WINTERBOURNE REVIEW

JOINT IMPROVEMENT PROGRAMME

FRAMEWORK FOR INDIVIDUAL CARE REVIEWS OF PEOPLE WITH CHALLENGING BEHAVIOUR CURRENTLY IN HOSPITAL PLACEMENTS

Winterbourne Joint Improvement Programme supported by

Local Government Association

NHS Commissioning Board

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IAN WINTER

WINTERBOURNE REVIEW JOINT IMPROVEMENT PROGRAMME
DRAFT OUTLINE FOR REVIEWS

1. Introduction

1.1. This document is for use by everyone involved in setting up and running the reviews that are required to be completed by 1st June 2013.

1.2. The background to the need for reviews is set out in "Transforming Care: A national response to Winterbourne View Hospital" and the accompanying Concordat: Programme of Action (December 2012).

1.3 The first and urgent requirement is to ensure the review all individuals with learning disability or autism who are placed in hospital in-patient beds (including enhanced, low and medium secure), assessment and treatment units or other specialist placements. Local services need to develop a timeline to ensure all individuals placed out of area are reviewed and appropriate plans are devised for their return. The objective is that these reviews must set in place plans to achieve alternative and less restrictive placements by June 2014 at the latest.

1.4 Priorities for these reviews should be:

- is there an identified commissioner (bearing in mind that there are approximately 500 patients for whom there is no identifiable commissioner linking them to local clinical teams)
- out of area placements
- duration of stay in placement with an emphasis on those patients who have had the longest stays out of area

1.5 It is crucial no individual is missed out during the review process. As already set out in Ian Dalton's letter of 24th January 2013, regions and localities are expected to know who people are and where they are placed. Where people were placed in hospitals in in-patient beds they must be reviewed. Any change in the meantime to that hospital's designation or categorisation, or any other change to the criteria for the establishment, does **not** alter the obligation to follow the required review process.

1.6 To achieve this outcome these reviews must be conducted on a joint basis with children or adult social care services as the solution must be jointly supported.

1.7 This first part of the activity is critically important to achieve rapid and safe change for people in hospital now.

1.8 But over coming months if things are really going to change then other reviews, service audits, market development and detailed service planning will need to be carried out.

1.9 While the current reviews are paramount the needs of people with learning disability or autism who will need services in the future must be planned for if genuine and sustainable change is going to be achieved.

1.10 The Winterbourne View Review Concordat: Programme of Action Vision of Change Statement sets out the commitment from 53 agencies supporting this (Appendix 5).

These first reviews are for people currently in hospital in-patient placements, who have learning disability or autism and who may have challenging behaviours.

Their placements must be reviewed by 1st June 2013.

Reviews must be developed on a joint basis across health and social care.

These reviews are one of the building blocks for developing new, different and less restrictive services for these people and future generations.

Commissioners will need to engage more widely than this initial group of people to develop real change.

2. Purpose

2.1 This paper sets out an overarching framework in which the individual care reviews for all current hospital placements are carried out. This is to support quality and consistency. It does not detract from existing good practice nor is it intended to interfere with local arrangements where these are working well. It highlights some of the most important elements of reviews and subsequent action that the Winterbourne Review Improvement Board and team believe are important.

2.2 These reviews are to be conducted in a tight timescale, while this should not detract from the quality or engagement it is perhaps inevitable that some aspects will need further follow-up and longer term work.

2.3 To ensure that the right issues are dealt with the following key questions may help. Each review should ask (and answer) the following as a minimum:

- Does this person have a good quality person-centred plan that has asked the right questions and had the person and their family at the centre of its development.
- Recognising that this a hospital and thus a short term service, is there an action plan in place and being actioned to support the person to move on to alternative services/supports in the future.
- Depending on the above, what further work is required and over what timescale to ensure this.

2.4 Individual reviews are a key stage in the continuing process of assessment and care and support planning – the point at which particular time and care is taken with a person to reflect upon their needs, their support and care systems and the effectiveness of these in meeting the outcomes they want to achieve. The review function also has a broader quality and monitoring purpose which should inform local assurance processes and drive commissioning intentions. The Winterbourne Reviews are a critical part of developing and putting in place the fundamental commissioning

and service changes that are required for individuals now and for the future to stop the incarceration of people in these types of placements.

2.5 The next document to be published soon will set out a similar set of principles and approach to the development of Joint Plans and will be followed up with other improvement development and assurance approaches to support changes.

This document is for all those who are involved in the reviews to make sure they are conducted with real and meaningful engagement of people, their family carers and/ or advocates. Drawing together all individual agencies in joint actions so that sustainable changes are made.

3. Why the reviews are important

3.1 Reviews have been the corner stone of health and social care practice for many years. At best, they ensure that through a thorough process the best possible outcomes with people are achieved. But at worst, they are a tick box exercise that fails to engage with people or their family carers. In the case of Winterbourne View the serious case review concluded that "Reviews …were ineffective and did not bring to light either concerns about the quality of assessment and treatment or detail of abusive practices…the CPA did not include wider quality and performance monitoring of the service."

3.2 The reviews that are now required are vital for two reasons. The first is for individuals and their family carers to be comprehensively supported in evaluating and deciding on their future options the support they need to achieve this. Second, if the commissioning and provision of services is to really change then the aggregation and analysis of review findings in a locality or area will be a fundamental building block for developing the joint plans for their area.

3.3 The review activity has many facets, including: understanding need, assessment and care planning. This must be both clinically and functionality based, carefully balancing need, choice, risk (safety) and capacity. The firm outcome must be that the individuals needs must be both fully understood and the plan must be as specific as possible about the pattern of provision and support to achieve what is required of those involved.

3.4 Reviews must be more than a single meeting. They should be an on-going dialogue and process which culminates in a more intense activity over a shorter period where individuals and their family carers are supported to express their hopes, aspirations, fears and concerns in a way that works for them. They must be at the centre of the review. Communication – the quality of the conversations that take place – need to be supported with both time and expertise and there should be a presumption of the need for and use of effective advocacy throughout the review process. Equally the workers who know individuals should assemble material, offer time to share it and then openly assess the options in honest, frank and supportive ways.

3.5 Reviews must be conducted in a way that is best for individuals and their family carers in their particular settings, ultimately those in local arrangements should know best.

However, there are some key elements that will help to achieve consistency in all reviews which may help.

Many reviews are very good. This is a reminder of what may help to make every review valuable.

Reviews should be based on:

- **Effective and appropriate communication**
- **Understanding need**
- **Assessment**
- **Care and support planning**
- **The careful balance of need, choice, risk and capacity**

The core components are:

- **Preparation**
- **Honesty and openness**
- **Individuals should properly supported and represented**
- **At the end everyone understanding what's going to happen next and this being confirmed in a way that everyone can understand.**

4. Key Principles

4.1 The first and primary principle is that people with learning disabilities, autism and/ or behaviour that challenges have the same rights as everyone else. Processes put in place for assessment, care planning and review must ensure that people are able to exercise their rights effectively and that circumstances that might make this difficult are recognised and supported.

4.2 To ensure that this happens, reviews must be conducted with the people concerned, their family carers and be based on a joint approach between health and social care. This will mean that future plans for individuals are understood and shared. It will also provide a coherent basis for joint commissioning and integrated planning for the future.

A review must have these points at its fingertips and this will underpin the review and planning:

- **A full understanding of the person's history and how they came to be labelled as challenging in terms of how services have failed to support them in the past.**
- **Have a mindset that the aim is not to treat the behaviour but rather to understand the causes and triggers of the behaviour that challenges services and put in place supports that will reduce or remove those as far**

as possible.

- **Have a desire to put in place as least restrictive service as is possible while being safe.**

- **Why is this person in hospital and how long do they need to stay, and why.**

4.3 Local commissioners and providers should work together to develop advocacy services. They should have in place approaches to assure themselves that organisations or individuals performing this service have sufficient experience, training and expertise.

4.4 Here are some other key principles that should be the hallmark of every review.

- **Person Centred:**

The individual and their needs are central to the review. It starts and concludes with them

- **Joint Engagement:**
  Reviews will be developed and conducted on a joint basis (health and social care)

- **Advocacy:**
  People must be offered independent advocacy services or appropriate others who can represent their views.

- **Family Carers:**
  Family Carers will receive support and information in their own right to ensure they can contribute fully and appropriately to reviews.

- **Reports:**
  All reports by workers or other professionals will be openly shared in a way that is understandable by individuals and their family carers.

  Some individuals may be subject to mental health or other requirements while reviews must be conducted in accordance with those requirements that should not detract from the key principles set out here.

  Accessible/Easy Read versions will be produced.

- **Responsibility:**
  What will happen after the review (who will do what and when) must be made clear at the review.

- **How it Happens:**
  Reviews must not be a one off event but an integral part of the ongoing engagement and involvement with this person and their family carer.

While reviews are about the individual, commissioners must have ways to assure themselves of the quality and effectiveness of the reviews they are responsible for and of the commissioning decisions they inform.

5. Support for Reviews

5.1 It is recognised that the need to conduct all the reviews will place extra work on many people. This should not impact on the quality or the importance of reviews but there is a tight timetable to meet agreed deadlines.

5.2 Working together with regions and localities it is very important to understand progress, analyse outcomes and support future planning. This must draw on existing information and data form a range of sources which can then be used nationally, regionally and locally to drive change.

5.3 Over coming weeks the programme will work with you on ways to draw existing information together to achieve these outcomes as a minimum it it of course expected that commissioners will already have a good deal of information which formed the basis of the original commissioning decision. This will form the basis of the next piece of work.

- **Sharing good practice and developing "what good looks like" material**
- **Direct support to engage with advocacy organisations (for all concerned)**
- **Work with commissioners across both health and social care to ensure joint engagement**
- **Help areas to analyse and use information effectively from reviews to develop joint plans for the future**
- **Individual advice where required**
- **Bespoke Support to localities and regions**

6. Review of former Winterbourne View residents

6.1 While all the above applies to those who were previously placed in Winterbourne View there is a particular need to ensure that these reviews are conducted carefully, sensitively and with a real understanding of the trauma and anxiety that many may be carrying from that experience. While specific to those who lived at Winterbourne there may well be other situations in which this sensitivity should be exercised.

6.2 The improvement programme team will give particular attention to working with this group to ensure the best possible engagement and outcomes.

6.3 This group of individuals and their family carers must be given opportunities to share their experiences of the reviews to shape good practice in the future.

6.4 The Improvement Team will pay particular attention to the process and outcomes of these reviews.

The people who lived at Winterbourne View and their family carers must have specific support for their reviews, and their effectiveness will be assessed.

7. The strategic impact – providing assurances and ensuring action

7.1 This first set of reviews provides a unique opportunity to set the building blocks for developing and changing services forever. It is essential both for the people concerned and for future planning that standards are set high and achieved. Ultimately Health and Wellbeing Boards (HWBB) should develop ways to assure themselves that:

(i) reviews are conducted appropriately

(ii) that the outcomes from the reviews are being used as a key element to inform service re-design and commissioning priorities

(iii) The HWBB should also ensure that service redesign is being driven by a detailed understanding of these reviews and also of all the factors that have led to these type of placements. Including, projections of future need and how this will be met.

7.2 To ensure future safe and appropriate care, the development of new services models and approaches must to be directly relevant to people's needs, as evidenced by these reviews, take account of the wishes of family carers and be designed to support people in all facets of their life and behaviour.

7.3 Some changes will take time but the evidence and the information that needs to drive change comes from what we already know and understand and from the analysis of these reviews. This will change commissioners understanding and thinking. It will also be a positive challenge to providers.

7.4 Localities must work together to develop viable and sustainable services. Some traditional boundaries will be challenged. The new health and wellbeing priority is the right vehicle to achieve this engagement as this is best done locally, taking full account of other learning disability services and needs that should already be identified through joint strategic needs assessments (JSNA), market position statements and commissioning intentions. Localities that have a number of placements would be expected to look at common elements including collating severity of learning disability/support needs, nature/severity of mental health

needs/challenging behaviour and alignment with the developing market development statement.

7.5 Elected representatives, Local HealthWatch, Clinical Commissioning Group leaders and all other senior officers will want to assure themselves that individual reviews have been conducted in a timely and effective way, and that the results of these are informing their priorities through the Health and WellBeing Board.

7.6 The improvement team will work with you to make the best possible use of opportunities, whilst supporting the whole sector in its improvement activity and how it demonstrates its public accountability. Over the next few weeks development and use of the joint plan will form the basis of a similar document and improvement opportunities.

Reviews are about people but if things are really going to change then what is learned from reviews must be used to make a difference. This is important for:

- **Making sure commissioners see the big picture of overall need.**
- **Getting providers to develop new ways of working, including involving people and families in designing and developing services.**
- **Using the Health and WellBeing Boards to challenge and change what is happening now.**
- **Build a basis of information for the development of future services.**

If you have any queries about this document or the Joint Improvement Programme itself, please contact Chris.Bull@local.gov.uk

12th March 2013

Appendix 1

There are many publications that can support the reviews. This is a list of some of them.

Final Report and Concordat at
http://www.dh.gov.uk/health/2012/12/final-winterbourne/

Winterbourne View Review good practice examples
https://www.wp.dh.gov.uk/publications/files/2012/12/good-practice-examples.pdf

Mansell Report – Services for people with learning disabilities and challenging behaviour or mental health needs (rev) 2007
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_080129

Challenging Behaviour: a unified approach
http://www.rcpsych.ac.uk/files/pdfversion/cr144.pdf

SCIE at a glance guides
http://www.scie.org.uk/publications/ataglance/

Personalisation and Mental Capacity
http://www.scie.org.uk/publications/ataglance/ataglance33.asp

Challenging behaviour – getting support for adults
http://www.scie.org.uk/publications/ataglance/ataglance37.asp

Challenging Behaviour – support for children
http://www.scie.org.uk/publications/ataglance/ataglance38.asp

Challenging behaviour – support for teenagers
http://www.scie.org.uk/publications/ataglance/ataglance39.asp

Challenging behaviour foundation
http://www.challengingbehaviour.org.uk/

http://www.challengingbehaviour.org.uk/learning-disability-files/Pamphlet-for-Commissioners_Adult.pdf

The aim of this programme will be to work with local areas and influence national policy, to support local areas to provide swift and sustainable action across the system and across people's life course. Local partners will need to ensure that the services that are commissioned from childhood onwards are personalised, safe and local. This should result both in a movement away from the use of long stay, large-scale hospital services and also lead to real and rapid change in the attitudes and culture around care.

Winterbourne View Improvement Programme Board Membership

NAME	**ORGANISATION**
Chris Bull	Chair
TBC	Department for Education
Bruce Calderwood	DH
Alan Rosenbach	CQC
Dr Katie Armstrong	CCGs
Andrea Pope-Smith	ADASS
TBC	ADCS
Beverly Dawkins	Challenging Behaviour National Strategy Group
Sally Burlington	LGA
Gavin Harding Karen Flood	National Forum representatives
Juliet Beal	NHSCB
Ivan Ellul	NHSCB
Martin McShane	NHSCB
Julian Hartley	NHS Improvement
Viv Cooper	National Valuing Families Forum
Professor Tony Holland	University of Cambridge
Professor Gyles Glover	University of Durham
Professor Eric Emerson	University of Lancaster
Dave Williams	Salford Council
Geoff Baines	SHA learning Disability leads
Tony Hunter	SOLACE

The Improvement Team:

Chris Bull	NHS CB
Sam Cramond	NHS CB
Emma Jenkins Sarah Brown	LGA
Ian Winter	DH

It is not the intention to create a large organisation but rather to support and engage with existing regional and local resources to achieve change.

Appendix 3

Extract from Executive Summary of "Transforming care: A national response to Winterbourne View Hospital" the Department of Health Review: Final Report

Page 9, paragraph 13:

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

- all current placements will be reviewed by 1 June 2013, and everyone inappropriately in hospital will move to community-based support as quickly as possible, and no later than 1 June 2014;

- by April 2014 each area will have a locally agreed joint plan to ensure high quality care and support services for all children, young people and adults with learning disabilities or autism and mental health conditions or behaviour described as challenging, in line with the model of good care set out at Annex A [of the Department of Health Review: Final Report]

- as a consequence, there will be a dramatic reduction in hospital placements for this group of people and the closure of large hospitals;

- a new NHS and local government-led joint improvement team, with funding from the Department of Health, will be created to lead and support this transformation;

- we will strengthen accountability of Boards of Directors and Managers for the safety and quality of care which their organisations provide, setting out proposals during Spring 2013 to close this gap;

- CQC will strengthen inspections and regulation of hospitals and care homes for this group of people. This will include unannounced inspections involving people who use services and their families, and steps to ensure that services are in line with the agreed model of care; and

- with the improvement team we will monitor and report on progress nationally."

Appendix 4

Letter to Regions from Ian Dalton CBE, Chief Operating Director and Deputy Chief Executive, 24th January 2013

Letter to Regional Directors re Winterbo