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# **Winterbourne View joint improvement programme**

Stocktake of progress report  
September 2013

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# Executive summary

## Background

The stocktake of progress questionnaire, requested from chief executives of local authorities, clinical leads of local Clinical Commissioning Groups (CCGs) and the chairs of Health and Wellbeing Boards (HWBs), was sent out as an integral part of the Winterbourne View joint improvement programme (WVJIP) in June 2013.

Its purpose was to enable local areas to assess their progress against commitments in the Winterbourne View Concordat and to allow for good practice and progress from local areas to be shared nationally.

It was further intended to assist in local discussions with key partners, including people who use services, family carers and advocacy organisations, as well as providers. It was based on the principle that the changes required as a response to Winterbourne View could only be successfully delivered through local partnerships.

The aim of the stocktake was also to help local areas identify what development support they might require from the WVJIP.

The stocktake covered 11 key areas of enquiry:

- Models of partnership
- Understanding the money
- Case management for individuals
- Current review programme
- Safeguarding
- Commissioning arrangements
- Developing local teams and services
- Prevention and crisis response capacity
- Understanding the population who may need/receive services
- Children and adults transition planning
- Current and future market requirements and capacity

Sent out on 1 June, returns were requested by 5 July 2013. The majority of returns were received before or on the return date; others subject to discussion and sign off have all been received. Every locality has completed a stocktake and they have all been appropriately agreed.

It is clear that the local work to complete the stocktake has of itself created much of the discussion and decision making that is required to fulfil the Concordat commitments.

The WVJIP has undertaken some rapid work to analyse and assess the responses to both support localities in the next steps and to provide regional and national information. The detail of the analysis is set out from page 16 below.

The analysis of the stocktake returns was completed in two stages. The first stage collated the responses to each question. The second considered the detailed responses that were made by the majority of places to each question. This has provided a very rich picture of strengths, opportunities and development needs at a local and regional level.

From this and other information fed in through questions and comments from partnerships, the following headline conclusions are drawn.

## Headline conclusions

As reported in the stocktake, there is evidence of:

- all localities engaging and working on the Concordat commitments
- progress and leadership across the partners
- HWBs being sighted on the Winterbourne priorities; many will be receiving detailed reports in the Autumn from their partnerships
- skilled and committed staff at commissioner, care management, community and provider levels and in leadership roles supporting change
- service user and family carer engagement, although this is not always consistent, nor evident everywhere
- safeguarding practices being followed consistently
- integrated/joint working, evident in assessment, commissioning and service development – though this is not evident everywhere
- the engagement of newly formed CCGs is bringing fresh impetus and priority in some localities
- innovation and strategic planning in some localities to reduce reliance on distant, long term Assessment and Treatment (A&T) placements, including financial understanding and flexibility
- over 340 examples of good practice and local policy/practice – to be further analysed in partnership with the Social Care Institute for Excellence (SCIE) and NHS England colleagues.

Reflecting concerns raised nationally, the stocktake highlights the following areas for development locally:

- an urgent need to resolve issues of definition raised in ‘Transforming Care’ and the Concordat and in particular a need to clarify and define the key individuals who need to be considered as part of the change programme both now and in the future
- the development of whole life course planning
- the need to rapidly improve engagement, understanding and joint working across the various commissioning functions (specialist, forensic and health and social care)
- the need for localities to work together both within and across geographical boundaries to achieve longer term sustainable solutions

- a resolution to continuing difficulties in relation to Ordinary Residence
- consistent application at local level of Continuing Health Care criteria
- investment in behaviour support and community based accommodation options to enable safe and local support services
- the integration of, and use of, financial resources with medium and long term financial strategies
- collaborative work with providers at national, regional and local level to develop alternatives to current provision
- expedite work to improve quality and consistency of care through robust commissioning
- Increase the development of, and investment in, service user, family carer and advocacy activity
- increase the understanding and application of personalisation for all individuals, notwithstanding the complexity of their situation.
- ensure wide understanding and application of the Mental Capacity Act (MCA)
- support HWBs in their strategic role.

This summary analysis demonstrates that while every locality has evidenced a clear commitment to fulfilling the Concordat commitments and all are making progress towards this, inevitably some are more developed than others. The key issues that mark out this differential progress are as follows:

### **Leadership and partnership**

**Findings:** Due to a range of factors the strength of the partnership between local authorities and their key partners are at

different stages: organisational changes, financial pressures and the historical legacy of arrangements all impact on progress. Every locality is reporting some progress in this regard. Following the stocktake it is clear that all HWBs are aware of the Winterbourne View joint improvement programme. This needs to be built on as a part of the developing role of HWB, and the Boards themselves are at different stages of development.

**Response:** The WVJIP will focus some of its improvement work on leadership and strategic partnership and support to HWB. This will link with the established Local Government Association (LGA) Health and Wellbeing System Improvement Programme and Partnership.

### **Engagement with individuals and families:**

**Findings:** In many areas, particularly those that have a strong tradition of working with partnership boards or similar, there is very good engagement at local level with the community and voluntary sector, as well as with user led and family carer groups, and this often includes advocacy. However this is not universal – organisational changes and other pressures on all parts of the sector have led to some diminution of this engagement.

**Response:** In the ongoing improvement work and with others, the importance of local engagement and the provision of high quality advocacy support must be reinforced. This will be integral to the programme itself, as will the development of personalised services and engagement with family carers.

## Work with providers

**Findings:** The stocktake shows that 93 per cent of localities have concluded or are progressing market intelligence/market development with their local providers. Many have already concluded a provider analysis.

Emerging relationships between commissioners and providers are variable. There are a few strong examples of good collaborative commissioning, but these are yet to have a real hold. Many places still rely on a more distant commissioning arrangement, too often characterised by supply appearing to determine commissioning outcomes. There remain very variable approaches to issues of quality and clarity of task, resulting in long term arrangements that do not meet the post Winterbourne View requirements.

There is some anecdotal reporting that a small number of providers may be seeking to re-designate provision from Assessment and Treatment (A&T) Centres to other similar types of provision without changing the nature and function of the service. If this is the situation it needs further explanation as this is clearly not acceptable.

**Response:** Alongside the national work that is being established with providers, regions and localities will be supported in developing their own strategic approach to commissioning services to meet the needs of people now and in the future.

The development of a core specification for services across all ages will support this, as will the Enhanced Quality Assurance Programme. The programme will work closely with the Care Quality Commission (CQC) in the continuing registration of providers.

## Development of commissioning

**Findings:** The development of commissioning is both at the heart of achieving the WV priority changes and is the most complex and difficult area of development.

The stocktake shows that issues of commissioning between the key partners are inextricably linked to the use and flexibility of resources. This is the biggest single area that requires support and development. There is a very variable picture indeed of progress in providing integrated or joint commissioning in which individuals have a seamless pathway starting with a single assessment and supported by consistent care management.

Within this key area the issues that create difficulties are reported as:

- ordinary residence rules and associated financial risks
- engagement between specialist, secure (forensic) and local commissioning (Health and Social Care)
- use and criteria for Continuing Health Care
- the development of pooled or integrated budgets
- flexible use of resources including workforce, workforce planning and development and local skills assessments
- lack of longer term financial planning
- agreed definitions of the key target groups
- limited use of care management type services
- inconsistent application of standards and quality requirements.

**Response:** Work with commissioners at all levels will be a priority for the programme as detailed throughout this report. We will link with other relevant work through LGA, NHS England and NHS Improving Quality.

### Planning for children, young people and adults – preparing a pathway

**Findings:** There are a few very fine examples of work to improve the transition of young people to adulthood across the partnership. However, there are very few examples from the stocktake of places where the needs of children are seen within the context of their longer term care into adolescence and adult opportunities.

**Response:** This is a national, regional and local priority for WVJIP and will also need to engage other Government departments, key national organisations and providers of services at all levels to achieve real change. Commissioning through Children’s Services is a vital component of this.

### Future support and development

The WVJIP has at its core an improvement programme that has regional, national and local components and is based on the core principles of sector led improvement.

The key objectives of the programme are set out in ‘Transforming Care’ and the Concordat but are now particularly defined by the work of recent months and the findings and conclusions from the stocktake of progress.

The key task is to ensure these objectives are turned into strategic (national) and operational (local) actions and outcomes.

An important feature of the stocktake has been the requests from each locality for on-going support and development. This has been encouraged in the spirit of sector led improvement. The stocktake will directly form the basis of the local and regional improvement offer from the programme.

The WVJIP Improvement Offer is aligned with the LGA and NHS England’s wider approach to improvement and the principles of sector led improvement. This ensures engaging political leadership, finding new ways of working with local people and communities, inviting challenge from peers and sharing good practice. The self-assessment stocktake is an exemplar of using comparative data as a driver for improvement.

Eighty-six specific requests for support are identified, with at least one request in each of the 61 questions. The largest number of requests (distinct from general support needs) are regarding Ordinary Residence and associated financial risks, a range of issues relating to specialist commissioning, capacity in crisis response services and pooled budget arrangements. A summary table of support requests is given at Appendix 7.

In addition there have been over 340 examples of good or demonstrative practice and local policy initiatives. These will provide a very rich source of information that will be used right across localities as part of development. This will be done over the autumn in conjunction with the Social Care Institute for Excellence (SCIE) using well established and proven methodology. Items included highlighting innovative practice, sample protocols and / or agreements (for example s75 agreements) as well as local



policy and practice examples. It is intended that this material will be available on the WVJIP knowledge hub in the coming weeks.

In the spirit of openness and transparency, the report will be widely available and publicised through both NHS and LGA channels. Local places are encouraged to use their own communication channels to further publicise and discuss this document, including potentially reporting to Health and Wellbeing Boards.

The detailed analysis of individual places will be made available to local area for their own use, with the expectation that these will be reported to the HWB as appropriate.

In addition, regional summaries will be made available to LGA, NHS England, Association of Directors of Adult Social Services (ADASS), Association of Directors of Children's Services (ADCS) and Department of Health (DH).

This material will then inform the development of the improvement offer and supporting programme using the established four national priorities and bespoke regional and local support:

- life course planning
- working with providers
- keeping people safe
- new financial models.

Findings from the stocktake will be further informed by the Learning Disability Census and Joint Health and Social Care Self-Assessment Framework (SAF).

Work with local areas will always be based on joint agreement regarding the issues to be explored and the approach to be used.

The key elements for regional activity will be:

- **Bespoke support** to partners or individual authorities based on their own reported current stage of development and their requests for support.
- The development of **regional priority plans** supported by resources from the improvement programme using local and existing networks and facilities to expedite progress, linking this to national work of both WVJIP and partner organisations. This will commence immediately with plans being in place by early November 2013. Existing work will not be impeded in this process.

This will also link with existing mechanisms regionally and nationally for supporting improvement, identifying areas in need of early or extra support, and assuring quality. This will include discussions with LGA Principal Advisers and Quality Surveillance Groups.

Challenge from peers will be through the development of a specific Winterbourne View module developed jointly with the Towards Excellence in Adult Social Care (TEASC) programme.

- The programme will provide **in-depth support and make links to existing programmes**. It is vital to draw on the range of development and support already existing and to ensure that good coverage is given to all those who will need to work together to achieve the policy and practice changes required by the Winterbourne View Concordat.

This will include working with existing programmes in NHS and Local Government including the Health and Wellbeing System

Improvement, Adult Safeguarding and the TEASC programmes. NHS England work with CCGs and NHS Improving Quality and transforming provision will also be engaged.

The rationale for any further in-depth support will be:

- partners request for ‘deep-dive’ support
- follow-up discussions on stocktake analysis that might warrant more study
- in-depth work to draw out exemplars of good practice or process
- significant numbers of challenging placements
- apparent stocktake responses that are out of step with regional findings
- where concerns about individual placements have been raised.

The sharing of innovative practice and local policy will be disseminated as described elsewhere and the further development of the Winterbourne JIP Knowledge Hub group will increase awareness of the material that is available.

The section in this report on improvement sets out more detail of this.

## Summary of WVJIP responses to issues raised in the stocktake

Set out below are the summary actions that will be built into the WVJIP improvement offer, determined by priorities identified from the self-reported stocktake of progress.

The WVJIP will focus some of its improvement work on leadership and strategic partnership and support to HWB. The apparent variability in the development of leadership arrangements across the regions will be followed up by the WVJIP. A key emphasis of the improvement programme will be to take account of the relative development of local partnerships and the need for progress.

In the on-going improvement work and with others, the importance of local engagement and the provision of high quality advocacy must be reinforced. This will be integral to the programme itself, as will the development of personalised services and engagement with family carers. The WVJIP will follow up on the availability and quality of advocacy arrangements locally and regionally.

Alongside the national work that is being established with providers, regions and localities will be supported in developing their own strategic approach to commissioning services to meet the needs of people now and in the future. As a priority this will include supporting regions to develop viable locally based alternatives to long term and geographically distant services. Work with the regulator, financiers and existing providers will be developed over the coming months to achieve step change in revised provision. “Jointness” of approach

may also be indicative of how effective joint care planning and review processes are for people in receipt of care and support and this will be an issue followed up in further detail by the WVJIP.

Pathway planning for children, young people and adults is a national, regional and local priority for WVJIP and there is a need to engage across Government departments, key national organisations and providers of services at all levels to achieve real change

Transforming Care invites a range of “definitions” of both people and places and there is a pressing need for clarity and focus. This key action has been taken forward by the WVJIP and is an issue the WVJIP will want to clarify shortly. This work will be a key feature of the improvement offer.

The improvement programme will need to work with those places that still need to establish good strategic planning to ensure that the financial aspects are understood and that the mechanisms are in place to support the flow and flexibility of resources.

The following are areas for further follow up with localities and have become key elements of the WVJIP programme. These will form the basis of improvement offer discussions.

- Alternative provision, including the ability to commission this within timescales and / or identifying suitable providers.
- Mental Health Act and / or Ministry of Justice restrictions.
- Funding arrangements, including lack of finance, clarity about specialist commissioning funding, NHS Continuing Care and Ordinary Residence.

Significant change is needed, particularly from early years through to adult care, if a fundamental shift in approach is to occur. Incremental change is not sufficient. The improvement programme needs to work with others to harness and target resources from Government, the sector and other sources to support some of the fundamental changes in the way planning, decision making and care is delivered to children, and in order to ensure a different way of working in the future. Continuing to react year on year to rising numbers of children needing costly, but less effective, adult placements is not tenable.

# The Winterbourne View joint improvement programme

The Winterbourne View joint improvement programme (WVJIP) was established in December 2012 with the purpose of providing leadership and support to the transformation of services locally. The team was established to work with local areas to provide focused and lasting action across the system to ensure that the supports and services that are commissioned throughout people's lives are personalised, safe and local.

The background to the programme's work is set out in Transforming Care: A National Response to Winterbourne View Hospital and the Winterbourne View Concordat: Programme of Action both published in December 2012.

The strategic objectives of the WVJIP include:

- To support the transformation of commissioning and provision of support and services for people with learning disability, autism and/or challenging behaviour so that they are personalised, safe and local.
- To significantly reduce in the reliance on long term placements in Assessment and Treatment (A&T) Centres.
- Development of more locally based provision enabling people to remain closer to home throughout the pathway of their care.

Specific progress measures include:

- The completion of joint reviews of all people in learning disability or autism inpatient beds by June 2013.
- A rapid reduction in the numbers of people in hospital or large scale residential care with people receiving personalised care and support in appropriate community settings by June 2014.

The WVJIP approach is shown at Appendix 1. In summary there are four key national priorities which interlink with local and regional improvement actions based on the progress identified by the sector.

The WVJIP is jointly supported by the Local Government Association (LGA) and NHS England with funding from the Department of Health (DH). It is steered by an advisory programme board (Appendix 2) and the whole programme is led and chaired by Chris Bull.

Ian Winter leads the Improvement Team, which includes two principal advisers, a policy adviser, a part time engagement adviser and a part time communications adviser.

Strong support is also given to the team from the LGA and NHS England, working in partnership across the programme.

# The stocktake of progress

## Background

In June 2013 the WVJIP asked local areas – specifically Local Authority Chief Executives, and Clinical Leads of Clinical Commissioning Groups (CCGs) – to undertake a local stocktake and self-assessment of progress against key activities that support local delivery of Transforming Care and Concordat commitments. This was to be done in partnership with other community and local groups and in consultation with the chair of the Health and Wellbeing Board (HWB). They were also asked to identify local good or demonstrative practice and any additional support needed to improve local delivery.

The stocktake is a self-assessment of progress across a number of strategic and practical domains that will need to be in place to enable people with learning disabilities or autism, who also have mental health conditions or behaviours viewed as challenging, to live in local community settings rather than in hospital.

It has been supported by the Society of Local Authority Chief Executives (SOLACE), Association of Directors of Adult Social Services (ADASS), LGA and NHS England as an important indicator of the extent – and pace – to which change is being achieved, and / or of inhibitors of progress.

Local areas have been frank about challenges. This self-assessment of progress supports the principles of sector led Improvement and encourages places that may need support to recognise and ask for it. This will help to target resources at the right place and for the right issues. The development of the action plan for improvement is set out in this report.

As a next step, the Winterbourne View joint improvement team will be talking to localities and regions to develop appropriate and responsive improvement support.

There has been a 100 per cent return of the stocktake from local authorities; all have been appropriately agreed.

Outcomes from this and subsequent actions are set out in sections below.

## The circulation of the stocktake

The development and completion of the stocktake was done at pace and in a relatively short timescale; local authorities and partners had just five weeks to make detailed returns.

In preparing the stocktake it is acknowledged that:

- out of necessity, the stocktake was put together very quickly and with little discussion with the sector or with a wider stakeholder group
- new collections from public bodies are usually subject to consultation (of 3 months) and / or gateway processes
- these usually include consultation on questions to be asked as well as matters of principle (i.e. why it is being done) – neither has happened in this case
- the sector was given a very short time to complete and return
- there has been no dedicated specialist resource to support completion of the initial headline or subsequent analysis. Support has been drawn from a small number of individuals, including LGA, and DH and NHS colleagues as well as the Winterbourne View team.

It is also the case that ‘Transforming Care’ and the Concordat raise definitional issues (relating both to people and to places) and it is recognised that these need to be resolved. The stocktake did not attempt to apply definitions beyond what is described in ‘Transforming Care’, though responding to questions raised by localities and in the rationale issued to support completion a broad and inclusive interpretation was encouraged.

Despite the points above:

- there has been 100 per cent return rate from local areas, as noted above
- additional to completing the return a substantial amount of supporting evidence and / or examples of demonstrative practice have been submitted (at time of writing 340 items have been listed amounting to some 4,000 pages)
- key themes were picked up for further analysis.

The stocktake has provided:

- a strong basis for follow up lines of enquiry with localities
- a consistent sense of both the challenges in the system and of strengths / weaknesses to address these
- a good test of challenges set out in ‘Transforming Care’ and of how robust responses to those are being developed
- a sector led indication of what needs to be put in place – and where it might be targeted – to support localities to achieve sustainable change.

A number of regions have already started to consider regional actions for support and development.

## Description

The stocktake asked 61 questions across the following key areas:

- Models of partnership
- Understanding the money
- Case management for individuals.
- Current review programme
- Safeguarding
- Commissioning arrangements
- Developing local teams and services
- Prevention and crisis response
- Understanding the population who need / receive services
- Children and adults transition planning
- Current and future market requirements and capacity

It also asked for good or demonstrative practice examples that could be shared and themes or issues that require national, regional or local support or clarification.

The stocktake is intended to give 'soft' intelligence of progress in key areas – for example, of engagement between local health and care commissioners and commissioners of specialist services, and the percentage of places where monitoring progress is routed through Learning Disability Partnership Boards. It therefore provides a narrative for the above areas for how, in each of the 152 localities, local leaders are bringing key partners together to quantify, plan and deliver local community supports for people as alternatives to hospital settings. Together, these local narratives build an account of progress nationally.

It is also intended that the stocktake will sit alongside other information collections either in process or planned – specifically the NHS England review of local registers and reviews and the planned Learning Disability Census of provider organisations.

The stocktake was circulated with a letter from Norman Lamb MP, Minister of State for Care and Support, on 3 June 2013, asking that HWBs take particular responsibility for the development of joint commissioning of new services. In June, Dame Barbara Hakin also requested progress reports on the transfer of registers and reviews.

Returns were requested by 5 July 2013. There has been a 100 per cent return from local areas, all appropriately agreed.

There is a clear expectation that the local stocktake will be reported to Local Health and Wellbeing Boards at an early opportunity. This supports transparency and local accountability.

# Analysis

## Overview

The critical issue following the Winterbourne View Concordat commitments is the degree to which places across health and social care and other partners are actually putting in place the arrangements needed to ensure that those individuals who may need services are able to be supported nearer to their home locality and without the extensive use of in-patient hospital settings.

That is not to say that for some people, and on some occasions, hospital care and other specialist care will not be required, or that there will not sometimes be a need to apply legislation to their situation through, for example, the Mental Health Act.

However, the findings following the abuse at Winterbourne View and the Concordat commitments make it clear that more local, appropriate accommodation and care is both possible and the best option for most people.

As set out above, the stocktake asked a number of open questions across key themes, for local areas to self-assess the progress being made by local partnerships and / or inhibitors to progress that need to be resolved.

In the main, localities have been very frank and open in their responses, not only in their assessments of progress but also in outlining the areas where additional focus, improvement and / or development is requested.

## Method

Responses to each of the 61 questions in each of the returns were coded to support analysis. The coding was not an evaluation or a scorecard, it was a device to capture the answers and collate them. A copy of the coding used is included at Appendix 3a. The outcome of coding was used to draw together an initial headline analysis against six key themes:

- Leadership across the system
- Strategic capacity
- Progress and delivery
- Managing money
- Safeguarding
- Children and young people

These themes were drawn from the questions reported in the stocktake in order to give an initial understanding of where progress is being made, as well as to scope and frame key issues for further analysis and to establish an initial view of where additional support may be required.

The strength of the stocktake response was the wealth of additional material that accompanied the responses to the questions. As stated elsewhere, over 340 individual documents developed and used locally were sent in. In addition, the vast majority of returns gave very detailed responses to the questions, providing a very rich and detailed



picture of progress, strengths, challenges and development opportunities.

The core of the narrative has been read and formed the basis of a response sent back to every single responder. It has been looked at in respect of areas of strength and areas for potential development. In many cases the area(s) for development are directly highlighted by the locality making the return, so in many instances strengths and developments go hand in hand.

A sample of the proforma that has been returned to each locality is shown at Appendix 7.

The WVJIP will collate development areas and strengths to support integrated work across both themes or subjects and geographical regions using the key principles of peer learning, support and development.

What follows is primarily taken from the first part of the analysis but is significantly informed by the individual narrative.

## Findings in very general terms

Returns demonstrate very strong commitment across partners in health and social care to achieving sustainable change in the nature of treatment, care and support available to people with learning disabilities or autism, who also have mental health conditions or behaviours viewed as challenging.

There are, however, a range of interpretations of both individuals included in local programmes and of the circumstances in which they are living. For example, some places have a focus on people in Assessment

and Treatment Centres only or hospital placements out of area. Other places have taken a broad view of the range of support and care available to people with disabilities in order to facilitate whole system change. It is also clear that local interpretation will be determined by local context – of how supports and services have developed over time, how partnerships have matured and responded to local challenges, etc.

Similarly differences in interpretation of a small number of stocktake questions are evident. This is the case in particular in relation to interventions and/ or supports that are described as “appropriate” – especially with regard to people subject to the Mental Health Act – or to the availability of advocacy support, particularly of that outside of statutory provision.

A number of areas have very clearly submitted returns that have been jointly completed by the local authority and the CCG. Notwithstanding sign off arrangements being in place, this is less clear in other areas and in a number of instances it is clear that returns have been submitted in the main either by the CCG or the local authority.

A large number of localities have provided very detailed returns, offering considerable detail of local partnership arrangements, progress, challenges and opportunities. A smaller number of locality submissions are less detailed and the WVJIP will be exploring information detail with them.

In addition, there have been over 340 examples of good or demonstrative practice and local policy incentives. These will provide a very rich source of information that will be used right across localities as part of development. Just some of these examples

as provided by local areas are highlighted in this document to demonstrate the range of innovative practice being undertaken locally. Further more detailed analysis will be done over the autumn in conjunction with the Social Care Institute for Excellence (SCIE) using well established and proven methodology and further shared with the sector.

## Leadership across the system

The changes required following the Winterbourne View scandal will not be achieved by method change alone or solely through the committed activity of commissioners and providers.

It will require new and flexible partnership and leadership at political and organisational level that is sustained and robust.

In order to give some indication of the leadership challenges and how they are being met, the stocktake examined responses to a number of key questions exploring strength of partnership, measures of engagement and organisational coherence.

The key questions are:

<b>Q3</b>	% of places with a dedicated planning function
<b>Q4</b>	% of places LDPB/alternative arrangements to monitor progress
<b>Q5</b>	% of HWBBs engaged with the programme
<b>Q8</b>	% of places where Ordinary Residence (OR) is identified as a barrier

The vast majority of places referred to strong, dedicated and high level leadership. The following is taken directly from some of the analysis of individual stocktake responses as examples of this.

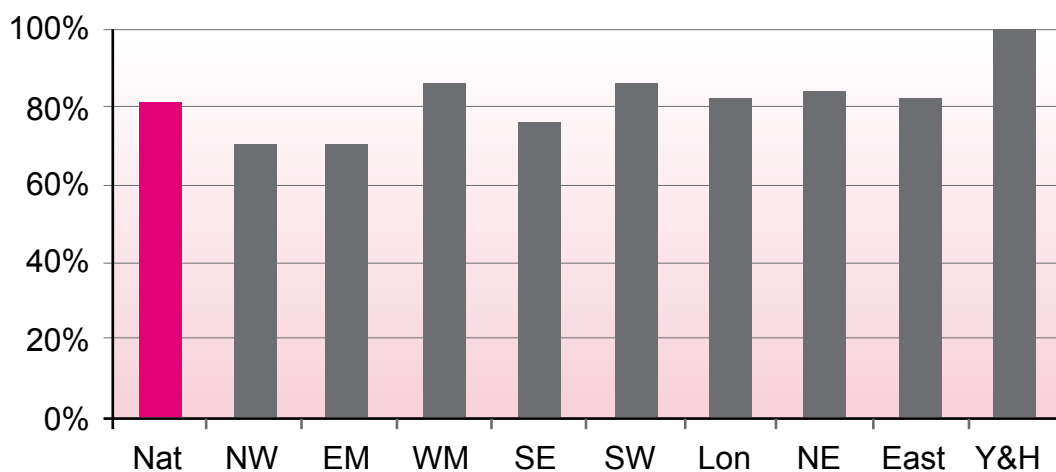
- **Durham CC:** The clarity of arrangements between local stakeholders particularly CCG and LA with oversight through HWB is a strength. There is good evidence of a partnership approach to implementing local and regional plans.
- **Manchester:** Robust leadership is in place and accountabilities are clear at the highest level. A joint team of long standing is in place. There are historic joint funding arrangements augmented by a programme approach which has finance as a core workstream. Arrangements appear to be well developed and Manchester is making good progress.
- **Oxfordshire:** Leadership and governance in place from existing and longstanding joint management arrangements. A good range of partners are involved in this process.
- **Islington:** Strong, well developed and highly functional partnership and leadership in place with well evidenced background material.
- **Solihull:** Set up a specific Review Board with good joint membership and links across sector and geography. A positive model of delivery has been identified to prevent inappropriate.

- **North Tyneside:** Good involvement of key partners and established mechanisms for development and delivery of local plans. There is clear evidence of joint planning between NHS and LA. A planning function is in place. The Learning Disability Commissioning Board and the Health and Wellbeing Board are actively involved. There are arrangements to resolve differences. There appears to be clarity of accountability.
- **Telford & Wrekin:** Positive work is underway through multi agency approach across the county. There is good provider and housing engagement. Further understanding of how the leadership across the programme is delivered in practice and how the governance arrangements within the individual organisations are applied.
- **Northumberland:** Evidence of strong local partnership working presented with clear focus on an action plan to deliver through existing commissioning structures overseen by senior leadership. There appear to be strong links to the Health and Wellbeing Board, the Overview and Scrutiny Committee and the Learning Disability Partnership Board. Northumberland provides strong evidence of joint working, planning, leadership and governance. The partnership appears to be confident in managing problems and finding solutions.

Regionally, the role of Learning Disability Partnership Boards (LDPBs) appears firmly embedded. In comparison the engagement of HWBs in the programme is less so, much of this may be due to HWBs being a new and developing activity.

Local leadership arrangements are reported to be in place (or are being put in place) in most localities, with LDPBs (81 per cent) monitoring the local improvement programme.

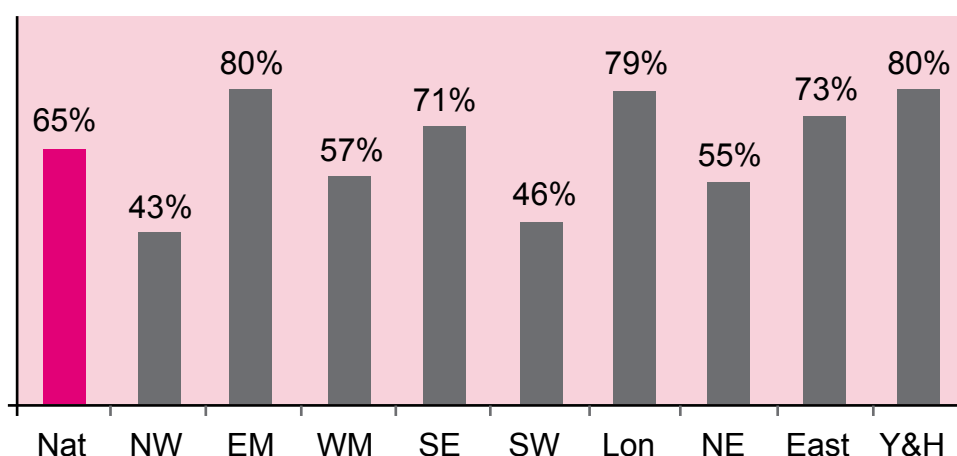
**Percentage of places LDPB/alternative arrangements to monitor progress**



Norman Lamb MP, the Minister of State for Care Services, wrote to HWBs in June 2013 to emphasise the role of HWBs. While there is good evidence that HWBs are engaged with local programmes (65 per cent at the time returns were made) many HWB are still in a formative stage and they have significant and growing agendas. Nearly a third of places (29 per cent) reported that updates on local programmes are being prepared and reports due to go to the HWB by September 2013.

While proper sign off was evident in all cases, it is clear from the text and the narrative that in some instances returns were overwhelmingly completed by one or other part of the system, i.e. by, health or local authority commissioners. It was clear that responses were jointly completed in just under half (49 per cent) of returns and not clear in 18 per cent.

**Percentage of reporting HWBs engaged with the programme**



While it is clear therefore that stocktake outcomes will be reported and discussed, there is a growing need to set out in HWB agendas the longer-term commissioning task required to achieve the Winterbourne View outcomes

Similarly, the majority of areas report clear arrangements for professional leadership of local programmes (84 per cent). In 13 per cent of areas this is either not clear or is currently under review.

Further examples of strong leadership across the partnership are outlined in:

- **Leeds:** a joint review programme has been in place since 2009. A Joint Commissioning Strategic Executive (JCSE) was set up following recommendations from an external audit as a means of improving governance, formalising relationships between organisations and improving performance. The JCSE is led by commissioners (Leeds North CCG and Adult Social Care).

- **Newham:** there is overall ownership with significant joint working between key organisations; with monthly Winterbourne meetings take place between local authority, CCG and Commissioning Support Unit (CSU) to track delivery of actions. Meetings are chaired by the LD lead from the CCG and reports to the HWB are timetabled in the forward plan.

Fundamental organisational changes brought about by the health reforms have had a significant impact on local partnerships, so too has the development of Health and Wellbeing Boards and the overall financial climate.

Some of this impact has been felt more markedly in some places than others while in some areas the reforms and the engagement of CCGs has given fresh impetus.

Commentary included in the analysis identified a number of ways that this is being approached in localities as follows in:

- **North Yorkshire,** due to the complex nature of the changes in health commissioning, the LA Health and Adult services has lead on the WV Concordat Actions to date. Senior NHS leadership will be achieved through the Director of Partnerships Commissioning, post September 2013.
- **Lambeth,** the Joint Commissioning Executive Group (JCEG) has responsibility for overseeing partnership working in Learning Disabilities. Where the JCEG can commission specific work areas to investigate and address any differences that may arise. An example of this would be the Challenging Behaviour Pathway / Autism pathway work and the Low BMI Project work, which facilitated a

multi-agency assessment and reporting. Recommendations were made that fed into the JCEG and joint commissioning arrangements to resolve differences or gaps in service provision within the partnership.

- **Tower Hamlets** report good relationships between the NHS commissioners and providers and social care. The configuration of the management of Continuing Healthcare was reviewed by Health and Social Care in 2012. This included a new NHS CHC Eligibility Panel, NHS Funding Panel, the continuation of joint working between both organisation and the formalisation of a Dispute Resolution Policy. A joint panel was set up between children's services and adults to agree joint funding for young people in transition. Section 75 agreements are under review and will include dispute resolution. Commissioners agree strategic commissioning priorities and disputes resolved director to director

## Strategic capacity

The stocktake returns demonstrate that a great deal of positive activity is underway across health and social care and the community and voluntary sector to achieve the changes necessary to meet the WV Concordat commitments.

Inevitably some of the actions are more crucial, or have more immediate impact, than others, although all are important.

While difficult to measure and validate, using the dimensions below an attempt has been made to look at the degree to which strategic capacity is in place:

Q	Strategic capacity
Q39	% of places assessment of commissioning requirements
Q42	% reporting plans for re-provision and diversion
Q52	% reporting assessment of crisis response capacity
Q54	% including workforce/skills assessment in commissioning intentions.
Q57	% including C&YP needs in commissioning intentions
Q59	% reporting progress with market assessments

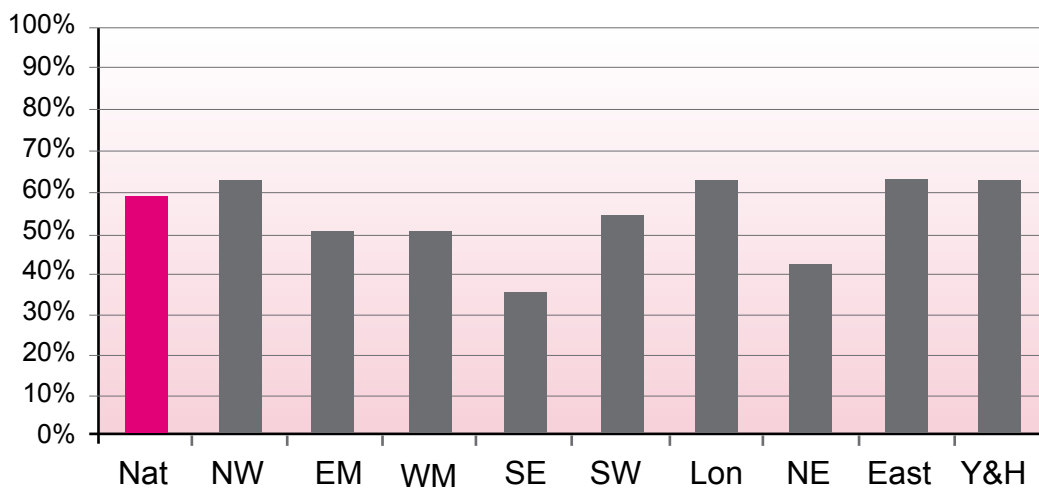
In both health and social care some dedicated posts/functions to support the changes have been identified and put in place.

In relation to the challenges outlined for local areas:

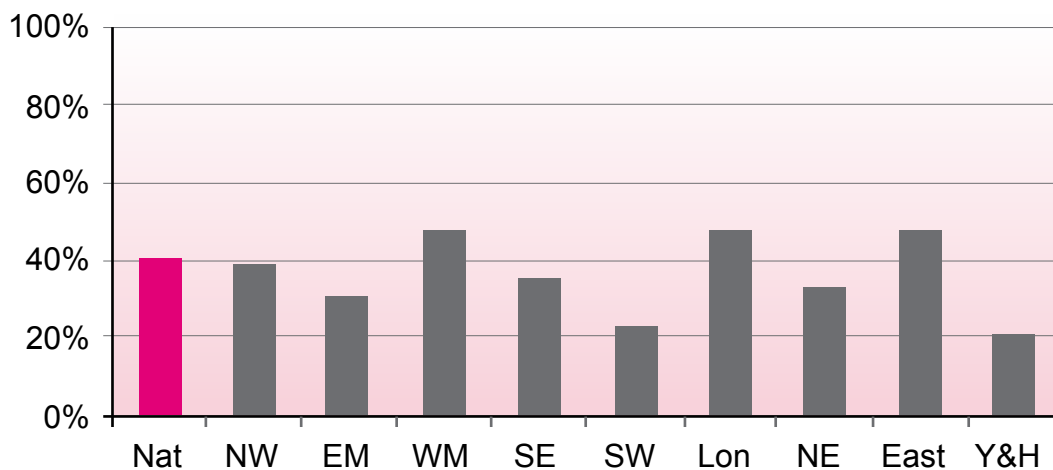
Fifty-nine per cent of places report having a dedicated planning function in place and a further 35 per cent of places report that this is being developed.

Many places have described a dedicated planning function for WV while others have made it clear in their narrative that a process is in place across a number of developments. This area will be a key question to follow up in individual and regional discussions.

### Percentage of places with a dedicated planning function



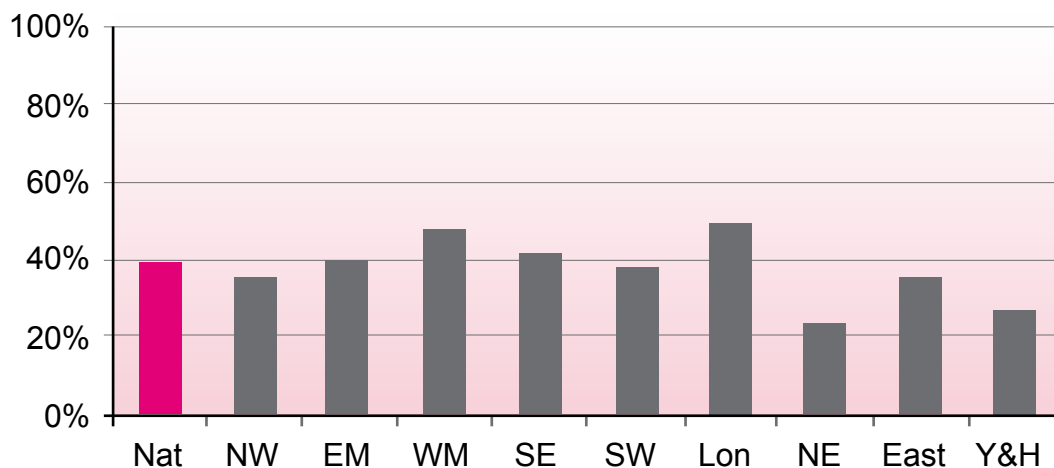
### Percentage including workforce/commissioning skills assessment in commissioning intentions





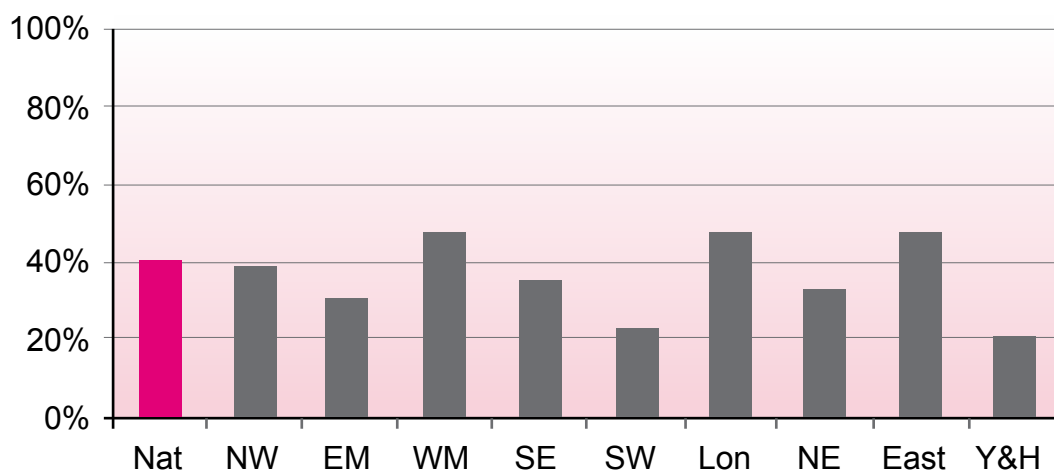
Just 41 per cent of places reported inclusion of workforce and skills assessments in commissioning plans. Thirty-nine per cent report an assessment of capacity in crisis and crisis response services, (though this is under review in over 50 per cent of places).

**Percentage reporting assessment of crisis response capacity**



Sixty-two per cent of places report that the needs of children and young people are included in commissioning intentions and 33 per cent report that they have this under review. Clearly lack of engagement with children’s services as part of strategic planning represents a significant challenge to ensuring a coherent life pathway.

**Percentage of places assessment of commissioning requirements**



However, a much smaller number have made an assessment of overall commissioning requirements. This is an area for follow up and development by WVJIP.

Although new and emerging commissioning relationships are vital, these cannot happen without the necessary strategic and development leadership across the system and partnerships.

As the stocktake demonstrates, there are good examples of how commissioning can drive change and this will be supported further by a specific piece of programme improvement work that is being developed jointly with the NHS Confederation for roll out in October 2013.

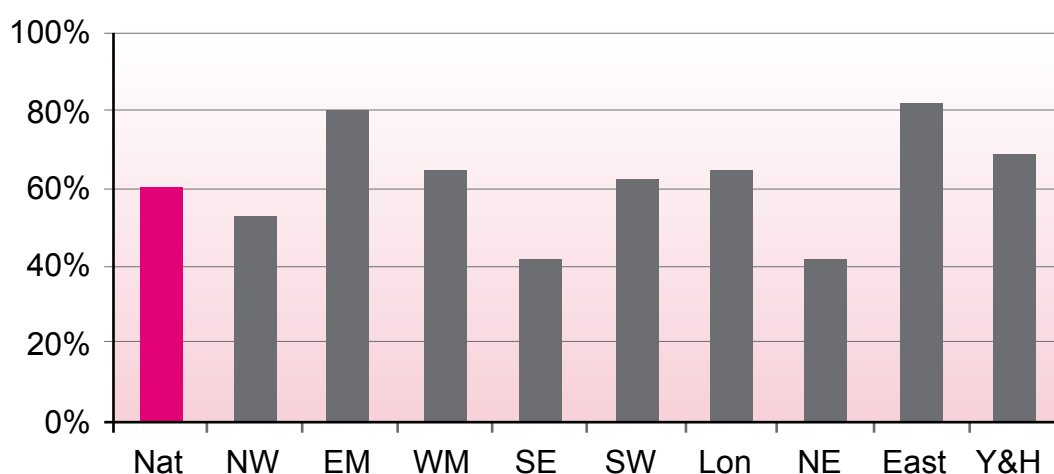
## Delivery and progress

Clear commitments were made regarding the comprehensive reviewing of current placements and putting plans in place to achieve safe and sustainable changes to the provision of care by June 2014. Central to these changes will be direct reduction in the number of people in Assessment and Treatment Centres (in-patient settings) and an emerging reduction of new admissions and length of stay for individuals.

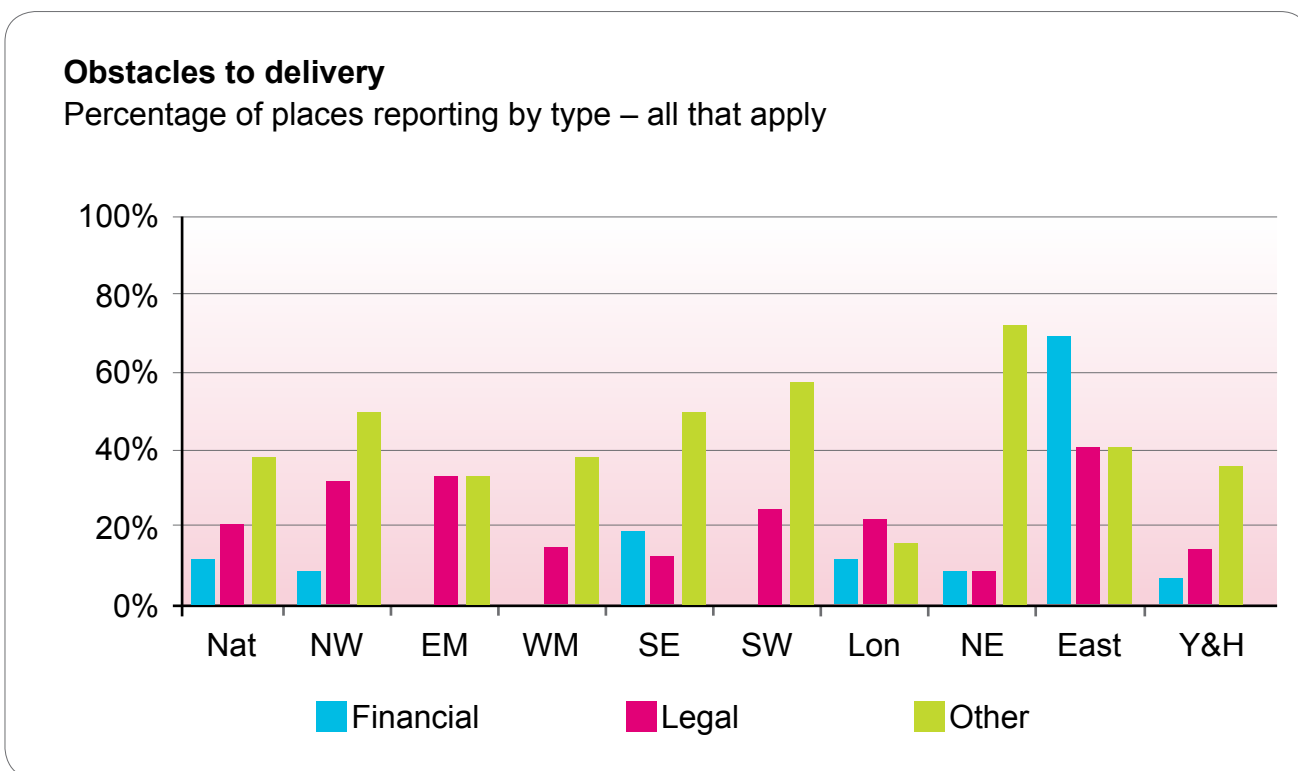
To achieve this change there is a need for real, reliable and robust alternatives to be developed. Some places have made tangible progress on this; other will need support and the WVJIP will offer this.

One requirement from the WV Concordat is to ensure the review and delivery of a plan to enable all current individuals to move from Assessment and Treatment Centres (in particular) to alternative and less restrictive settings by June 2014. People were asked in the stocktake to report their confidence in achieving that outcome. Reporting was as follows:

**Percentage reporting confidence of achieving the 1 June 2014 target**



It should be noted as a strong caveat to the figures outlined opposite that many places also set out their concerns for achieving this in the timescale, recognising that some changes may inevitably take longer. However, all places were reporting as being fully engaged in carrying out the changes with robust and safe plans for individuals. Places were asked specifically about obstacles to delivery and in particular to detail financial and legal issues. Besides reporting on these other issues were reported, in particular issues relating to capacity in local provider services and issues relating to appropriate housing.



A key test of the partnership is the degree to which places appear to be realistic about the challenges that they may face. No single question can answer this but consideration across each of the dimensions of the stocktake was used.

Stocktake responses are impressive in the degree to which they are open and candid about the challenges ahead, as well as in their openness about particular local situations.

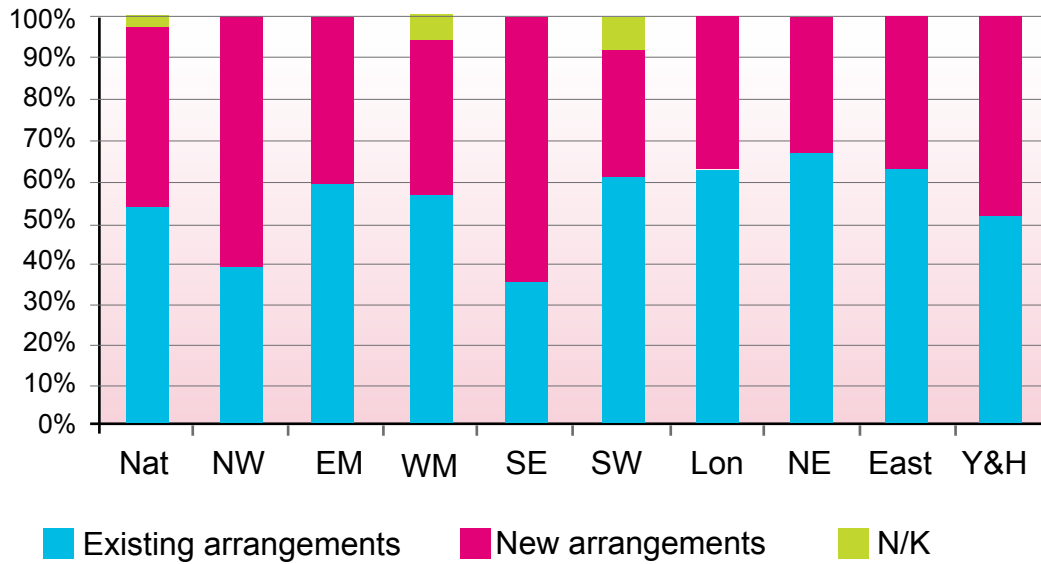
No single activity will make this happen. The following section sets out the progress and challenges of delivery, based on the self-reported stocktake.

Q Delivery, progress and capacity	
Q1	% reporting joint delivery arrangements are in place
Q2	% reporting joint planning that includes specialist commissioners
Q17	% reporting a joint, integrated community team
Q19	% reporting confidence in Community Team capacity to deliver
Q21	% reporting named workers
Q22	% reporting agreement about numbers affected by the programme
Q23	% reporting clarity about specialist commissioning arrangements
Q24	% reporting inclusive reviewing arrangements in place
Q27	% reporting that advocacy support is available
Q47	% reporting confidence of achieving the 1 June 2014 target
Q50	% reporting confidence in quality of advocacy support

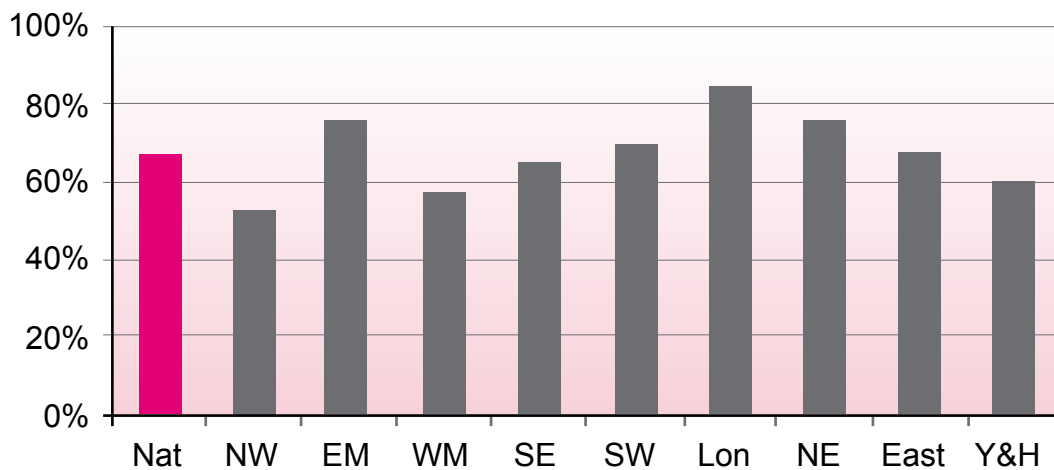
Joint arrangements for delivery of local improvement programmes are reported to be in place (or are being put in place) in nearly all localities (98 per cent) either through existing mechanisms or through new arrangements specific to this purpose. **This is a very key strength.** To ensure comprehensive progress the WVJIP will focus on the key delivery issues that make the real difference.

Community teams or other integrated/shared services are vital to the success and capacity to support people in new settings. Confidence is shown in current community teams as follows:

### Joint delivery arrangements



### Percentage reporting confidence in Community Team to deliver



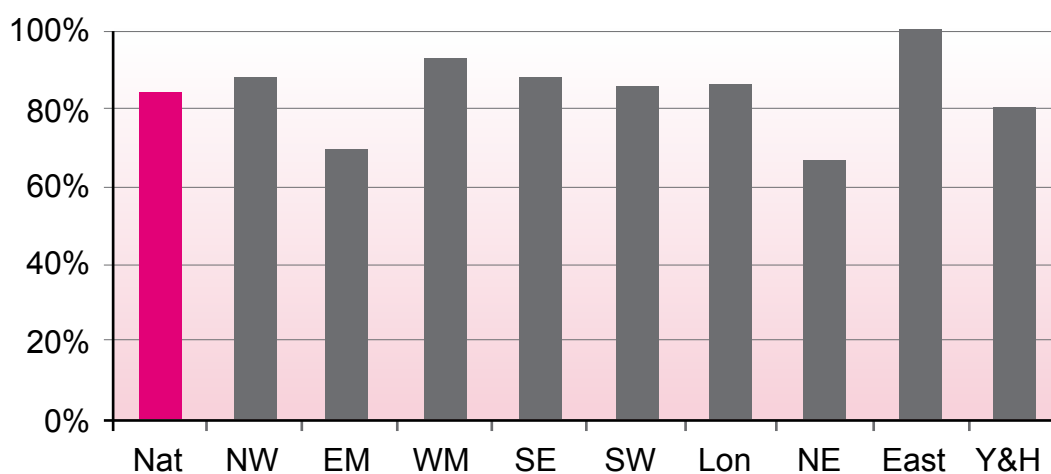
Similarly, a number of places identified multiple obstacles to delivery. The most significant challenges identified (detailed below by “Primary” concern) are:

- alternative provision – including the ability to commission this within timescales and / or identifying suitable providers
- Mental Health Act and / or Ministry of Justice restrictions
- funding arrangements, including lack of finance, clarity about specialist commissioning funding, NHS Continuing care.

These will form the basis of WVJIP discussions.

Given the contributions needed from a range of professionals working in different contexts and environments (i.e. in social care, GGC, specialist commissioning and provider teams) it is clearly important for there to be clarity about who is giving oversight and professional leadership to local programmes. This was reported as reported as follows:

**Percentage of places reporting clarity about overall professional leadership of the review programme**



As set out in ‘Transforming Care’ and the Winterbourne View Concordat, a joint or integrated approach to commissioning is critical to establishing the changes that are required. The stocktake returns indicate a very mixed picture of development. However, there are many examples of collaborative commissioning exemplified by:

- **Knowsley**, there is work with local MH Trusts, NHS England Specialist commissioning and neighbouring local authorities / CCGs to create a consistent picture across Merseyside. The model of care had already realigned to shift focus from bed based treatment to community based treatment. At the same time there has been a shift of investment from those bed based services into community based services. There is a Positive

Behaviour Support Service which provides personalised and person centred interventions for people with behaviour viewed as challenging and provides training, advice and support for both families and staff teams.

- **Salford** a multi agency working group has been established including: local authority commissioners, safeguarding, care management; emergency services; health; children's services; CCG/CSU. A provider assurance working group has also been established and provider assurance questionnaire completed by all LD providers.
- **South Gloucestershire** there is a Strategic Steering Group that is working with providers locally to shape changes to services to meet the needs of people with learning difficulties. The JSNA and Joint Health and Wellbeing Strategy for South Gloucestershire has been completed and the next step is the review of the Learning Difficulties Strategy through the South Gloucestershire Partnership Board in 2013.
- **Enfield** a project group to review the assessment and treatment pathway has been formed. Membership includes the head of integrated learning disability services, mental health commissioner, lead psychiatrist, service manager for LD community nursing, LD commissioners, provider of A&T and the LD care management service manager. A community intervention model has been presented to the CCG.

Eighty-two per cent of places report agreement about the numbers of people who will be affected by the local programme. However, as indicated above, there are some differences in interpretation in relation to both people and places.

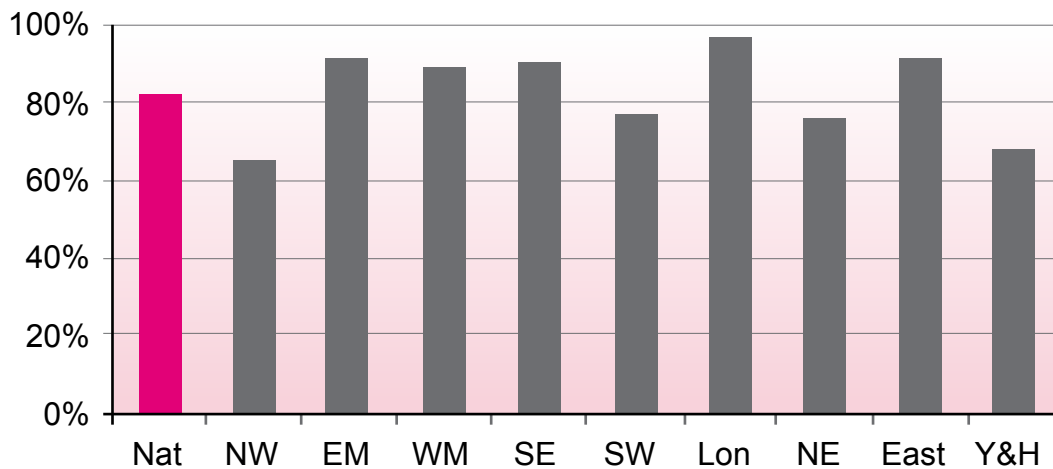
For example:

- some made clear that their local registers and review programme includes all people with learning disabilities, with autism or behaviour that challenges (e.g. **Lambeth**)
- some have included all people with complex needs (e.g. **Oldham**)
- others have given detailed descriptors of the range of people with disabilities included in the programme (e.g. **North Yorks**)
- in other areas detail is only given in relation to people in A&T units, or of people funded via health
- some have only included people in out of area placements
- in some cases the approach taken to care planning for people subject to detention under the Mental Health Act is not always clear.

As indicated above, 'Transforming Care' invites a range of "definitions" of both people and places and there is a pressing need for clarity and focus. This key action has been taken forward by the WVJIP, which the programme will want to confirm shortly. This work will be a key feature of the improvement offer.

While there may be local agreement there are some differences regionally and nationally. In the development of local programmes this will need to be clarified.

### Percentage reporting agreement about numbers affected by the programme



The initial analysis also indicated a number of significant challenges being faced by localities. Not surprisingly, resource issues are flagged across a range of dimensions – for example, in relation to capacity, workforce and workforce development, and development of local community resources – in particular accommodation / housing.

## Specialist and forensic commissioning

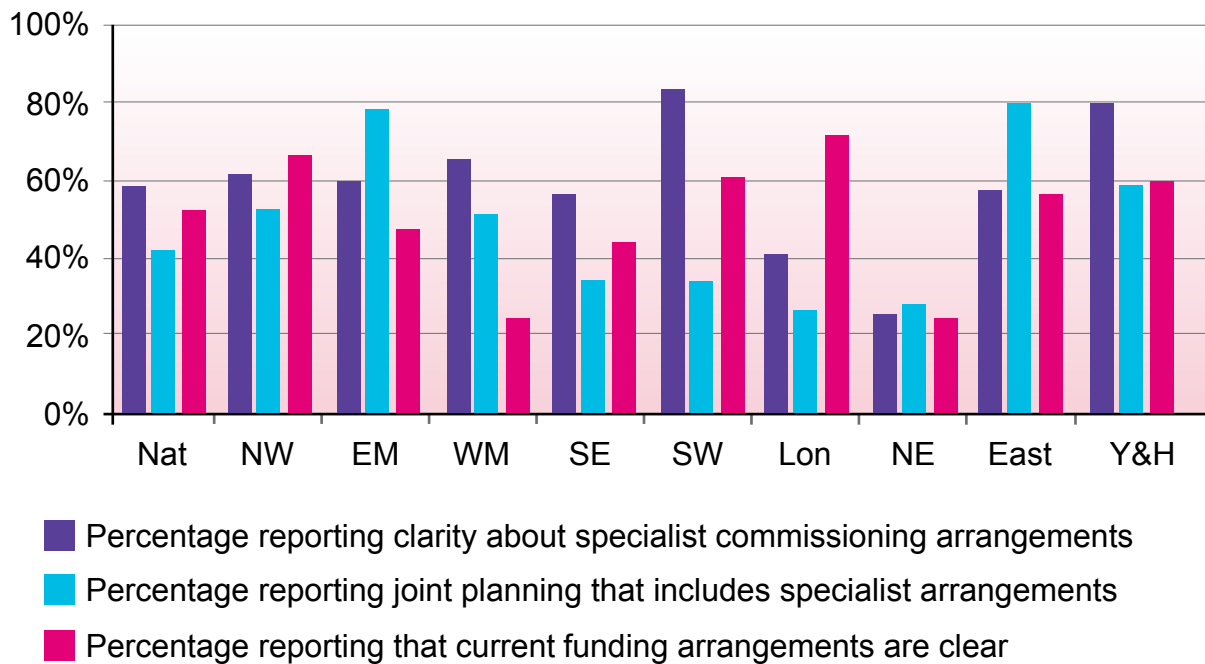
A number of responses, when looked at nationally and regionally may appear inconsistent or contradictory, the most significant of these being in relation to arrangements with specialist commissioners, as follows:

- 98 per cent of places report that joint delivery arrangements are in place and, in some places this is specifically reported as including specialist commissioners. However:
- just 58 per cent of places report clarity about specialist commissioning arrangements
- 55 per cent report that funding arrangements (including from specialist commissioning) are clear and
- 45 per cent of places report that joint planning includes specialist commissioners.

This suggests significant lack of clarity overall about how specialist commissioners are engaged with the programme, though it is also clear that there is some significant regional variation in this regard as set out opposite:



## Dimensions relating to specialist commissioning



There is a comprehensive understanding that the role of specialist and forensic commissioning is crucial to the particular groups of people in relation to the Winterbourne View priorities. However, there is a very mixed picture across the country of how well relationships with specialist commissioners are integrated into local and regional planning processes. This appears to have been impacted (at least in part) by organisational changes. However, a number of places report either lack of clarity or continuing dialogue about the role and engagement of specialist commissioners and, in some places, very significant frustration about the lack of engagement – or reported lack of responsiveness – from specialist commissioning.

It is clear that a key task for the WVJIP will be to support many places to develop and improve both understanding and relationships and support innovation and commissioning if the next steps are to be achieved.

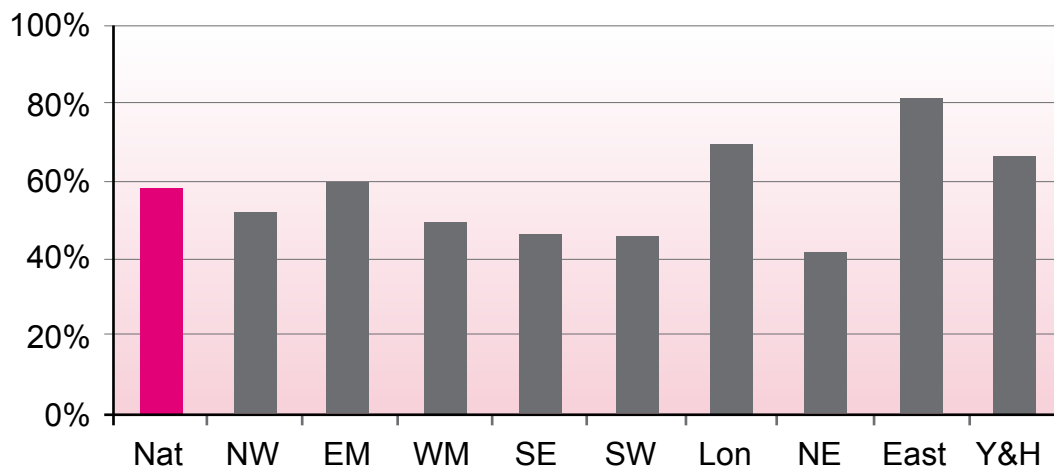
Examples from the returns include:

- inclusion of milestone dates and clear lead in times to achieving targets
- complex health and social care economies (for example counties covering a large number of CCGs) which are at different stages of planning and delivery
- plans contingent on developing plans with providers with uncertain track record.

## Involvement and advocacy

The number of places reporting inclusive (i.e. of people and families) arrangements in place.

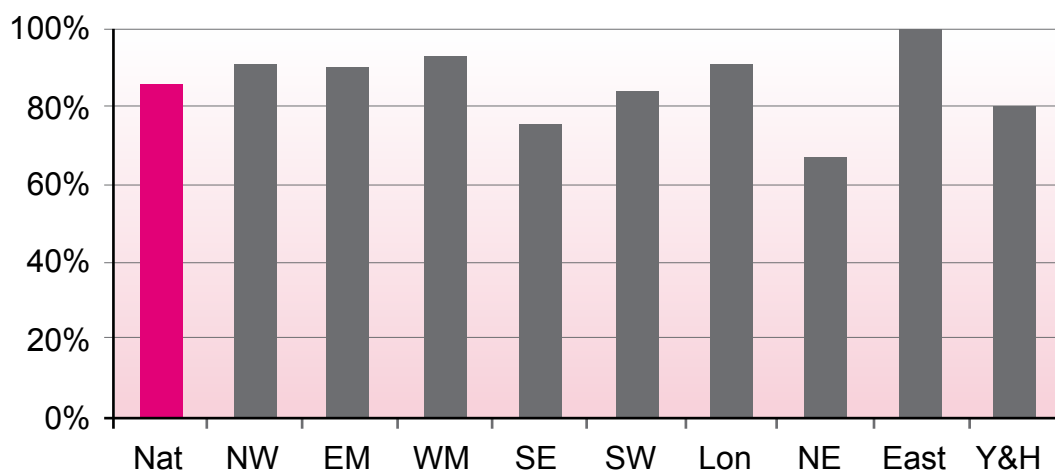
**Percentage reporting inclusive reviewing arrangements in place**



This is evident in 58 per cent of places.

It is reported that advocacy arrangements are available in 86 per cent of places.

**Percentage reporting that advocacy support is available**



As noted opposite, when considered alongside a snapshot of information from advocacy and family carer organisations there is a reported considerable variation in the effectiveness and availability of such arrangements.

As part of the WVJIP engagement programme this will be a key area of support in the improvement activity.

There are, however, clear examples of processes in place to assure the quality of practice, as outlined here.

In 76 per cent of places it was felt that there are clear and evidence based monitoring processes in place. Examples include:

- **Blackpool** quarterly monitoring meetings take place with all advocacy providers to ensure that everyone understands the quality and effectiveness of advocacy arrangements. They also receive feedback directly from service users, carers and care management professionals in relation to both of these issues and can respond accordingly.
- **Manchester** contractual arrangements allow for the continuous monitoring and review of quality and effectiveness (performance indicators, activity, and customer satisfaction). The Partnership has also commissioned a specialist advocacy service and two specialist LD advocacy services. There is also an option to use a broker via a trial with mybroker.com and Breakthrough UK via Right to Control.
- **Redcar and Cleveland** are undertaking a scoping exercise to identify opportunities for improvement; this is linked to the introduction of new contracts from April

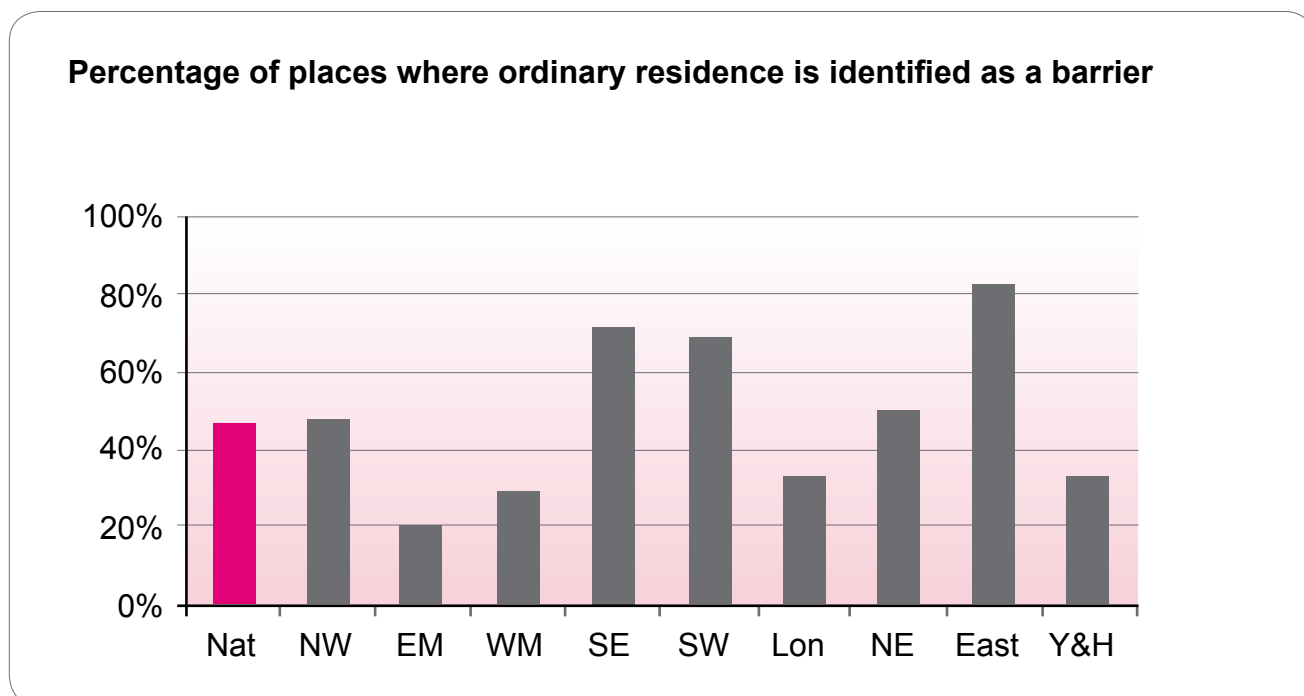
2014. This work is being supported by Inclusion North and Action for Advocacy.

- In **Sheffield** an additional Person Centred Planner / Support Planner / advocate has been appointed via Mencap to improve the quality and capacity of advocacy arrangements for individuals. The work of this post integrates with the Out of City Team Clinical Specialists. This is in addition to the block contract that is held with Mencap for which there is a clear specification. This contract is overseen with key performance indicators and regular monitoring by the lead service manager for this area within City Council and contracts team.

This is a more encouraging picture. There is some evidence that the core service specification development work may help with this. In addition, the joint programme of Enhanced Quality Assurance Programme (EQAP) will provide tools and methodology to use, which will help progress this.

## Ordinary residence

The issue of clarity and agreement about who is responsible for the funding and care arrangements of individuals has emerged as an issue for many places, as follows:



The WVJIP will work to clarify any uncertainties in the definition. In the meantime, it is expected that authorities will work together to resolve any outstanding uncertainties and that this should not be a reason for individuals remaining “stuck” in inappropriate situations.

## Work with providers

Work with providers is also a national priority and this will be led at the highest levels in the programme.

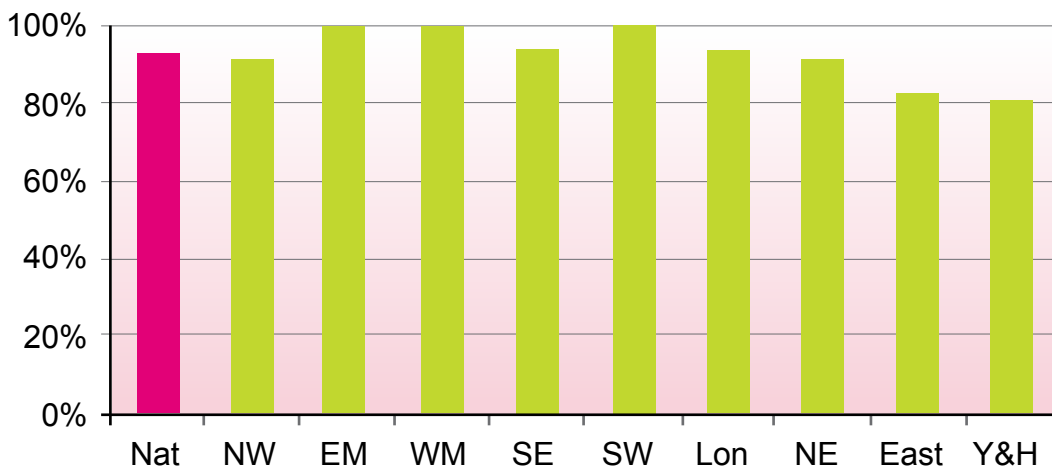
Work with the regulator, financiers and existing providers will be developed over the coming months.

Existing providers and the market generally have a vital role to play in supporting the development of alternative forms of provision. A new model of collaborative commissioning is urgently needed.

There may well be a need for Government input in helping to develop the market. This is particularly true in relation to the development of affordable, sustainable and appropriate housing options. National work will support this.

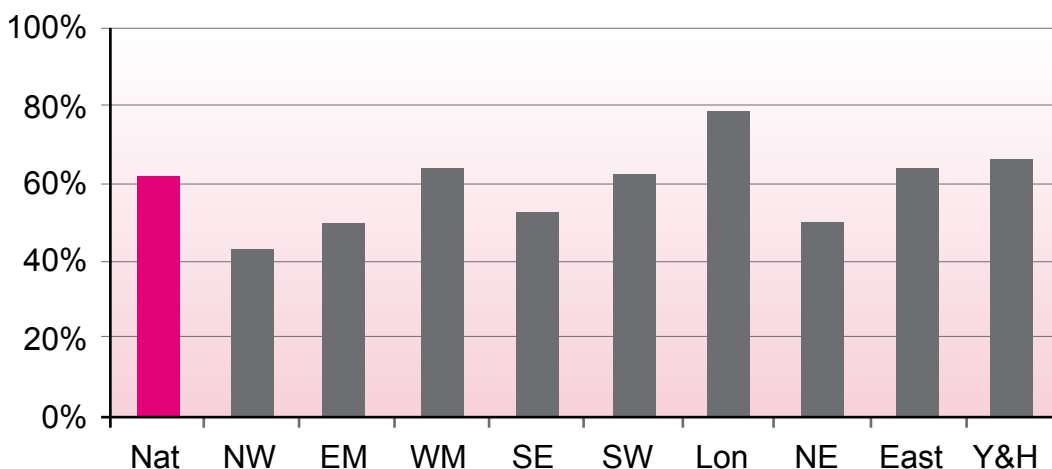
Commissioners cannot do this on their own. Current providers will need to change approach as will commissioners and providers who will need to work more collaboratively. Part of this may be supported by market assessment, at least as a starting point. The following is reported as progress on market assessment.

**Percentage reporting progress with market assessments**



The London region has completed a very detailed and comprehensive Market Position Statement specific to LD and Winterbourne View requirements.

**Percentage working with care providers to ensure sharing of information and developing risk assessments**



It is clear that people receiving support and care are not a single or homogenous group. Needs are highly individualised and may be impacted by a range of factors including both physical and mental health conditions or the environments in which they are living. The range of supports for people that will be required locally will need to reflect the range of personal circumstances and requirements of individuals, careful planning and, essentially, sufficient time to work through proposed plans with people and with family carers.

There are some excellent examples throughout the stocktake of well tried and tested arrangements at front line level, showing real evidence of skilled, committed and dedicated staff across all sectors in many organisations. This is very encouraging but they must have the support and arrangements to carry out their tasks.

In Salford, as an example, commissioning arrangements for complex needs are deeply embedded, the development of local infrastructures to support people with complex needs having been a priority for the last 10 years.

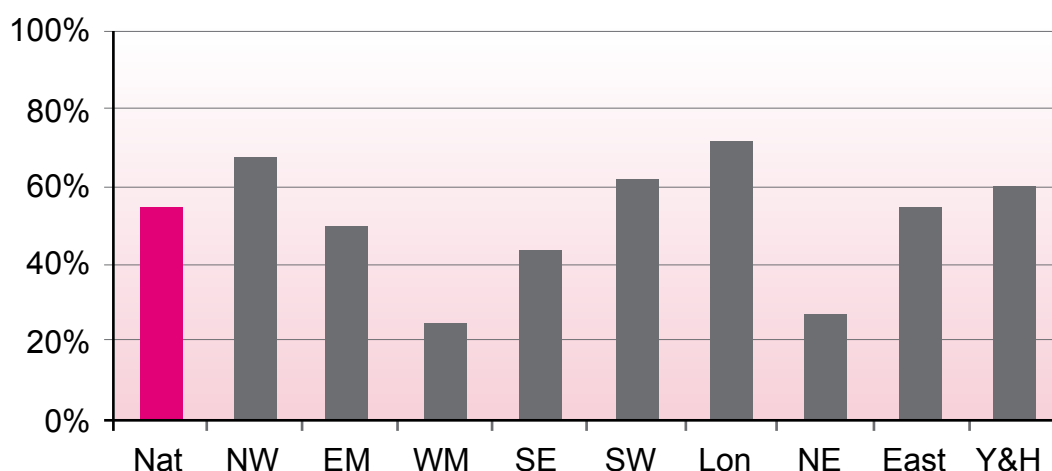
## Managing the money

While commissioning for individuals on a personalised basis is vital, there is considerable concern that too few places have yet been able to grasp the opportunity of a joint, integrated and strategic approach. There are considerable concerns that financial flows and considerations / flexibility in the use of resources is a determining factor.

Q Managing the money	
10	% that reported shared understanding of total costs of current services
11	% reporting that current funding arrangements are clear
13	% using pooled budgets
14	% where funding contributions are agreed
15	% where funding for C&YP is included in a pooled budget
16	% developing medium term financial strategy

Many discussions about financial planning appear rather tentative and are not well supported by other elements of integration on the assessment commissioning and service side.

### Percentage working with care providers to ensure sharing of information and developing risk assessments



Both stages of analysis have shown this to be one of the most complex and problematic areas for development with inevitable negative impact on progress across local programmes.

In a number of places historical difficulties around this or other funding streams continue to impact. As indicated above, the picture regarding the flow or flexibility of money is variable. The flow and use of resources is not a single issue and the following 5 sub areas are integral to developing some solutions.

## Section 75 Agreements (s75)

There is a mixed picture on the use of s75 agreements. Although 44 per cent of places report use of s75, it is clear in a slightly lower number of cases (41 per cent) that this is specific to the needs of Winterbourne Programme (i.e. s75 agreements in some cases predated WV programme or arrangements have been incorporated for this purpose). A further 13 per cent of places report that they are progressing s75 agreements

- There are a number of s75 agreements currently in place across the LA and CCGs however many do not relate to this specific programme. **Newcastle** is an example of a specific agreement.
- The existing s75 agreement has been transferred to the CCG, however work is underway to review this agreement in light of recent changes to national and local organisational structures, exemplified by **Lewisham**.
- **Wandsworth** reports that they are actively reviewing their formal arrangements taking into account recent developments integrating health and social care, such as the creation of the joint commissioning unit and establishment of the Health and Wellbeing Board. This

includes consideration of an s75 arrangement and a pooled budget.

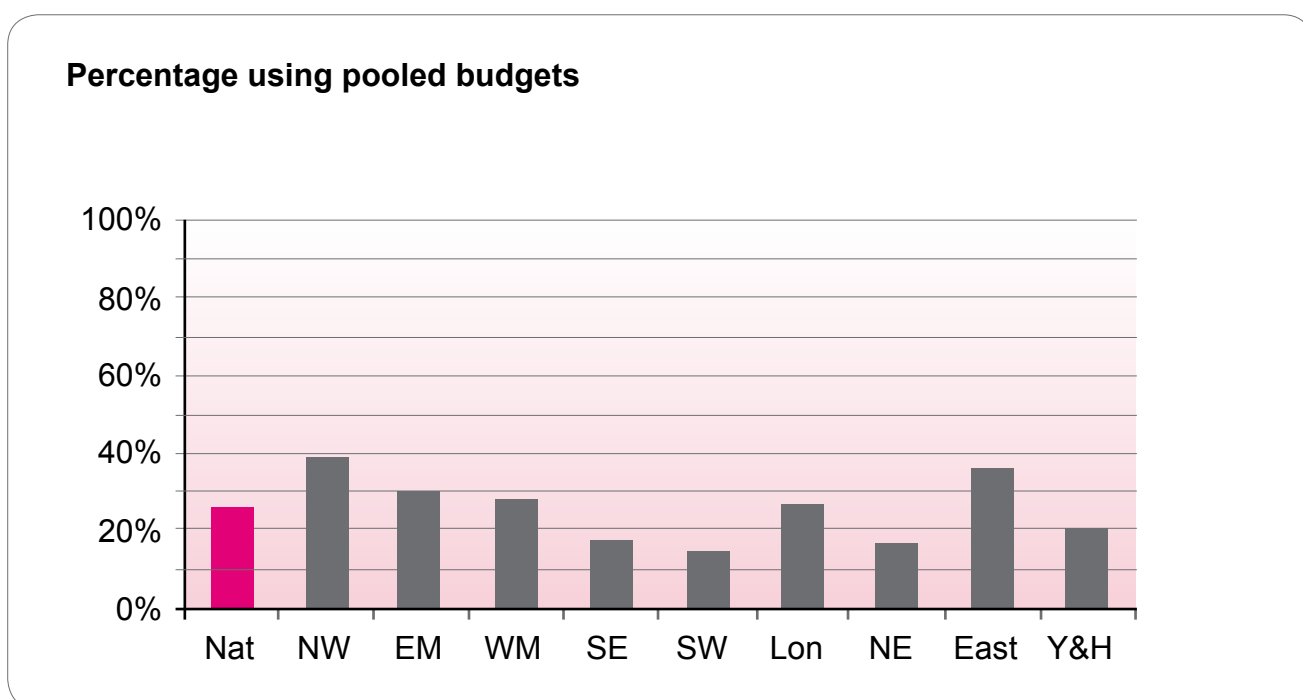
- **Suffolk** report that for adult services, since the LD Health and Reform Grant transferred former long stay hospital funding directly to the County Council, there has been no s75 agreement for LD services. Shared care arrangements are discussed on an appropriate proportion of funding basis as required following assessment. The potential benefits of both joint commissioning and the establishment of a pooled budget (and consequently a new s75 agreement) are being discussed.

Key strengths taken from stocktake reports are exemplified in:

- **Croydon** have s75 agreements in place which are being revised and have a clear alignment of budgets.
- **Walsall** stocktake indicates that pooled budgets are established. There are shared financial risks and agreed contributions to the pool are agreed annually.

### Use of pooled budgets

The Concordat (Action 33) made a strong presumption of the use of pooled budgets. In reality the use of this is very variable. A number of places, including for example **Westminster**, have a comprehensive s75 agreement but not a pooled budget.



While pooled budgets are less well used many places report well tried arrangements particularly now in place between LA/CCG. The arrangements with specialist commissioning are less well developed.

There are a number of examples in the North West where historical patterns of strategic planning, including financial and flexible use of funding are cited and are well established.



Other localities report that they have arrangements and risk sharing, which they describe as effective. This is exemplified by **Hartlepool** who developed an alternative arrangement which has virtually the same impact as a pooled budget. Others, partly perhaps because of their stage of development, have yet to quantify full costs, contributions and future demand.

To a great extent the variability across partnerships in relation to their financial planning and activities are mirrored by the strength, or otherwise, of their partnership and organisational arrangements for commissioning, assessment and care management and their relationships across the wider health and wellbeing spectrum.

While the term “pooled budget” is helpful, the improvement programme will need to work with those places that are still to establish good strategic planning to ensure that the financial aspects are understood and that the mechanisms are in place to support the flow and flexibility of resources.

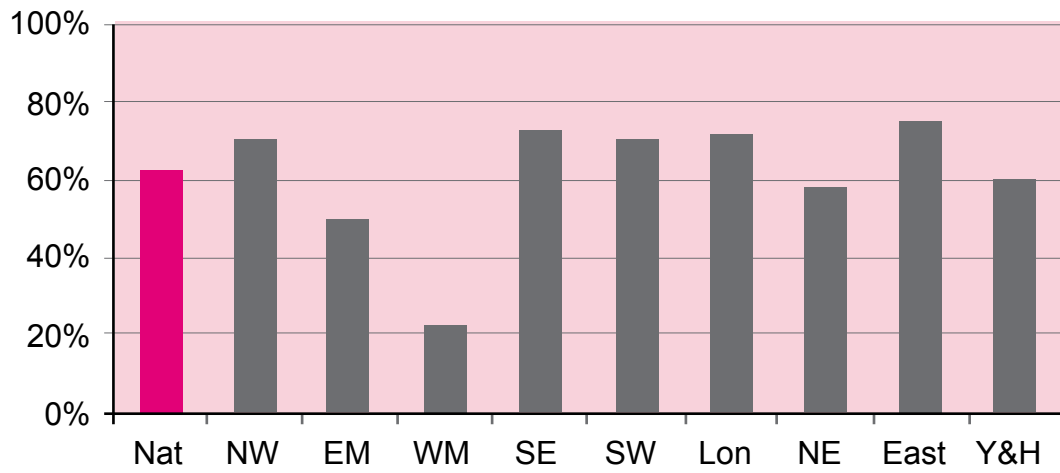
Rigid and sometimes arbitrary decisions between the areas of commissioning (specialist/ other) are an impediment to fulfilling both Concordat and Winterbourne View Programme requirements.

From these stocktake returns “managing the money” is a very mixed picture. Some places have well established historical shared funding arrangements and this seems to have follow through to the Winterbourne programme. For example, **Redbridge** has a proven track record over 10 years in this regard.

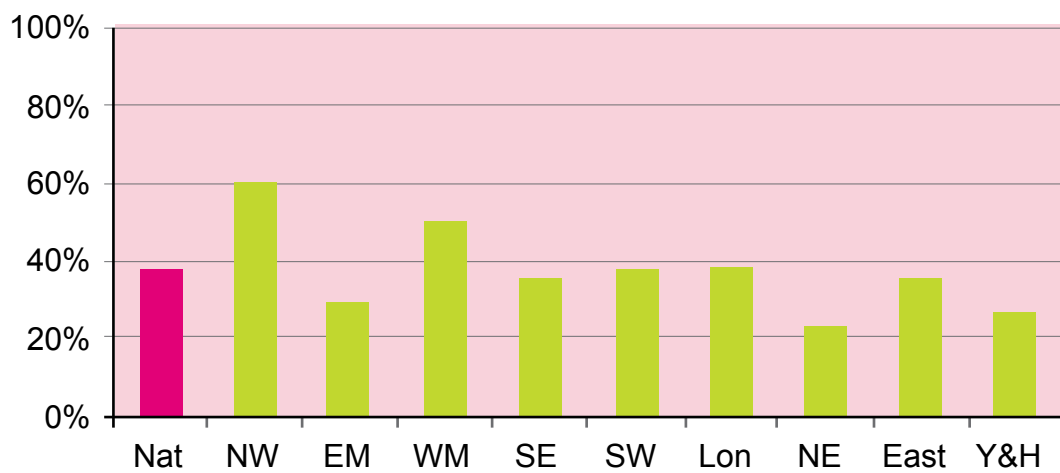
Analysis from responses is mixed and while it is difficult to form a firm picture, there are indicators of where development support would be useful. Thirty places have specifically asked for examples or support to develop approaches with some asking for support with a variety of aspects of this (44 requests for support in total).

The bar charts overleaf set the financial picture in more context:

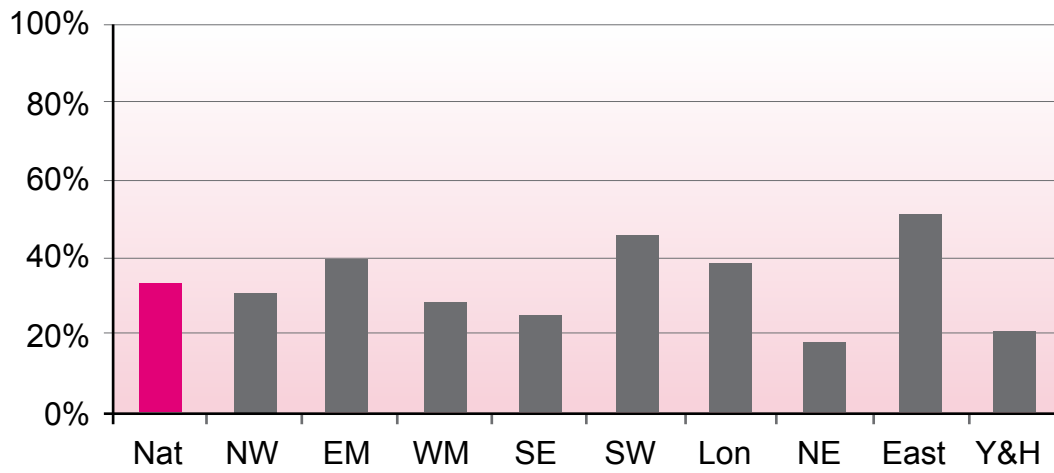
### Percentage that report shared understanding of total costs of current services



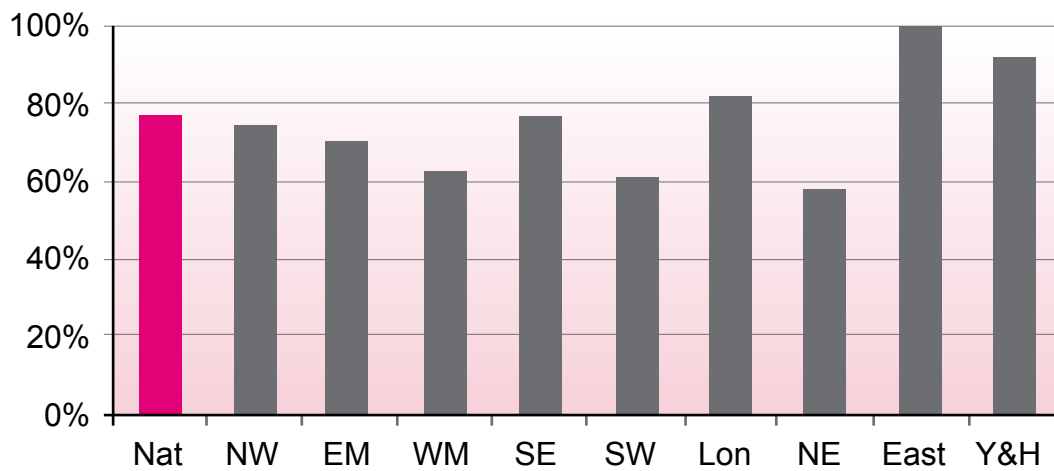
### Percentage where funding contributions are agreed



### Percentage where funding for C&YP is included in a pooled budget



### Percentage developing medium term financial strategy



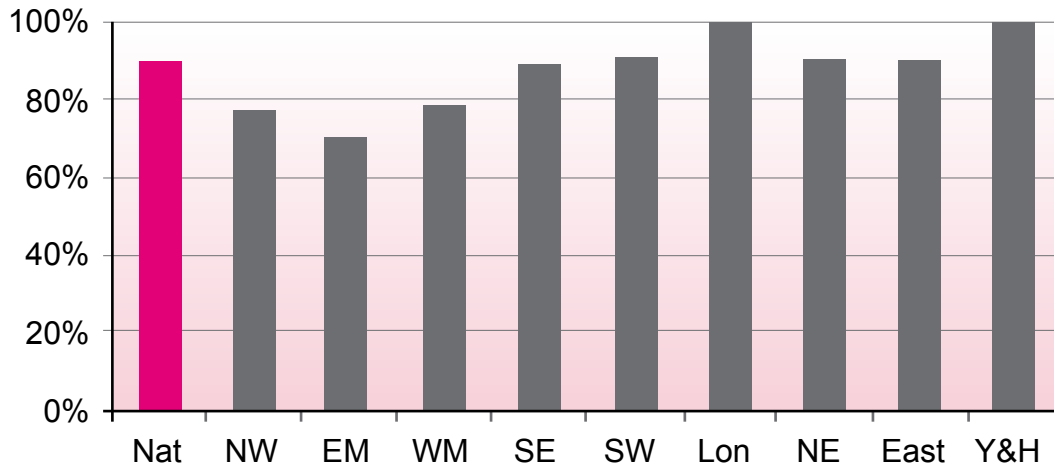
## Safeguarding

Keeping people safe is the single and most important duty. People were failed at Winterbourne View. Good well developed and consistent safeguarding processes, procedures and practice are vital. The following dimensions were considered.

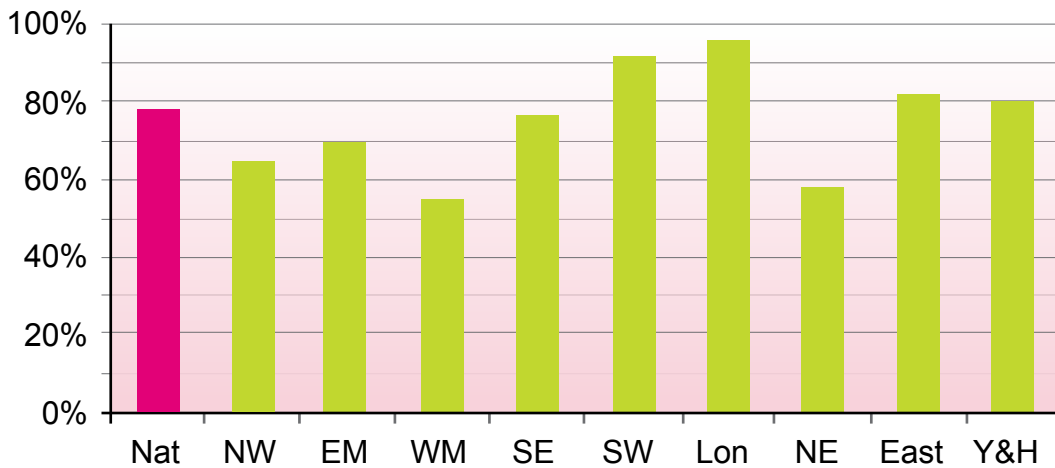
Q	Safeguarding
31	% arrangements for people placed out of area / ADASS protocol
32	% reporting information sharing with providers
34	% reporting children and adults safeguarding boards are engaged
35	% reporting monitoring arrangements in respect of DOLS /use of restraint
38	% reporting working links with practitioners in quality/regulatory roles
51	% reporting plans to ensure sufficiency of Best Interest Assessors

Local safeguarding children and adults boards are reported to be engaged with the local programme and most places (88 per cent) report ADASS protocols for people placed out of area are in use.

### Percentage arrangements for people placed out of area / ADASS protocol



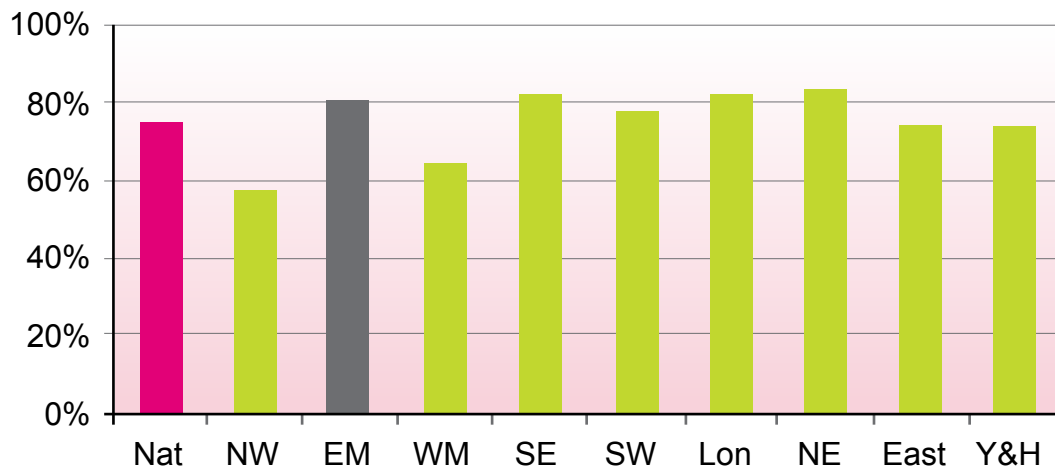
### Percentage reporting CYP and SAB engaged



Across the board, safeguarding was comprehensively reported and all places demonstrated this as a priority.

One area for development is the understanding and use of the Mental Capacity Act (MCA) and the Deprivation of Liberty Safeguards (DoLS) where there are indications that this may not be fully utilised or followed.

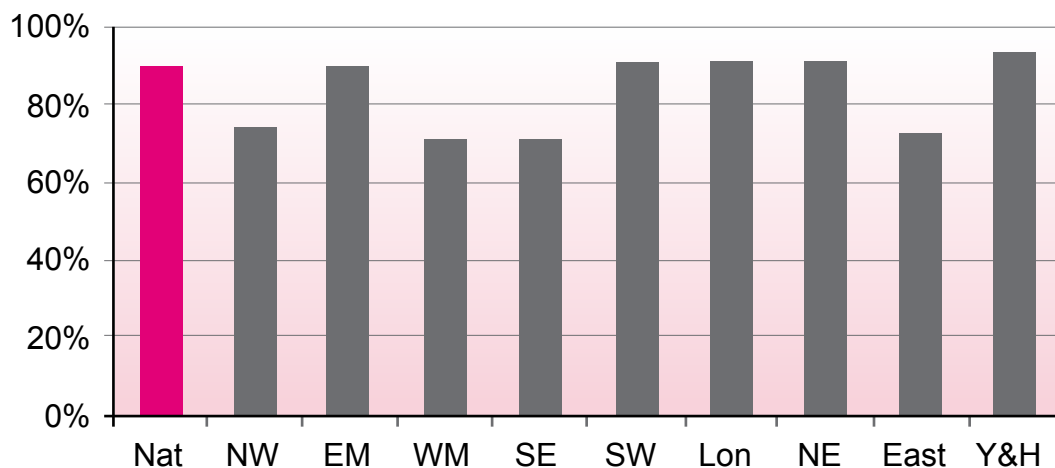
**Percentage reporting monitoring arrangements in respect of DOLS/ use of restraint**



While the response above is reasonable many places have asked for development work to improve knowledge and application of the MCA.

The need for this was further emphasised at a seminar with people who may use services, family carers and advocates covering the North West region on 11 October 2013.

**Percentage reporting plans to ensure sufficiency of Best Interests Assessors**

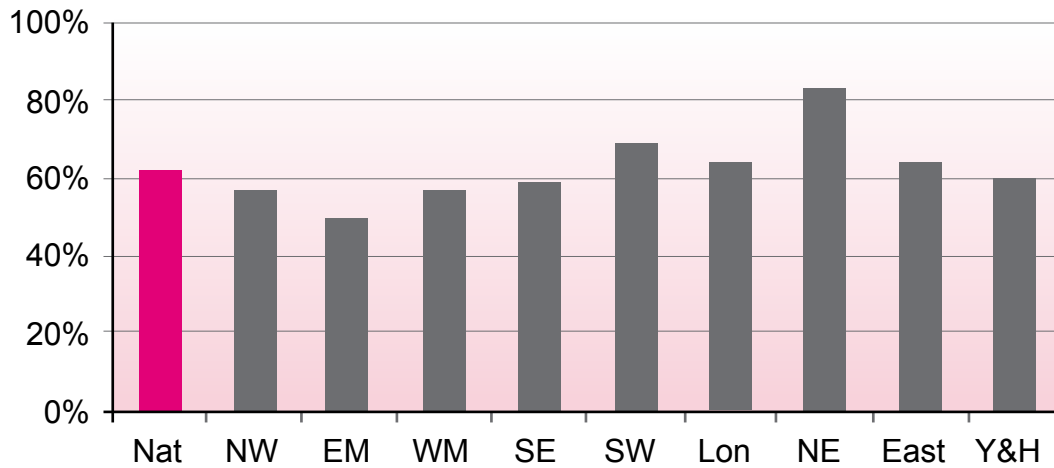


This will be a priority for the work of the WVJIP over the coming months in conjunction with ADASS, DH and safeguarding leads.

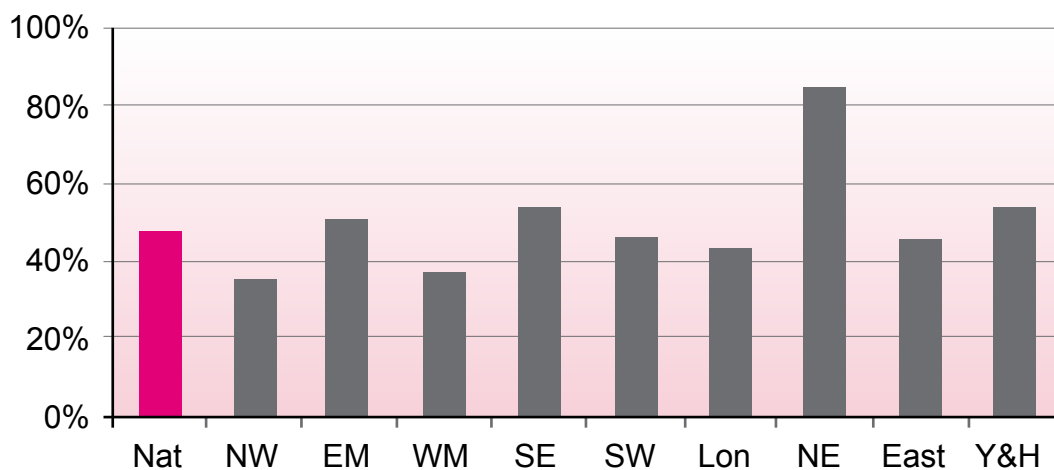
Specific work will be undertaken with advocacy and family carer groups.

## Findings: children and young people

**Percentage including C&YP need in commissioning intentions**



**Percentage reporting developed ways to understanding future demand re: C&YP in transition**



This is an area that will require priority work. There is limited effective commissioning activity for children, (this is more appropriately described as spot purchasing or placement services) which is inevitably difficult to set out within a whole pathway approach to planning and delivery. There are some examples of good work around transitions (adolescents):

- **Blackburn with Darwen** are working jointly with key partners to develop a 0 years to 25 years complex case pathway for families and young people (this approach is not just LD specific). They are working jointly with children services, education, and health colleagues with young people and their families who are in transition and continue to support individuals on a 'whole of life' basis, based on individual needs.
- In **Lambeth** a business case is being developed for the creation of a lifelong disabilities team.
- **Northumberland** commissioners and care managers are engaged in strategic meetings with children's services identifying all young people with challenging behaviours. There is also joint working between adult and children's social care and health commissioners supporting the work of the HWB.
- **East Riding of Yorkshire** note significant progress in recent months with more work planned to integrate data to better inform planning. The resources currently committed to supporting those with LD across children and adult services in health and LA are being mapped with an ambition to develop an all age disability service.

- **Southwark** WV steering group are establishing a project board to oversee the redesign of a special educational needs and disabilities pathway for 0 -25 year olds. The intention is to make challenging needs, including LD and autism, one of the workstreams to identify and support young people who may be at risk of ending up in an inappropriate hospital or Assessment and Treatment setting and developing capable and compassionate support in the community.

There are both national and regional exemplars of good practice in this area and a number of programmes have supported this. However, significant change is needed from early years through to adult care if a fundamental shift is to occur. While laudable, incremental change is not sufficient, the improvement programme needs to work with others to harness and target resources from Government, the sector and other sources to achieve fundamental changes in the way planning, decision making and care is delivered to the most complex children's situations to change patterns for the future.

## Dimensions referred to in stocktake returns for further discussion

The stocktake identifies a number of key issues to be resolved – either from questions raised since the stocktake was launched or identified in discussion with the sector. These have included:

- Awareness of people placed by Devolved Administrations / Republic of Ireland.
- Specialist commissioning arrangements and in particular forensic placements



and functions of reviewing and future responsibility.

- Funding arrangements and in particular NHS Continuing Care.
- Variable understanding and arrangements in relation to Ordinary Residence.
- The degree to which individuals subject to placement under the Mental Health Act have been considered in or out of scope.
- The adverse impacts of resource reductions – for example on community teams – on the capacity to deliver.

# Information from NHS England and the Learning Disability Census

As indicated throughout this report there is a need to consolidate and more clearly define the scope and detail of the various parts of the population being considered.

## NHS England returns

There have recently been two data collection exercises carried out by NHS England in line with the Winterbourne View Concordat. Both exercises collected anonymous information on care commissioned for 'people with challenging behaviour' (that is, children, young people and adults with learning disabilities or autism and who have mental health conditions or behaviours that challenge).

The first data collection exercise collected information from Clinical Commissioning Groups (CCGs) on:

- how many patients met the definition for a review in line with Concordat commitments and how many reviews have taken place
- whether, from April 2013, CCGs had registers of people with challenging behaviour in place
- whether the first point of contact had been identified for each individual

1,317 individuals (100 per cent) identified by CCGs had reviews by 31 July 2013.

The second data collection was a census of all those diagnosed with a learning

disability or Autistic Spectrum Disorder in a secure (high, medium, low) or Child and Adolescent Mental Health Service inpatient bed. The census was conducted on 30 June 2013 by NHS England direct specialised commissioners. This exercise collated information on:

- the number of patients diagnosed as having a learning disability or an Autistic Spectrum Disorder
- the total number of patients with that diagnosis in secure services (split by high, medium or low secure) or inpatient CAMHS on 30 June 2013
- whether reviews (as agreed in the Concordat) have been completed
- whether CCGs have been notified

The data collected in the second exercise indicated there were 1,358 individuals with the diagnosis of which 1,017 had been reviewed as per the Winterbourne View Concordat actions and with 883 CCGs informed (705 included the date the CCG had been informed).

The process of completing and handing over the registers delivered the Winterbourne View commitments in Transforming Care action 22. However, CCGs and other organisations have highlighted the need to do more work to ensure the registers are consistent across data collection exercises, comprehensive, with complete data including patient age profile.

NHS England are working to align and reconcile the NHS data with that in the “Transforming Care” to ensure that there is consistent, clear, and transparent information available. They are also working with the JIP and DH on a number of actions to understand data inconsistencies, including the need to triangulate the information from NHS England with the forthcoming Learning Disability census. This will ensure that the intentions of the Concordat are met and individuals receive safe, appropriate and high quality care.

This is clearly work in progress and where appropriate is being jointly conducted with the WVJIP.

## The Learning Disability Census

In addition, the Learning Disability Census conducted on 30 September 2013 has met the ‘Transforming Care Action’ 17 commitment to commission an audit of current inpatient 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.

The census is based on the previous “Count Me In” census with a number of changes to reflect the Transforming Care commitments.

The census will include:

- people of any age in in-patient beds for mental and / or behavioural healthcare who have either Learning disabilities or Autistic Spectrum Disorder (including Asperger’s Syndrome)

- any level of security (General / Low / Medium / High)
- any status under the Mental Health Act (Informal or detained).

The census will not include:

- people in accommodation not registered with the CQC as hospital beds
- people in beds for physical health care
- people who do not have either learning disabilities or autism.

An initial overview report will be issued by the HSCIC in December with a further detailed analysis to be conducted by LDPHO completed by March / April 2014.

## Good practice and local guidance

One of the strong features in responses to the stocktake has been the significant number of local guidance, protocols, practice initiatives and local agreements.

There is a wealth of material in 340 individual documents that are worthy of wider dissemination.

To ensure that this is done on a systematic and consistent basis, the WVJIP will be working with the Social Care Institute for Excellence (SCIE) over the next short period to produce a comprehensive outline of this work that both collates and makes the work accessible across the whole sector to improve learning and development.

Items included highlighted innovative practice, sample protocols and / or agreements (for example s75 agreements) as well as local policy and practice examples.

## Development and support priorities

As a part of completing their stocktake return the key partners were asked to identify areas where they might need individual place-based support and development or where they felt further guidance or clarification might be required.

This is an important feature of the stocktake, supported through the principles of sector led improvement. It provides a basis for national, regional and local discussions. Appendix 7 sets out a summary of the stocktake returns in this regard.

Eighty-two specific requests for support are identified, with at least one request in each of the 61 questions. The most numbers of requests made (distinct from general support needs) are regarding Ordinary Residence and associated financial risks, a range of issues relating to specialist commissioning, capacity in crisis response services and pooled budget arrangements. A summary table of support requests is given at Appendix 7.

## Enhanced Quality Assurance Programme

The Enhanced Quality Assurance Programme (EQAP) is primarily funded by NHS England and has a clear remit on the following:

- Fulfilling the Concordat commitment to support former Winterbourne View patients.
- Responding to concerns regarding individuals where their review/planning appears problematic across the health and social care dimension.
- Concerns regarding the quality of the care of individuals in A&T and where this may also extend across a particular set of providers.

The programme is essentially established in the NHS but it has been agreed that it will be firmly embedded across the WVJIP, with CQC and other commissioning development. As this is part of the joint improvement programme, work will be undertaken with the NHS to ensure that the sector led approach is fully considered. The essence of the work is to support the development of commissioning, the development of quality and service planning and achieve the Concordat commitments.

# The improvement programme response

Supported by NHS England, the LGA and the DH, the WVJIP has at its core an improvement programme that has regional, national and local components and is based on the core principles of sector led improvement.

The key objectives of the programme are set out in Transforming Care and the Concordat but are now particularly defined by the work of recent months and the findings and conclusions from the stocktake of progress. A supporting programme plan has been developed.

The key task is to ensure these objectives are turned into **strategic** (national) and **operational** (local) actions and outcomes.

They support the achievement of the key outcomes for people set out in policy and achieved through the significant system, method and practice changes that are required.

## Key principles of the improvement offer

- Coproduction of offers and outcomes with people with learning disability, autism and behaviour which challenges and their families.
- All development will operate within the context of the engagement strategy agreed by the Board in May 2013.
- The improvement work will use existing local, regional and national structures and approaches to improvement.

- The improvement work will relate to wider views and approaches to improvement.
- It will align to and complement the existing improvement and development work of key partners at national and local level.
- Work with local areas will always be based on joint agreement regarding the areas to be explored and the approach to be used.
- Any support and development will be provided in a transparent, constructive and supportive way while providing appropriate challenge and will not seek to duplicate existing mechanism or structures.
- All support activity will seek to use or share resources in a way that encourages local sustainability.
- While national offers may be developed these will be fine-tuned to support bespoke local application.
- The use of shared learning, the collation and sharing of innovative practice and peer development and challenge.

The key building blocks for improvement and a bench mark for progress are:

- Local leadership arrangements put in place to drive the programme.
- A clear understanding of current costs and commitments, sources of funding via the LA, CCG and specialist commissioning and a determination to tackle longstanding barriers in relation to these (e.g. NHS Continuing Care).

- A clear, resourced, joint delivery plan focused on personalised community provision.
- Developed care management to ensure progress and quality.

Further details of the improvement offer will be presented to the WVJIP Board and key partners in early October and then publicised more widely after that.

The improvement team is:

**Ian Winter** – Lead

**Zandrea Stewart** – Principal Adviser

**Steve Taylor** – Principal Adviser

**Angela Ellis** – Engagement Adviser

**Jane Alltimes** – Policy Adviser

**Kristian Hibberd** – Communications Adviser

**Project support:** Marie Coffey

Contact details are given in the appendices.

The team is working with:

**Emma Jenkins** and LGA Principal Advisers

**Sam Cramond** and **Ray Avery**,  
NHS England

The key messages from the stocktake of progress have impact across national, regional and local dimensions.

Working with the four national priorities, the improvement team will engage directly with localities, generally across the 4 NHS England regions and the nine geographic ADASS/ADCS groupings.

Follow up may be based on one or more of the below but will always be decided through joint agreement regarding the need for further study and the areas to be explored.

The key elements for regional activity will be:

### **Bespoke support**

The first task will be to offer individualised engagement with partners in localities based on stocktake returns and analysis. This could include engagement at HWB level and strategic commissioning to assist in advice, planning and shaping based on the locality's own self-assessment. This will be based on the analysis returned to each partnership.

### **Regional support**

The second activity will be to work in each of the nine LGA regions using the existing networks and arrangements to develop the most appropriate work and responses based on aggregated stocktake returns and the leadership priorities. This will take place during September and October 2013. Resources will be made available to support local networks to develop this work. Each LGA region will be supported to develop its own regional priority plan during November 2013. Existing work will not be impeded in this process.

This will also link with existing mechanisms regionally and nationally for supporting improvement, identifying areas in need of early or extra support, and assuring quality. This will include discussions with LGA Principal Advisers and Quality Surveillance Groups.

Challenge from peers will be through the development of a specific Winterbourne View module developed jointly with TEASC.

## In-depth support and links to existing programmes

It is vital to draw on the range of development and support already existing and to ensure that good coverage is given to all those who will need to work together to achieve the policy and practice changes required by the Winterbourne View Concordat.

This will include working with existing programmes in NHS and Local Government including the Health and Wellbeing System Improvement, Adult Safeguarding and the Towards Excellence in Adult Social Care programmes. NHS England work with CCGs and NHS Improving Quality and transforming provision will also be engaged.

The rationale for further in-depth support will be:

- Partners request for 'deep-dive' support.
- Follow up discussions on stocktake analysis that might warrant more study.
- In depth work to draw out exemplars of good practice or process.
- Significant numbers of challenging placements.
- Apparent stocktake responses that are out of step with regional findings.
- Where concerns about individual placements have been raised.

Based on the above the in-depth or deep dive approach must be a collaborative response that will support the partners in the locality and develop skill and knowledge that can be shared more widely.

Using principles already well established, for example by the sector led improvement activity and other methodology including appreciative enquiry etc. the deep dive will have a basic outline that is then matched to local requirements and priorities following discussions with the partners.

Where appropriate it will be linked to the EQAP initiative outlined above.

Winterbourne View Principal Advisers will be central in the discussions and local developments, though to achieve breadth of development with expertise and challenge it is very likely that a partner organisation(s) would be asked to work with us to set up the programme in detail.

National activity is already taking place which will feed into local developments.

### Sharing innovative practice

The collation of good practice and local policy will be disseminated as described elsewhere and the further development of the Winterbourne JIP Knowledge Hub group will increase awareness of the material that is available. Resources will be made available broadly on a regional basis to support priorities and be allocated according to the key principles as outlines above and the stocktake analysis of priorities.

The requests for support from the stocktake returns will be collated and fed into this process.

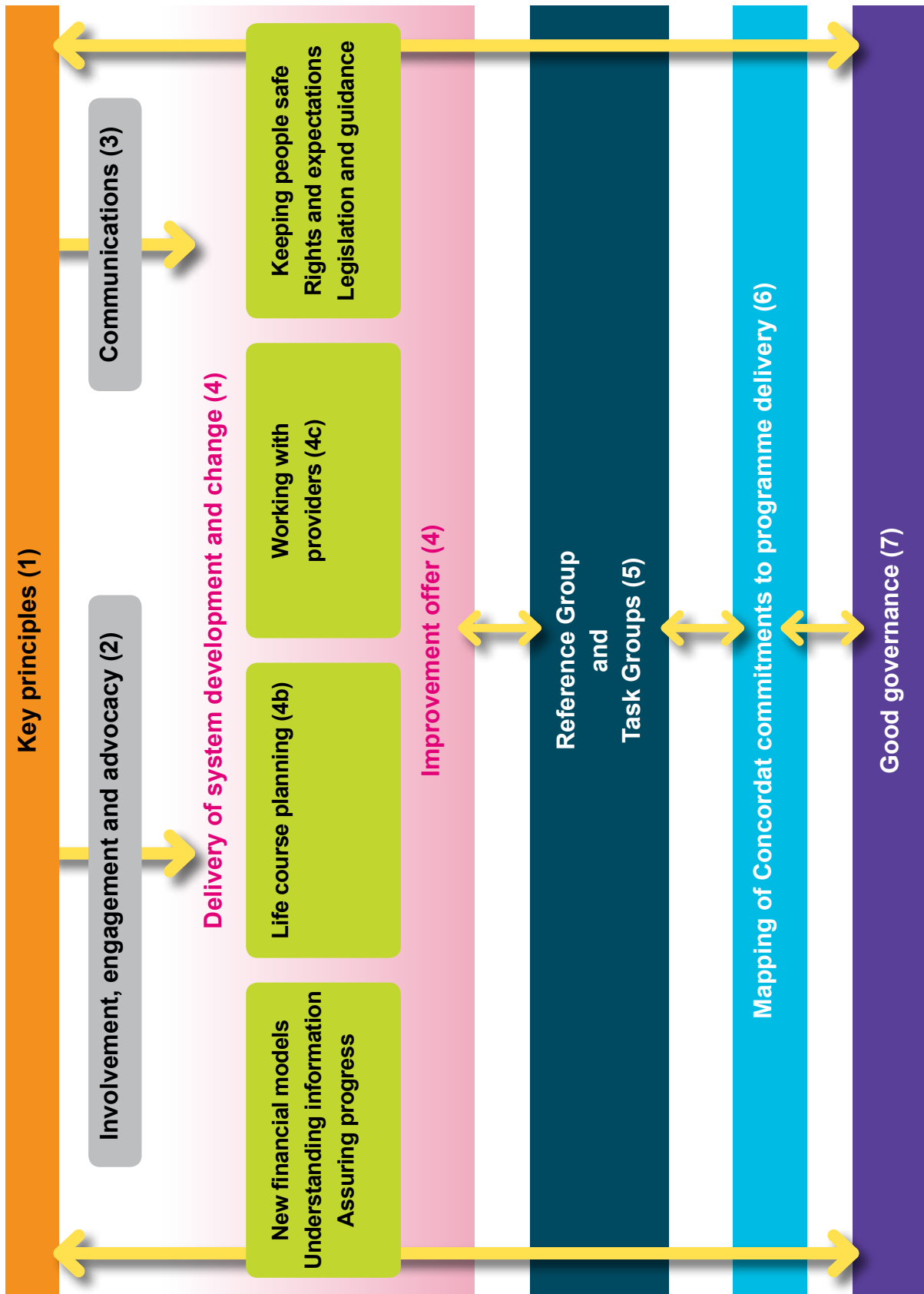




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# Appendix 1: Outline of the programme and process



## Appendix 2: Winterbourne View programme board members and improvement team

Organisation	Name
Chair	Chris Bull
ADASS	Andrea Pope-Smith
ADCS	Terry Parkin, Rachael Shimmin
Challenging Behaviour National Strategy Group	Beverley Dawkins
CCGs	Dr Katie Armstrong
CQC	Alan Rosenbach
Department for Education	Helen Nix
Department of Health	Karen Turner
Learning Disabilities Observatory	Professor Gyles Glover
LGA	Sally Burlington
National Forum representative	Gavin Harding
NHS	Sir Leonard Fenwick
NHS England	Marie Batey
NHS England	Ivan Ellul
NHS England	Martin McShane
NHS Improvement	Julian Hartley
National Valuing Families Forum	Viv Cooper
University of Cambridge	Professor Tony Holland
University of Lancaster	Professor Eric Emerson
Salford Council	Dave Williams
SOLACE	Tony Hunter

<b>Winterbourne View Improvement team</b>		
<b>Name</b>	<b>Role</b>	<b>Email</b>
<b>Ian Winter</b>	Lead	ianjwinter@gmail.com
<b>Zandrea Stewart</b>	Improvement Adviser	zandrea.stewart@local.gov.uk
<b>Stephen Taylor</b>	Improvement Adviser	stephen.taylor@local.gov.uk
<b>Angela Ellis</b>	Engagement Adviser	angela.ellis@local.gov.uk
<b>Kristian Hibberd</b>	Communications Adviser	kristian.hibberd@local.gov.uk
<b>Jane Alltimes</b>	Policy Adviser	jane.alltimes@local.gov.uk
<b>Marie Coffey</b>	Programme Support Officer	marie.coffey@local.gov.uk
<b>Supported by:</b>		
<b>Emma Jenkins</b>	Senior Adviser	emma.jenkins@local.gov.uk
<b>Sam Cramond</b>	Head of Partnerships	sam.cramond1@nhs.net
<b>Ray Avery</b>	Partnership Manager	ray.avery@nhs.net

## Appendix 3a: Stage 1 Analysis: codes used

Q	1.Models of partnership	Codes to be used Code blank cells in E as NR
1	1.1 Are you establishing local arrangements for joint delivery of this programme between the Local Authority and the CCG(s).	0 - No arrangement 1 - Included in existing arrangement local 2 - Included in existing arrangement with other(s) 3 - New arrangement
2	1.2 Are other key partners working with you to support this; if so who. (Please comment on housing specialist commissioning & providers).	Include all identified. 0 - No 1 - Ask 2 -Children Services 3 -Housing 4 -Other Council Depts. 5 - CCG(s) 6 -Specialist Commissioners 7- Other providers
3	1.3 Have you established a planning function that will support the development of the kind of services needed for those people that have been reviewed and for other people with complex needs.	0 - No 1 - Yes 2 - Not clear 3 - In development
4	1.4 Is the Learning Disability Partnership Board (or alternate arrangement) monitoring and reporting on progress.	0 - No 1 - Yes 2 - Yes (via SAF) 3 - Not clear 4 - Other arrangement 5 - In Progress
5	1.5 Is the Health and Wellbeing Board engaged with local arrangements for delivery and receiving reports on progress.	0 - No 1 - Yes 2 - Not clear 3 - In process
6	1.6 Does the partnership have arrangements in place to resolve differences should they arise.	0 - No 1 - Yes 2 - Not clear 3 - In process/ discussion
7	1.7 Are accountabilities to local regional and national bodies clear and understood across the partnership – e.g. HWB Board NHSE Local Area Teams / CCG fora clinical partnerships & Safeguarding Boards.	0 - No 1 - Yes 2 - Not clear 3 - In process 4 - In part
8	1.8 Do you have any current issues regarding Ordinary Residence and the potential financial risks associated with this.	0 - No 1 - Yes 2 - Not clear
9	1.9 Has consideration been given to key areas where you might be able to use further support to develop and deliver your plan.	0 - No 1 - Yes 2 - Not clear 3 - Other local support

<b>2. Understanding the money</b>		
<b>10</b>	2.1 Are the costs of current services understood across the partnership.	0 - No 1 - Yes 2 - Not clear 3 - In process 4 - In part
<b>11</b>	2.2 Is there clarity about source(s) of funds to meet current costs including funding from specialist commissioning bodies continuing Health Care and NHS and Social Care.	0 - No 1 - Yes 2 - Not clear 3 - In process 4 - In part
<b>12</b>	2.3 Do you currently use S75 arrangements that are sufficient & robust.	0 - No 1 - Yes 2 - Not clear 3- Informal arrangements 4 - Included in overall partnership agreement 5 - other methods 6 - In progress
<b>13</b>	2.4 Is there a pooled budget and / or clear arrangements to share financial risk.	0 - No 1 - Yes 2 - Not clear 3 - Alternative risk share agreement 4 - being put in place
<b>14</b>	2.5 Have you agreed individual contributions to any pool.	0 - No 1 - Yes 2 - Not clear 3 - N/A 4 - being put in place
<b>15</b>	2.6 Does it include potential costs of young people in transition and of children's services.	0 - No 1 - Yes 2 - Not clear 3 - Included in ASC budget build 4 - Under review 5 - N/A
<b>16</b>	2.7 Between the partners is there an emerging financial strategy in the medium term that is built on current cost future investment and potential for savings.	0 - No 1 - Yes 2 - Not clear 3 - in process/ development
<b>3. Case management for individuals</b>		
<b>17</b>	3.1 Do you have a joint integrated community team.	0 - No 1 - Yes 2 - Not clear 3 Co-located 4 - other arrangements
<b>18</b>	3.2 Is there clarity about the role and function of the local community team.	0 - No 1 - Yes 2 - Not clear 3 - Under review
<b>19</b>	3.3 Does it have capacity to deliver the review and re-provision programme.	0 - No 1 - Yes 2 - Not clear 3 - Under review

20	3.4 Is there clarity about overall professional leadership of the review programme.	0 - No 1 - Yes 2 - Not clear 3 - Under review
21	3.5 Are the interests of people who are being reviewed and of family carers supported by named workers and / or advocates	0 - No 1 - Yes 2 - Not clear
<b>4. Current Review Programme</b>		
22	4.1 Is there agreement about the numbers of people who will be affected by the programme and are arrangements being put in place to support them and their families through the process.	0 - No 1 - Yes 2 - Not clear 3 - in part
23	4.2 Are arrangements for review of people funded through specialist commissioning clear.	0 - No 1 - Yes 2 - Not clear 3 - Further discussion / in process
24	4.3 Are the necessary joint arrangements (including people with learning disability carers advocacy organisations Local Healthwatch) agreed and in place.	0 - No 1 - Yes 2 - Not clear 3 - Further discussion / in process
25	4.4 Is there confidence that comprehensive local registers of people with behaviour that challenges have been developed and are being used.	0 - No 1 - Yes 2 - Not clear 3 - Registers but not as specified
26	4.5 Is there clarity about ownership maintenance and monitoring of local registers following transition to CCG including identifying who should be the first point of contact for each individual	0 - No 1 - Yes 2 - Not clear 3 - In process (e.g. registers in place but need to confirm point of contact)
27	4.6 Is advocacy routinely available to people (and family) to support assessment care planning and review processes	0 - No 1 - Yes 2 - Not clear 3 - in process
28	4.7 How do you know about the quality of the reviews and how good practice in this area is being developed.	0 - No process 1 - Process in place 2 - Not clear 3 - Work in progress
29	4.8 Do completed reviews give a good understanding of behaviour support being offered in individual situations.	0 - No 1 - Yes 2 - Not clear 3 - in part / some instances
30	4.9 Have all the required reviews been completed. Are you satisfied that there are clear plans for any outstanding reviews to be completed	0 - No 1 - Yes 2 - Not clear 3 - Most completed timescales for completion 4 - Some completed timescales for completion

<b>5. Safeguarding</b>		
<b>31</b>	5.1 Where people are placed out of your area are you engaged with local safeguarding arrangements – e.g. in line with the ADASS protocol.	0 - No 1 - Yes 2 - Not clear 3 - Under review
<b>32</b>	5.2 How are you working with care providers (including housing) to ensure sharing of information & develop risk assessments.	0 - No arrangement 1 - Provider forum (or similar) 2 - Not clear 3 - being developed 4 - Done on case by case basis
<b>33</b>	5.3 Have you been fully briefed on whether inspection of units in your locality have taken place and if so are issues that may have been identified being worked on.	0 - No 1 - Yes 2 - Not clear 3 - N/A
<b>34</b>	5.4 Are you satisfied that your Children and Adults Safeguarding Boards are in touch with your Winterbourne View review and development programme.	0 - No 1 - Yes 2 - Not clear 3 - In process / being developed
<b>35</b>	5.5 Have they agreed a clear role to ensure that all current placements take account of existing concerns/alerts the requirements of DoLS and the monitoring of restraint.	0 - No 1 - Yes 2 - Not clear 3 - In progress/ Being developed
<b>36</b>	5.6 Are there agreed multi-agency programmes that support staff in all settings to share information and good practice regarding people with learning disability and behaviour that challenges who are currently placed in hospital settings.	0 - No 1 - Yes (Local) 2 - Not clear 3 - In progress/ Being developed 4 Yes regional only
<b>37</b>	5.7 Is your Community Safety Partnership considering any of the issues that might impact on people with learning disability living in less restrictive environments.	0 - No 1 - Yes 2 - Not clear 3 - Considered / not required 4 - IN progress
<b>38</b>	5.8 Has your Safeguarding Board got working links between CQC contracts management safeguarding staff and care/case managers to maintain alertness to concerns	0 - No 1 - Yes 2 - Not clear 3 - in development
<b>6. Commissioning arrangements</b>		
<b>39</b>	6.1 Are you completing an initial assessment of commissioning requirements to support peoples' move from assessment and treatment/in-patient settings.	0 - No 1 - Yes 2 - Not clear 3 - In progress 4 - Already completed
<b>40</b>	6.2 Are these being jointly reviewed developed and delivered.	0 - No 1 - Yes 2 - Not clear 3 - In progress
<b>41</b>	6.3 Is there a shared understanding of how many people are placed out of area and of the proportion of this to total numbers of people fully funded by NHS CHC and those jointly supported by health and care services.	0 - No 1 - Yes 2 - Not clear 3 - In progress



42	6.4 Do commissioning intentions reflect both the need deliver a re-provision programme for existing people and the need to substantially reduce future hospital placements for new people	0 - No 1 - Yes 2 - Not clear 3 - Yes though significant challenges 4 - IN progress
43	6.5 Have joint reviewing and (de)commissioning arrangements been agreed with specialist commissioning teams.	0 - No 1 - Yes 2 - Not clear 3 - In progress 4 Not applicable - e.g. none placed by specialist commissioners
44	6.6 Have the potential costs and source(s) of funds of future commissioning arrangements been assessed.	0 - No 1 - Yes 2 - Not clear 3 - In progress
45	6.7 Are local arrangements for the commissioning of advocacy support sufficient if not are changes being developed.	0 - No 1 - Yes 2 - Not clear 3 - In progress/ under review
46	6.8 Is your local delivery plan in the process of being developed resourced and agreed.	0 - No 1 - Yes 2 - Not clear 3 - In progress 4 - Already completed
47	6.9 Are you confident that the 1 June 2014 target will be achieved (the commitment is for all people currently in in-patient settings to be placed nearer home and in a less restrictive environment).	0 - No 1 - Yes 2 - Not clear 3 - Timescales problematic / unrealistic 4 - Yes but challenging 5 - One or more people subject to court order
48	6.10 If no what are the obstacles to delivery (e.g. organisational financial legal).	0 - None 1 - Financial 2 - Legal (e.g. MHA) 3 - other
<b>7. Developing local teams and services</b>		
49	7.1 Are you completing an initial assessment of commissioning requirements to support peoples' move from assessment and treatment/in-patient settings.	0 - No 1 - Yes 2 - Not clear 3 - In progress 4 - Already completed
50	7.2 Do you have ways of knowing about the quality and effectiveness of advocacy arrangements.	0 - No 1 - Yes 2 - Not clear 3 - In part 4 - In progress
51	7.3 Do you have plans to ensure that there is capacity to ensure that Best Interests assessors are involved in care planning.	0 - No 1 - Yes 2 - Not clear 3 - In part
<b>8. Prevention and crisis response capacity - Local/shared capacity to manage emergencies</b>		
52	8.1 Do commissioning intentions include an assessment of capacity that will be required to deliver crisis response services locally.	0 - No 1 - Yes 2 - Not clear 3 - In progress / under review

53	8.2 Do you have / are you working on developing emergency responses that would avoid hospital admission (including under section of MHA.)	0 - No 1 - Yes 2 - Not clear 3 - In progress / under review
54	8.3 Do commissioning intentions include a workforce and skills assessment development.	0 - No 1 - Yes 2 - Not clear 3 - In progress / under review
	<b>9 Understanding the population who need/receive services</b>	
55	9.1 Do your local planning functions and market assessments support the development of support for all people with complex needs including people with behaviour that challenges.	0 - No 1 - Yes 2 - Not clear 3 - In progress / under review
56	9.2 From the current people who need to be reviewed are you taking account of ethnicity age profile and gender issues in planning and understanding future care services.	0 - No 1 - Yes 2 - Not clear 3 - In part
	<b>10. Children and adults – transition planning</b>	
57	10.1 Do commissioning arrangements take account of the needs of children and young people in transition as well as of adults.	0 - No 1 - Yes 2 - Not clear 3 - In progress / under review
58	10.2 Have you developed ways of understanding future demand in terms of numbers of people and likely services.	0 - No 1 - Yes 2 - Not clear 3 - In progress / under review
	<b>11. Current and future market requirements and capacity</b>	
59	11.1 Is an assessment of local market capacity in progress.	0 - No 1 - Yes 2 - Not clear 3 - In progress 4 - Already completed
60	11.2 Does this include an updated gap analysis.	0 - No 1 - Yes 2 - Not clear 3 - In progress 4 - Part completed
61	11.3 Are there local examples of innovative practice that can be shared more widely e.g. the development of local fora to share/learn and develop best practice.	0 - No 1 - Yes 2 - Not clear

## Appendix 3b: Summary reports drawn from Stage 1 coding

<b>Report: - National</b>			
	<b>Leadership across the system</b>		<b>Responses</b>
Q			
5	% of Health and Wellbeing Boards engaged with the programme	65%	29% report arrangements in process
4	% of places Learning Disability Partnership Boards/ alternative arrangements to monitor progress.	81%	Alternative arrangements 5%
34	% reporting children and adults safeguarding boards engaged	77%	18% report arrangements in process
3	% of places with a dedicated planning function	59%	35% report this is being developed
8	% of places where Ordinary Residence is identified as a barrier	47%	
	<b>Strategic Capacity</b>		<b>Responses</b>
39	% of places reporting assessment of commissioning requirements	42%	42% of places report progress on this.
42	% reporting plans for re-provision and diversion	54%	30% report this is being developed
59	% reporting progress with market assessments.	94%	
57	% including C&YP needs in commissioning intentions.	62%	33% report this is under review
52	% reporting assessment of crisis response capacity	39%	49% report this is under review.
54	% including workforce /skills assessment in commissioning intentions	41%	43% report this is being developed.
	<b>Delivery, Progress and Capacity</b>		<b>Responses</b>
17	% reporting a joint, integrated community team.	50%	12% report co-located teams
22	% reporting agreement about numbers affected by the programme.	82%	
23	% reporting clarity about specialist commissioning arrangements	58%	16% report this is under discussion
2	% reporting joint planning that includes specialist commissioners	45%	
19	% reporting confidence in Community Team capacity to deliver.	68%	19% report that this is under review
24	% reporting inclusive reviewing arrangements in place	59%	29% report that this is under review
21	% reporting named workers	86%	
27	% reporting that advocacy support is available	85%	
47	% reporting confidence of achieving the 1 June 2014 target.	59%	14% report the timescale is problematic
50	% reporting confidence in quality of advocacy support	76%	20% report that this is being worked on
1	% reporting joint delivery arrangements are in place	97%	53% existing and 44% new arrangements
	<b>Managing The Money</b>		<b>Responses</b>
16	% developing medium term financial strategy	77%	
13	% using pooled budgets	27%	20% other risk share agreements
14	% where funding contributions are agreed	40%	11% Being put in place
11	% reporting that current funding arrangements are clear	55%	20% further work in progress
15	% where funding for C&YP is included in a pooled budget	32%	
10	% that report shared understanding of total costs of current services	63%	33% further work in progress
	<b>Safeguarding</b>		<b>Responses</b>
31	% arrangements for people placed out of area / ADASS protocol	88%	
32	% reporting information sharing with providers	61%	24% in development
35	% reporting monitoring arrangements in respect of DOLS / use of restraint	74%	18% arrangements in development
51	% reporting plans to ensure sufficiency of B.I.As	84%	
38	% reporting working links with practitioners in quality/regulatory roles	61%	

<b>Report: - North West</b>		
<b>Leadership across the system</b>		
% of Health and Wellbeing Boards engaged with the programme	43%	43% report arrangements in process
% of places Learning Disability Partnership Boards/ alternative arrangements to monitor progress.	70%	Alternative arrangements 4%
% reporting children and adults safeguarding boards engaged	65%	22% report arrangements in process
% of places with a dedicated planning function	70%	22% report this is being developed
% of places where Ordinary Residence is identified as a barrier	48%	
<b>Strategic Capacity</b>		
% of places reporting assessment of commissioning requirements	17%	48% of places report progress on this.
% reporting plans for re-provision and diversion	43%	30% report this is being developed
% reporting progress with market assessments.	91%	
% including C&YP needs in commissioning intentions.	61%	35% report this is under review
% reporting assessment of crisis response capacity	35%	39% report this is under review.
% including workforce /skills assessment in commissioning intentions	39%	48% report this is being developed.
<b>Delivery, Progress and Capacity</b>		
% reporting a joint, integrated community team.	43%	13% report co-located teams
% reporting agreement about numbers affected by the programme.	65%	
% reporting clarity about specialist commissioning arrangements	61%	9% report this is under discussion
% reporting joint planning that includes specialist commissioners	55%	
% reporting confidence in Community Team capacity to deliver.	52%	17% report that this is under review
% reporting inclusive reviewing arrangements in place	52%	39% report that this is under review
% reporting named workers	87%	
% reporting that advocacy support is available	87%	
% reporting confidence of achieving the 1 June 2014 target.	52%	13% report the timescale is problematic
% reporting confidence in quality of advocacy support	74%	22% report that this is being worked on
% reporting joint delivery arrangements are in place	100%	39% existing and 61% new arrangements
<b>Managing The Money</b>		
% developing medium term financial strategy	74%	
% using pooled budgets	39%	26% other risk share agreements
% where funding contributions are agreed	61%	22% Being put in place
% reporting that current funding arrangements are clear	65%	9% further work in progress
% where funding for C&YP is included in a pooled budget	30%	
% that report shared understanding of total costs of current services	70%	26% further work in progress
<b>Safeguarding</b>		
% arrangements for people placed out of area / ADASS protocol	78%	
% reporting information sharing with providers	43%	22% in development
% reporting monitoring arrangements in respect of DOLS / use of restraint	57%	35% arrangements in development
% reporting plans to ensure sufficiency of B.I.As	74%	
% reporting working links with practitioners in quality/regulatory roles	43%	

<b>Report: - East Midlands</b>		
<b>Leadership across the system</b>		
% of Health and Wellbeing Boards engaged with the programme	80%	20% report arrangements in process
% of places Learning Disability Partnership Boards/ alternative arrangements to monitor progress.	70%	Alternative arrangements 10%
% reporting children and adults safeguarding boards engaged	70%	10% report arrangements in process
% of places with a dedicated planning function	50%	40% report this is being developed
% of places where Ordinary Residence is identified as a barrier	20%	
<b>Strategic Capacity</b>		
% of places reporting assessment of commissioning requirements	40%	60% of places report progress on this.
% reporting plans for re-provision and diversion	60%	30% report this is being developed
% reporting progress with market assessments.	100%	
% including C&YP needs in commissioning intentions.	50%	50% report this is under review
% reporting assessment of crisis response capacity	40%	50% report this is under review.
% including workforce /skills assessment in commissioning intentions	30%	50% report this is being developed.
<b>Delivery, Progress and Capacity</b>		
% reporting a joint, integrated community team.	30%	20% report co-located teams
% reporting agreement about numbers affected by the programme.	90%	
% reporting clarity about specialist commissioning arrangements	60%	10% report this is under discussion
% reporting joint planning that includes specialist commissioners	78%	
% reporting confidence in Community Team capacity to deliver.	70%	30% report that this is under review
% reporting inclusive reviewing arrangements in place	60%	20% report that this is under review
% reporting named workers	60%	
% reporting that advocacy support is available	90%	
% reporting confidence of achieving the 1 June 2014 target.	80%	0% report the timescale is problematic
% reporting confidence in quality of advocacy support	70%	30% report that this is being worked on
% reporting joint delivery arrangements are in place	100%	60% existing and 40% new arrangements
<b>Managing The Money</b>		
% developing medium term financial strategy	70%	
% using pooled budgets	30%	10% other risk share agreements
% where funding contributions are agreed	30%	0% Being put in place
% reporting that current funding arrangements are clear	50%	40% further work in progress
% where funding for C&YP is included in a pooled budget	40%	
% that report shared understanding of total costs of current services	50%	40% further work in progress
<b>Safeguarding</b>		
% arrangements for people placed out of area / ADASS protocol	70%	
% reporting information sharing with providers	50%	50% in development
% reporting monitoring arrangements in respect of DOLS / use of restraint	80%	20% arrangements in development
% reporting plans to ensure sufficiency of B.I.As	90%	
% reporting working links with practitioners in quality/regulatory roles	50%	

<b>Report: - West Midlands</b>		
<b>Leadership across the system</b>		
% of Health and Wellbeing Boards engaged with the programme	57%	43% report arrangements in process
% of places Learning Disability Partnership Boards/ alternative arrangements to monitor progress.	86%	Alternative arrangements 7%
% reporting children and adults safeguarding boards engaged	57%	43% report arrangements in process
% of places with a dedicated planning function	50%	36% report this is being developed
% of places where Ordinary Residence is identified as a barrier	29%	
<b>Strategic Capacity</b>		
% of places reporting assessment of commissioning requirements	29%	43% of places report progress on this.
% reporting plans for re-provision and diversion	79%	14% report this is being developed
% reporting progress with market assessments.	100%	
% including C&YP needs in commissioning intentions.	57%	43% report this is under review
% reporting assessment of crisis response capacity	50%	43% report this is under review.
% including workforce /skills assessment in commissioning intentions	57%	21% report this is being developed.
<b>Delivery, Progress and Capacity</b>		
% reporting a joint, integrated community team.	36%	21% report co-located teams
% reporting agreement about numbers affected by the programme.	86%	
% reporting clarity about specialist commissioning arrangements	71%	7% report this is under discussion
% reporting joint planning that includes specialist commissioners	54%	
% reporting confidence in Community Team capacity to deliver.	57%	43% report that this is under review
% reporting inclusive reviewing arrangements in place	50%	36% report that this is under review
% reporting named workers	79%	
% reporting that advocacy support is available	93%	
% reporting confidence of achieving the 1 June 2014 target.	64%	7% report the timescale is problematic
% reporting confidence in quality of advocacy support	79%	14% report that this is being worked on
% reporting joint delivery arrangements are in place	86%	50% existing and 36% new arrangements
<b>Managing The Money</b>		
% developing medium term financial strategy	64%	
% using pooled budgets	29%	7% other risk share agreements
% where funding contributions are agreed	50%	14% Being put in place
% reporting that current funding arrangements are clear	29%	29% further work in progress
% where funding for C&YP is included in a pooled budget	29%	
% that report shared understanding of total costs of current services	21%	72% further work in progress
<b>Safeguarding</b>		
% arrangements for people placed out of area / ADASS protocol	79%	
% reporting information sharing with providers	64%	14% in development
% reporting monitoring arrangements in respect of DOLS / use of restraint	64%	21% arrangements in development
% reporting plans to ensure sufficiency of B.I.As	71%	
% reporting working links with practitioners in quality/regulatory roles	64%	

<b>Report: - South East</b>		
<b>Leadership across the system</b>		
% of Health and Wellbeing Boards engaged with the programme	71%	24% report arrangements in process
% of places Learning Disability Partnership Boards/ alternative arrangements to monitor progress.	76%	Alternative arrangements 6%
% reporting children and adults safeguarding boards engaged	76%	18% report arrangements in process
% of places with a dedicated planning function	35%	59% report this is being developed
% of places where Ordinary Residence is identified as a barrier	71%	
<b>Strategic Capacity</b>		
% of places reporting assessment of commissioning requirements	35%	41% of places report progress on this.
% reporting plans for re-provision and diversion	35%	29% report this is being developed
% reporting progress with market assessments.	94%	
% including C&YP needs in commissioning intentions.	59%	29% report this is under review
% reporting assessment of crisis response capacity	41%	47% report this is under review.
% including workforce /skills assessment in commissioning intentions	35%	41% report this is being developed.
<b>Delivery, Progress and Capacity</b>		
% reporting a joint, integrated community team.	59%	12% report co-located teams
% reporting agreement about numbers affected by the programme.	88%	
% reporting clarity about specialist commissioning arrangements	59%	18% report this is under discussion
% reporting joint planning that includes specialist commissioners	38%	
% reporting confidence in Community Team capacity to deliver.	65%	18% report that this is under review
% reporting inclusive reviewing arrangements in place	47%	47% report that this is under review
% reporting named workers	88%	
% reporting that advocacy support is available	76%	
% reporting confidence of achieving the 1 June 2014 target.	36%	24% report the timescale is problematic
% reporting confidence in quality of advocacy support	65%	24% report that this is being worked on
% reporting joint delivery arrangements are in place	95%	36% existing and 59% new arrangements
<b>Managing The Money</b>		
% developing medium term financial strategy	77%	
% using pooled budgets	18%	24% other risk share agreements
% where funding contributions are agreed	35%	6% Being put in place
% reporting that current funding arrangements are clear	41%	35% further work in progress
% where funding for C&YP is included in a pooled budget	24%	
% that report shared understanding of total costs of current services	71%	30% further work in progress
<b>Safeguarding</b>		
% arrangements for people placed out of area / ADASS protocol	88%	
% reporting information sharing with providers	53%	24% in development
% reporting monitoring arrangements in respect of DOLS / use of restraint	82%	6% arrangements in development
% reporting plans to ensure sufficiency of B.I.As	71%	
% reporting working links with practitioners in quality/regulatory roles	53%	

<b>Report: - South West</b>		
<b>Leadership across the system</b>		
% of Health and Wellbeing Boards engaged with the programme	46%	46% report arrangements in process
% of places Learning Disability Partnership Boards/ alternative arrangements to monitor progress.	85%	Alternative arrangements 8%
% reporting children and adults safeguarding boards engaged	92%	8% report arrangements in process
% of places with a dedicated planning function	54%	46% report this is being developed
% of places where Ordinary Residence is identified as a barrier	69%	
<b>Strategic Capacity</b>		
% of places reporting assessment of commissioning requirements	54%	46% of places report progress on this.
% reporting plans for re-provision and diversion	69%	31% report this is being developed
% reporting progress with market assessments.	100%	
% including C&YP needs in commissioning intentions.	69%	23% report this is under review
% reporting assessment of crisis response capacity	38%	46% report this is under review.
% including workforce /skills assessment in commissioning intentions	23%	62% report this is being developed.
<b>Delivery, Progress and Capacity</b>		
% reporting a joint, integrated community team.	62%	8% report co-located teams
% reporting agreement about numbers affected by the programme.	77%	
% reporting clarity about specialist commissioning arrangements	85%	8% report this is under discussion
% reporting joint planning that includes specialist commissioners	33%	
% reporting confidence in Community Team capacity to deliver.	69%	0% report that this is under review
% reporting inclusive reviewing arrangements in place	46%	15% report that this is under review
% reporting named workers	100%	
% reporting that advocacy support is available	85%	
% reporting confidence of achieving the 1 June 2014 target.	61%	15% report the timescale is problematic
% reporting confidence in quality of advocacy support	85%	15% report that this is being worked on
% reporting joint delivery arrangements are in place	93%	62% existing and 31% new arrangements
<b>Managing The Money</b>		
% developing medium term financial strategy	61%	
% using pooled budgets	15%	31% other risk share agreements
% where funding contributions are agreed	38%	15% Being put in place
% reporting that current funding arrangements are clear	62%	15% further work in progress
% where funding for C&YP is included in a pooled budget	46%	
% that report shared understanding of total costs of current services	69%	16% further work in progress
<b>Safeguarding</b>		
% arrangements for people placed out of area / ADASS protocol	92%	
% reporting information sharing with providers	62%	15% in development
% reporting monitoring arrangements in respect of DOLS / use of restraint	77%	8% arrangements in development
% reporting plans to ensure sufficiency of B.I.As	92%	
% reporting working links with practitioners in quality/regulatory roles	62%	



<b>Report: - London</b>		
<b>Leadership across the system</b>		
% of Health and Wellbeing Boards engaged with the programme	79%	18% report arrangements in process
% of places Learning Disability Partnership Boards/ alternative arrangements to monitor progress.	79%	Alternative arrangements 6%
% reporting children and adults safeguarding boards engaged	97%	3% report arrangements in process
% of places with a dedicated planning function	64%	36% report this is being developed
% of places where Ordinary Residence is identified as a barrier	33%	
<b>Strategic Capacity</b>		
% of places reporting assessment of commissioning requirements	76%	15% of places report progress on this.
% reporting plans for re-provision and diversion	61%	18% report this is being developed
% reporting progress with market assessments.	93%	
% including C&YP needs in commissioning intentions.	64%	30% report this is under review
% reporting assessment of crisis response capacity	48%	42% report this is under review.
% including workforce /skills assessment in commissioning intentions	52%	39% report this is being developed.
<b>Delivery, Progress and Capacity</b>		
% reporting a joint, integrated community team.	64%	3% report co-located teams
% reporting agreement about numbers affected by the programme.	97%	
% reporting clarity about specialist commissioning arrangements	39%	18% report this is under discussion
% reporting joint planning that includes specialist commissioners	31%	
% reporting confidence in Community Team capacity to deliver.	85%	6% report that this is under review
% reporting inclusive reviewing arrangements in place	70%	27% report that this is under review
% reporting named workers	94%	
% reporting that advocacy support is available	91%	
% reporting confidence of achieving the 1 June 2014 target.	61%	6% report the timescale is problematic
% reporting confidence in quality of advocacy support	82%	15% report that this is being worked on
% reporting joint delivery arrangements are in place	99%	60% existing and 39% new arrangements
<b>Managing The Money</b>		
% developing medium term financial strategy	81%	
% using pooled budgets	27%	15% other risk share agreements
% where funding contributions are agreed	39%	9% Being put in place
% reporting that current funding arrangements are clear	73%	6% further work in progress
% where funding for C&YP is included in a pooled budget	39%	
% that report shared understanding of total costs of current services	70%	30% further work in progress
<b>Safeguarding</b>		
% arrangements for people placed out of area / ADASS protocol	100%	
% reporting information sharing with providers	76%	15% in development
% reporting monitoring arrangements in respect of DOLS / use of restraint	79%	21% arrangements in development
% reporting plans to ensure sufficiency of B.I.As	91%	
% reporting working links with practitioners in quality/regulatory roles	76%	

<b>Report: - North East</b>		
<b>Leadership across the system</b>		
% of Health and Wellbeing Boards engaged with the programme	55%	45% report arrangements in process
% of places Learning Disability Partnership Boards/ alternative arrangements to monitor progress.	82%	Alternative arrangements 9%
% reporting children and adults safeguarding boards engaged	64%	36% report arrangements in process
% of places with a dedicated planning function	45%	36% report this is being developed
% of places where Ordinary Residence is identified as a barrier	55%	
<b>Strategic Capacity</b>		
% of places reporting assessment of commissioning requirements	18%	73% of places report progress on this.
% reporting plans for re-provision and diversion	36%	45% report this is being developed
% reporting progress with market assessments.	100%	
% including C&YP needs in commissioning intentions.	73%	18% report this is under review
% reporting assessment of crisis response capacity	27%	73% report this is under review.
% including workforce /skills assessment in commissioning intentions	27%	36% report this is being developed.
<b>Delivery, Progress and Capacity</b>		
% reporting a joint, integrated community team.	18%	36% report co-located teams
% reporting agreement about numbers affected by the programme.	73%	
% reporting clarity about specialist commissioning arrangements	27%	36% report this is under discussion
% reporting joint planning that includes specialist commissioners	30%	
% reporting confidence in Community Team capacity to deliver.	82%	18% report that this is under review
% reporting inclusive reviewing arrangements in place	45%	18% report that this is under review
% reporting named workers	73%	
% reporting that advocacy support is available	64%	
% reporting confidence of achieving the 1 June 2014 target.	45%	55% report the timescale is problematic
% reporting confidence in quality of advocacy support	55%	36% report that this is being worked on
% reporting joint delivery arrangements are in place	99%	63% existing and 36% new arrangements
<b>Managing The Money</b>		
% developing medium term financial strategy	64%	
% using pooled budgets	18%	36% other risk share agreements
% where funding contributions are agreed	18%	9% Being put in place
% reporting that current funding arrangements are clear	27%	64% further work in progress
% where funding for C&YP is included in a pooled budget	9%	
% that report shared understanding of total costs of current services	64%	36% further work in progress
<b>Safeguarding</b>		
% arrangements for people placed out of area / ADASS protocol	91%	
% reporting information sharing with providers	45%	54% in development
% reporting monitoring arrangements in respect of DOLS / use of restraint	82%	18% arrangements in development
% reporting plans to ensure sufficiency of B.I.As	100%	
% reporting working links with practitioners in quality/regulatory roles	45%	

<b>Report: - East</b>		
<b>Leadership across the system</b>		
% of Health and Wellbeing Boards engaged with the programme	73%	9% report arrangements in process
% of places Learning Disability Partnership Boards/ alternative arrangements to monitor progress.	82%	Alternative arrangements 0%
% reporting children and adults safeguarding boards engaged	82%	18% report arrangements in process
% of places with a dedicated planning function	73%	18% report this is being developed
% of places where Ordinary Residence is identified as a barrier	82%	
<b>Strategic Capacity</b>		
% of places reporting assessment of commissioning requirements	27%	73% of places report progress on this.
% reporting plans for re-provision and diversion	45%	55% report this is being developed
% reporting progress with market assessments.	82%	
% including C&YP needs in commissioning intentions.	64%	36% report this is under review
% reporting assessment of crisis response capacity	36%	64% report this is under review.
% including workforce /skills assessment in commissioning intentions	64%	36% report this is being developed.
<b>Delivery, Progress and Capacity</b>		
% reporting a joint, integrated community team.	45%	9% report co-located teams
% reporting agreement about numbers affected by the programme.	91%	
% reporting clarity about specialist commissioning arrangements	55%	18% report this is under discussion
% reporting joint planning that includes specialist commissioners	80%	
% reporting confidence in Community Team capacity to deliver.	64%	27% report that this is under review
% reporting inclusive reviewing arrangements in place	82%	18% report that this is under review
% reporting named workers	91%	
% reporting that advocacy support is available	91%	
% reporting confidence of achieving the 1 June 2014 target.	72%	9% report the timescale is problematic
% reporting confidence in quality of advocacy support	73%	27% report that this is being worked on
% reporting joint delivery arrangements are in place	99%	63% existing and 36% new arrangements
<b>Managing The Money</b>		
% developing medium term financial strategy	100%	
% using pooled budgets	36%	9% other risk share agreements
% where funding contributions are agreed	36%	18% Being put in place
% reporting that current funding arrangements are clear	55%	9% further work in progress
% where funding for C&YP is included in a pooled budget	55%	
% that report shared understanding of total costs of current services	73%	18% further work in progress
<b>Safeguarding</b>		
% arrangements for people placed out of area / ADASS protocol	91%	
% reporting information sharing with providers	64%	36% in development
% reporting monitoring arrangements in respect of DOLS / use of restraint	73%	18% arrangements in development
% reporting plans to ensure sufficiency of B.I.As	73%	
% reporting working links with practitioners in quality/regulatory roles	64%	

<b>Report: - Yorkshire and Humber</b>		
<b>Leadership across the system</b>		
% of Health and Wellbeing Boards engaged with the programme	80%	13% report arrangements in process
% of places Learning Disability Partnership Boards/ alternative arrangements to monitor progress.	100%	Alternative arrangements 0%
% reporting children and adults safeguarding boards engaged	67%	20% report arrangements in process
% of places with a dedicated planning function	73%	20% report this is being developed
% of places where Ordinary Residence is identified as a barrier	33%	
<b>Strategic Capacity</b>		
% of places reporting assessment of commissioning requirements	47%	33% of places report progress on this.
% reporting plans for re-provision and diversion	53%	40% report this is being developed
% reporting progress with market assessments.	80%	
% including C&YP needs in commissioning intentions.	60%	40% report this is under review
% reporting assessment of crisis response capacity	27%	60% report this is under review.
% including workforce /skills assessment in commissioning intentions	20%	60% report this is being developed.
<b>Delivery, Progress and Capacity</b>		
% reporting a joint, integrated community team.	60%	7% report co-located teams
% reporting agreement about numbers affected by the programme.	67%	
% reporting clarity about specialist commissioning arrangements	80%	20% report this is under discussion
% reporting joint planning that includes specialist commissioners	57%	
% reporting confidence in Community Team capacity to deliver.	60%	33% report that this is under review
% reporting inclusive reviewing arrangements in place	67%	20% report that this is under review
% reporting named workers	87%	
% reporting that advocacy support is available	80%	
% reporting confidence of achieving the 1 June 2014 target.	67%	7% report the timescale is problematic
% reporting confidence in quality of advocacy support	87%	13% report that this is being worked on
% reporting joint delivery arrangements are in place	101%	54% existing and 47% new arrangements
<b>Managing The Money</b>		
% developing medium term financial strategy	93%	
% using pooled budgets	20%	20% other risk share agreements
% where funding contributions are agreed	27%	0% Being put in place
% reporting that current funding arrangements are clear	60%	7% further work in progress
% where funding for C&YP is included in a pooled budget	13%	
% that report shared understanding of total costs of current services	60%	33% further work in progress
<b>Safeguarding</b>		
% arrangements for people placed out of area / ADASS protocol	93%	
% reporting information sharing with providers	67%	20% in development
% reporting monitoring arrangements in respect of DOLS / use of restraint	73%	13% arrangements in development
% reporting plans to ensure sufficiency of B.I.As	93%	
% reporting working links with practitioners in quality/regulatory roles	67%	

## Appendix 4: Summary of support requested

Dimensions of the stocktake where there have been five or more requests for support

Q No.	Detail of Question	Requests for support
9	1.9 Has consideration been given to key areas where you might be able to use further support to develop and deliver your plan.	35
8	1.8 Do you have any current issues regarding Ordinary Residence and the potential financial risks associated with this.	21
43	6.5 Have joint reviewing and (de)commissioning arrangements been agreed with specialist commissioning teams.	15
3	1.3 Have you established a planning function that will support the development of the kind of services needed for those people that have been reviewed and for other people with complex needs.	12
11	2.2 Is there clarity about source(s) of funds to meet current costs including funding from specialist commissioning bodies continuing Health Care and NHS and Social Care.	12
23	4.2 Are arrangements for review of people funded through specialist commissioning clear.	12
2	1.2 Are other key partners working with you to support this; if so who. (Please comment on housing specialist commissioning & providers).	11
52	8.1 Do commissioning intentions include an assessment of capacity that will be required to deliver crisis response services locally.	11
25	4.4 Is there confidence that comprehensive local registers of people with behaviour that challenges have been developed and are being used.	10
48	6.10 If no what are the obstacles to delivery (e.g. organisational financial legal).	10
7	1.7 Are accountabilities to local regional and national bodies clear and understood across the partnership – e.g. HWB Board NHSE Local Area Teams / CCG fora clinical partnerships & Safeguarding Boards.	9
13	2.4 Is there a pooled budget and / or clear arrangements to share financial risk.	9
6	1.6 Does the partnership have arrangements in place to resolve differences should they arise.	8
28	4.7 How do you know about the quality of the reviews and how good practice in this area is being developed.	8
47	6.9 Are you confident that the 1 June 2014 target will be achieved (the commitment is for all people currently in in-patient settings to be placed nearer home and in a less restrictive environment).	8
1	1.1 Are you establishing local arrangements for joint delivery of this programme between the Local Authority and the CCG(s).	7
12	2.3 Do you currently use S75 arrangements that are sufficient & robust.	7
54	8.3 Do commissioning intentions include a workforce and skills assessment development.	7
59	11.1 Is an assessment of local market capacity in progress.	7
16	2.7 Between the partners is there an emerging financial strategy in the medium term that is built on current cost future investment and potential for savings.	6
44	6.6 Have the potential costs and source(s) of funds of future commissioning arrangements been assessed.	6
10	2.1 Are the costs of current services understood across the partnership.	5
19	3.3 Does it have capacity to deliver the review and re-provision programme.	5
39	6.1 Are you completing an initial assessment of commissioning requirements to support peoples' move from assessment and treatment/in-patient settings.	5
53	8.2 Do you have / are you working on developing emergency responses that would avoid hospital admission (including under section of MHA.)	5
55	9.1 Do your local planning functions and market assessments support the development of support for all people with complex needs including people with behaviour that challenges.	5

## Appendix 5: The original stocktake document



### Winterbourne View Joint Improvement Programme

#### Initial Stocktake of Progress against key Winterbourne View Concordat Commitment

The Winterbourne View Joint Improvement Programme is asking local areas to complete a stocktake of progress against the commitments made nationally that should lead to all individuals receiving personalised care and support in appropriate community settings no later than 1 June 2014.

The purpose of the stocktake is to enable local areas to assess their progress and for that to be shared nationally. The stocktake is also intended to enable local areas to identify what help and assistance they require from the Joint Improvement Programme and to help identify where resources can best be targeted.

The sharing of good practice is also an expected outcome. Please mark on your return if you have good practice examples and attach further details.

This document follows the recent letter from Norman Lamb, Minister of State regarding the role of HWBB and the stocktake will provide a local assurance tool for your HWBB.

While this stocktake is specific to Winterbourne View, it will feed directly into the CCG Assurance requirements and the soon to be published joint Strategic Assessment Framework (SAF). Information compiled here will support that process.

This stocktake can only successfully be delivered through local partnerships. The programme is asking local authorities to lead this process given their leadership role through Health and Well Being Boards but responses need to be developed with local partners, including CCGs, and shared with Health and Wellbeing Boards.

The deadline for this completed stocktake is Friday 5 July. Any queries or final responses should be sent to [sarah.brown@local.gov.uk](mailto:sarah.brown@local.gov.uk).

An easy read version is available on the LGA website.

Winterbourne View Local Stocktake June 2013

1. Models of partnership	Assessment of current position evidence of work and issues arising	Good practice example (please tick and attach)	Support required
<p>1.1 Are you establishing local arrangements for joint delivery of this programme between the Local Authority and the CCG(s).</p> <p>1.2 Are other key partners working with you to support this; if so, who. (Please comment on housing, specialist commissioning &amp; providers).</p> <p>1.3 Have you established a planning function that will support the development of the kind of services needed for those people that have been reviewed and for other people with complex needs.</p> <p>1.4 Is the Learning Disability Partnership Board (or alternate arrangement) monitoring and reporting on progress.</p> <p>1.5 Is the Health and Wellbeing Board engaged with local arrangements for delivery and receiving reports on progress.</p> <p>1.6 Does the partnership have arrangements in place to resolve differences should they arise.</p> <p>1.7 Are accountabilities to local, regional and national bodies clear and understood across the partnership – e.g. HWB Board, NHSE Local Area Teams / CCG fora, clinical partnerships &amp; Safeguarding Boards.</p> <p>1.8 Do you have any current issues regarding Ordinary Residence and the potential financial risks associated with this.</p> <p>1.9 Has consideration been given to key areas where you might be able to use further support to develop and deliver your plan.</p>			
<p><b>2. Understanding the money</b></p> <p>2.1 Are the costs of current services understood across the partnership.</p> <p>2.2 Is there clarity about source(s) of funds to meet current costs, including funding from specialist commissioning bodies, continuing Health Care and NHS and Social Care.</p> <p>2.3 Do you currently use S75 arrangements that are sufficient &amp; robust.</p>			

<p>2.4 Is there a pooled budget and / or clear arrangements to share financial risk.</p> <p>2.5 Have you agreed individual contributions to any pool.</p> <p>2.6 Does it include potential costs of young people in transition and of children's services.</p> <p>2.7 Between the partners is there an emerging financial strategy in the medium term that is built on current cost, future investment and potential for savings.</p>			
<p><b>3. Case management for individuals</b></p> <p>3.1 Do you have a joint, integrated community team.</p> <p>3.2 Is there clarity about the role and function of the local community team.</p> <p>3.3 Does it have capacity to deliver the review and re-provision programme.</p> <p>3.4 Is there clarity about overall professional leadership of the review programme.</p> <p>3.5 Are the interests of people who are being reviewed, and of family carers, supported by named workers and / or advocates.</p>			
<p><b>4. Current Review Programme</b></p> <p>4.1 Is there agreement about the numbers of people who will be affected by the programme and are arrangements being put in place to support them and their families through the process.</p> <p>4.2 Are arrangements for review of people funded through specialist commissioning clear.</p> <p>4.3 Are the necessary joint arrangements (including people with learning disability, carers, advocacy organisations, Local Healthwatch) agreed and in place.</p> <p>4.4 Is there confidence that comprehensive local registers of people with behaviour that challenges have been developed and are being used.</p> <p>4.5 Is there clarity about ownership, maintenance and monitoring of local registers following transition to CCG, including identifying who should be the first point of contact for each individual</p> <p>4.6 Is advocacy routinely available to people (and family) to support assessment, care planning and review processes</p> <p>4.7 How do you know about the quality of the reviews and how good practice in this area is being developed.</p> <p>4.8 Do completed reviews give a good understanding of behaviour support being offered in individual situations.</p> <p>4.9 Have all the required reviews been completed. Are you satisfied that there are clear plans for any outstanding reviews to be completed.</p>			



<p><b>5. Safeguarding</b></p> <p>5.1 Where people are placed out of your area, are you engaged with local safeguarding arrangements – e.g. in line with the ADASS protocol.</p> <p>5.2 How are you working with care providers (including housing) to ensure sharing of information &amp; develop risk assessments.</p> <p>5.3 Have you been fully briefed on whether inspection of units in your locality have taken place, and if so are issues that may have been identified being worked on.</p> <p>5.4 Are you satisfied that your Children and Adults Safeguarding Boards are in touch with your Winterbourne View review and development programme.</p> <p>5.5 Have they agreed a clear role to ensure that all current placements take account of existing concerns/alerts, the requirements of DoLS and the monitoring of restraint.</p> <p>5.6 Are there agreed multi-agency programmes that support staff in all settings to share information and good practice regarding people with learning disability and behaviour that challenges who are currently placed in hospital settings.</p> <p>5.7 Is your Community Safety Partnership considering any of the issues that might impact on people with learning disability living in less restrictive environments.</p> <p>5.8 Has your Safeguarding Board got working links between CQC, contracts management, safeguarding staff and care/case managers to maintain alertness to concerns.</p>			
<p><b>6. Commissioning arrangements</b></p> <p>6.1 Are you completing an initial assessment of commissioning requirements to support peoples' move from assessment and treatment/in-patient settings.</p> <p>6.2 Are these being jointly reviewed, developed and delivered.</p> <p>6.3 Is there a shared understanding of how many people are placed out of area and of the proportion of this to total numbers of people fully funded by NHS CHC and those jointly supported by health and care services.</p> <p>6.4 Do commissioning intentions reflect both the need deliver a re-provision programme for existing people and the need to substantially reduce future hospital placements for new people.</p> <p>6.5 Have joint reviewing and (de)commissioning arrangements been agreed with specialist commissioning teams.</p>			

<p>6.6 Have the potential costs and source(s) of funds of future commissioning arrangements been assessed.</p>			
<p>6.7 Are local arrangements for the commissioning of advocacy support sufficient, if not, are changes being developed.</p> <p>6.8 Is your local delivery plan in the process of being developed, resourced and agreed.</p> <p>6.9 Are you confident that the 1 June 2014 target will be achieved (the commitment is for all people currently in in-patient settings to be placed nearer home and in a less restrictive environment).</p> <p>6.10 If no, what are the obstacles, to delivery (e.g. organisational, financial, legal).</p>			
<p><b>7. Developing local teams and services</b></p> <p>7.1 Are you completing an initial assessment of commissioning requirements to support peoples' move from assessment and treatment/in-patient settings.</p> <p>7.2 Do you have ways of knowing about the quality and effectiveness of advocacy arrangements.</p> <p>7.3 Do you have plans to ensure that there is capacity to ensure that Best Interests assessors are involved in care planning.</p>			
<p><b>8. Prevention and crisis response capacity - Local/shared capacity to manage emergencies</b></p> <p>8.1 Do commissioning intentions include an assessment of capacity that will be required to deliver crisis response services locally.</p> <p>8.2 Do you have / are you working on developing emergency responses that would avoid hospital admission (including under section of MHA.)</p> <p>8.3 Do commissioning intentions include a workforce and skills assessment development.</p>			
<p><b>9. Understanding the population who need/receive services</b></p> <p>9.1 Do your local planning functions and market assessments support the development of support for all people with complex needs, including people with behaviour that challenges.</p> <p>9.2 From the current people who need to be reviewed, are you taking account of ethnicity, age profile and gender issues in planning and understanding future care services.</p>			

<p><b>10. Children and adults – transition planning</b></p> <p>10.1 Do commissioning arrangements take account of the needs of children and young people in transition as well as of adults.</p> <p>10.2 Have you developed ways of understanding future demand in terms of numbers of people and likely services.</p>			
<p><b>11. Current and future market requirements and capacity</b></p> <p>11.1 Is an assessment of local market capacity in progress.</p> <p>11.2 Does this include an updated gap analysis.</p> <p>11.3 Are there local examples of innovative practice that can be shared more widely, e.g. the development of local fora to share/learn and develop best practice.</p>			

Please send questions, queries or completed stocktake to [Sarah.brown@local.gov.uk](mailto:Sarah.brown@local.gov.uk) by 5<sup>th</sup> July 2013

**This document has been completed by**

Name.....

Organisation.....

Contact.....

Signed by:

Chair HWB .....

LA Chief Executive .....

CCG rep.....

## Appendix 6: Those who helped in the stocktake

Achieving the preparation and collection of the stocktake was a major undertaking completed in a very short time. All those in locations that responded and their considerable time to complete the papers and helped us to achieve a 100% return rate deserve thanks.

In addition the individuals named below assisted during the process in completing analysis of returns or supporting the final report. Many did this on top of already busy schedules.

All deserve thanks.

<b>Ray Avery</b>	NHS England
<b>Wendy Balmain</b>	Department of Health
<b>Sarah Darby</b>	Adviser
<b>Tommy Denning</b>	Department of Health
<b>Anne Hackett</b>	Department of Health
<b>Kevin Halden</b>	LGA
<b>Tim Hind</b>	Adviser
<b>Emma Jenkins</b>	LGA
<b>David Jones</b>	Department of Health
<b>Rebecca Matthews</b>	Department of Health
<b>Adam Papaphilippopoulos</b>	Adviser
<b>Debbie Robinson</b>	Kaleidoscope
<b>Zandrea Stewart</b>	WVJIP Improvement Adviser
<b>Helen Sumner</b>	LGA
<b>Steve Taylor</b>	WVJIP Improvement Adviser
<b>Jacqui White</b>	Adviser
<b>Helen Wilkinson</b>	LGA
<b>Ian Winter</b>	WVJIP Improvement Lead
<b>Howard Miller</b>	Adviser
<b>Penny Prior</b>	Adviser
<b>Sarah Brown</b>	LGA
<b>Marie Coffey</b>	LGA

## Appendix 7: A sample of the pro-forma that has been returned to each locality

### Winterbourne View Joint Improvement Programme

#### Stocktake of Progress

##### Local analysis:

Attached is your stocktake return with analysis  
This analysis is set out in 2 parts.

Set out below are comments taken from your narrative and summarised to form an outline of key strengths and potential areas for development.

The strengths are taken from the responses you have made and are significantly summarised.

Many of the development points are taken directly either from your specific requests for further information or support or your comments about work in progress. Often the strength and the development go hand in hand.

The spreadsheet sets out the original stocktake questions, your responses and the coding that was used to collate the responses. There is no scoring or grading. What all this provides is a comprehensive picture about some excellent progress and pointers to what the priorities are to work on now. This will be the basis for our developing work with you.

Thank you for your detailed responses and for any submission of material, which will be made available in coming weeks.

The JIP Team

[Ian Winter. ianjwinter@gmail.com](mailto:ianjwinter@gmail.com)

[Steve Taylor. Stephen.taylor@local.gov.uk](mailto:Stephen.taylor@local.gov.uk)

[Zandrea Stewart. Zandrea.stewart@local.gov.uk](mailto:Zandrea.stewart@local.gov.uk)

10 October 2013

Key strengths	Areas for development / potential development

#### Dimensions of the stocktake about which you have requested support



# Winterbourne View joint improvement programme

The programme has a small improvement team led by Ian Winter. The purpose is to lead national priorities and support action with regions to ensure that the Winterbourne View Concordat commitments are met.

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## **Stephen Taylor**

Telephone: 07920 061189

Email: Stephen.Taylor@local.gov.uk

Programme priority: New financial models, understanding information, and assuring progress in developing alternative models of commissioning.

Regional contact for: South East, South West and North East

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## **Zandrea Stewart**

Telephone: 07900 931056

Email: Zandrea.Stewart@local.gov.uk

Programme priority: Life course planning, for people from childhood into adulthood.

Regional contact for: Midlands, East of England and Yorkshire and Humber

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## **Ian Winter CBE**

Telephone: 07963 144128

Email: ianjwinter@gmail.com

Programme priority: Working with providers and developing quality standards.

Regional contact for: London and North West

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## **Stephen Taylor, Zandrea Stewart and Ian Winter**

Programme priority: Keeping people safe, appropriate use of legislation and guidance, promoting rights and raising expectations.

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## **Chris Bull**

Chair, Winterbourne View Joint Improvement Board

Email: Chris.Bull@local.gov.uk



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please contact us on 020 7664 3000.  
We consider requests on an individual basis.