NHS
Partnership Commissioning Unit

On behalf of
Hambleton, Richmondshire and Whitby CCG
Harrogate and Rural District CCG
Scarborough and Ryedale CCG
Vale of York CCG

REPORT TO:	**North Yorkshire Health and Wellbeing Board**
REPORT SPONSOR	**Janet Probert** **Director of Partnerships Commissioning Unit**
REPORT FROM:	**Judith Knapton (Head of Mental health and Vulnerable Adults)** **Partnership Commissioning Unit** **Joss Harbron** **Service Development Manager- Valuing People Now** **Health and Adult Services** **North Yorkshire County Council**
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REPORT STATUS:	
Ref	
REPORT SUBJECT:	**Winterbourne concordat**

1. Purpose

The purpose of this report is to provide assurance to the North Yorkshire Health and Wellbeing Board that the requirements of the Winterbourne Concordat are being met, inform the Board of the progress made over the last six months and issues for consideration.

2. Background

2.1 The Winterbourne concordat required Health and Social Care commissioners to work together to ensure services commissioned for people with Learning Disabilities (LD), Autistic Spectrum Disorder (ASD) and challenging behaviour were safe, of good quality and meets the individual needs of each person.

2.2 In July 2013 the Winterbourne View Joint Improvement Programme asked each Local Area to complete an initial stocktake of progress against the

Winterbourne concordat commitment. The stocktake asked about the following:

- Partnership working
- Understanding the money
- Case Management of individuals
- Current review programme
- Safeguarding
- Commissioning arrangements
- Developing local teams and services
- Prevention and crisis response
- Understanding the population
- Children and adults – transition planning
- Current and future market requirements

3. Progress to date

3.1 Partnership Working

A Winterbourne Strategic Implementation Group has been established (chaired by Janet Probert, Director of Partnerships, Partnerships Commissioning Unit) and includes North Yorkshire County Council, City of York Council, Tees Esk Wear Valley Foundation Trust, Leeds and York Partnership Foundation Trust, chair of the NY LD Partnership Board and Innovation North. The group has developed an Action Plan to address each area highlighted in the Stocktake. The aim of the group is:

- To ensure the necessary evidence to provide assurance that the Winterbourne Concordat is delivered
- To be a champion for continuous improvement, aspire to excellence and to be the best in the treatment and care of those who are vulnerable.

To support the implementation of the Action Plan, Operational Groups are in place to co-ordinate the reviews of individuals and ensure a joint approach.

A Commissioning Group is being established to analyse the feedback from the reviews, identify any themes or gaps and implications for commissioning of services and how commissioners will work with the Independent sector to ensure the correct provision of services are available within North Yorkshire to meet people's needs.

See appendix 1 for structure

3.2 Understanding the Money

Each organisation can identify the spend on those funded. There are currently no pooled budgets. The focus at this time is on ensuring each

person is reviewed and being cared for appropriately. The development of pooled budgets will be considered at a later stage.

3.3 Case management of individuals and the review process

I. As of 13th January 2014 the total number of people with LD/ASD in receipt of NHS funded care is 444 across NY and York. 368 are from NYCC area.

II. Of this total the total number of people in in-patient hospital settings is 21. Sixteen of these are in the two in-patient units White Horse View (Easingwold) and Oak Rise (York). All of these have been reviewed in the last six months. Nine of these are due to be discharged to community settings before June 2014.

III. Those who are not due to be discharged remain in the hospital setting because they are either on a section under the mental health act or their needs are considered to be too complex to move to a community setting at this time.

IV. 351 of the total are in residential placements and 81 of these are placed outside of North Yorkshire and York. No placements have been to residential settings out of area in recent months.

V. NYCC have 318 people placed out of area as of August 1st 2013 and 115 of these have LD/ASD. Of the 318 placed out of area, approximately 50% are within a 50 mile radius of the North Yorkshire Borders.

VI. Of the 444 in receipt of NHS funded care 282 people are jointly funded between health and social care.

VII. NYCC and PCU have invested in extra capacity to carry out the reviews of those out of area in line with the Winterbourne concordat.

VIII. The NYCC Operational group has drafted guidance for staff on 'What a good review should look like'. This was used by NYCC and PCU to develop a joint checklist for the reviews of individuals to ensure a consistent approach is taken.

IX. NYCC has taken the position of undertaking a complete reassessment of all people placed out of area. 229 reassessments have been completed. There remains 89 reassessments outstanding. These will be completed by 31st May 2014.

X. Of those with LD/ASD placed out of area 93 have been reviewed and 22 NYCC placements and 72 (CHC funded) are to be reviewed by end of May 2014.

XI. The reviews completed to date have indicated that the majority are in safe and appropriate placements and a move back within NYY would not be in their best interests. However at present ten people with complex needs they have been moved back into area which has been positive and of benefit to the person and their families.

See appendix 2: case studies

3.4 Safeguarding

I. Before someone is placed with a provider a check is made on the CQC status and for any safeguarding issues. This is recorded on the Winterbourne registers. Whenever someone is reviewed the checks are repeated.

II. If a safeguarding alert is raised colleagues within health and social care, commissioners, operational staff and safeguarding leads work closely to make sure the appropriate action is taken to ensure the safety of the individual. This is via direct communication between the safeguarding leads, the Operational Groups or multiagency safeguarding groups.

III. If concerns are picked up through the review of an individual discussions are held with the safeguarding team staff to agree any actions that need to be taken.

IV. NHS England has developed a protocol for the notification of NHS Out of Area Placements (including Continuing Healthcare). This protocol is being implemented by the PCU. This enables local and out of area commissioning services to work together and communicate information, including escalating concerns about the quality of care and incidents.

V. NYCC engage fully with other Local Authorities in accordance with ADASS whenever contacted by other LAs. However, there have been some situations identified where other LAs safeguarding arrangements delegate the investigation process to care providers which can be unsatisfactory. NYCC are monitoring this process.

VI. Safeguarding training is offered to all providers in the area. This is monitored and actions taken where a provider has low take up of the training.

VII. Regular reports on the progress against the Winterbourne Concordat are presented to the Safeguarding Boards and Learning Disability Partnership Board.

VIII. It is recognised that there is a need to identify those living within NY who are funded by other LA and CCGs. A register is currently being developed to support this.

3.5 Commissioning arrangements

The Commissioning Group will identify the commissioning requirements and develop a joint commissioning plan informed by the outcomes of the reviews. This will be developed through July and August.

3.6 Developing local teams and services

One of the issues being raised through the review process is the access to advocacy services, both in area and when someone is placed out of area.

In area: NYCC and the CCGs jointly commission Advocacy services from the advocacy consortium. The capacity to meet demand within the current services was raised at the last contract monitoring meeting in November 2013. The services reported that demand was high and on occasion some people have had to wait up to about 2 weeks. The highest concern was for the Craven area and the services were asked to consider how the other services could support this area.

The CCGs and NYCC will look at how the views of service users and carers can inform the continuous improvement of these services. Questionnaires have been used to gain more feedback from people who have used the service. However there is no consistent approach across the Advocacy consortium. The PCU/NYCC will contact the Advocacy consortium to discuss the development of a consistent approach across the North Yorkshire.

Out of area: On the 23rd January a Regional workshop is being held by Inclusion North on behalf of NHS England to focus on improving commissioning and person-centred care through excellent case management and reviewing processes. Staff attending will raise the issue of accessing advocacy services in placements out of area and consider how it can be improved. Feedback from this will be given to the next meeting of the Winterbourne Implementation Group on the 6th February.

3.7 Prevention and crisis response

The development of s136 services in North Yorkshire will ensure those being detained will be supported appropriately in health services and not detained in police cells. This will include those with LD/ASD and other vulnerable people detained under s136 of the Mental Health Act.

3.8 Understanding the population including children and transition

The North Yorkshire Transition group is considering the development of integrated transitions services which will take into account the population and future demands on service delivery. If implemented the integrated transitions service would improve the transitions journey for young people 14-25, support young people to achieve better life outcomes and provide young people and their families with consistent communication, information and approaches.
A report will be presented to the Transitions Steering group in April 2014.

3.9 Current and future market requirements

NYCC are developing a Market Position Statement which will provide information to enable providers with future business development.

Engagement with service users and carers will take place to gain their views on approaches to personalised support. These views will be presented to Independent providers to inform the development of services that meet people's needs and are in line with the principles of the Winterbourne concordat. An engagement workshop led by Inclusion North is planned for late February 2014

4. Issues

4.1 The Specialist Commissioning Group (SCG) linked to the Area Team commission services for those in forensic services. Changes to the area each SCG is responsible for has resulted in difficulties in collating the information of those from North Yorkshire. The recent development of a national database will allow each CCG to receive information regarding the people from their area.

4.2 Independent Providers: some have seen the Winterbourne Concordat as an opportunity to develop multiple residential units/ complexes which may exceed the local demand. This may result in people from other areas being 'imported' to fill the units. This contravenes the principles of the Concordat and would not be supported by NYCC, PCU or CCGs who will actively discourage any such developments.

5. Feedback from the National and Regional Winterbourne View Groups

5.1 In the Autumn of 2013 each LA area was asked to complete the Health and Social Care Self-Assessment framework. A number of difficulties were experienced (nationally) in gathering this data due to the changes in the NHS structures. A summary report will be presented to the Winterbourne Implementation group for consideration.

5.2 The national Winterbourne Joint Improvement Programme has developed the national Enhanced Quality Assurance Programme (EQAP). This will be jointly run by the Association of Directors of Adult Social Services, NHS England and CQC and will engage representatives of users and carers and their families.

The objectives include:

- To understand where people live now and if they are close to their family home
- For people to have high quality reviews, have a clear care plan and are receiving the best care and support possible
- New people are not wrongly admitted to assessment and treatment units and other inpatient units
- For hospitals not to be homes for anyone else in a similar situation; and
- Work is underway in local areas to provide good quality support to people in communities to support these objectives a new data collection process is being proposed.

EQAP are making final adjustments to the data tool and then will write to CCG commissioners to request the data. It is anticipated that a short turnaround time for the first admission in January and thereafter be collected on a quarterly basis beginning March 2014.

6. Next Steps

The Winterbourne Implementation Group will continue to ensure the actions are taken to meet the concordat and to give assurance to the Board.

The PCU will complete the data collection as required by the EQAP.

An update on progress will be provided to the Health and Wellbeing Board in six months or as requested

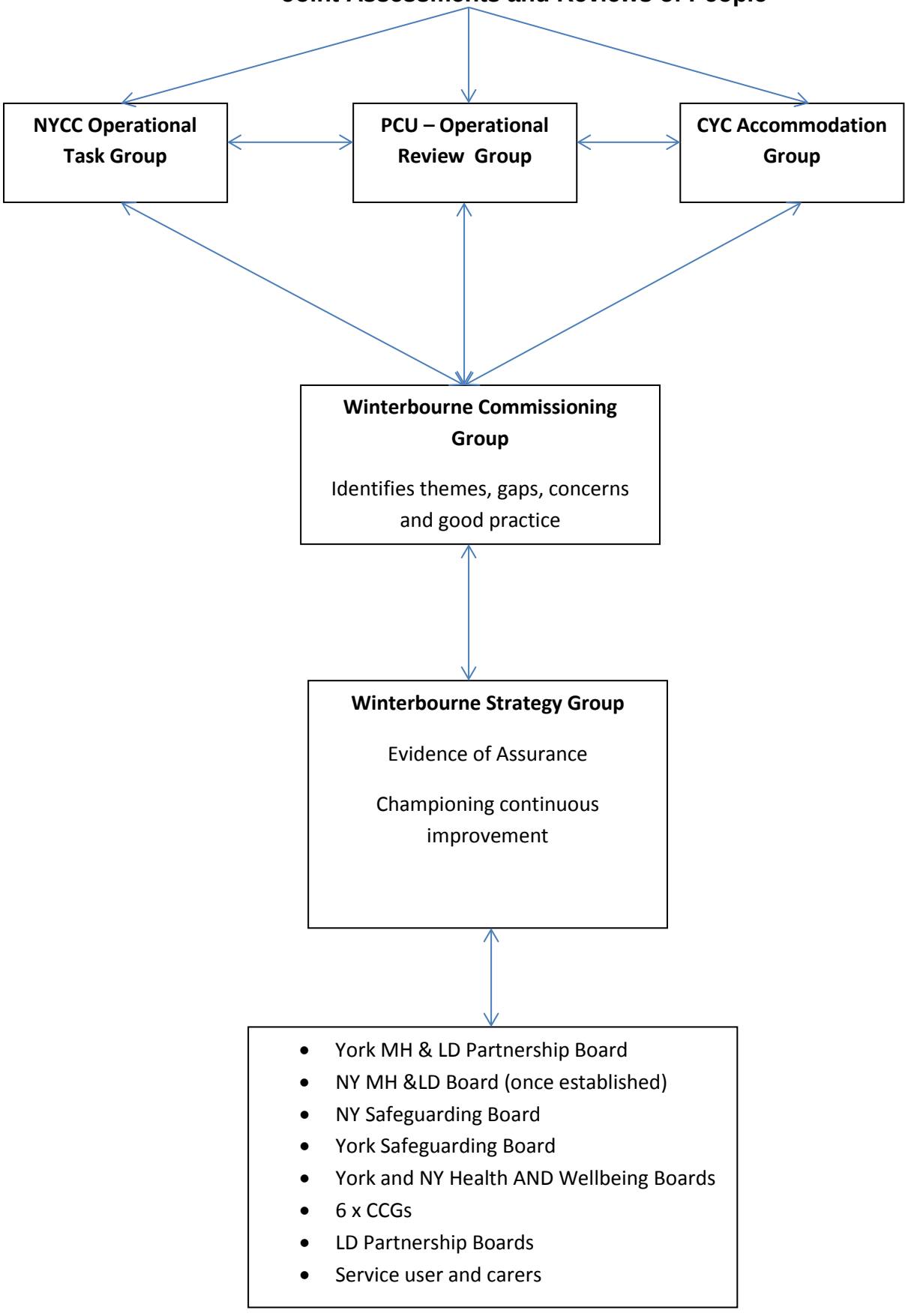
7. Recommendations

The Board are asked to:

- Note the content of the report.
- Agree date for an update on progress

Appendix 1

Joint Assessments and Reviews of People



Appendix 2

CASE STUDY 1

What were the person's difficulties or issues? In a residential care home in Cambridgeshire meaning infrequent visits from NYCC staff. Family in Scarborough. E became mentally unwell, isolated, suffered from self-neglect and self-harm, introvert and unresponsive to most interventions.
What did we do about it with the person Supported a move to a new home near to family (within York) with new boundaries and a fresh start.
How did things then change for the person? 3 months later – fully engaging with staff, no evidence of self-harm. Smiling and talkative. Talking about the future already and moving to live nearer her family in Scarborough. Is eating well and has gained weight.
What did the person say about their life following our support? Says she 'likes it here' and agrees that she is 'much better now'.
What did our partners say about joint working? Excellent communication between both providers to ensure a smooth transition.
What was the outcome/benefit for the person? More staff support so less inclined to self-harm or use violence as a way of expressing herself. Much improved relationship with family who now visit regularly. The visits are less intense and do not cause the upset they did previously. Increased support and input from NYCC health and adult services.
Anything else to add? Awaiting input from psychiatric services in order to progress further as still not managing to leave the grounds of the home.

Case Study 2

What were the person's difficulties or issues?

A (now 21) was a looked after child for most of her life, living in an array of foster homes. After age 18 she had moved in with a boyfriend with incidents of violence, later became homeless and housed in a hostel, moved into a flat, engaged in harmful sexual relationships. She was at risk of abuse, sexual exploitation, self neglect, self harm, homelessness. MCA evidence her lack of understanding of the risks. Best Interests decision made re move to residential care. She was placed in a home in Scotland, then later moved to residential care in County Durham

What did we do about it with the person

Re-assessed needs established that with significant input A was managing her personal care needs however still getting herself into debt and still demonstrating need to engage in sexual relationships with males of any age and background. Safeguarding alert received in after concerns raised about her relationship with a 50 year male in the Durham area. Investigated and concluded by police to be consensual and could not establish risks to A.

Options for supported living explored, arranged for A to visit two options in county she made her choice, held a MDT involving local police, new provider, current provider, NYCC legal, LD health services, with , to discuss move and action plan for potential risks.
A is now living in her own flat with support in a coastal town in North Yorkshire
A has been supported to access Level 2 Equine Studies.

How did things then change for the person?

A is now attending college for her equine studies course 5 days a week and has been managing to pay the majority of her bills on time with some prompting and has met a boyfriend her age whom she has been seeing for two months now, she sees him every two weeks on a Saturday.

There has been significant reduction in the support she now needs.

still needs regular support to attend medical appointments (especially to attend important appointments for contraceptives and general health checks) and to encourage her to attend college. She still has some debt to manage but is managing it when prompted by staff and the package is reducing as her needs change.

A has visited her grandma who lives in further down the coast and her sister who lives in York. Her Mother and brother live also live in the same district.

A voices her need for some support but no longer talks about her need to move or needing more 'freedom'. She also has more benefits then she had, and is supported to pay her bills. She has bought herself a rabbit and got

herself a tattoo.

What did the person say about their life following our support?

A doesn't say much about her life, however she has stated having a flat is 'much better than living in a home with other people' and talks often about her boyfriend, her bunny rabbit (she has bought since being there) and the horses at college and states that they are teaching her to teach other people to ride after acknowledging her talent.

What did our partners say about joint working?

Whitby police stated that it was a really positive move to inform them about AS and her needs before her move via the MDT and wished other teams would do this.

The care home supported her to visit her options which meant that she was always involved in her decisions and was able to make her own decision based on what she had seen.

What was the outcome/benefit for the person?
A has said that she feels more independent. The agency who support her have a positive approach to her relationships, supporting her to have her independence, she knows who to go to when things become difficult, she is very open about her relationship and her current one appears to be a positive one.

Previously A has 'absconded' to be with males the support she now receives has meant that she now talks things through wants to complete her college course before thinking about moving in with her boyfriend.

As is closer to her family, exercising her choices and the package is reducing as per her needs and wishes.

Anything else to add?

This has been truly person centred. A has returned to her home county, she has more opportunities, is developing independence and is closer to her family.

CASE STUDY 3

What were the person's difficulties or issues? Young female with behaviours that challenge placed in independent hospital out of area 10 years ago. Complex mental health and learning disability. Mental health took 6 years to stabilise to a point where discharge from Section 3 MHA.
What did we do about it with the person Met with person and mother at CPAs and initiated input from LA. However relapse in mental health indicated that discharge not likely at this point. Requested that LA input remains to enable discharge. Behaviours that challenge still present but discharge pathway identified. Person wishes to stay out of area to remain close to her mother who moved near there.
How did things then change for the person? Person looking forward to moving to another unit, with a plan of moving into supported living when developed more skills of managing behaviours that challenge that may put supported living placement at risk. Assessed by another hospital that is planning to deregister as hospital but retain trained nursing staff.
What did the person say about their life following our support? Looking forward to moving out, meeting some new staff and being in a town where she is able to be involved in more community activities.
What did our partners say about joint working? Disappointed that not able to support direct discharge into community, but confident that a much closer joint working arrangement will still allow a pathway to supported living.
What was the outcome/benefit for the person? Continues to have nursing support for complex mental health and LD needs, whilst being in a less restrictive environment and more community focused placement, in an area she wishes to be.
Anything else to add? Progressing through a pathway to supported living. Much closer working with NHS and LA. Person, mother and advocate pleased with plans.

CASE STUDY 4

What were the person's difficulties or issues? Arrested for sexual assault in 2001, was placed in low secure by the courts and transferred to NHS inpatient services in 2011.Currently detained under Section 37/41. Access in community restricted and risk assessments in place.
What did we do about it with the person The PCU Case Manager attends CPAs, meeting with person and their brother. Developing relationship/knowledge of this person's needs that will support the discharge process when able.
How did things then change for the person? Access to the community is restricted by Ministry of Justice. Challenging behaviour. Undergoing sex offender therapy. Progress is working towards less restrictive environment.
What did the person say about their life following our support? He states he is very appreciative of the input provided by the Case Managers Would like things to progress but aware of annual review from Ministry of Justice and knows he has to wait.
What did our partners say about joint working? Presently limited involvement with LA, again due to Ministry of Justice.
What was the outcome/benefit for the person? Additional support/monitoring by external parties to enable discharge when Home Office restrictions allow. Positive about increased access to community and social activities and progress being made. He appears to fully understand that he is under restrictions, but doesn't necessarily respond to them. eg advised not to contact female in community but attempts to do so. Lack of understanding of consequences of his actions, both to their pathway and to risk to others.
Anything else to add? Whilst discharge is out of his control, he is positively working hard at developing any skills he will need when discharged.