Health and wellbeing boards: leading local response to Winterbourne View

Appendix

Case study 1: Facilitating the involvement of individuals, their families, carers and advocates, in Salford

Over the last seven years, 20 people with learning disabilities and behaviour that challenges have been supported to return to Salford from out-of-area placements. Furthermore since 2009 only one individual* in this vulnerable group has been placed in a hospital and assessment treatment unit. Working in partnership with individuals, their families, carers and advocates is a key element in Salford's successful model of care. The involvement of individuals in the vulnerable group is integral to the assessment process for returning or maintaining placements in the local community. A project team is set up around each person and in collaboration with them and their family, carer and advocate, will determine what services need to be drawn on from the community team. In cases where an individual moved out of area because there were not the local services to support them, as part of a coming home plan there may be a need to regain the family's trust; especially in relation to the availability and quality of local services. It is important that all areas of the service are working in partnership to enable people to return to their local area but also that they are supported to remain in the area.

Once a local community place has been identified for an individual and appropriate support services commissioned, attention is given to developing good relationships between the person and their support team. Recognising the changing needs of many people in the vulnerable group, there is also constant ongoing discussion around what support services are appropriate and necessary. It is this local expertise and support that will assist in individual placements being robust and long term.

All training provided to staff is offered to parents and carers of individuals in the vulnerable group. This enables better joint working as families and carers are able to share the same information as staff. Parents are encouraged to become involved in training the staff that will support their family member. Individuals and their parents also play an active role in recruitment of new staff to the support team.

For more information, contact Dave Williams, clinical nurse specialist
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*in Salford the term person supported is used.

Case study 2: Supporting vulnerable individuals to stay in their own homes in Dudley

The Accommodation and Support Team (AST) in Dudley, part of the learning disability service, focus on preventing hospital admissions, ensuring any people referred to them with learning disabilities or autism and behaviour that challenges have the support and resources to remain within their local community. The AST includes social workers, a community nurse, team managers, and a welfare benefits officer. In the last four years they have supported 75 vulnerable people to move into a home of their own in Dudley, 23 of these being people who also presented challenges to service provision.

The success of their work is built on strong, collaborative partnership working with providers. Emphasis is put on providers' ability to deliver the complex services required, tailored to each individual's needs. This enables the AST to better support individuals in a person-centred way, including those with very complex needs or those who are going through a crisis.

Referrals received by the AST include:

- young people in transition
- those accessing services of the autism spectrum condition team
- individuals known to the community learning disability team and identified as wanting or needing to move into their own home
- individuals identified through the learning disability network as living with elderly carers and who may need to consider longer-term housing and support to avoid a crisis
- individuals living in registered care services or a failed supported living situation.

For each individual referred, the AST develop a person-centred accommodation and support specification covering personal care, daily living, leisure and recreation, mobility, sensory and welfare benefit needs. It includes the individual's preferences on choice of location in Dudley; distance from family, shops, bus routes, amenities, place of worship; type and size of accommodation; and specific needs around level access, size, adaptations and assistive technology. A transition plan is then used to coordinate the housing and care services needed to move an individual to their own home with safe and effective ongoing support.

For more information, contact **LDCommissioning.Dachs@dudley.gov.uk**

Case study 3: Making use of personal budgets to support independent living in Trafford

To promote greater independence and choice for vulnerable individuals, a wider variety of housing options have recently been developed in Trafford. A strategic move has been made away from traditional housing and accommodation models in favour of innovative developments that respond directly to what individuals have said they want and need, such as extra care and supported living. In tandem the local authority has encouraged commissioning of support services linked to personal budgets.

An example of recent success is the development of a shared housing complex Eden Square, in Urmston, championed by the local authority. The development has a mixed tenancy approach with apartments being available to rent through a not-for-profit company. 18 of the apartments have tenants with a learning disability, autistic spectrum condition, mental health needs and physical disabilities. These individuals, who had no previous experience of living independently, now do so successfully in their own apartments with access to on-site support day and night. This support is purchased through a personal budget with the personal budget holder having choice of provider.

Another innovative example is the use of personal budgets by six individuals with learning disabilities, enabling them to share a house and remain living in the local community. With the help of family members, they specified what services they wanted to purchase with their personal budgets and selected a service provider to deliver their required supported living service.

For more information, contact Linda Harper, deputy corporate director, **linda.harper@trafford.gov.uk**

Case study 4: Using a dementia care pathway for people with learning disabilities in Northamptonshire

More people with a learning disability or autism are affected by dementia, potentially resulting in an increase in challenging behaviour with age. A local dementia care pathway for people with learning disabilities has been used since 2010 in Northamptonshire. Based on guidance from the Royal College of Psychiatrists and local best clinical practice, it sets out clear guidance for multi-disciplinary team members through the pathway from referral to screening and diagnosis, treatment and end-of-life care. The pathway includes regular assessment to check for early signs of dementia with findings linked to a baseline assessment. It is hoped that the assessment process can in future become part of a local annual GP-led health check for people in the vulnerable group concerned.

Service users with Down's Syndrome are offered a baseline assessment at the age of 30 years, then again at 40 years old and every two years until 50 years of age when the assessment becomes annual. Screening for dementia is offered to all individuals with a learning disability at the age of 50 years and is repeated annually. Introduction of the pathway raised awareness among local GPs and care workers of the value of baseline screening. This resulted in a significant increase in the number of individuals referred for screening.

Earlier identification of dementia through screening has enabled individuals to benefit from more coordinated and effective multi-disciplinary team support including care management, physiotherapy, occupational therapy, speech and language therapy, community nursing, psychology and psychiatry. Use of the pathways has also encouraged better communication between clinicians and care professionals, increased consistency of care, and generated valuable information on individuals' needs to help future service planning. As Dr Maggie Labib explains: "People with learning disabilities and dementia who are not on the care pathway can deteriorate very quickly. For those on the pathway, speed of deterioration is slower and they can also enjoy a better quality of life."

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