COUNCIL FOR DISABLED CHILDREN

After Hesley: what changes would children and young people want to see?

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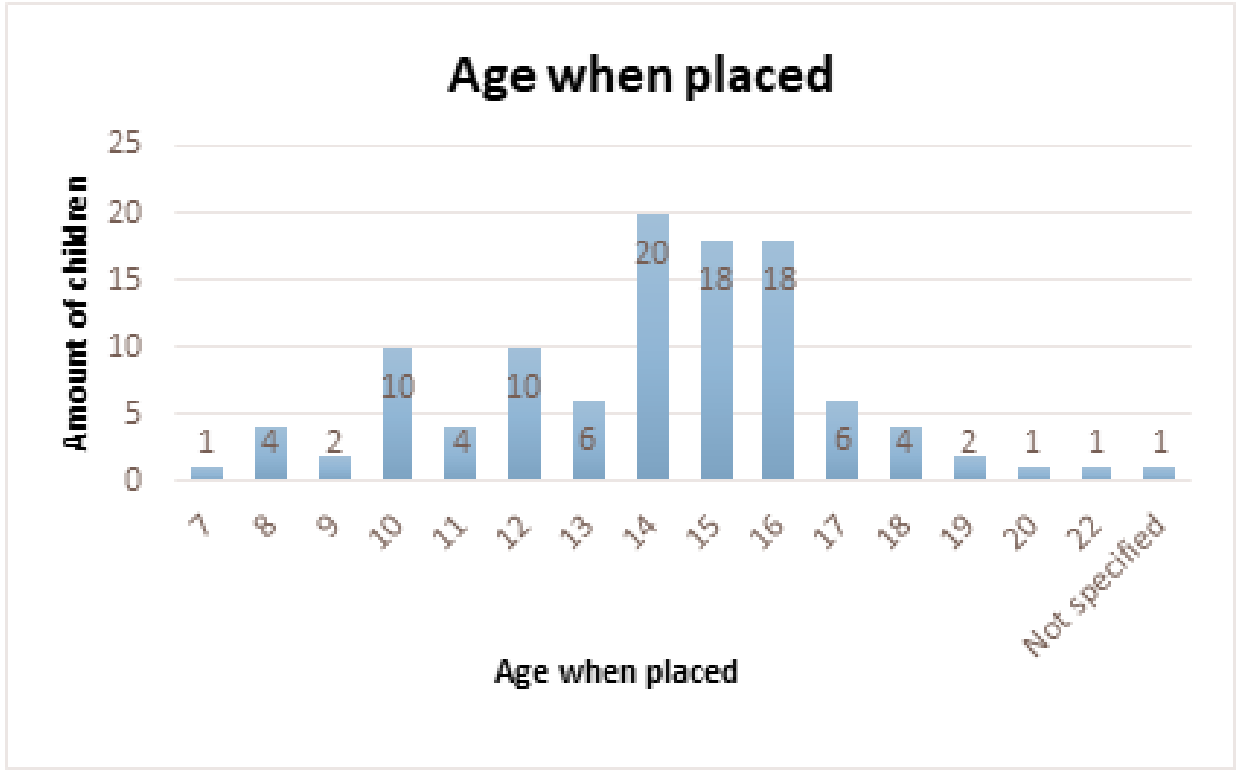
Director

Why us?

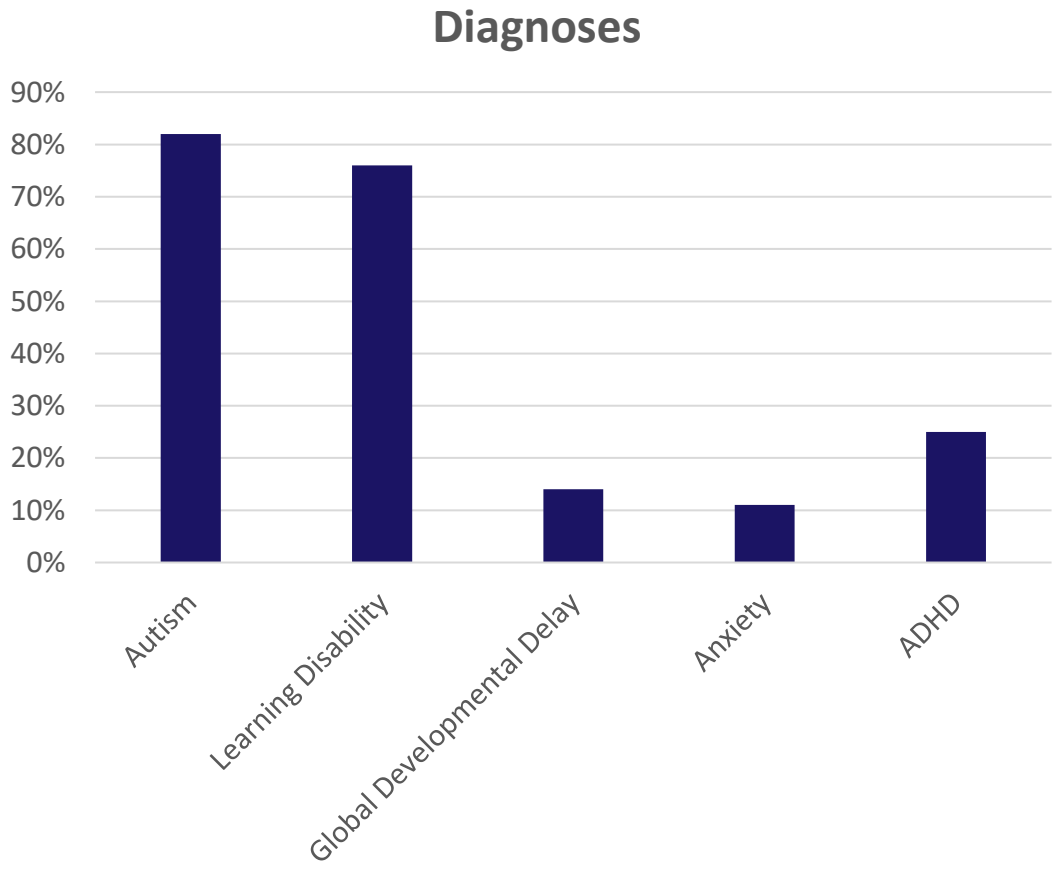
- CDC's engagement in this area was heightened following the Winterbourne View Scandal in 2011. Especially because the initial response focused only on adults.
- In 2013 we began a 3-year partnership with the Challenging Behaviour Foundation, funded by the Department of Health which resulted in a number of resources including: **Paving the Way** https://www.challengingbehaviour.org.uk/wp-content/uploads/2021/02/Paving-the-Way.pdf
- **DH/DfE Guidance - Reducing the need for restraint and restrictive intervention -** How to support children and young people with learning disabilities, autistic spectrum conditions and mental health difficulties who are at risk of restrictive intervention.
- CDC were asked by the Department of Health to conduct a review into children with autism/learning disabilities in Tier 4 inpatient settings. These are our children - January 2017.
- CDC review the experiences and outcomes of children and young people in residential special schools and colleges. The Report Good Intentions, Good Enough? November 2017
- Continued work to support local systems with their thinking on support for this cohort

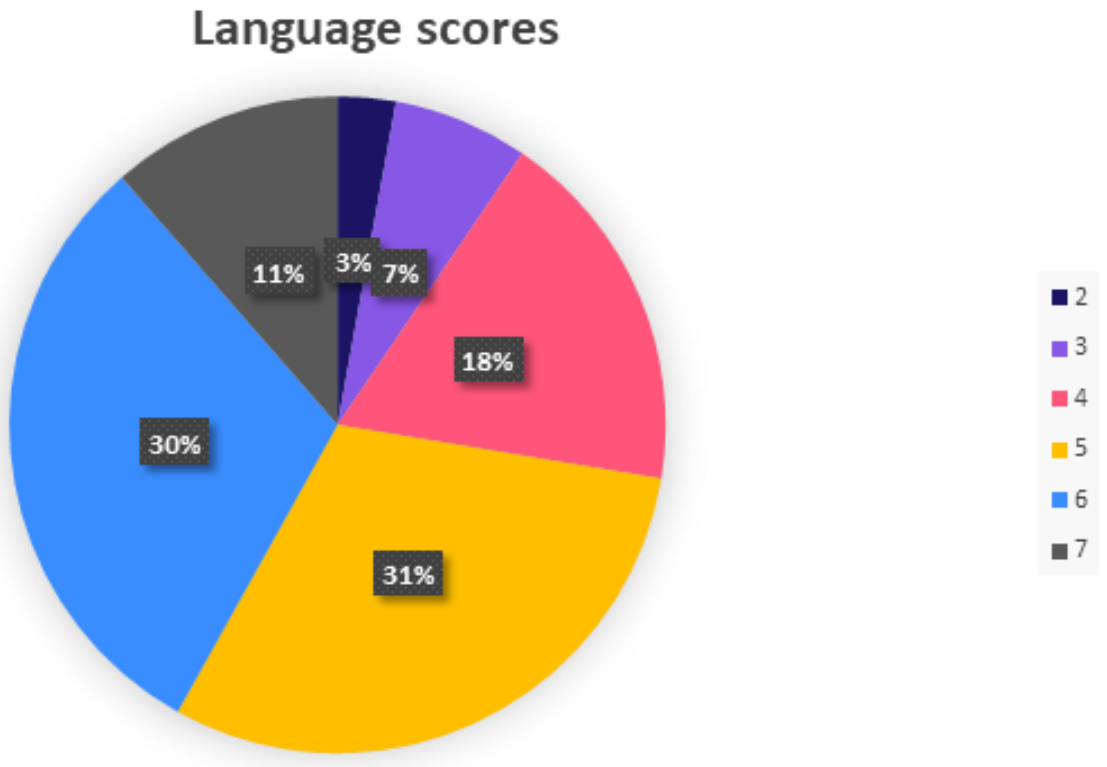
Who were the children?

- 108 children and young people were ‘in scope’
- 77.77% were male and 22.22% female
- On average they were 13.8 years when placed. 7 children were placed when under 10.

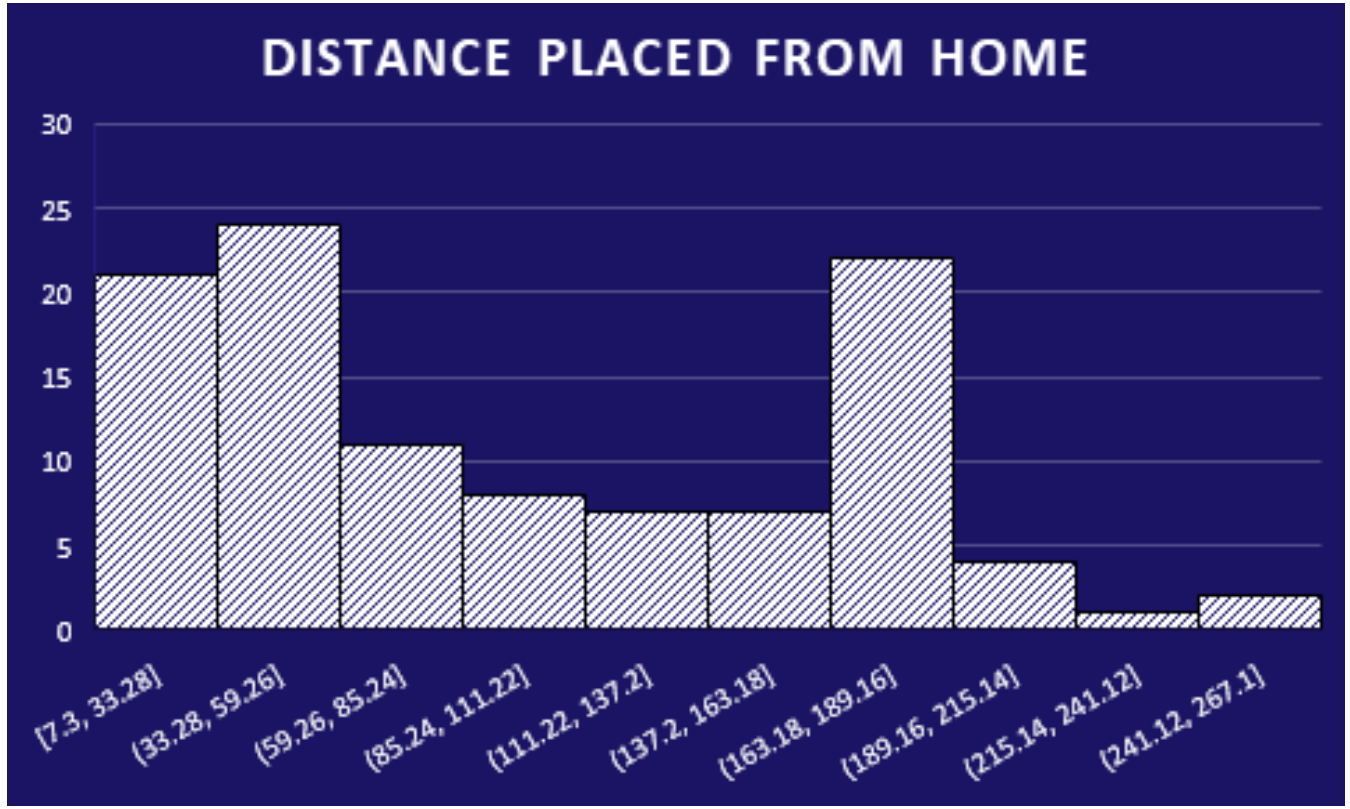


Who were the children?



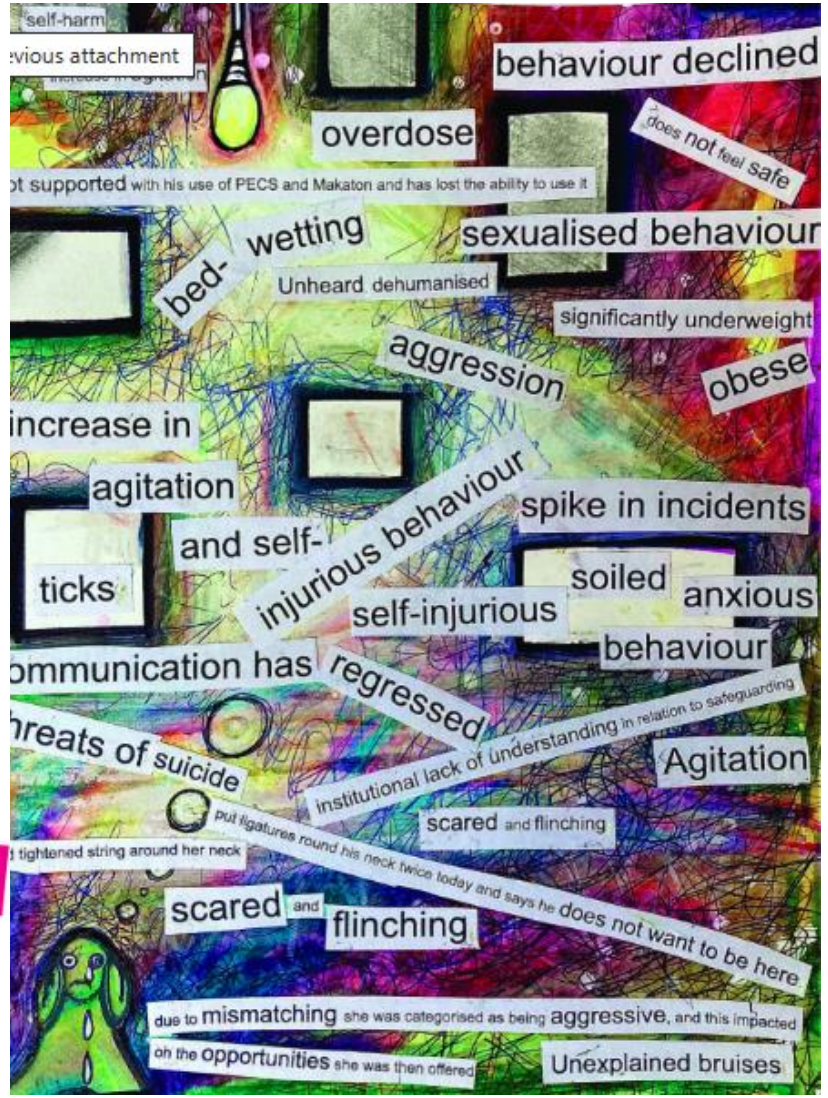


Where were they from?



The average distance the children were placed from their home authority was 95.16 miles, with a range of 7.3 to 267.1 miles. 60% of the children were placed over 50 miles away from their home. **14 children aged from 7 to 10 years old were placed, on average, 59.75 miles away from their home, with one 9-year-old child placed 178.9 miles away from home.**

What happened and what was the impact?



Case Illustration 3: Fred

Fred was diagnosed with autism and had behaviour that could be seen as challenging. Given his limited verbal communication, he used certain types of behaviour to get his basic needs met. Before being placed at Hesley's children's residential settings, Fred had been taught to use the Picture Exchange Communication Scheme, a common method which enables young people to show staff pictures of what they need. Fred could use this to ask for food and drink, to go to the toilet and to show when he felt anxious. The scheme was not used with Fred at Hesley's children's residential settings in Doncaster, and there was limited evidence that staff working with him made effective use of the communication training from the Hesley Enhancing Lives Programme. As a result, Fred was deprived of his voice and choice. His behaviour escalated and became more challenging, leading to disproportionate and unjustifiable use of physical restraint.

Hesley Group's Mission Statement & Values

Our mission is simple. Everyone at Hesley Group is here to enable young people with complex needs to achieve their full potential.

Therapeutic services

We have a team of over 30 young people within Therapeutic services. The members of the team work together with the individual towards reaching their full potential, alongside those who are important to them. The Multi-disciplinary Team (MDT) aims to enable all staff to understand and meet the needs of the young people we support, helping them stay safe and calm enough in the short term to learn the skills that will improve their wellbeing and engagement in the long term.

The mission of the Therapeutic Team is that:

We will create opportunities for engagement and communication to improve and increase independence and quality of life for the young people we support

What support do young people receive?

We strive to ensure that every individual is well supported from day one, we call this 'Universal Support'. Throughout someone's time with us the following is in place:

- Written guidelines focusing on supporting their communication and occupational needs
- Training for those working with the individual to ensure their needs are met
- Regular MDT meetings to keep up-to-date with their progress
- Yearly annual reviews with the MDT
- An environment which meets the needs of each

Positive Behavioural Support (PBS)

Our aim is to improve a young person's quality of life and reduce behaviours that challenge using PBS, an approach that is used to develop an understanding of the behaviours that may challenge that may be displayed by an individual, based on an assessment of the environment where it happens. We include a range of
the important people in a young young
helps us develop and implement a pers
support that supports behaviour chang
quality of life for a young person in the
al. 2013).

Principles and procedures of Applied Be
(ABA) are an important part of Positive
Support. ABA is based on behavioural le
seeks to understand behaviour within th
occurs. All behaviours occur for a reason
why a behaviour happens, we can put ir
centred support to help them to access
want and need in a more appropriate w
clearly understand a behaviour and the
measurable goals. Everything we do is b
focus on teaching skills which increase t
opportunities and independence. We us
approaches and make decisions based
bring about meaningful change in youn

Speech and Language Therapy

Working as part of the multi-disciplinary team (MDT) our aim is to support each p young person's speech, language and communication needs, looking at understanding and using communication. We value and promote all types of interaction aiming to encourage an environment throughout the Hesley Group which reduces barriers to communication. We call this an inclusive communication approach. This approach can include using alternative types of communication such as:

- Makaton Signing
- Picture Exchange Communication System (PECS)
- Photographs and symbols
- Objects of reference
- IT based communication eg iPads

Another aspect of our role is ensuring that everyone has safe and enjoyable mealtimes. Each young person who lives here will have an assessment to see if they have any difficulties with eating and drinking (dysphagia) within 3-6 months of admission, unless we have been made aware of risks prior to admission. All our SLTs have basic skills in supporting and assessing eating and drinking skills, with several members of the team qualified to carry out more formal assessment. If we find that someone needs additional support with their eating and drinking, we will put guidelines in place to help them have safe and enjoyable mealtimes and will give staff additional training if needed.

Occupational Therapy

Occupational Therapy supports individual's health and wellbeing through enabling them to participate in life by encouraging engagement in occupation. In Occupational Therapy, occupations refer to the everyday activities that young people do as individuals, in families and

As a profession, we consider that each individual has the ability to develop skills which enable them to achieve their own goals in life. We consider that human occupation is made up of the following elements;

- The motivation for occupation (interest, expectations and commitment).
- Patterns of occupation (routine, adaptability, roles and responsibilities).
- The ability to communicate and interact to meet occupational goals.
- The young person's ability to use their processing (mental) skills to engage in occupation.
- The young person's ability to us their motor (physical) skills to engage in occupation.
- The impact that the young person's environment has on their ability to engage in the occupation.

Clinical Psychology

We provide specialist clinical psychology services to young people with learning disabilities of all ability levels, across the Hesley Group. This can be delivered to the young people we support, the multi-disciplinary team (MDT) and the wider care team as a whole. We spend our time making sure that those who use our services are able to enjoy a high quality of life and engage in as much as possible, to help them achieve the best they can from life.

A variety of psychological assessments are able to be completed which helps us to understand the young people we support as well as guide our formulation as to the best way to help staff work with those young people. We can then employ a variety of therapeutic techniques with the young person and/or their care team, as well as providing consultation on service structure and to other professional carers. The team can evaluate and make decisions about treatment options taking into

Psychiatry

Our two Consultant Psychiatrists provide expert psychiatric input into the multi-disciplinary team. This involves medical management of a range of psychiatric disorders and psychological difficulties, often manifesting as challenging behaviour, in the individuals we support. This is done by means of regular clinics as well as telephone consultations as and when required. They also liaise with local primary and secondary health teams regarding individuals where necessary. Both Psychiatrists work in partnership with individuals, their families and staff teams to help support positive outcomes.

Hesley Enhancing Lives Programme (HELP)

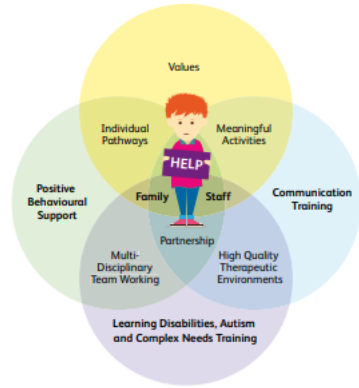
All staff undertake training in the Hesley Enhancing Lives Programme, a positive behaviour support approach based on Therapeutic Crisis Intervention (TCI), which is accredited by the British Institute of Learning Disabilities (BILD). TCI is an internationally recognised, crisis prevention and management system that reduces the potential for reliance on high-risk interventions. TCI recognises that it is the actions and reactions of those around young people that strongly shape and influence their behaviour, including their social interactions and emotional responses. Its emphasis is on empathic relationships and proactive support, while physical interventions are very much considered a last resort. HELP focuses on supporting and enabling young people in their personal journey, making these as positive and progressive as possible.

The safety and well-being of the young people we support is paramount and through everything we do we seek to ensure we work in the best interests of the young person. To keep young people safe there are times when physical

The use of any potential interventions are fully discussed with the young person concerned and/or their family and other appropriate representatives - as far as possible before they take place. Any such interventions are discontinued as soon as it is safe to do so.

Physical interventions are delivered in line with PRoACT-SCIP (r) UK guidance and the BILD Code of Practice. Both of these approaches can be explored further via the BILD website – www.bild.org.uk – in the section: Physical Intervention Accreditation.

HELPWorks



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How did the children end up in the schools?

- Unrecognised complexity of need
- Lack of early multi-agency engagement
- Inadequate and insufficient short breaks and/or family support
- Multiple education placements
- Failure to support the management of risk?

What went wrong?

- There was little opportunity for children's voices to be heard
- Placement far away from home
- Settings inappropriate for need and/or poor matching
- Inadequate leadership and management
- Closed shop mentality
- Workforce issues
- Poor practice

Why didn’t the high levels of concern result in more immediate action?

- Diagnostic overshadowing
- Covid 19
- Commissioning to go away, oversight to stay away

A number of placing authorities reflected that their reliance on the information provided by Hesley meant that over time their monitoring and quality assurance processes did not adequately interrogate all the information they received.

Overall, this constituted a form of outsourcing of Quality Assurance to Hesley

> *We rely on promises of, yeah placements to stick to what they're saying and yes, those incident reports will be with you tomorrow, and yes we’ll keep you updated and yes we are following his care plan.*
>
> *What we can’t see is any external viewpoint being brought in on this Hesley observe it, they mark their own behaviour, they determine their own outcomes from it... We haven’t critically engaged with that particular issue, we accept on face value what Hesley group are telling us.*

Key conclusions in Phase 1

- Children's voices were not heard
- Children were placed significant distance from home and in settings that did not meet their needs. This increased their vulnerability
- There was practice, regulatory and quality assurance failure at all levels and this allowed abuse to flourish.
- The workforce at the settings was not managed, supported and trained in a manner that enabled children to thrive.
- Concerns were raised, but these did not give rise to thorough investigations that might have prevented further abuse.
- We are not currently commissioning the right support for these children

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Areas for recommendation

- For children to have advocacy and children and families to have information and support
- Much stronger links to DSR processes
- A challenge to make these children a shared multi agency responsibility with guidance that underpins this
- Key recognition of workforce challenges both for community services and within residential settings
- Over half of these children should and could have stayed at home with better multi agency community support so clear need to understand that development
- We do not have effective commissioning strategies for these children, locally, regionally and nationally
- Clearly QA is not working effectively, so need to look again

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Next steps

- Report published
- Work needed to ensure implementation of recommendations
- Government has to respond within six months (now late….)
- Workstreams underway linking this to SENDAP Improvement Plan and Children’s Social Care Implementation Strategy
- DHSE/NHSE and ICB’s will need to be engaged at every level

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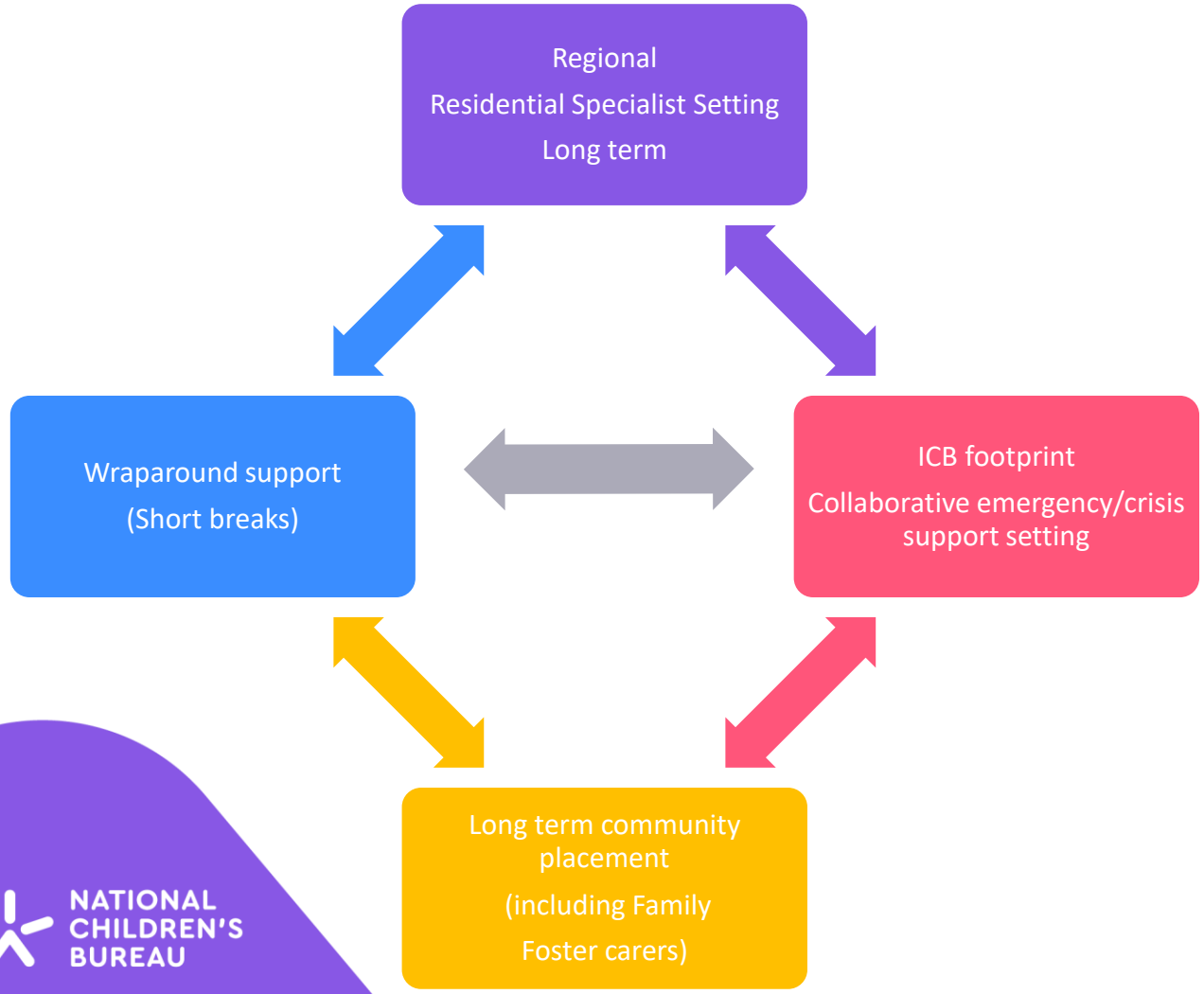
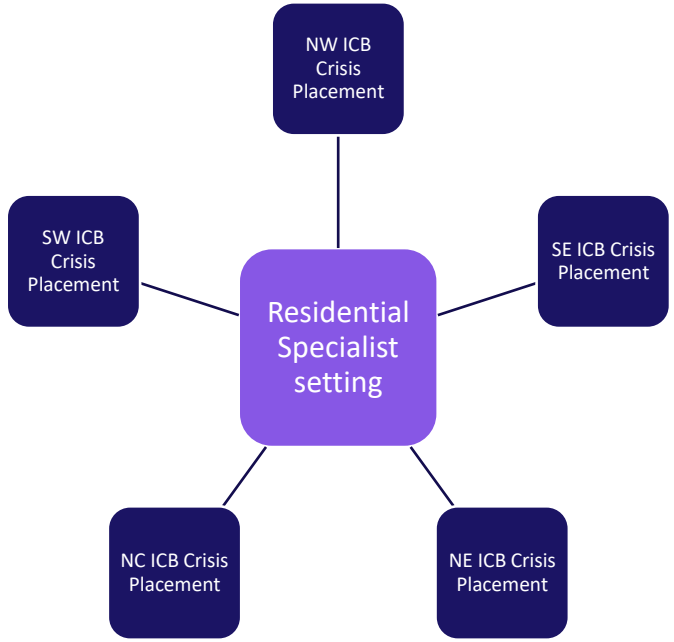
Exploring a collaborative model





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