;

- **Social care bodies** have ongoing responsibility for individuals, even where they are in NHS-funded acute or mental health services, including working with all partners to develop and work towards delivering a discharge plan;
- **Health and social care commissioners** should audit provision to assess which services are good at supporting people with challenging behaviour (the Health Self Assessment Framework is an effective way to monitor outcomes);
- **Health and social care commissioners** should develop effective links with children's services to ensure early planning at transition and joint services. The SEND Green Paper proposal for an integrated health, education and care plan from 0-25 will also help to ensure that children's services are similarly thinking about a young person's transition to adult services at an early stage.

Service Providers

- **All service providers** (community, residential, health, care, housing – public, for-profit and not-for-profit providers) have a duty of care to the individuals for whom they provide services and a legal duty to refer. This includes ensuring that:
    - people are safe and protected from harm;
    - their health and well-being are supported;
    - their care needs are met;
    - people are supported to make decisions about their daily lives;
    - people are supported to maintain friendships and family links.

Providers should:

- provide effective and appropriate leadership, management, mentoring and supervision. Good leadership is essential in setting the culture and values;
- have a whole organisation approach to Positive Behaviour Support training;
- recruit for values and ensure that staff have training for skills - mandatory training which can include training on value bases when working with people with learning disabilities, positive behaviour support, types of communication including non-verbal communication, active support and engaging in meaningful activities and Mental Capacity requirements. Best practice includes involving people with learning disabilities and families in the training;
- operate good clinical governance arrangements;
- monitor quality and safety of care;
- Work with commissioners to promote innovation – new and different ideas, especially for the most challenging.

Assessment and treatment services

- **Health and care commissioners** are responsible for commissioning assessment and treatment services where these are needed. The focus should be on services (which can be community based) rather than units**.** Where a person is at risk (or is putting others at risk) in a way that community support cannot help and needs to be moved to a safe place, **commissioners** should focus on this being provided close to home.
- **Health and care commissioners** should look to review any placement in assessment and treatment services regularly, and focus on moving the individual on into more appropriate community based services as soon as it is safe for the individual to do so.

- **Social care services** should be closely involved in decisions to admit to assessment and treatment services.
- All **assessment and treatment services providers** must comply with statutory guidance on the use of physical restraint.

Prisons and secure services

- **Social care services** should work closely with prison and secure services to ensure person centred planning and health action planning and to plan for appropriate provision when people move on from prison or secure services.
- **Offender management processes** should include health screening programmes that identify an offender's learning disability and any physical and/or mental health issues.

Workforce should demonstrate that they are providing quality care and support which includes:

- personal and professional accountability;
- training in working with people with complex needs and behaviour which challenges;
- developing good communication and involving advocates and families'
- monitoring an individual's progress and reviewing plans; and
- good understanding of the legislative framework and human rights;
- Taking action to report any concerns identified.

System and professional regulators

As a regulator, the Care Quality Commission (CQC) should:

- monitor whether services are meeting essential standards;
- take enforcement action if a provider is not compliant;
- monitor the operation of the Mental Health Act 1983.

Professional regulators such as the Nursing and Midwifery Council (NMC) and General Medical Council (GMC), have a role to play to protect and promote public safety. They do this by:

- setting and maintaining professional standards;and
- investigating and taking appropriate action where concerns are raised about registrants, which can include the registrant being removed from the register and where appropriate being referred to the Independent Safeguarding Authority (ISA).

The professional regulators have produced a leaflet to help the public to ensure that they receive the care and treatment from professionals who meet the right standards.

Annex B: Timetable of Actions

This Report sets out a range of national actions which the Department of Health and its partners will deliver to lead a redesign in care and support for people with learning disabilities or autism and mental health conditions or behaviours viewed as challenging.

The Department of Health is committed to working with partners to monitor progress, hold all players to account for delivery, and ensure better experiences and improved outcomes for this very vulnerable group of people.

No.	Date	Action
1.	From June 2012	CQC will continue to make unannounced inspections of providers of learning disability and mental health services employing people who use services and families as vital members of the team.
2.	From June 2012	CQC will take tough enforcement action including prosecutions, restricting the provision of services, or closing providers down, where providers consistently fail to have a registered manager in place.
3.	From June 2012	CQC will take enforcement action against providers who do not operate effective processes to ensure they have sufficient numbers of properly trained staff.
4.	From November 2012	The cross-government Learning Disability Programme Board will measure progress against milestones, monitor risks to delivery and challenge external delivery partners to deliver to the action plan of all commitments. CQC, the NHSCB and the head of the LGA, ADASS, NHSCB development and improvement programme will, with other delivery partners, be members of the Programme Board, and report on progress.
5.	From December 2012	The Department of Health will work with the CQC to agree how best to raise awareness of and ensure compliance with Deprivation of Liberty Safeguards provisions to protect individuals and their human rights and will report by Spring 2014.
6.	From December 2012	The Department of Health will, together with CQC, consider what further action may be needed to check how providers record and monitor restraint**.**
7.	From December 2012	The Department of Health will work with independent advocacy organisations to identify the key factors to take account of in commissioning advocacy for people with learning disabilities in hospitals so that people in hospital get good access to information, advice and advocacy that supports their particular needs.
8.	From December 2012	The Department of Health will work with independent advocacy organisations to drive up the quality of independent advocacy, through strengthening the Action for Advocacy Quality Performance Mark and reviewing the Code of Practice for advocates to clarify their role.
9.	From December 2012	A specific workstream has been created by the police force to identify a process to trigger early identification of abuse. The lessons learnt from the work undertaken will be disseminated nationally. All associated learning from the review will be incorporated into training and practice,

No.	Date	Action
		including Authorised Professional Practice.
10.	From December 2012	The College of Social Work, to produce key points guidance for social workers on good practice in working with people with learning disabilities who also have mental health conditions;
11.	From December 2012	The British Psychological Society, to provide leadership to promote training in, and appropriate implementation of, Positive Behavioural Support across the full range of care settings.
12.	From December 2012	The Royal College of Speech and Language Therapists, to produce good practice standards for commissioners and providers to promote reasonable adjustments required to meet the speech, language and communication needs of people with learning disabilities in specialist learning disability or autism hospital and residential settings.
13.	By end of December 2012	The Local Government Association and NHS Commissioning Board will establish a joint improvement programme to provide leadership and support to the transformation of services locally. They will involve key partners including DH, ADASS, ADCS and CQC in this work, as well as people with challenging behaviour and their families. The programme will be operating within three months and Board and leadership arrangements will be in place by the end of December 2012. DH will provide funding to support this work.
14.	By end December 2012	By December 2012 the professional bodies that make up the Learning Disability Professional Senate will refresh *Challenging Behaviour: A Unified Approach* to support clinicians in community learning disability teams to deliver actions that provide better integrated services.
15.	By January 2013	Skills for Health and Skills for Care will develop national minimum training standards and a code of conduct for healthcare support workers and adult social care workers. These can be used as the basis for standards in the establishment of a voluntary register for healthcare support workers and adult social care workers in England.
16.	By February 2013	Skills for Care will develop a framework of guidance and support on commissioning workforce solutions to meet the needs of people with challenging behaviour
17.	By March 2013	The Department of Health will commission an audit of current services for people with challenging behaviour to take a snapshot of provision, numbers of out of area placements and lengths of stay. The audit will be repeated one year on to enable the learning disability programme board to assess what is happening.
18.	By March 2013	The NHSCB will work with ADASS to develop practical resources for commissioners of services for people with learning disabilities, including: ▪ model service specifications; ▪ new NHS contract schedules for specialist learning disability services; ▪ models for rewarding best practice through the NHS; commissioning for Quality and Innovation (CQUIN) framework; and ▪ a joint health and social care self-assessment framework to support local agencies to measure and benchmark progress.
19.	By March 2013	The NHSCB and ADASS will develop service specifications to support CCGs in commissioning specialist services for children, young people and

No.	Date	Action
		adults with challenging behaviour built around the model of care in Annex A.
20.	By March 2013	The Joint Commissioning Panel of the Royal College of General Practitioners and the Royal College of Psychiatrists will produce detailed guidance on commissioning services for people with learning disabilities who also have mental health conditions.
21.	By March 2013	The Royal College of Psychiatrists will issue guidance about the different types of inpatient services for people with learning disabilities and how they should most appropriately be used.
22.	By 1 April 2013	The NHSCB will ensure that all Primary Care Trust develop local registers of all people with challenging behaviour in NHS-funded care.
23.	By 1 April 2013	The Academy of Medical Royal Colleges and the bodies that make up the Learning Disability Professional Senate will develop core principles on a statement of ethics to reflect wider responsibilities in the health and care system.
24.	By 1 April 2013	The National Quality Board will set out how the new health system should operate to improve and maintain quality.
25.	By 1 April 2013	The Department of Health will work with key partners to agree how Quality of Life principles should be adopted in social care contracts to drive up standards.
26.	From 1 April 2013	The NHSCB will make clear to CCGs in their handover and legacy arrangements what is expected of them in maintaining local registers, and reviewing individual's care with the Local Authority, including identifying who should be the first point of contact for each individual.
27.	From April 2013	The NHSCB will hold CCGs to account for their progress in transforming the way they commission services for people with learning disabilities/autism and challenging behaviours.
28.	From April 2013	Health Education England will take on the duty for education and training across the health and care workforce and will work with the Department of Health, providers, clinical leaders and other partners to improve skills and capability to respond the needs of people with complex needs.
29.	From April 2013	CQC will take action to ensure the model of care is included as part of inspection and registration of relevant services from 2013. CQC will set out the new operation of its regulatory model, in response to consultation, in Spring 2013.
30.	From April 2013	CQC will share the information, data and details they have about providers with the relevant CCGs and local authorities.
31.	From April 2013	CQC will assess whether providers are delivering care consistent with the statement of purpose made at the time of registration.
32.	From April 2013	Monitor will consider in developing provider licence conditions, the inclusion of internal reporting requirements for the Boards of licensable provider services to strengthen the monitoring of outcomes and clinical governance arrangements at Board level.
33.	From April 2013	The strong presumption will be in favour of pooled budget arrangements with local commissioners offering justification where this is not done. The NHSCB, ADASS and ADCS will promote and facilitate joint

No.	Date	Action
		commissioning arrangements.
34.	From April 2013	The NHSCB will ensure that CCGs work with local authorities to ensure that vulnerable people, particularly those with learning disabilities and autism receive safe, appropriate and high quality care. The presumption should always be for services to be local and that people remain in their communities.
35.	From April 2013	Health and care commissioners should use contracts to hold providers to account for the quality and safety of the services they provide.
36.	From April 2013	Directors, management and leaders of organisations providing NHS or local authority funded services to ensure that systems and processes are in place to provide assurance that essential requirements are being met and that they have governance systems in place to ensure they deliver high quality and appropriate care.
37.	From April 2013	The Department of Health, the Health and Social Care Information Centre and the NHSCB will develop measures and key performance indicators to support commissioners in monitoring their progress.
38.	From April 2013	The NHSCB and ADASS will implement a joint health and social care self assessment framework to monitor progress of key health and social care inequalities from April 2013. The results of progress from local areas will be published.
39.	From April 2013	The Department of Health will work with the LGA and Healthwatch England to embed the importance of local Healthwatch involving people with learning disabilities and their families. A key way for local Healthwatch to benefit from the voice of people with learning disabilities and families is by engaging with existing local Learning Disability Partnership Boards. LINks (local involvement networks) and those preparing for Healthwatch can begin to build these relationships with their Boards in advance of local Healthwatch organisations starting up on 1 April 2013.
40.	By Spring 2013	The Department of Health will immediately examine how corporate bodies, their Boards of Directors and financiers can be held to account for the provision of poor care and harm, and set out proposals during Spring 2013 on strengthening the system where there are gaps. We will consider both regulatory sanctions available to CQC and criminal sanctions. We will determine whether CQC's current regulatory powers and its primary legislative powers need to be strengthened to hold Boards to account and will assess whether a fit and proper persons test could be introduced for board members.
41.	From Spring 2013	CQC will take steps now to strengthen the way it uses its existing powers to hold organisations to account for failures to provide quality care. It will report on changes to be made from Spring 2013.
42.	By 1 June 2013	Health and care commissioners, working with service providers, people who use services and families, will review the care of all people in learning disability or autism inpatient beds and agree a personal care plan for each individual based around their and their families' needs and agreed outcomes.
43.	By Summer 2013	Provider organisations will set out a pledge or code model based on shared principles - along the lines of the Think Local Act Personal (TLAP)

No.	Date	Action
		Making it Real principles.
44.	By Summer 2013	The Department of Health, with the National Valuing Families Forum, the National Forum of People with Learning Disabilities, ADASS, LGA and the NHS will identify and promote good practice for people with learning disabilities across health and social care.
45.	By summer 2013	The Department of Health will explore with the Royal College of Psychiatrists and others whether there is a need to commission an audit of use of medication for this group. As the first stage of this, we will commission a wider review of the prescribing of antipsychotic and antidepressant medicines for people with challenging behaviour.
46.	By June 2013	The Department of Health and the Department for Education will work with the independent experts on the Children and Young People's Health Outcomes Forum to prioritise improvement outcomes for children and young people with challenging behaviour and agree how best to support young people with complex needs in making the transition to adulthood.
47.	In 2013	The Department of Health and the Department for Education will develop and issue statutory guidance on children in long-term residential care.
48.	In 2013	The Department of Health and the Department for Education will jointly explore the issues and opportunities for children with learning disabilities whose behaviour is described as challenging through both the SEN and Disability reform programme and the work of the Children's Health Strategy.
49.	In 2013	The Department of Health will work with independent advocacy organisations to drive up the quality of independent advocacy.
50.	In 2013	The Department for Education will revise the statutory guidance *Working together to safeguard Children.*
51.	In 2013	The Royal College of Psychiatrists, the Royal Pharmaceutical Society ad other professional leadership organisations will work with ADASS and ADCS to ensure medicines are used in a safe, appropriate and proportionate way and their use optimised in the treatment of children, young people and adults with challenging behaviour. This should include a focus on the safe and appropriate use of antipsychotic and antidepressant medicines.
52.	By December 2013	The Department of Health will work with the improvement team to monitor and report on progress nationally, including reporting comparative information on localities. We will publish a follow up report by December 2013.
53.	By end 2013	The Department of Health with external partners will publish guidance on best practice around positive behaviour support so that physical restraint is only ever used as a last resort where the safety of individuals would otherwise be at risk and never to punish or humiliate.
54.	By end 2013	There will be a progress report on actions to implement the recommendations in *Strengthening the Commitment* the report of the UK Modernising learning disability Nursing Review.
55.	By end 2013	CQC will also include reference to the model in their revised guidance about compliance. Their revised guidance abut compliance will be linked to the Department of Health timetable of review of the quality and safety regulations in 2013. However, they will specifically update providers about

No.	Date	Action
		the proposed changes to our registration process about models of care for learning disability services in 2013.
56.	From 2014	The Department of Health will work with the Department for Education to introduce a new single assessment process and Education, Health and Care Plan to replace the current system of statements and learning difficulty assessments for children and young people with special educational needs; supported by joint commissioning between local partners (subject to parliamentary approval). The process will include young people up to the age of 25, to ensure they are supported in making the transition to adulthood.
57.	By April 2014	CCGs and local authorities will set out a joint strategic plan to commission the range of local health, housing and care support services to meet the needs of people with challenging behaviour in their area. This could potentially be undertaken through the health and wellbeing board and could be considered as part of the local Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy (JHWS) processes.
58.	No later than 1 June 2014	Health and care commissioners should put plans into action as soon as possible and all individuals should be receiving personalised care and support in appropriate community settings no later than 1 June 2014.
59.	In 2014	The Department of Health will update the Mental Health Act Code of Practice and will take account of findings from this review.
60.	By December 2014	The Department of Health will publish a second annual report following up progress in delivering agreed actions.
61.	From 2014/15	The Department of Health will develop a new learning disability minimum data set to be collected through the Health and Social Care Information Centre.
62.	By Summer 2015	NICE will publish quality standards and clinical guidelines on challenging behaviour and learning disability.
63.	By Summer 2016	NICE will publish quality standards and clinical guidelines on mental health and learning disability.

Glossary

ACPO	Association of Chief Police Officers
A & E	Accident and Emergency
A & T	Assessment and Treatment
A4A	Action for advocacy
ADASS	Association of Directors for Adult Social Services
ADCS	Association of Directors of Children's Services
BBC	British Broadcasting Corporation
CCG	Clinical Commissioning Groups
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
DfE	Department for Education
DH	Department of Health
DOLS	Deprivation of Liberty Safeguards
EOF	Education Outcomes Framework
GP	General Practitioner
HEE	Health Education England
JHWSs	Joint Health and Wellbeing Strategies
JSNAs	Joint Strategic Needs Assessments
LA	Local Authorities
LD	Learning Disability
LGA	Local Government Association
LINKS	Local involvement networks
NHS	National Health Service
NHSCB	National Health Service Commissioning Board
NICE	National Institute for Health and Clinical Excellence
NQB	National Quality Board
Ofsted	Office for Standards in Education, Children’s Services and Skills
RCGP	Royal College of General Practitioners
RCPsych	Royal College of Psychiatrists
SAB	Safeguarding Adults Boards
SCR	Serious Case Review
TLAP	Think Local Act Personal

Brent	**Community and Wellbeing Scrutiny Committee** 17 April 2019
	Report from the Strategic Director of Policy Performance and Partnerships

Community and Wellbeing Scrutiny Committee Work Plan 2018-2019 Update

Wards Affected:	All
Key or Non-Key Decision:	Non-key
Open or Part/Fully Exempt:	Open
No. of Appendices:	Two Appendices: Appendix A – Work Programme Appendix B – Public Health - Air Quality Action Plan 2017-2022
Background Papers:	None
Contact Officer:	James Diamond, Scrutiny Officer, Strategy and Partnerships, Chief Executive's Department, james.diamond@brent.gov.uk 020 8937 1068

1.0 Purpose of the Report

1.1 This report updates members on the committee's work programme for 2018/19 and captures scrutiny activity which has taken place outside of its meetings.

2.0 Recommendation(s)

2.1 Committee to discuss and note the contents of the report, including updates about scrutiny issues outside of the work programme.

2.2 Committee agrees the task group membership so far for the members' overview and scrutiny task group which will be set up to review childhood obesity.

3.0 Detail

3.1 Members of the Community and Wellbeing Scrutiny Committee discussed their work programme for 2018/19 last year, which is published as Appendix A. The programme sets out what items will be heard at committee and which items will be looked at as task groups. However, the assumption made was that it would

evolve according to the needs of the committee, and spare capacity would be left to look at issues as they arise.

3.2 For practical reasons it may be necessary to move items to be heard at a particular committee date. In addition, members and co-opted members can at any time suggest an item, which if agreed by the chair, would mean the work plan changes. One change is that the report on the safeguarding adult review for Adult B will now be discussed at committee in the new municipal year.

3.3 In addition, the scoping paper on childhood obesity will now go to committee in the next municipal year when members are expected to confirm the full scoping paper and terms of reference for the task group. The scoping paper will set out the overall objectives for the review, areas of interest, and how it will approach evidence gathering. It is proposed that members on the task group will be:

- Councillor Thakkar, chair
- Councillor Knight
- Councillor Hassan

3.4 If the committee wishes to appoint any other members to the task group then this will have to be confirmed on 17 April or at the committee meeting in July.

3.5 The new municipal year and the next cycle of committee meetings will start from 1 May 2019. The committee has previously moved items from this year into the next municipal year to allow more time for discussion at the committee meetings. Members may want to consider now what other items they would like to discuss in the next municipal year. Members will need to be mindful that at Council on 25 February 2019, there was a change to the terms of reference for the Community and Wellbeing Scrutiny Committee which means that housing will be part of its remit from the next year. Members of the committee have said they want to carry over a number of reports including but not limited to dementia, and open spaces and physical activity, to the next municipal year.

3.6 An update on public health in the Air Quality Action Plan 2017-2022 has been done by the Regeneration and Environment department and is in appendix B.

4.0 Financial Implications

4.1 There are no financial implications arising from this report.

5.0 Legal Implications

5.1 There are no legal implications arising from this report.

6.0 Equality Implications

6.1 There are no equality implications arising from this report.

7.0 Consultation with Ward Members and Stakeholders

7.1 Ward members who are committee members will review this report.

REPORT SIGN-OFF

Peter Gadsdon
Director Performance Policy and Partnerships

Appendix A: Community and Wellbeing Scrutiny Committee Work Programme 2018-19

Tuesday 10 July 2018

Agenda Rank	Item	Themes	Cabinet Member	Brent Council Officers	External Organisations
1.	Diabetes: Diagnosis, Treatment and Prevention in Brent	Review of prevention and services for those with diabetes	Cllr Krupesh Hirani, Public Health, Culture and Leisure	Dr Melanie Smith, Director of Public Health Minesh Patel, Head of Finance	Healthwatch Brent Brent Diabetes Champion
2.*	Immunisation for Children and Young People in Brent	Review of immunisation rates among under 18s.	Cllr Krupesh Hirani, Public Health, Culture and Leisure	Dr Melanie Smith, Director of Public Health Minesh Patel, Head of Finance	Healthwatch Brent

*Items involving school education. ** Items which may involve partnership work with schools.

Monday 8 October 2018

Agenda Rank	Item	Themes	Cabinet Member	Brent Council Officers	Other Organisations
1.**	Brent Local Safeguarding Children Board annual report	Scrutinise the 2017/18 annual report	Cllr Mili Patel, Children's Safeguarding, Early Help and Social Care	Gail Tolley, Strategic Director, Children and Young People Andrew Ward, Head of Finance	Independent Chair, Brent LSCB
2.	Brent Safeguarding Adults Board Annual Report	Scrutinise the 2017/18 annual report.	Cllr Harbi Farah, Adult Social Care	Phil Porter, Strategic Director Community Wellbeing Helen Woodland, Operational Director Social Care Minesh Patel, Head of Finance	Independent Chair, Brent SAB
3.	Children, Young People and Contextual Safeguarding Task Group	Set up a members' overview and scrutiny task group.	Cllr Mili Patel, Children's Safeguarding, Early Help and Social Care	Gail Tolley, Strategic Director, Children and Young People Andrew Ward, Head of Finance	

*Items involving school education. ** Items which may involve partnership work with schools.

Special Committee Meeting

21 November 2018

Agenda Rank	Item	Themes	Cabinet Member	Brent Council Officers	Other Organisations
1.	London Borough of Culture 2020	Proposals for borough of culture.	Cllr Krupesh Hirani, Public Health, Culture and Leisure	Dr Melanie Smith, Director of Public Health Phil Porter, Strategic Director Community Wellbeing Minesh Patel, Head of Finance	Brent Youth Parliament

Wednesday 28 November 2018

Agenda Rank	Item	Themes	Cabinet Member	Brent Council Officers	Other Organisations
1.**	Child and Adolescent Mental Health (CAMHS) Update	Update on CAMHS provision in Brent. Update on recommendations made in members' task group report.	Cllr Mili Patel, Children's Safeguarding, Early Help and Social Care	Gail Tolley, Strategic Director, Children and Young People Andrew Ward, Head of Finance	Sheik Auladin, Chief Operating Officer, Brent CCG Duncan Ambrose, Assistant Director, Brent CCG
2.	Development of Family Hubs	Developing family hubs	Cllr Mili Patel, Children's Safeguarding, Early Help and Social Care	Gail Tolley, Strategic Director, Children and Young People Andrew Ward, Head of Finance	
3.	Youth Offer in Brent	Review youth offer in Brent.	Cllr Mili Patel, Children's Safeguarding, Early Help and Social Care	Gail Tolley, Strategic Director, Children and Young People Andrew Ward, Head of Finance	Young Brent Foundation Brent Youth Parliament

*Items involving school education. ** Items which may involve partnership work with schools.

Special Committee Meeting

13 December 2018

Agenda Rank	Item	Themes	Cabinet Member	Brent Council Officers	Other Organisations
1.	Care Quality Commission report on London North West Healthcare NHS Trust	Discussion of report and action plan for improvements.	Cllr Harbi Farah, Cabinet Member for Health	Phil Porter, Strategic Director Community Wellbeing	Simon Crawford, Director of Strategy and Deputy Chief Executive, London North West Healthcare NHS Trust. Care Quality Commission Healthwatch Brent

Wednesday 30 January 2019

Agenda Rank	Item	Themes	Cabinet Member	Brent Council Officers	Other Organisations
1.	Contextual Safeguarding Task Group: Interim Report	To discuss emerging recommendations and findings from the task group.	Cllr Mili Patel Cabinet Member, Safeguarding, Early Help and Social Care	Gail Tolley, Strategic Director Children and Young People	
2.	Winter planning and NHS Services	Review urgent care and other services in winter.	Cllr Harbi Farah, Adult Social Care		Brent CCG Healthwatch Brent Imperial College Healthcare NHS Trust CNWL London North West NHS Healthcare Trust
3.	Corporate Complaints Report	Scrutinise the 2017/18 annual corporate complaints report	Cllr Margaret McLennan, Deputy Leader	Irene Bremang, Head of Performance and Improvement Helen Woodland, Operational Director Social Care Gail Tolley, Strategic Director, Children and Young People	

*Items involving school education. ** Items which may involve partnership work with schools.

Monday 18 March 2019

Agenda Rank	Item	Report Details	Cabinet Member	Brent Council Officers	Other Organisations
1.**	Contextual Safeguarding Overview task group	Full report and recommendations of the members' task group	Cllr Mili Patel, Children's Safeguarding, Early Help and Social Care	Gail Tolley, Strategic Director, Children and Young People	
2.*	School Standards and Achievement Report 2017-18	Scrutinise school standards for 2017-18	Cllr Amer Agha, Schools, Employment and Skills	Gail Tolley, Strategic Director, Children and Young People	
3.*	Improving educational achievement of Black Caribbean boys	Review of underachievement in schools of boys of black and Caribbean heritage.	Cllr Amer Agha, Schools, Employment and Skills	Gail Tolley, Strategic Director, Children and Young People	

*Items involving school education. ** Items which may involve partnership work with schools.

Wednesday 17 April 2019

Agenda Rank	Item	Themes	Cabinet Member	Brent Council Officers	Other Organisations
1.	Transforming Care	Implementation of Brent's Transforming Care programme set up in response to Winterbourne View report.	Cllr Harbi Farah, Adult Social Care	Phil Porter, Strategic Director Community Wellbeing Helen Woodland, Operational Director Social Care	Sheik Auladin, Chief Operating Officer, Brent CCG

*Items involving school education. ** Items which may involve partnership work with schools.

Appendix B: Update on Public Health Actions in Air Quality Action Plan 2017-2022

All measures outlined in the air quality action plan 2017-2022 aim to improve local air quality and the environment for all.

Action 6: Engage with local business to reduce local air pollution
The focus of the work in the last 12 months has been air quality action associated with engine idling at schools. As a result, work has just begun to draft proposals for reducing emissions from business in potential Low Emission Neighbourhoods.

Action 7: Promote air quality action days
The council signed up to the Greater London Authority's Idling Action Group, consisting of 17 boroughs, in 2017. This enabled us to deliver anti-idling projects at relatively low cost and by sharing campaign materials and the delivery of training to local volunteers, we were able to maximise our use of existing resources.

The council organised four community events with a launch of the programme in Wembley in June 2018, Wembley Central and Cricklewood in September 2018 and Harlesden in January 2019. Each campaign was used to target local drivers and provide on-the-spot advice about the law and their contribution to poor air quality. We trained officers to be able to issue fixed penalty notices for enforcement against drivers who do not comply with requests to stop. We have not issued any notices to date.

Additional idling action events were also planned for 27th February 2019 in Kilburn (in collaboration with the London Borough of Camden) and 3rd April 2019 in Neasden Town Centre.

Brent celebrated National Clean Air Day on the 21st June 2018 with an event to promote the council's anti-idling work and communicate the council's plans to tackle pollution.

The event was held in Wembley in collaboration with Global Action Plan, Idling Action London, Brent Friends of the Earth and Clean Air for Brent (CAfB), a local community group. MP Smarter Travel, Dr Bike and Source London also participated and were on hand to field specific queries about cleaner transport, local cycling initiatives and options for electric vehicle charging. Council officers and volunteers engaged with drivers as well as with parents at four Wembley primary schools. Feedback from local residents and children, councillors, MPs and London Assembly members who attended was positive.

Brent celebrated Car Free Day on the 22nd September 2018, supported by local volunteers from various groups including Friends of the Earth, London Cycling Campaign, Play London and Harlesden Neighbourhood Forum. The aim of the day was to promote healthier car free travel alternatives including cycling and walking. It provided an opportunity for the community to host local events in streets that are closed to traffic.

Action 8: Ensure schools join the school travel planning programme

All Brent schools have travel plans and we are currently working with those with existing travel plans to achieve higher levels of compliance, attain STARS accreditation or maintain existing gold accreditation in the same scheme. In Brent 50 schools and 20 nurseries have an active travel plan promoting sustainable and safe ways of travelling; 40% of schools with existing travel plans have attained a higher level of compliance.

School Travel Planning is part of a wider programme to engage with schools (teachers, parents and children) to tackle local air pollution. This programme includes further engagement via school assemblies, improved and increased signage and provision of information about idling engines, audits of schools to identify measures they could employ and additional local air quality monitoring around schools to determine which schools should be our highest priority for future interventions.

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