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TRAFFORD COUNCIL

# AGENDA PAPERS MARKED 'TO FOLLOW'

## HEALTH AND WELLBEING BOARD

**Date: Thursday, 6 June 2013**

**Time: 6.30 p.m.**

**Place: Committee Room 2 and 3, Trafford Town Hall, Talbot Road, Stretford M32 0TH**

| | **A G E N D A** | **PART I** | **Pages** |
|---|---|---|---|
| 4. | **TRAFFORD'S INTEGRATED CARE PLAN** | | To Follow |
| | To receive a report and presentation from Gina Lawrence, Director of Commissioning and Operations, Trafford Clinical Commissioning Group. | | |
| 5. | **JOINT HEALTH AND WELLBEING STRATEGY UPDATE** | | To Follow |
| | To receive a report from Abdul Razzaq, Joint Director of Public Health. | | |
| 7. | **PROPOSED CHANGES TO HEALTH AND WELLBEING MEMBERSHIP** | | 1 - 6 |
| | To receive a report from the Chairman, Councillor Dr. Barclay. | | |
| 8. | **DELIVERY OF THE WINTERBOURNE REVIEW AND CONCORDAT** | | 7 - 106 |
| | To receive a report and presentation from Gina Lawrence, Director of Commissioning and Operations, Trafford Clinical Commissioning Group. | | |

**THERESA GRANT**
Chief Executive

Membership of the Committee

Councillor Dr. K. Barclay (Chairman), Dr. N. Guest (Vice-Chairman), Councillor J. Baugh, Councillor Miss L. Blackburn, D. Brownlee, A. Day, G. Lawrence, A. Razzaq, Councillor M. Young and T. Atherton

Further Information
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This agenda was issued on 30.5.13 by the Legal and Democratic Services Section, Trafford Council, Trafford Town Hall, Talbot Road, Stretford, M32 0TH.

**TRAFFORD COUNCIL**

**Report to:** **Health and Well Being Board**
**Date:** **28th May 2013**
**Report for:** **Decision**
**Report of:** **Executive Member for Community Health and Wellbeing**

**Report Title**

**Health and Wellbeing Board – Membership Update**

**Summary**

The Health and Well Being Board development and sub governance sessions in March, April and May 2013 have highlighted that the following areas of work are central to the work of the Board:

- Ensure the effective delivery of the integrated care plans;
- System reform and integrated care redesign of health and social care services.

The Health and Well Being Board sub group proposed that the main providers from the NHS and voluntary/third sector should be invited onto the board as they would be crucial partners in bringing about the system reform and improvement in the next few years.

**Recommendation**

1. Agree to the proposed change in Health and Well Being Board membership to include the identified five provider organisations as recommended by the sub governance group.

Contact person for access to background papers and further information:

Name: Imran Khan, (Partnerships Officer). Ext. 1361.

## Health and Well Being Board – Membership Update

### 1. Functions of Health and Well Being Board

The Health and Social Care Act 2012 gives health and wellbeing boards specific functions. These are a statutory minimum and further functions can be given to the boards in line with local circumstances. The statutory functions are:

- To prepare Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWSs), which is a duty of local authorities and clinical commissioning groups (CCGs).
- A duty to encourage integrated working between health and social care commissioners, including providing advice, assistance or other support to encourage arrangements under section 75 of the National Health Service Act 2006 (ie lead commissioning, pooled budgets and/or integrated provision) in connection with the provision of health and social care services.
- A power to encourage close working between commissioners of health-related services and the board itself.
- A power to encourage close working between commissioners of health-related services (such as housing and many other local government services) and commissioners of health and social care services.

- Any other functions that may be delegated by the council under section 196(2) of the Health and Social Care Act 2012. For example, this could include certain public health functions and/or functions relating to the joint commissioning of services and the operation of pooled budgets between the NHS and the council. Such delegated functions need not be confined to public health and social care. Where appropriate, they could also, for example, include housing, planning, work on deprivation and poverty, leisure and cultural services, all of which have an impact on health, wellbeing and health inequalities.

### 2. Regulations relating to Health & Well Being Boards: Statutory Instrument 2013 No. 218

The regulations relating to health and wellbeing boards have been published as Statutory Instrument 2013 No. 218 entitled, The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 http://www.legislation.gov.uk/uksi/2013/218/ contents/made

The regulations modify certain legislation as it applies to health and wellbeing boards and disapply certain legislation in relation to the boards. The provisions which are modified or disapplied are in the Local Government Act 1972 and the Local Government and Housing Act 1989.

Under section 194 of the Health and Social Care Act 2012, a health and wellbeing board is a committee of the council which established it and for the purposes of any enactment is to be treated as if appointed under section 102 of the Local Government Act 1972. It is therefore a 'section 102 committee', as it is sometimes called within local government. However, the regulations modify and disapply certain provisions of section 102 and other sections of the Local Government Act 1972 and also provisions of the Local Government and Housing Act 1989 in relation to health and wellbeing boards.

This means that it is best not to think of health and wellbeing boards according to the strict model of other section 102 committees, but to think of them as a basic section 102 committee with some differences. The sections below discuss the characteristics shared by health and wellbeing boards with other council committees and where they do or may diverge under the new regulations.

The modifications and disapplications which apply to health and wellbeing boards within the regulations generally also apply to subcommittees and joint sub-committees of boards.

## 3. Membership of Health & Well Being Boards

The Health and Social Care Act 2012 indicates that health and wellbeing boards are different to other section 102 committees, in particular in relation to the appointment of members. Specifically, the Act:

- sets a core membership that health and wellbeing boards must include:
    - at least one councillor from the relevant council
    - the director of adult social services
    - the director of children's services
    - the director of public health
    - a representative of the local Healthwatch organisation (which will come into being on a statutory footing on 1 April 2013)
    - a representative of each relevant clinical commissioning group (CCG)
    - any other members considered appropriate by the council

- requires that the councillor membership is nominated by the executive leader or elected mayor (in councils operating executive arrangements) or by the council (where executive arrangements are not in operation) with powers for the mayor/ leader to be a member of the board in addition to or instead of nominating another councillor.

- under the regulations (Regulation 7) modifies sections 15 to 16 and Schedule 1 of the Local Government and Housing Act 1989 to disapply the political proportionality requirements for section 102 committees in respect of health and wellbeing boards – this means that councils can decide the approach to councillor membership of health and wellbeing boards.

- requires that the CCG and local Healthwatch organisation appoint persons to represent them on the board.
- enables the council to include other members as it thinks appropriate but requires the authority to consult the health and wellbeing board if doing so any time after a board is established.
- the NHS Commissioning Board must appoint a representative for the purpose of participating in the preparation of JSNAs and the development of JHWSs and to join the health and wellbeing board when it is considering a matter relating to the exercise, or proposed exercise, of the NHS Commissioning Board's commissioning functions in relation to the area and it is requested to do so by the board.

The Shadow Health and Wellbeing board opted for a small membership in line with the guidelines set out by the Department of Health. The membership of the board during 2012/13 was as follows:

- Executive Member for Community Health and Wellbeing
- Executive Member for Adult Social Services
- Executive Member for Supporting Children and Families
- Shadow Executive Member for Community Health and Wellbeing
- Non Executive Member GM Cluster Board
- Corporate Director of Communities and Wellbeing
- Corporate Director of Children and Young People
- Director of Public Health
- Chair of Pathfinder Clinical Commissioning Group
- Nominated Director Pathfinder Clinical Commissioning Group
- Pathfinder Clinical Commissioning Group Lay Member
- Chair of LINk until such time that it becomes Health Watch

The Executive Member for Community Health and Wellbeing is the Chair of the Board and the Chief Clinical Officer, Trafford Clinical Commissioning Group is the nominated vice chair.

## 4. Priorities of the Health & Well Being Board

The Health and Well Being Board development and sub governance sessions in March, April and May 2013 have highlighted that the following areas of work are central to the work of the Board:

- Ensure the effective delivery of the integrated care plans;
- System reform and integrated care redesign of health and social care services.

## 5. Proposed New Health and Well Being Board Membership

Following recent Health and Well Being Board development sessions and feedback from the Health and Well Being sub governance task and finish group it is now proposed to amend the membership of the Board to the following:

- Executive Member for Community Health and Wellbeing
- Executive Member for Adult Social Services
- Executive Member for Supporting Children and Families
- Shadow Executive Member for Community Health and Wellbeing
- NHS England representative
- Corporate Director of Children, Families and Well Being
- Director of Public Health
- Chief Clinical Officer Trafford Clinical Commissioning Group
- Nominated Director Trafford Clinical Commissioning Group
- Chair of Health Watch

The Health and Well Being Board sub group proposed that the main providers from the NHS and voluntary/third sector should be invited onto the board as they would be crucial partners in bringing about the system reform and improvement in the next few years. In order to meet the Health and Well Being Board identified priorities and objectives for integrated care and system reform it is proposed that the following provider organisations would also become members of the Health and Well Being Board.

- Central Manchester University Hospital NHS Foundation Trust
- University Hospital South Manchester NHS Foundation Trust
- Pennine Care NHS Foundation Trust
- Greater Manchester West Mental Health NHS Foundation Trust
- A representative from the Trafford voluntary/third sector

The providers have been contacted and have agreed to provide a senior level strategic Director to attend the Trafford Health and Well Being Board.

Other provider organisations such as Trafford Housing Trust, Trafford Leisure Trust and Care Providers are represented on the Trafford Partnership or existing Provider Forums and the Board will seek their continued involvement and engagement through existing governance arrangements.

A joint workshop is planned for July 2013 where the Health and Well Being Board, Strong Communities Board, Safer Trafford and Children's Trust Board would meet to share their priorities and discuss areas of further collaboration.

## 6. Recommendation

The Health and Well Being Board is asked to:

- Agree to the proposed change in Health and Well Being Board membership to include the identified five provider organisations as recommended by the sub governance group.

**TRAFFORD COUNCIL**

**Report to:** **Health & Well Being Board**
**Date:** **28th May 2013**
**Report for:** **Information**
**Report of:** **Executive Member for Community Health and Wellbeing**

**Report Title**

Update on Trafford Response to the Winterbourne View Concordat and Review Recommendations

**Summary**

A recent communication by the Minister of State for Care and Support, Norman Lamb MP urged Health and Well Being Boards to seek a progress and assurance report on the Winterbourne View Concordat and review recommendations.

This report provides an update on the current action plans in place with respect to the actions required by CCGs and Local Authorities with regard to the recommendations from the DH Report into Winterbourne View, and nationally defined priorities noted in the NHS Mandate and Everyone Counts planning guidance.

This update makes use of the feedback from discussions with the Trafford LD Partnership Board and Safeguarding Board, and joint action plans agreed through the Health and Well Being Board. This work is in line with outcome of externally validated reviews of current performance in the key areas to meet the defined responsibilities in relation to commissioning high quality sustainable mental health and learning disability services. This includes reference to actions necessary to ensure safe, sound and supportive services to vulnerable people and their carers, at a time when transformational local and city-region wide change is being effected across health and social care systems.

As such it is important to note that the Trafford approach to commissioning specialist health services has been identified as an exemplar for the national programme concerned with establishing best practice service specifications and improvement plans.

Further work is continuing to agree longer-term CCG collaborative and shared programmes to meet the identified local and national priorities in line with the planned agreement for the Association of Greater Manchester CCGs. Support has been continuing through the reconfigured Mental Health Network and Cluster Mental Health/LD Leads to those localities and work streams identified as needing additional specialist input through active dialogue with local CCG leads.

Continued support is requested for this work and approach to collaborative commissioning across Trafford and Greater Manchester, as well as the specific feedback to be provided to both the SHA and NCB LAT with regards to progress in meeting the required actions to prevent a repetition of the events at Winterbourne View, and more effective local responses to challenging behaviour.

Currently the CCG and Council are reviewing the progress to meet the national target for completion of a comprehensive refreshed local challenging behaviour support plan and check all individual reports completed/reviewed for the small number of people in WV-type placements as required by end May 2013.

**Recommendations**

1. The HWB receives the progress update on the Winterbourne View Concordat and review report recommendations.

Contact person for access to background papers and further information:

Name: Imran Khan, (Partnerships Officer). Ext. 1361.

Sandy Bering - Lead Commissioner / Consultant, Trafford CCG
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## Update on Trafford Response to the Winterbourne View Concordat and Review Recommendations

### 1 Background

The NHS Mandate and Everyone Counts planning guidance for the NHS makes clear that it wants to ensure people with mental health and learning disabilities benefit in relation to the defined key NHS Outcomes. Specifically:

- The NHS is being asked to reduce the number of early deaths from those illnesses that can be prevented through better early diagnosis and treatment, such as cancer and heart disease, so that more people can enjoy a long and healthy old age. Too many people die too soon from illnesses that can be prevented or treated, and there are persistent inequalities in life expectancy and healthy life expectancy between communities. One specific group recognized as requiring particular attention are people with learning disabilities, in line with the results of the Confidential Inquiry into Premature Deaths of people with learning disabilities. This includes:
    - earlier diagnosis of illness
    - ensuring that everyone has the same access to the best available care
    - reducing unjustified variation in avoidable mortality
    - focusing on preventing illness, with staff using every contact they have with people as an opportunity to help people stay in good health.

- The NHS will make sure people experience better care, not just better treatment, so that everyone can expect to be treated with compassion, dignity and respect whenever they come into contact with the NHS. Quality of care is as important as quality of treatment

- No one going in to hospital should have to worry about being left in pain, unable to eat or drink, or go to the toilet. And those who have relatives or friends who need support should have peace of mind that they will be treated with compassion, respect and dignity – whether in hospitals, at home or in residential care.
    - In incidents of major failings in care, it is frequently older and vulnerable people and those with complex conditions who bear the brunt – people who are less likely or less able to complain. This is at the heart of the Winterbourne View Review and Concordat recommendations

- The NHS Commissioning Board is being asked to do a range of things to help improve people's experience of care. This includes:
    - making rapid progress in measuring and understanding how people really feel about the care they receive and taking action to address poor performance
    - asking people whether they would recommend their place of treatment to a family member or friend
    - ensuring timely access to services by upholding the rights and commitments set out in the NHS Constitution

- The NHS will provide safe care, so that everyone is treated in a clean and safe environment and people are at a lower risk of avoidable health problems

The key pertinent objectives and outcome indicators agreed to judge CCG progress include:

- Higher standards and reduced extent of harm or death caused or contributed to by NHS (e.g. LD Health Self Assessment Framework and Winterbourne View action plans)

The government published its final report into the events at Winterbourne View at the end of 2012. The report sets out a programme of action to transform services so that vulnerable people no longer live inappropriately in hospitals and are cared for in line with best practice. This brief update report and

attachments with respect to the agreed local action plans in line with this agenda, and to inform the QIPP service delivery challenges and local commissioning plans.

## 2 The Winterborne View Review and Report

### Summary of Programme

| Completion Date | Action |
|---|---|
| Spring 2013 | the department will set out proposals to strengthen accountability of boards of directors and senior managers for the safety and quality of care which their organisations provide |
| June 2013 | all current placements will be reviewed, everyone in hospital inappropriately will move to community-based support as quickly as possible, and no later than June 2014 |
| April 2014 | each area will have a joint plan to ensure high quality care and support services for all people with learning disabilities or autism and mental health conditions or behaviour described as challenging, in line with best practice |

As a consequence of the programme it is anticipated that there will be a dramatic reduction in hospital placements for people with learning disabilities, mental health and autistic spectrum conditions.

The Care Quality Commission will strengthen inspections and regulation of hospitals and care homes for this group of people, including unannounced inspections involving people who use services and their families.

A new NHS and local government-led joint improvement team will be created to lead and support this transformation in line with identified best commissioning practice and principles


Concordat.pdf


easy-read-of-final-report.pdf


Facing_the_Commissioning_Challenge_-_C

This programme is backed by a concordat signed by more than 50 partners, setting out what changes they will deliver and by when. The government will publish a progress report on these actions by December 2013.

### The Report

The final report into the events at Winterbourne View Hospital states that staff routinely mistreated and abused patients, and management allowed a culture of abuse to flourish. The warning signs were not picked up, and concerns raised by a whistleblower went unheeded.

The report also reveals weaknesses in the system's ability to hold the leaders of care organisations to account. In addition, it finds that many people are in hospital who don't need to be. People with learning disabilities or autism, who also have mental health conditions or challenging behaviour can be, and have a right to be, given the support and care they need in the community, near to family and friends.

The aim of the review was to:

- Look into what happened at Winterbourne View hospital so that lessons can be learned
- Look into how people with challenging behaviour are supported all over England

- As part of the review, Department of Health officials looked at reports/evidence from other reviews
- They looked at what reports and evidence the Department of Health looked at?
- They looked at evidence from the criminal proceedings.
- They looked the Castlebeck Ltd report

The CQC inspected 150 hospitals and care homes that provide services for people with learning disabilities.

The NHS report looked into how people from Winterbourne View hospital came to be placed there.

There was a Serious Case Review by South Gloucestershire Council.

The review gave a detailed picture of what happened at Winterbourne View hospital.
Department of Health officials also spoke to different people to hear their views about how people with challenging behaviour are supported all over England. These people included:

- People with learning disabilities
- People with autism
- Families of people with learning disabilities/autism
- Commissioners
- Providers
- Workers

In June 2012, the Department of Health published an interim report. In the interim report it was explained that information about what happened at Winterbourne View hospital couldn't be discussed until after the criminal proceedings.

The 11 members of staff who abused patients at Winterbourne View have been sentenced for the criminal acts.

The final report builds on the evidence set out in the interim report. As the criminal proceedings are now over, the final report can set out findings. The report sets out:

- The facts about Winterbourne View
- What happened to people who were at Winterbourne View
- What needs to be changed in the system
- Learn lessons for the future
- What the Government needs to do

**About Winterbourne View**

Winterbourne View hospital was a private hospital. It was owned by Castlebeck Care Limited and was opened in December 2006.

The hospital was registered to provide assessment and treatment and rehabilitation for people with learning disabilities.

The hospital had enough beds for 24 patients with learning disabilities. Most of the patients in Winterbourne had been placed at the hospital under the Mental Health Act.

A total of 48 patients were placed at Winterbourne. The patients in Winterbourne were placed there by different commissioners from all over England.

On average, it cost £3,500 per week to place a patient at Winterbourne View. Almost 50% of the patients at Winterbourne View were placed far away from their homes.

One of the main reasons individuals were placed in Winterbourne was to manage a crisis, the patients placed at Winterbourne were there for a very long time; some patients were there for more than 3 years.

This suggested a lack of local services to support people with challenging behaviour. Evidence gathered as part of the review demonstrated that it does not appear that there was much hurry to move patients on from Winterbourne.
The number of times patients were restrained by staff at Winterbourne was unacceptably high, for example - a family provided evidence that their son was restrained 45 times in 5 months.

The Serious Case Review provides evidence of poor quality care in Winterbourne View hospital, for example some people had poor dental health care.

The Serious Case Review found that for a lot of the time Winterbourne was open families were not allowed to visit patients on the ward or in their bedrooms. This made the abuse of patients even harder to spot.

The patients at Winterbourne View had very little access to advocacy; also patients' complaints were not handled properly.

The abuse of patients at Winterbourne View hospital should have been noticed earlier.

**Castlebeck Care Limited**

Castlebeck Care Limited had very good policies and procedures; however these were not put into practice. An example of this is in relation to the recruitment of staff, recruitment did not appear to focus on quality. The job descriptions of staff did not ask for staff to have experience in supporting people with learning disabilities/autism and challenging behaviour.

Evidence also suggests that staff training at Winterbourne was focused too much on the use of restraint.

**The Safeguarding Authority**

South Gloucestershire Council were told about safeguarding issues at Winterbourne but failed to identify a trend in the number of times they were contacted.

**The Commissioners**

Commissioners failed to ensure that the support they were purchasing was of a high quality and met people's needs.

**The Care Quality Commission**

A whistle-blower told the Care Quality Commission that he was worried about the way patients at Winterbourne View were being treated. The Care Quality Commission failed to respond to the concerns raised by the whistle-blower.

**The Mental Health Act Commission**

The Mental Health Act Commission were told about incidents at Winterbourne and said there was a need to improve but did not follow up to make sure improvements had happened.

**The Police**

29 incidents were reported to the police, of these, 8 incidents concerned staff using physical restraint on patients. The police didn't follow up the incidents because they believed the reasons given by staff at Winterbourne View.

## Trafford's Key Actions and Timescales

| Timescales | Action | Local Progress and Plans |
|---|---|---|
| Initiating in April 2013 | There should always be a presumption that services are local and people remain in their communities | Approximately 2-5 people are placed in hospitals, this information will be clarified by the CLDT and Health Commissioner as some are in secure services not subject to the Review .<br><br>A strategy will be produced which will support the operational team to move people back to their community. |
| Initiating in April 2013 | There will be a substantial reduction in reliance on inpatient care | In Trafford there is little reliance on in-patient services.<br><br>A system is in place for A&E staff to alert Adult Safeguarding of anyone going into hospital, individuals are flagged when entering the service and a liaison nurse is notified |
| Beginning of June 2013 | All current placements reviewed | CLDT Manager has been asked to confirm the total number of out of borough placements.<br><br>A programme will be devised to visit each placement over the next 3-4 months – including secure and non-inpatient services.<br><br>We will use the Formal Out Of Area Protocol and will approach commissioners in other authorities to ask them to share information in relation to our placements. |
| End of April 2014 | Each area will have locally agreed joint plan to ensure high quality care and support services for everyone with learning disability or autism and mental health conditions or behaviour described as challenging | Health and Care Commissioners will produce a locally agreed plan, endorsed by key stakeholders, which ensures high quality services |
| End of June 2014 | Transformational programme of action so people no longer live inappropriately in hospital | Commissioners will ask Operational Teams to produce a timetable of when individuals were last reviewed; a programme of reviews will then be produced based on this information.<br><br>Contact in these areas will be made via Health and Care Commissioners to ensure a more formal approach to moving individuals.<br><br>Trafford Council and NHS Trafford are much more proactive than other areas when working with providers and checking care is appropriate and of a high quality, this approach will be strengthened through a partnership approach and transformational strategy |

## 3 Progress Update

To date the Winterbourne View Concordat: Programme of Action requires the CCG to complete several key actions (all of which have now been confirmed by NHS Trafford). That is:

- Primary Care Trust/CCG to develop registers of all people with a learning disability or autism who have mental health conditions or behaviour that challenges in NHS funded care as soon as possible and certainly on later than 1 April 2013, handing over the registers to Clinical Commissioning Group's who will have responsibility for maintaining the local register from 1 April 2013 and confirming between the Clinical Commissioning Group and Local Authority the nominated lead commissioner.

    - Confirmation that arrangements are in place to ensure a register of all people with a learning disabilities or autism who have a mental health condition or behaviour that challenges in NHS funded care is available by 28 February 2013 in order to be handed to Clinical Commissioning Group's.

    - Name and contact details of the nominated lead within the Clinical Commissioning Group who will hold and maintain the register from 1 April 2013.

    - By 1 June 2013, working together with service provider, people who use services and families, review the care of all people in learning disability or autism inpatient beds to agree a personal care plan for each individual based on their and their families' needs and agreed outcomes, putting these plans into action as soon as possible so that all individuals receive personalised care and support in appropriate community settings no later than 1 June 2014.

    - Confirmation that a review has taken place since 1 November 2012 or is planned to take place by 31 May 2013 for all people in learning disability or autism inpatient beds identified on your register; The content of the review should include:

        - A personalised care plan;
        - Evidence of involving families and carers where appropriate;
        - A discharge plan;
        - A realistic estimated discharge date;
        - Highlighting whether the discharge is before or after June 2014;
        - An identified lead local commission;
        - Date of a comprehensive physical health check;
        - Identified appropriate and available independent advocacy to support the move on.

    - Confirmation of the number of people within local registers currently in learning disability or autism inpatient beds;

    - The number of people in learning disability or autism inpatient beds who have received an appropriate review between the 1 November 2012 and 28 February 2013;

    - The number of people in learning disability or autism inpatient units yet to be reviewed by 31 May 2013;

    - Confirmation that the capacity is in place to complete outstanding reviews by 31 May 2013.

## 6 Recommendations And Next Steps

The PCT/CCG is asked to note and confirm continued joint action to improve the life chances of local people with learning disabilities in Trafford, and their families/carers in line with national guidance, local needs assessment and best practice evidence/consultations with the LD Partnership Board and Safeguarding Board (e.g. to respond to the recognised health inequality outcomes, health service

assurance problems arising from the Winterbourne Review programme, and requirement to ensure through the New Health and Social Care Bill equity for Mental Health to that of Physical Health support).

## 7 Appendices

### Appendix One – Full Action Plan

| No. | Date | Action |
|---|---|---|
| 1. | From June 2012 | CQC will continue to make unannounced inspections of providers of learning disability and mental health services employing people who use services and families as vital members of the team. |
| 2. | From June 2012 | CQC will take tough enforcement action including prosecutions, restricting the provision of services, or closing providers down, where providers consistently fail to have a registered manager in place. |
| 3. | From June 2012 | CQC will take enforcement action against providers who do not operate effective processes to ensure they have sufficient numbers of properly trained staff. |
| 4. | From November 2012 | The cross-government Learning Disability Programme Board will measure progress against milestones, monitor risks to delivery and challenge external delivery partners to deliver to the action plan of all commitments. CQC, the NHSCB and the head of the LGA, ADASS, NHSCB development and improvement programme will, with other delivery partners, be members of the Programme Board, and report on progress. |
| 5. | From December 2012 | The Department of Health will work with the CQC to agree how best to raise awareness of and ensure compliance with Deprivation of Liberty Safeguards provisions to protect individuals and their human rights and will report by Spring 2014. |
| 6. | From December 2012 | The Department of Health will, together with CQC, consider what further action may be needed to check how providers record and monitor restraint. |
| 7. | From December 2012 | The Department of Health will work with independent advocacy organisations to identify the key factors to take account of in commissioning advocacy for people with learning disabilities in hospitals so that people in hospital get good access to information, advice and advocacy that supports their particular needs. |
| 8. | From December 2012 | The Department of Health will work with independent advocacy organisations to drive up the quality of independent advocacy, through strengthening the Action for Advocacy Quality Performance Mark and reviewing the Code of Practice for advocates to clarify their role. |
| 9. | From December 2012 | A specific workstream has been created by the police force to identify a process to trigger early identification of abuse. The lessons learnt from the work undertaken will be disseminated nationally. All associated learning from the review will be incorporated into training and practice, including Authorised Professional Practice. |
| 10. | From December 2012 | The College of Social Work, to produce key points guidance for social workers on good practice in working with people with learning disabilities who also have mental health conditions; |
| 11. | From December 2012 | The British Psychological Society, to provide leadership to promote training in, and appropriate implementation of, Positive Behavioural Support across the full range of care settings. |
| 12. | From December 2012 | The Royal College of Speech and Language Therapists, to produce good practice standards for commissioners and providers to promote reasonable adjustments required to meet the speech, language and communication needs of people with learning disabilities in specialist learning disability or autism hospital and residential settings. |

| | | |
|---|---|---|
| 13. | By end of December 2012 | The Local Government Association and NHS Commissioning Board will establish a joint improvement programme to provide leadership and support to the transformation of services locally. They will involve key partners including DH, ADASS, ADCS and CQC in this work, as well as people with challenging behaviour and their families. The programme will be operating within three months and Board and leadership arrangements will be in place by the end of December 2012. DH will provide funding to support this work. |
| 14. | By end December 2012 | By December 2012 the professional bodies that make up the Learning Disability Professional Senate will refresh *Challenging Behaviour: A Unified Approach* to support clinicians in community learning disability teams to deliver actions that provide better integrated services. |
| 15. | By January 2013 | Skills for Health and Skills for Care will develop national minimum training standards and a code of conduct for healthcare support workers and adult social care workers. These can be used as the basis for standards in the establishment of a voluntary register for healthcare support workers and adult social care workers in England. |
| 16. | By February 2013 | Skills for Care will develop a framework of guidance and support on commissioning workforce solutions to meet the needs of people with challenging behaviour |
| 17. | By March 2013 | The Department of Health will commission an audit of current 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. |
| 18. | By March 2013 | The NHSCB will work with ADASS to develop practical resources for commissioners of services for people with learning disabilities, including: □□model service specifications; □□new NHS contract schedules for specialist learning disability services; □□models for rewarding best practice through the NHS; commissioning for Quality and Innovation (CQUIN) framework; and □□a joint health and social care self-assessment framework to support local agencies to measure and benchmark progress. |
| 19. | By March 2013 | The NHSCB and ADASS will develop service specifications to support CCGs in commissioning specialist services for children, young people and adults with challenging behaviour built around the model of care in Annex A |
| 20. | By March 2013 | The Joint Commissioning Panel of the Royal College of General Practitioners and the Royal College of Psychiatrists will produce detailed guidance on commissioning services for people with learning disabilities who also have mental health conditions. |
| 21. | By March 2013 | The Royal College of Psychiatrists will issue guidance about the different types of inpatient services for people with learning disabilities and how they should most appropriately be used. |
| 22. | By 1 April 2013 | The NHSCB will ensure that all Primary Care Trust develop local registers of all people with challenging behaviour in NHS-funded care. |
| 23. | By 1 April 2013 | The Academy of Medical Royal Colleges and the bodies that make up the Learning Disability Professional Senate will develop core principles on a statement of ethics to reflect wider responsibilities in the health and care system. |
| 24. | By 1 April 2013 | The National Quality Board will set out how the new health system should operate to improve and maintain quality. |
| 25. | By 1 April 2013 | The Department of Health will work with key partners to agree how Quality of Life principles should be adopted in social care contracts to drive up standards. |
| 26. | From 1 April 2013 | The NHSCB will make clear to CCGs in their handover and legacy arrangements what is expected of them in maintaining local registers, and reviewing individual's care with the Local Authority, including identifying who should be the first point of contact for each individual. |
| 27. | From April 2013 | The NHSCB will hold CCGs to account for their progress in transforming the way they commission services for people with learning disabilities/autism and |

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|---|---|---|
| | | challenging behaviours. |
| 28. | From April 2013 | Health Education England will take on the duty for education and training across the health and care workforce and will work with the Department of Health, providers, clinical leaders and other partners to improve skills and capability to respond the needs of people with complex needs. |
| 29. | From April 2013 | CQC will take action to ensure the model of care is included as part of inspection and registration of relevant services from 2013. CQC will set out the new operation of its regulatory model, in response to consultation, in Spring 2013. |
| 30. | From April 2013 | CQC will share the information, data and details they have about providers with the relevant CCGs and local authorities. |
| 31. | From April 2013 | CQC will assess whether providers are delivering care consistent with the statement of purpose made at the time of registration. |
| 32. | From April 2013 | Monitor will consider in developing provider licence conditions, the inclusion of internal reporting requirements for the Boards of licensable provider services to strengthen the monitoring of outcomes and clinical governance arrangements at Board level. |
| 33. | From April 2013 | The strong presumption will be in favour of pooled budget arrangements with local commissioners offering justification where this is not done. The NHSCB, ADASS and ADCS will promote and facilitate joint commissioning arrangements. |
| 34. | From April 2013 | The NHSCB will ensure that CCGs work with local authorities to ensure that vulnerable people, particularly those with learning disabilities and autism receive safe, appropriate and high quality care. The presumption should always be for services to be local and that people remain in their communities. |
| 35. | From April 2013 | Health and care commissioners should use contracts to hold providers to account for the quality and safety of the services they provide. |
| 36. | From April 2013 | Directors, management and leaders of organisations providing NHS or local authority funded services to ensure that systems and processes are in place to provide assurance that essential requirements are being met and that they have governance systems in place to ensure they deliver high quality and appropriate care. |
| 37. | From April 2013 | The Department of Health, the Health and Social Care Information Centre and the NHSCB will develop measures and key performance indicators to support commissioners in monitoring their progress. |
| 38. | From April 2013 | The NHSCB and ADASS will implement a joint health and social care self-assessment framework to monitor progress of key health and social care inequalities from April 2013. The results of progress from local areas will be published. |
| 39. | From April 2013 | The Department of Health will work with the LGA and Healthwatch England to embed the importance of local Healthwatch involving people with learning disabilities and their families. A key way for local Healthwatch to benefit from the voice of people with learning disabilities and families is by engaging with existing local Learning Disability Partnership Boards. LINks (local involvement networks) and those preparing for Healthwatch can begin to build these relationships with their Boards in advance of local Healthwatch organisations starting up on 1 April 2013. |
| 40. | By Spring 2013 | The Department of Health will immediately examine how corporate bodies, their Boards of Directors and financiers can be held to account for the provision of poor care and harm, and set out proposals during Spring 2013 on strengthening the system where there are gaps. We will consider both regulatory sanctions available to CQC and criminal sanctions. We will determine whether CQC's current regulatory powers and its primary legislative powers need to be strengthened to hold Boards to account and will assess whether a fit and proper persons test could be introduced for board members. |
| 41. | From Spring 2013 | CQC will take steps now to strengthen the way it uses its existing powers to hold organisations to account for failures to provide quality care. It will report on |

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|---|---|---|
| | | changes to be made from Spring 2013. |
| 42. | By 1 June 2013 | Health and care commissioners, working with service providers, people who use services and families, will review the care of all people in learning disability or autism inpatient beds and agree a personal care plan for each individual based around their and their families' needs and agreed outcomes. |
| 43. | By Summer 2013 | Provider organisations will set out a pledge or code model based on shared principles - along the lines of the Think Local Act Personal (TLAP) Making it Real principles |
| 44. | By Summer 2013 | The Department of Health, with the National Valuing Families Forum, the National Forum of People with Learning Disabilities, ADASS, LGA and the NHS will identify and promote good practice for people with learning disabilities across health and social care. |
| 45. | By summer 2013 | The Department of Health will explore with the Royal College of Psychiatrists and others whether there is a need to commission an audit of use of medication for this group. As the first stage of this, we will commission a wider review of the prescribing of antipsychotic and antidepressant medicines for people with challenging behaviour. |
| 46. | By June 2013 | The Department of Health and the Department for Education will work with the independent experts on the Children and Young People's Health Outcomes Forum to prioritise improvement outcomes for children and young people with challenging behaviour and agree how best to support young people with complex needs in making the transition to adulthood. |
| 47. | In 2013 | The Department of Health and the Department for Education will develop and issue statutory guidance on children in long-term residential care. |
| 48. | In 2013 | The Department of Health and the Department for Education will jointly explore the issues and opportunities for children with learning disabilities whose behaviour is described as challenging through both the SEN and Disability reform programme and the work of the Children's Health Strategy. |
| 49. | In 2013 | The Department of Health will work with independent advocacy organisations to drive up the quality of independent advocacy. |
| 50. | In 2013 | The Department for Education will revise the statutory guidance *Working together to safeguard Children.* |
| 51. | In 2013 | The Royal College of Psychiatrists, the Royal Pharmaceutical Society and other professional leadership organisations will work with ADASS and ADCS to ensure medicines are used in a safe, appropriate and proportionate way and their use optimised in the treatment of children, young people and adults with challenging behaviour. This should include a focus on the safe and appropriate use of antipsychotic and antidepressant medicines. |
| 52. | By December 2013 | The Department of Health will work with the improvement team to monitor and report on progress nationally, including reporting comparative information on localities. We will publish a follow up report by December 2013. |
| 53. | By end 2013 | The Department of Health with external partners will publish guidance on best practice around positive behaviour support so that physical restraint is only ever used as a last resort where the safety of individuals would otherwise be at risk and never to punish or humiliate. |
| 54. | By end 2013 | There will be a progress report on actions to implement the recommendations in *Strengthening the Commitment* the report of the UK Modernising learning disability Nursing Review. |
| 55. | By end 2013 | CQC will also include reference to the model in their revised guidance about compliance. Their revised guidance abut compliance will be linked to the Department of Health timetable of review of the quality and safety regulations in 2013. However, they will specifically update providers about the proposed changes to our registration process about models of care for learning disability services in 2013. |

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|---|---|---|
| 56. | From 2014 | The Department of Health will work with the Department for Education to introduce a new single assessment process and Education, Health and Care Plan to replace the current system of statements and learning difficulty assessments for children and young people with special educational needs; supported by joint commissioning between local partners (subject to parliamentary approval). The process will include young people up to the age of 25, to ensure they are supported in making the transition to adulthood. |
| 57. | By April 2014 | CCGs and local authorities will set out a joint strategic plan to commission the range of local health, housing and care support services to meet the needs of people with challenging behaviour in their area. This could potentially be undertaken through the health and wellbeing board and could be considered as part of the local Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy (JHWS) processes. |
| 58. | No later than 1 June 2014 | Health and care commissioners should put plans into action as soon as possible and all individuals should be receiving personalised care and support in appropriate community settings no later than 1 June 2014. |
| 59. | In 2014 | The Department of Health will update the Mental Health Act Code of Practice and will take account of findings from this review. |
| 60. | By December 2014 | The Department of Health will publish a second annual report following up progress in delivering agreed actions. |
| 61. | From 2014/15 | The Department of Health will develop a new learning disability minimum data set to be collected through the Health and Social Care Information Centre. |
| 62. | By Summer 2015 | NICE will publish quality standards and clinical guidelines on challenging behaviour and learning disability. |
| 63. | By Summer 2016 | NICE will publish quality standards and clinical guidelines on mental health and learning disability. |

**Appendix Two: Winterbourne View Update - October 2012 Following Second Panorama Programme**

## Introduction

Winterbourne View was a private hospital for people with learning disabilities and challenging behaviour.

The hospital was run by Castlebeck, a private company, but it was funded by public money.

The hospital was not based in a community; instead it was on an industrial estate where there were no other houses.

In 2011 a BBC Panorama programme aired distressing coverage of the failings of the Castelbeck Service, Winterbourne View.

It uncovered violent and systematic institutional abuse of adults with learning disabilities through undercover filming over the course of 16 shifts.

The coverage also, perhaps more disturbingly, highlighted the shortcomings of the Care Quality Commission, and their failure to do something about it even though there had been three allegations of abuse from a senior nurse whistle-blower.

It was also concerning because CQC had failed to raise the issues highlighted by Panorama on any of their inspection visits to the service. This made people think that CQC's inspection visits were not very good.

In response to Castlebeck Trafford's Director of Commissioning called for a review which focused on the quality of learning disability services in Trafford.

The review meant that unannounced visits were undertaken on all services which looked to assure the Council, the individuals who use services and their families that institutional abuse and bad practice was not happening in Trafford.

The review was positive with no areas of major concerns noted. Following the review a robust quality monitoring process has been put in place by Trafford Council.

A year after the first programme aired, Panorama have revisited the story in October 2012.

## A Year On…

### Simon's Story

The programme followed the story of a man called Simon who lived at Winterbourne View.

He is only now telling his family about the terrible things which happened to him when he lived at Winterbourne View, these are things like being hit and restrained by the people who worked there, having his head put down the toilet and being put in a cold shower.

Simon lived in the community for 16 years but a change in his behaviour meant that the care home he lived at said that they needed additional staff to support him; they said they needed £600 more a week.

Wiltshire Council, who would need to pay for this extra support, asked doctors to assess Simon's behaviour, but instead of doing this at home, they wanted to do this at Hospital, the family were told that if they refused this then Simon would be sectioned and would be taken to hospital forcibly.

So after 16 years of living in a community based home Simon was moved to a number of secure hospitals where he was being physically restrained on a regular basis.

Simon had been away from his home for 9 months, he was living at Postern House - a hospital ran by a NHS Trust – he told an advocate that he had been hit by a staff member. The BBC had accessed records about 3 incidents which had happened there – one where he had been "frogmarched" with his arm behind back to his room – another incident he had been restrained inappropriately and a person had lay across his chest, and a third incident where he got a cut on the head – the family were only aware of one of these incidents.

Postern House investigated but did not involve the family or the advocate, a few days later Simon moved to Winterbourne View. 2 people were disciplined over one of these incidents.

Simon is now back where he wants to be, in the community a few miles from his mum, costing £1,400 a week less than Winterbourne, getting the care he wants, with his friends and family close to him.

### Simone's Story

Simone went to another hospital after Winterbourne – Postern House.

For the first few weeks she was very calm, however there were instances of restraint recorded, one day she was restrained on 12 separate occasions.

Simone's family received a letter from Wiltshire about a safeguarding concern, this was in relation to how she was supported by staff when she was upset and agitated, the family were given no further details but they were told that 4 members of staff had been suspended.

In a matter of weeks Simone was moved, this decision was taken following an attack on two members of staff, Simone was moved 400 miles away to another hospital – her family are unable to see her.

**What Happened After Winterbourne**

Change was promised – Winterbourne was closed and CQC inspected all similar establishments.

There was a Serious Care Review that looked at Winterbourne in detail, it concluded that

- Professional let people down
- Safeguarding let people down
- Police let people down
- Commissioners let people down

Even though all of these people missed things a lot of the responsibility lies with the provider, Castelbeck, as it promoted an unworkable management structure, and acknowledges that there was limited executive oversight. This means that the people who were in charge of making sure the service was good did not do their job.

The Serious Case Review said that is was not confident that those in charge of Castlebeck learnt any lessons

Castelbeck have said they changed their structure and invested over £8million pounds in a "turnaround programme"

Financially, Winterbourne was one of Castlebeck's best performing homes, with 24 beds it turned over £3.7million a year, with an average weekly fee of for patients of £3.5k

The judge who looked at the cases of the staff arrested in connection with Winterbourne said that Castlebeck was an organisation run with profit in mind with no regard for residents and staff.

Castlebeck deny that profit came before welfare – however the inquiry have found it hard to find out where public money was spent – when they asked for information about what was spent on things like activities or staff development they were told it was commercially sensitive information.

Following the closure of Castlebeck at least 19 of the 51 patients have had alerts raised about them, although this does not mean that they have come to harm. Just under half of the patients have been moved to another hospital.

This report has found that patients were left traumatised - because they were abused in places where we all should feel at their safest like our bedrooms – this is an appalling legacy

**What Trafford have learnt – what are we still learning?**

**Quality and Values**
It would be silly to say that it isn't possible for another Castlebeck to happen

We are doing all we can to recognise areas of good practice and to share these with other areas

We are doing all we can to challenge and stop bad practice under our safeguarding processes

We are giving people a voice when it comes to telling us about their services

Trafford continue to monitor its learning disability services to make sure that the culture of staff and services promote people's dignity, choice and independence

For all new services commissioned since Winterbourne we have asked specific questions about what people have learnt and changed as a result of what happened

**Physical Intervention**

There were 129 instances of physical restraint at Winterbourne reported to CQC in the first 3 months of 2011.

The Castlebeck training was done by an internal member of staff; there have been a number of criticisms of the advice given by the training officer.

Trafford Council monitor what training is accessed by providers and what the quality of this is through regular contact, Trafford also offer training to provider through Trafford's Training Consortium.

Trafford Council are revisiting the process it uses to ensure that Physical Intervention is only used as a final resort, and in these instances it is legal, the least invasive and individual to the person.

**The Future…**

It is felt nationally that the Government needs to do more than just give "guidance" the government is publishing it's finding's later in the year.

There is a term called "warehousing" which some professionals use to describe what happens when people are placed in hospitals. When it comes to Challenging Behaviour, hospitals, which should be the last resort, are used too frequently. This is not the case in Trafford.

It is reported that there has been an "out of sight, out of mind" mentality. This means that because people didn't see what was happening at Winterbourne, they didn't care. This is not the case in Trafford, we have a dedicated team ensuring that services are good quality and who support services who are struggling. People receive a face to face review once a year even if they are placed out of area.

For years it has been widely encouraged that people with learning disabilities live in the community – in Trafford we strongly believe this and will continue to ensure that people live where they are part of the community, contributing to it and being respected as citizens.

Winterbourne is a stark reminder of what can go wrong when commissioners and practitioners don't have good relationships with service providers; we have the strongest approach we have ever had in Trafford to make sure that we have good relationships with providers and to make sure that people are safe and well supported.

**Appendix Three: Trafford LD Partnership Board Summary Presentation and Feedback**


Winterbourne_for_L
DPB


Trafford LD
Partnership Board Sui

**Appendix Four: Greater Manchester LD Health Self Assessment Validation Ratings**


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Appendix 3(i)

# Transforming Care A National Response to Winterbourne View Hospital

## Department of Health Review Final Report

*Joanne Willmott, Sandy Bering and Jenny Holt*

*January 2013*

# Winterbourne: The Report

- The government published its final report into the events at Winterbourne View


- The report sets out a programme to change services so that vulnerable people no longer live inappropriately in hospitals and are cared for in line with best practice



# Winterbourne: The Report

- Staff routinely mistreated and abused patients, and management allowed a culture of abuse to flourish
- The warning signs were not picked up, and concerns raised by a whistleblower went unheeded



# Winterbourne: The Report

- Weaknesses in holding the leaders of care organisations to account.
- Many people living in hospital don't need to be.
- People with learning disabilities or autism have a right to be given the support and care they need in the community, near to family and friends.

# Winterbourne: The Report

- The aim of the review was to look into what happened at Winterbourne View hospital so that lessons can be learned
- The review looked at how people with challenging behaviour are supported all over England

# Winterbourne: Key Actions

| Timescales | Action | Local Progress and Plans |
|---|---|---|
| **Initiating in April 2013** | There should always be a presumption that services are local and people remain in their communities | Approximately 3-6 people are placed in hospitals, this information will be clarified by the CLDT and Health Commissioner.<br><br>A strategy will be produced which will support the operational team to move people back to their community. |
| **Initiating in April 2013** | There will be a substantial reduction in reliance on inpatient care | In Trafford there is little reliance on in-patient services.<br><br>A system is in place for A&E staff to alert Adult Safeguarding of anyone going into hospital, individuals are flagged when entering the service and a liaison nurse is notified |



# Winterbourne: Key Actions

| Timescales | Action | Local Progress and Plans |
|---|---|---|
| **Beginning of June 2013** | All current placements reviewed | CLDT Manager has been asked to confirm the number of out of borough placements. A programme will be devised to visit each placement over the next 3-4 months. We will use the Formal Out Of Area Protocol and will approach commissioners in other authorities to ask them to share information in relation to our placements. |



# Winterbourne: Key Actions

| Timescales | Action | Local Progress and Plans |
|---|---|---|
| **End of April 2014** | Each area will have locally agreed joint plan to ensure high quality care and support services for everyone with learning disability or autism and mental health conditions or behaviour described as challenging | Health and Care Commissioners will produce a locally agreed plan, endorsed by key stakeholders, which ensures high quality services |

# Winterbourne: Key Actions

| Timescales | Action | Local Progress and Plans |
|---|---|---|
| **End of June 2014** | Transformational programme of action so people no longer live inappropriately in hospital | Commissioners will ask Operational Teams to produce a timetable of when individuals were last reviewed; a programme of reviews will then be produced based on this information.<br><br>Contact in these areas will be made via Health and Care Commissioners to ensure a more formal approach to moving individuals.<br><br>Trafford Council and NHS Trafford are much more proactive than other areas when working with providers and checking care is appropriate and of a high quality, this approach will be strengthened through a partnership approach and transformational strategy |



# Winterbourne: Key Dates

| Completion Date | Action |
|---|---|
| **Spring 2013** | the department of health will set out proposals to strengthen accountability of boards of directors and senior managers for the safety and quality of care which their organisations provide |
| **June 2013** | all current placements will be reviewed, everyone in hospital inappropriately will move to community-based support as quickly as possible, and no later than June 2014 |
| **April 2014** | each area will have a joint plan to ensure high quality care and support services for all people with learning disabilities or autism and mental health conditions or behaviour described as challenging, in line with best practice |

**This programme is backed by a concordat signed by more than 50 partners, setting out what changes they will deliver and by when. The government will publish a progress report on these actions by December 2013**

# Winterbourne: Results

- There will be a big reduction in hospital placements for people with learning disabilities, mental health and autistic spectrum conditions.
- The Care Quality Commission will make their inspections of hospitals and care homes better, including unannounced inspections involving people who use services and their families.
- A new NHS and local government-led joint improvement team will be created to lead and support these actions

# Winterbourne: Discussion

- What changes do you want to see
- How can you be involved
- Why did this happen – how can we get people with the right values?

**Appendix 3(ii)**

## Trafford LD Partnership Board Summary Response to Winterbourne View Review

- Total numbers on complete list vary across localities – Trafford should include as part of this work all people presenting with severe challenging behaviours and/or placed out of area
- Numbers also vary regarding children's services actions – so need to agree a joint action plan with CYPS
- Remaining issues regarding the quality of local services
- Not all out-of-area placements are bad or wrong – this needs assessing and flexibility of options based on real personal choices
- Pressures for families increasing – so need practical support especially respite / day options for people with complex needs and targeted at older carers
- Need to build up confidence regarding accessing pragmatic solutions such as the Shawe road planned/crisis support services
- Advanced proactive reviews and checking to be prioritised – especially for vulnerable people in family homes as well as care/supported homes
- CQC inspections better checks now re issues and links with families – To sustain
- Honesty needed regarding safeguarding concerns
- Family involvement - not same as family control as sometimes conflict of interest with individual service users
- Some honesty regarding fact that some families can be part of the problem as well as the solution
- Honesty and practical help needed regarding good recruitment and training proposes
- LD provider frameworks – focus on culture that needs to be sustained by good role modelling not just paper specifications
- Trafford very good regarding sharing info eg complaints, CQC reviews, family feedback - so more eyes together with triangulating feedback
- This can be strengthened with commissioners increasing unannounced visits
- Some recent weak links identified by CQC - with respect to adequate district nurses teams feedback – needs review
- Referrals need to be managed and any grumblings better managed/responded to
- Issues regarding personal budgets / personalisation and possible unintended negative consequences
- Need specialist skilled non-ordinary services sometimes (eg nursing homes)
- Supporting staff essential as it is a hard job that difficult to keep going long-term
- Need technical competence and training (including IABA, MVA, autism, MH, physical health, etc) regarding better and more timely responses to CB by CLDT - to be reviewed with CWP
- Lots more values training +++ led by service users and families/carers – building on PCP - Training Team Consortium approaches
- Recognition of better more informed recent revised reports from CQC - a lot better re dignity and compassion including easy read options
- Better focus on good things that need to be strengthened/sustained ed as well as problems that need addressing
- Commissioners to pull together the action plans together and report back/review with the LD Partnership Board in June 2013

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**LD Health Self Assessment Framework**
**Validated Results – 2012/13**

**Appendix 4**

| Top Target / Key Objective | AWL | Bolton | Bury | HMR | Manchester | Oldham | Salford | Stockport | T&G | Trafford | GM G | GM A | GM R |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | G,A | G,G | A,G | G,A | G,G | A,R | G,G | A,A | G,G | G,G | 1 | 7 | 2 |
| 1.1 | G,A | G,G | G,G | G,G | G,G | G,R | G,G | G,A | G,G | G,G | 5 | 4 | 1 |
| 1.2 | G,A | G,G | G,G | G,G | G,G | G,R | G,G | G,G | G,G | G,G | 1 | 3 | 6 |
| 1.3 | G | G | A | G | G | A | G | R | G | G | X | X | X |
| 2 | A,A | R,A | A,A | A,A | A,A | A,A | A,G | A,A | A,A | A,A | 1 | 7 | 2 |
| 2.1 | R,A | R,A | A,R | A,G | A,R | R,R | R,G | R,R | R,R | A,R | 1 | 4 | 5 |
| 2.2 | A,A | A,A | A,G | A,G | A,A | A,A | G,G | A,A | A,A | A,A | 0 | 8 | 2 |
| 2.3 | R,A | R,R | A,R | A,G | A,R | A,R | G,G | A,A | R,R | A,R | 1 | 1 | 8 |
| 2.4 | A,G | G,G | G,G | A,G | G,G | A,R | G,G | A,A | G,G | A,G | 4 | 5 | 1 |
| 2.5 | A,A | A,A | A,G | A,G | A,A | A,A | A,A | A,A | G,G | A,A | 2 | 4 | 4 |
| 2.6 | G,A | A,A | A,A | A,A | A,A | A,A | A,A | A,A | G,A | R,A | 3 | 5 | 2 |
| 2.7 | R,A | R,A | A,A | R,A | A,R | R,R | A,A | R,A | R,R | A,R | 2 | 6 | 2 |
| 2.8 | A,A | R,R | R,A | A,A | A,A | A,R | A,A | R,A | A,A | A,A | 1 | 7 | 2 |
| 2.9 | G,G | R,R | A,G | G,G | A,A | R,R | G,G | R,A | R,R | A,A | 2 | 7 | 1 |
| 2.10 | | | | | | | | | | | 0 | 7 | 3 |
| 3 | A,A | A,A | A,A | A,A | A,A | A,A | A,A | A,A | A,A | A,A | 1 | 9 | 0 |
| 3.1 | A,G | G,G | A,G | G,G | G,A | G,G | G,G | A,A | A,G | A,G | 1 | 8 | 1 |
| 3.2 | R,A | A,R | A,A | G,R | G,A | R,R | G,G | G,R | A,R | A,G | 6 | 4 | 0 |
| 3.3 | A,A | A,R | A,G | A,G | A,A | A,R | A,A | A,A | A,G | A,A | 5 | 2 | 3 |
| 3.4 | A,G | A,G | A,A | A,A | A,A | R,A | A,A | A,A | R,A | A,G | 3 | 7 | 0 |
| 3.5 | | | | | | | | | | | 3 | 7 | 0 |
| 4 | A,A | A,A | A,A | A,A | A,A | A,A | A,G | A,A | A,A | A,A | 2 | 7 | 1 |
| 4.1 | | | | | | | | | | | 3 | 7 | 0 |
| 4.2 | G,G | G,G | A,R | A,G | A,A | G,R | G,R | A,R | A,R | A,G | 1 | 7 | 2 |
| 4.3 | G,G | A,G | A,R | G,G | A,A | A,R | G,R | A,R | A,R | A,G | 3 | 5 | 2 |
| 4.4 | A,G | G,A | A,G | G,G | A,G | A,A | A,G | A,A | G,G | A,A | 1 | 5 | 4 |
| 4.5 | A,G | A,A | A,G | A,A | A,G | A,A | A,G | A,A | A,G | G,G | 5 | 4 | 1 |
| 4.6 | A,G | G,G | A,G | A,A | G,G | R,R | A,G | A,A | A,R | G,G | 3 | 4 | 3 |

Coloured cells denote 2012/13 validated ratings while the Background initials noted in each cell are the preceding 2 years ratings

**LD Health Self Assessment Framework**
**Validated Results – 2012/13**

**Appendix 4**

| | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **4.7** | A,R | A,A | R,A | A,R | A,R | A,R | A,G | R,A | A,A | G,A | **X** | **X** | **X** |
| **4.8** | G,G | A,A | A,A | G,G | G,A | G,A | G,G | R,R | A,G | A,A | **2** | **7** | **1** |
| **4.9** | A,A | A,A | A,G | A,A | A,A | A,A | A,A | R,R | A,G | G,G | **3** | **6** | **1** |
| **4.10** | A,R | G,R | A,A | G,A | A,R | R,A | R,A | A,A | A,G | R,A | **1** | **6** | **3** |
| **4.11** | A,G | G,R | R,A | A,G | G,A | R,R | R,A | A,R | R,R | G,A | **3** | **4** | **3** |
| **Total RED** | **4** | **7** | **3** | **6** | **3** | **13** | **0** | **15** | **8** | **2** | | | |
| **Total AMBER** | **15** | **19** | **18** | **13** | **16** | **12** | **6** | **12** | **15** | **12** | | | |
| **Total GREEN** | **8** | **1** | **6** | **8** | **2** | **2** | **21** | **0** | **4** | **13** | | | |
| **Total G/A** | **24** | **19** | **24** | **21** | **18** | **14** | **27** | **12** | **22** | **25** | | | |
| **Total Points (2/1/0)** | **32** | **20** | **30** | **29** | **20** | **16** | **48** | **12** | **28** | **38** | | | |

**Draft Priorities for Action across GM Cluster in addition to Locality-specific CCG/LA HWB plans**

- **Localities**

- **Specific Action Plans**

Coloured cells denote 2012/13 validated ratings while the Background initials noted in each cell are the preceding 2 years ratings

**LD Health Self Assessment Framework**
**Validated Results – 2012/13** **Appendix 4**

**Summary of Provider Statements received and Self Assessment Levels**

| Provider Trust Name | Specify Type of provider (Acute Hospital, Mental Health, Learning Disability, Community or Specialist Trusts) | C5 Specify Level of Self Assessment for Board Assurance | C6 Specify Level of Self Assessment for Equality Act 2010 | C7 Specify Level of Self Assessment for Safeguarding Adults | C8 Specify Level of Self Assessment for Mental Capacity Act | Attach link to Provider Statement Or Lead Commissioner |
|---|---|---|---|---|---|---|
| NWAS | Ambulance | | | | | NHS Blackpool |
| Bridgewater – TPS | Community | | | | | NHS Ashton, Leigh & Wigan |
| Greater Manchester West | Mental Health | | | | | NHS Trafford |
| CMFT | Acute | | | | | NHS Manchester |
| UHSM | Acute | | | | | NHS Manchester |
| CWP | Mental Health / LD | | | | | NHS Trafford / NHS Wirral |
| MMHSCT | Mental Health | | | | | NHS Manchester |
| Pennine Care | Mental Health | | | | | NHS |
| Pennine Acute | Acute | | | | | NHS |
| Stockport | Acute | | | | | NHS Stockport |
| Salford Royal | Acute | | | | | NHS Salford |
| Bolton | Acute | | | | | NHS Bolton |
| Christies | Acute | NWSCT | NWSCT | NWSCT | NWSCT | NHS Manchester |
| 5 Boroughs | Mental Health / LD | | | | | NHS Knowsley |
| Wrightington/Wigan/Leigh | Acute | | | | | NHS Ashton, Leigh & Wigan |
| | | | | | | |
| | | | | | | |



Coloured cells denote 2012/13 validated ratings while the Background initials noted in each cell are the preceding 2 years ratings

**Key**

| **Top Targets and Key Objectives** |
|---|
| **1. People who are or who were formerly in NHS provided long term care have settled accommodation that reflects their person centred plans and there is a system in place to ensure minimum of annual review** |
| 1.1 The commissioners can demonstrate that people with learning disabilities, families and carers are involved in the process planning and decision making in order to ensure that their needs, choices and preferences are understood and that services are available to reflect individual choices |
| 1.2 The commissioners know of the all NHS funded (fully and jointly with LA) individual care packages for people with learning disabilities and have mechanisms in place for on-going placement monitoring and individual reviews:<br>§ OATS (Out of Area Placements)<br>§ Spot Purchase<br>§ Specialist Provision (Crisis and Assessment and Treatment)<br>§ Individual Short Breaks<br>§ Providers of flexible and personal budgets (supported living) |
| **2. Commissioners are working closely with local CCG, Boards (e.g. Learning disability Partnership Boards and Health and Wellbeing Boards) and statutory and other partners, to address the health inequalities faced by people with learning disabilities** |
| 2.1 LD QOF registers in primary care.<br>Learning Disability Direct Enhanced Service (DES) for Annual Health Check Registers |
| 2.2 Annual health checks |
| 2.3 a People with learning disabilities access disease prevention, screening, and health screening and health promotion in each of the following health areas: Obesity, Diabetes, Cardio vascular disease, epilepsy<br><br>2.3 b Screening-Comparative data of PWLD against similar age of non-learning disabled population in each health screening area for:<br>§ Cervical screening<br>§ Breast screening<br>§ Bowel Screening (as applicable)<br>Measures:<br>§ Attended screening<br>§ Did not attend screening<br>§ Refused or exempted screening |
| 2.4 Additional quality indicator left in NHS commissioned wider primary and community care services:<br>§ Dentistry<br>§ Optometry<br>§ Community Pharmacy<br>§ Podiatry<br>§ Community nursing and midwifery |

| **Top Targets and Key Objectives** |
|---|
| 2.5 Commissioners have assurance that the Four Outcomes of the Equality Act 2010 include people with learning disabilities within all NHS services and use a system such as the Equality Delivery System (EDS) to demonstrate this |
| 2.6 The local JSNA includes needs assessment and corresponding plans are in place which reflect policy and best practice guidelines.<br><br>For people with learning disability and:<br>§ Profound and Multiple Learning Disability (PMLD)<br>§ Autism,<br>§ challenging behaviour<br>§ Mental Health needs.<br>§ Older adults<br>§ Dementia |
| 2.7 Primary care communication of LD status to other healthcare providers * |
| 2.8 Commissioners have agreed with local partner agencies a long term 'across system' strategy to address services to meet the needs of people with learning disability from ethnic minority groups, and their carers |
| 2.9 There is a long-term strategy in place to achieve inclusion and equality of healthcare and outcomes for people with complex or profound disabilities and their carers |
| 2.10 Annual Health Action Plans |
| **3. People with learning disability who are in services that the NHS commissions or provides, are safe** |
| 3.1 Monitor Compliance Framework – Governance Indicators (learning disability) per trust within the locality<br><br>Learning disability liaison function or equivalent process in acute setting: e.g. Lead for learning disabilities |
| 3.2 Commissioners are assured that each health Trust routinely monitors, across the whole organisation, its implementation of the Mental Capacity Act (including Consent and Deprivation of Liberty Safeguards) and restriction<br><br>Can evidence action taken to improve and embed practice where necessary |
| 3.3 Commissioners ensure that all providers can demonstrate that there is evidence of patient experience and review and analysis of complaints and use of the whistle blowing policy affecting people with learning disabilities leading to improved practice |
| 3.4 There are effective multi agency partnerships in place with the agency partners of the Local SS Safeguarding Adults Board (LSAB) to ensure a coherent approach to Safeguarding Adults at risk of abuse |

| **Top Targets and Key Objectives** |
|---|
| Commissioners are able demonstrate this for its own organisation's practice<br><br>Commissioners are able to demonstrate this for all commissioned services |
| 3.5 Each of the **commissioners** listed **Acute, Mental Health, Non-Acute/ Community , LD, Ambulance, Specialist** can assure through their commissioning, and contract monitoring with provider service that quality, safety and safeguarding for people with learning disabilities is being addressed |
| **4. Progress is being made in developing local services for those needing more help to be healthy** |
| 4.1 Health and Wellbeing Boards, Clinical Commissioning Groups and Clinical Support Units (CSU's) can demonstrate that any plans include people with learning disability<br>• Clinical commissioning Groups<br>• Health and Wellbeing Board<br>• Information Revolution<br>• Health watch<br>• CS/CSU |
| 4.2 The commissioners can demonstrate that the PCT/ CCG/ Health and Well being Boards/ LDPBs has been informed of the services commissioned and assured that the service is going to deliver safe services of acceptable quality |
| 4.3 Plans are in place to ensure locally available provision of the future mainstream and specialist health services needed to **support young people** approaching adulthood - and their families |
| 4.4 Commissioner can demonstrate that people with learning disabilities and families involved in recruitment/ training and monitoring of staff/ services in LD provider organisations |
| 4.5 There are well functioning partnership agreements between health and social care organisations |
| 4.6 Commissioner can demonstrate that they use a range of collated evidence/information/data including the needs of aging population to ensure evidence based commissioning.<br><br>Local Profile and future trajectories of needs informs the commissioning of a range of person centred and cost effective options. |
| 4.7 Same as 4.3 - Plans are in place to ensure locally available provision of the future mainstream and specialist health services needed to **support young people** approaching adulthood - and their families |
| 4.8 There are a range of local services available to individuals who are described as having challenging behaviour. Such services take account of key standards from policy and best practice e.g. Mansell 2 Report or updated equivalent and Challenging Behaviour Charter |

| **Top Targets and Key Objectives** |
|---|
| |
| 4.9 The National mental health policy 'No Health without Mental Health' is equally and equitably applied to people with learning disability who require mental health services |
| 4.10 Commissioners have a learning disability workforce development plan in place which includes reference to the future training and development of people working in learning disability services, in both specialist and mainstream health care areas including Ambulance service and offender health |
| 4.11 Commissioners are working in partnership with local and regional teams to ensure that **people with learning disability in the criminal justice system** have access to a full range of healthcare provision – in line with legislation, policy and best practice<br>• Localities without a prison should consider the following:<br>• Point of arrest schemes<br>• Training in custody schemes<br>• Referrals to Appropriate Adults and diversion Schemes etc |

# DH Winterbourne View Review

*Concordat: Programme of Action*

**DH INFORMATION READER BOX**

| | | |
|---|---|---|
| **Policy** | Clinical | Estates |
| HR / Workforce | Commissioner Development | IM & T |
| Management | Provider Development | Finance |
| Planning / Performance | Improvement and Efficiency | Social Care / Partnership Working |

| | |
|---|---|
| **Document Purpose** | For Information |
| **Gateway Reference** | 18518 |
| **Title** | Winterbourne View Review: Concordat: A Programme of Action |
| **Author** | Department of Health |
| **Publication Date** | **December 2012** |
| **Target Audience** | PCT Cluster CEs, NHS Trust CEs, SHA Cluster CEs, Care Trust CEs, Foundation Trust CEs , Medical Directors, Directors of PH, Directors of Nursing, Local Authority CEs, Directors of Adult SSs, GPs, Directors of Children's SSs |
| **Circulation List** | PCT PEC Chairs, PCT Cluster Chairs, NHS Trust Board Chairs, Special HA CEs, Directors of HR, Directors of Finance, Allied Health Professionals, Communications Leads, Emergency Care Leads, Voluntary Organisations/NDPBs |
| **Description** | The concordat / agreement sets out a programme of action to transform services for people with learning disabilities or autism and mental health conditions or behaviours described as challenging. It sets out specific actions to which each organisation has committed to take forward within clear timeframes. |
| **Cross Ref** | DH Review - Transforming care: A National Response to Winterbourne View Hospital<br>DH Review: Winterbourne View Hospital Interim Report |
| **Superseded Docs** | N/A |
| **Action Required** | N/A |
| **Timing** | **N/A** |
| **Contact Details** | Mental Health, Disability and Equality<br>Department of Health<br>Room 313A Richmond House<br>79 Whitehall<br>SW1A 2NS |
| **For Recipient's Use** | |

# DH Winterbourne View Review

*Concordat: Programme of Action*


**Learning Disability Professional Senate**

Vision for change

**The abuse of people at Winterbourne View hospital was horrifying. Children, young people and adults with learning disabilities or autism and who have mental health conditions or behaviour that challenges have for too long and in too many cases received poor quality and inappropriate care. We know there are examples of good practice. But we also know that too many people are ending up unnecessarily in hospital and they are staying there for too long. This must stop.**

**We (the undersigned) commit to a programme for change to transform health and care services and improve the quality of the care offered to children, young people and adults with learning disabilities or autism who have mental health conditions or behaviour that challenges to ensure better care outcomes for them[1].**

**These actions are expected to lead to a rapid reduction in hospital placements for this group of people by 1 June 2014. People should not live in hospital for long periods of time. Hospitals are not homes.**

**We will safeguard people's dignity and rights through a commitment to the development of personalised, local, high quality services alongside the closure of large-scale inpatient services and by ensuring that failures when they do occur are dealt with quickly and decisively through improved safeguarding arrangements. Safeguarding is everybody's business.**

**All parts of the system - commissioners, providers, the workforce, regulators and government - and all agencies - councils, providers, the NHS and police - have a role to play in driving up standards for this group of people. There should be zero tolerance of abuse or neglect.**

**The Government's Mandate to the NHS Commissioning Board[2] sets out:**

> **"The NHS Commissioning Board's objective is to ensure that Clinical Commissioning Groups work with local authorities to ensure that vulnerable people, particularly those with learning disabilities and autism, receive safe, appropriate, high quality care. The presumption should always be that services are local and that people remain in their communities; we expect to see a substantial reduction in reliance on inpatient care for these groups of people."**

**We commit to working together, with individuals and their families and with the groups that represent them, to deliver real change. Our shared objective is to see the health and care system get to grips with past failings by listening to this very vulnerable group of people and their families, meeting their needs and working together to commission the range of support which will enable them to lead fulfilling and safe lives in their communities.**

[1] For the purpose of this Concordat we will use the phrase "people with challenging behaviour" as shorthand for this group

[2] http://www.dh.gov.uk/health/2012/11/nhs-mandate/

# How we will make change happen:

The key actions are:

- **Health and care commissioners will review all current hospital placements and support everyone inappropriately placed in hospital to move to community-based support as quickly as possible and no later than 1 June 2014:**

  The NHS Commissioning Board (NHSCB) will:
  - ensure that all Primary Care Trusts develop registers of all people with learning disabilities or autism who have mental health conditions or behaviour that challenges in NHS-funded care as soon as possible and certainly no later than 1 April 2013;
  - make clear to Clinical Commissioning Groups (CCGs) in their handover and legacy arrangements what is expected of them, including:
    - in maintaining the local register from 1 April 2013; and
    - reviewing individuals' care with the Local Authority and identifying who should be the first point of contact for each individual.

  Health and care commissioners will:
  - by 1 June 2013, working together and with service providers, people who use services and families review the care of all people in learning disability or autism inpatient beds and agree a personal care plan for each individual, based on their and their families' needs and agreed outcomes;
  - put these plans into action as soon as possible, so that all individuals receive personalised care and support in appropriate community settings no later than 1 June 2014;
  - ensure that all individuals have the information, advice and advocacy support they need to understand and have the opportunity to express their views. This support will include self-advocacy and independent advocacy where appropriate for the person and their family.

- **Every area will put in place a locally agreed joint plan for high quality care and support services for people of all ages with challenging behaviour, that accords with the model of good care.** These plans should ensure that a new generation of inpatients does not take the place of people currently in hospital.

  - This joint plan could potentially be undertaken through the health and wellbeing board and considered alongside the local Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy processes.
  - The strong presumption will be in favour of supporting this with pooled budget arrangements with local commissioners offering justification where this is not done.

- **There will be national leadership and support for local change.** The Local Government Association and NHSCB will establish a joint improvement programme to provide leadership and support to transform services locally. They will involve key partners including the Department of Health (DH), The Society of Local Authority Chief Executives and Senior Managers (SOLACE), the Association of Directors of Adult Social Services (ADASS) and Association of Directors of Children's Services (ADCS) and the Care Quality

Commission (CQC) and will closely involve service providers, people with learning disabilities and autism and their families in their work. The programme will be operating within three months, with the Board and leadership arrangements in place by the end of December 2012. DH will provide funding to support this work.

- **Planning will start from childhood.**

  - DH will work with the Department for Education (DfE) to introduce a new single assessment process and Education, Health and Care Plan to replace the current system of statements and learning difficulty assessments for children and young people with special educational needs; supported by joint commissioning between local partners (subject to parliamentary approval). The process will include young people up to the age of 25, to ensure they are supported in making the transition to adulthood;
  - DH and DfE will work with the independent experts on the Children and Young People's Health Outcomes Forum to consider how to prioritise improvement outcomes for children and young people with challenging behaviour and how best to support young people with complex needs in making the transition to adulthood. This will report by June 2013;
  - From June 2013 Ofsted, CQC, Her Majesty's Inspectorate of Constabulary (HMIC), Her Majesty's Inspectorate of Probation and Her Majesty's Inspectorate of Prisons will introduce a new joint inspection of multi-agency arrangements for the protection of children in England.

- **Improving the quality and safety of care:**

  - DH commits to putting Safeguarding Adults Boards on a statutory footing and to supporting those Boards to reach maximum effectiveness;
  - All statutory partners, as well as wider partners across the sector will work collaboratively to ensure that safeguarding boards are fully effective in safeguarding children, young people and adults;
  - Over the next 12 months all signatories will work to continue to improve the skills and capabilities of the workforce across the sector through access to appropriate training and support and to involve people and families in this training, eg through self-advocacy and family carer groups.

- **Accountability and corporate responsibility for the quality of care will be strengthened:** DH will immediately examine how corporate bodies and their Boards of Directors can be held to account for the provision of poor care and harm, and set out proposals during Spring 2013 on strengthening the system where there are gaps.

- **Regulation and inspection of providers will be tightened:** CQC will use existing powers to seek assurance that providers have regard to national guidance and good models of care. CQC will continue to make unannounced inspections of providers of learning disability and mental health services, employing people who use services and family carers as vital parts of the team when relevant and appropriate to do so.

- **Progress** in transforming care and redesigning services **will be monitored and reported:**

  - The Learning Disability Programme Board, chaired by the Minister for Care and Support, will lead delivery of the programme of change by measuring progress against

milestones, monitoring risks to delivery and challenging external delivery partners to deliver to plan, regularly publishing updates;
- The Department of Health will publish a follow-up report one year on by December 2013 and again as soon as possible following 1 June 2014, to ensure that the steps set out in this Concordat are achieved.

Detailed commitments are set out at **Annex A.**

**Signed by:**

- Action for Advocacy
- Adults with Learning Disabilities Services Forum
- Association of Chief Police Officers
- Association of Directors of Adult Services
- Association of Directors of Children's Services
- Association for Real Change
- Autism Alliance UK
- British Association of Social Workers
- British Institute of Learning Disabilities
- British Psychological Society
- Care Quality Commission
- Challenging Behaviour Foundation
- Changing our Lives
- Chartered Society of Physiotherapy
- College of Occupational Therapists
- Council for Disabled Children
- Department of Health
- English Community Care Association (ECCA)
- Healthwatch England
- Health Education England
- Housing Learning and Improvement Network
- Housing & Support Alliance[3]
- Independent Healthcare Advisory Services
- Learning Disability Professional Senate
- Local Government Association (LGA)
- Mencap
- National Autistic Society
- National Care Association
- National Development Team for Inclusion
- National Forum of People with Learning Disabilities
- National Institute for Health and Clinical Excellence
- National Housing Federation
- National Quality Board
- National Valuing Families Forum
- NHS Clinical Commissioners
- NHS Commissioning Board
- NHS Confederation
- Royal College of General Practitioners
- Royal College of Psychiatrists
- Royal College of Nursing
- Royal College of Speech and Language Therapists
- Royal Pharmaceutical Society
- Shared Lives
- Sitra
- Skills for Care
- Skills for Health
- The Health and Social Care Information Centre
- The College of Social Work
- The Society of Local Authority Chief Executives and Senior Managers (SOLACE)
- United Response
- Voluntary Organisations Disability Group

[3] formerly the Association of Supported Living and Housing Options

**Annex A**

## Concordat commitments

**The NHS Commissioning Board (NHSCB), NHS Clinical Commissioners, the Local Government Association (LGA), Association of Directors of Adult Social Services (ADASS) and Association of Directors of Children's Services (ADCS)** commit to working collaboratively with CCGs and Local Authorities to achieve the following objectives by 1 June 2014 to:

- ensure that the right local services are available, regardless of who commissions them, for children, young people and adults with learning disabilities or autism who also have mental health conditions or behaviour that challenges;[4]
- all people with challenging behaviour in inpatient assessment and treatment services are appropriately placed and safe, and if not make alternative arrangements for them as soon as possible. We expect most cases to take less than 12 months;
- review funding arrangements for these people and develop local action plans to deliver the best support to meet individuals' needs;
- review existing contracts to ensure they include an appropriate specification, clear individual outcomes and sufficient resource to meet the needs of the individual and appropriate information requirements to enable the commissioner to monitor the quality of care being provided;
- ensure that everyone has a named care co-ordinator;
- improve the general healthcare and physical health of people with learning disabilities – for example, all individuals in these services have a comprehensive health check within 6 months and a health action plan;
- involve children, young people and adults with challenging behaviour and their families, carers and advocates in planning and commissioning services and seek and act on feedback about individual experience;
- ensure that planning starts early with commissioners of children's services to achieve good local support and services for children and better transition planning for children with disabilities moving from children's to adult services;
- ensure that from April 2013, health and care commissioners, set out a joint strategic plan to commission the range of local health, housing and care support services to meet the needs of children, young people and adults with challenging behaviour in their area. This could be undertaken through the health and wellbeing board and could be considered as part of the local Joint Strategic Needs Assessment and Joint Health and Well-Being Strategy (JHWS) process;

- The strong presumption will be in favour of supporting this with pooled budget arrangements with local commissioners offering justification where this is not done.
- We will promote and facilitate joint and collaborative commissioning by local authorities and CCGs to support these objectives.
- We will take account of the information and data shared by CQC when making decisions to commission care from proposed service providers.
- We will expect CCGs and directors of adult social services to provide assurance to the Joint Improvement Programme that they are making progress in these areas and are commissioning safe and appropriate care.

[4] For the purpose of this Concordat we will use the phrase "people with challenging behaviour" as shorthand for this group.

- Directors of children's services will be responsible for overseeing the overall quality and delivery of health and wellbeing services for children and young people for local authority commissioners; and directors of adult services will have similar responsibility for the overall quality and delivery of health and wellbeing services for adults.

**Provider representative organisations**[5]

We commit to publish plans that support our members to provide good quality care across health, housing and social care, as set out in the model of care[6] and including:

- safe recruitment practices which select people who are suitable for working with people with learning disabilities or autism and behaviour that challenges;
- providing appropriate training for staff on how to support people with challenging behaviour;
- having appropriately trained, qualified and experienced staff,
- providing good management and right supervision;
- providing leadership in developing the right values and cultures in the organisation and respecting people's dignity and human rights as set out in the NHS Constitution;
- having systems in place which assure themselves, service users and families, carers, local Healthwatch and the public that essential requirements are being met and that they deliver high quality and appropriate care;
- identifying a senior manager or, where appropriate, a Director, to ensure that the organisation pays proper regard to quality, safety and clinical governance for that organisation.

In addition:

- We will bring forward a pledge or code model based on shared principles along the lines of the Think Local Act Personal (TLAP) Making it Real principles for learning disability providers by April 2013;
- We commit to working to significantly reduce the number of specialist hospitals in line with proposals in this concordat and working with our members to develop models that reflect the need for high quality community based approaches.[7]

**Care Quality Commission**

We commit to take the following actions – we will:

- use existing powers to seek assurance that providers have regard to national guidance and good models of care;
- take steps now to strengthen the way we use existing powers to hold organisations to account for failures to provide quality care and report on changes to be made from Spring 2013;
- take action to ensure the model of care is included as part of inspection and registration of relevant services from 2013. CQC will set out its new regulatory model in its response to the consultation in Spring 2013;
- include reference to the model in our revised guidance about compliance. Our revised guidance about compliance will be linked to the Department of Health timetable for the

[5] Includes the Adults with Learning Disability Services Forum, Association for Real Change, ECCA, Housing & Support Alliance, the Independent Healthcare Advisory Services, National Care Association, National Housing Federation, NHS Confederation, Shared Lives, Sitra and Voluntary Organisations Disability Group.

[6] References to the model of care are to the model set out in the Department of Health Review: Winterbourne View Hospital Interim Report (2012)

[7] Signed up to by the Housing and Support Alliance, Voluntary Organisations Disability Group, Sitra, National Housing Federation and Housing LIN.

review of the quality and safety regulations in 2013. However, we will specifically update providers about the proposed changes to our registration process about models of care for learning disability services in 2013;

- continue to make unannounced inspections of providers of learning disability and mental health services, employing people who use services and family carers as vital members of the team;
- share the information, data and details we have about prospective providers with the relevant CCGs and local authorities through our existing arrangements;
- take a differentiated approach to inspections between different sectors of care provision to ensure the inspections are appropriate to the vulnerability and risk for the different care user groups, subject to the outcome of consultation on its new strategy;
- assess whether providers are delivering care consistent with the statement of purpose made at the time of registration, in particular whether treatment being offered and length of stay is aligned to the statement of purpose. Where it is not, CQC will take the necessary action to ensure that a provider addresses discrepancies either through changes to its services or changes to its statement of purpose;
- take tough enforcement action, including prosecutions, restricting the provision of services, or closing providers down, where providers consistently fail to have a registered manager in place or where there are other breaches of registration requirements;
- also consider whether it is able to use its existing powers to carry out a fit and proper person test of Board members as part of the registration of providers;
- take enforcement action against providers that do not operate effective recruitment procedures to ensure that their staff are suitably skilled, of good character and legally entitled to do the work in question. Operating effective recruitment procedures is a legal requirement and providers must be able to demonstrate to CQC that they have adequate procedures in place;
- continue to run the CQC stakeholder group that helped to shape and define the inspection of the 150 learning disability services. This will continue to meet twice yearly and will be chaired by the CQC Chief Executive. CQC will review the role and function of the group as part of that work programme to make sure it continues to provide advice and critique on CQC's inspection and monitoring of providers;
- meet with executives of provider organisations when there are serious concerns about quality and safety issues to discuss their governance and improvement initiatives to deliver safe and effective care;
- CQC's strategic review, launched in September 2012, includes a review of the delivery of its responsibilities under s120 of the Mental Health Act 1983 for the general protection of patients detained under the Act. This includes wide powers for CQC to review the exercise of functions and use of safeguards under the Act and investigating complaints by any person detained under the Act.

**Skills for Care and Skills for Health**

We commit to driving up the competency of the workforce by promoting positive behaviours, values and attitudes and by improving the skills, the learning and the qualifications of those working with people with learning disabilities and behaviour that challenges:

- Skills for Care will develop by February 2013 a framework of guidance and support on commissioning workforce solutions to meet the needs of people with challenging behaviour;

- Skills for Care and Skills for Health have been jointly commissioned by the Department of Health (DH) to develop a code of conduct and training standards that could be used by a body (or bodies) establishing a voluntary register(s) for healthcare support workers and adult social care workers in England as part of its standards for inclusion on a register from 2013.

**Professional bodies that make up the Learning Disability Professional Senate[8] and other professional bodies**

We commit to providing clear professional leadership and support training of professionals providing care – in particular:

- to develop core principles on a statement of ethics to reflect wider responsibilities in the new health and care system by April 2013;
- to carry out a review of *Challenging Behaviour: A Unified Approach* by early 2013 to support professionals in community learning disability teams to deliver actions that provide better integrated services;
- as the Royal College of Nursing, to work with all 4 UK leads in taking forward the recommendations in *Strengthening the Commitment*, the report of the UK modernising Learning Disability Nursing Review, with a focus on workforce, leadership and education;
- as the Royal College of General Practitioners (RCGP) to commit to improving the lives and the care of people with learning disabilities and their families in their local communities and to the training of doctors to look after vulnerable groups in our society;
- as the Joint Commissioning Panel of the RCGP and the Royal College of Psychiatrists, to produce guidance on working with people with learning disabilities who also have mental health conditions by March 2013;
- as the Royal College of Psychiatrists, to issue guidance about the different types of inpatient services for people with learning disabilities, including some guidance aimed at commissioners;
- as the Royal College of Psychiatrists, the Royal Pharmaceutical Society and other professional leadership organisations, to work with ADASS and ADCS to ensure medicines are used in a safe, appropriate and proportionate way and their use optimised in the treatment of children and adults with learning disabilities. This should include a focus on the safe and appropriate use of anti-psychotics and anti-depressants;
- as the College of Social Work, working in collaboration with BASW and other professional organisations and with service user led groups, to produce key points guidance for social workers on good practice in working with people with learning disabilities who also have mental health conditions;
- as the British Psychological Society, to provide leadership to promote training in, and appropriate implementation of, Positive Behavioural Support across the full range of care settings;
- as the Royal College of Speech and Language Therapists, to produce good practice standards for commissioners and providers to promote reasonable adjustments required

[8] This includes the Royal College of Psychiatrists, the Royal College of Nursing, the College of Occupational Therapists, the Royal College of General Practitioners, the College of Social Work, Chartered Society of Physiotherapy, the Royal College of Speech and Language Therapists, other professional bodies include the British Association of Social Workers and . the British Psychological Society.

to meet the speech, language and communication needs of people with learning disabilities in specialist learning disability or autism hospital and residential settings.
- To ensure that these actions are taken forward with people with learning disabilities and their families.

**National Quality Board**
The National Quality Board will by April 2013 set out how the new health system should operate to improve and maintain quality. This will provide clarity on the distinct roles and responsibilities of different parts of the system and how they should work together in the best interests of those using services.

**The National Institute for Health and Clinical Excellence (NICE)**
The National Institute for Health and Clinical Excellence (NICE) will publish Quality Standards and clinical guidelines on challenging behaviour in learning disability in Summer 2015 and on mental health and learning disability in Summer 2016.

**Healthwatch**
Healthwatch England will work with the Department of Health and the Local Government Association on how local Healthwatch will involve people with learning disabilities and their families, including working with Learning Disability Partnership Boards.

**Health Education England**
HEE commits to improving the quality of care for all patients from April 2013, including those with challenging behaviour, by identifying training needs and ensuring there is an education and training system fit to supply a highly trained and high quality workforce.

**NHS Commissioning Board**
In addition to the above actions, we commit to supporting changes in services that deliver improved outcomes - in particular, we will work with partners including ADASS and providers to develop practical resources for commissioners, including:
- model service specifications by March 2013;
- new NHS contract schedules for specialist learning disability services;
- models for rewarding best practice through the NHS Commissioning for Quality and Innovation (CQUIN) framework;
- a joint health and social care self-assessment framework to support local agencies to measure and benchmark progress.

In January 2013, with DH, we will set out how to embed Quality of Health Principles in the system, using NHS contracting and guidance.

**Association of Directors of Adult Social Services (ADASS) and Association of Directors of Children's Services (ADCS)**
We commit to helping members to share best practice and to work with the LGA, the NHS CB and CCGs on the above actions and in addition:

- all local authorities and their local safeguarding partners, including the police and NHS organisations, should take action from now, ensuring that they have robust safeguarding boards and other arrangements in place;
- Safeguarding Adults Boards should review their arrangements and ensure they have the right information sharing processes in place across health and care to identify and deal with safeguarding alerts;
- We will produce guidance notes and simple key questions to raise awareness, ensure visibility and action at a local level and to empower members of Safeguarding Adults Boards, Health and Wellbeing Boards and Learning Disability Partnership Boards by December 2012.

**Local Government Association (LGA)**

- We commit to working with the NHS CB to provide leadership and support to the transformation of services locally via the development of an improvement programme. This will include supporting commissioning authorities to develop comprehensive, integrated local strategies for services for people with challenging behaviour. We will involve key partners including DH, SOLACE, ADASS, ADCS, NHS Clinical Commissioners and CQC in this work. The programme will be operating within three months with the Board and leadership arrangements being in place by the end of December 2012.

**Association of Chief Police Officers (ACPO)**

We recognise the importance of working together with statutory agencies, local authorities and safeguarding partners to enhance the service provided to vulnerable adults. We have reviewed the overall learning from Winterbourne View and will ensure the following:

- The one direct recommendation relating to the police regarding the early identification of trends and patterns of abuse has been fully recognised by Avon & Somerset Police. A specific workstream has been created by the force to identify a process to trigger early identification of abuse. The lessons learnt from the work undertaken will be disseminated nationally.
- All associated learning from the review will be incorporated into training and practice, including Authorised Professional Practice.

**The Department of Health**

We have set the strategic direction and proposals for legislation to reform health and social care. We commit to the following additional actions to provide a clear framework and improve quality, enable change to happen and to measure and monitor progress:

*Children and transition*

- The Department of Health (DH) and Department for Education (DfE) will work with the independent experts on the Children and Young People's Health Outcomes Forum to consider how to prioritise improvement outcomes for children and young people with challenging behaviour and how best to support young people with complex needs in making the transition to adulthood. This will report by June 2013;
- DH will work with the DfE to introduce a new single assessment process and Education, Health and Care Plan to replace the current system of statements and learning difficulty assessments for children and young people with special educational needs; supported by joint commissioning between local partners (subject to parliamentary approval). The

process will include young people up to the age of 25, to ensure they are supported in making the transition to adulthood;

- DH will work with DfE to develop and issue statutory guidance on children in long-term residential care (s85 and s86 of the Children Act 1989) in 2013;
- DH and DfE will jointly explore the issues and opportunities for children with learning disabilities whose behaviour is described as challenging through both the SEN and Disability reform programme and the work of the Children's Health Strategy.
- DfE is revising *Working Together to Safeguard Children,* statutory guidance on how organisations and individuals working with children should work together to safeguard and promote their welfare. The guidance will be published in due course. *Working Together to Safeguard Children* will make clear that professionals will be required to recognise and consider the differing needs of all children - babies, disabled children and older children - so that they can offer them the most appropriate help and support at the right time;
- From June 2013 Ofsted, CQC, Her Majesty's Inspectorate of Constabulary (HMIC), Her Majesty's Inspectorate of Probation and Her Majesty's Inspectorate of Prisons will introduce a new joint inspection of multi-agency arrangements for the protection of children in England;
- Under the new inspection frameworks published in September 2012, Ofsted will make judgements on the overall effectiveness, outcomes for children and young people, quality of care, safeguarding as well as leadership and management.

*National leadership and support for local change*

- DH will provide funding to support the Local Government Association and NHSCB to establish a joint improvement programme to provide leadership and support to the transformation of services locally;
- The national market development forum within the TLAP partnership will work with DH to identify barriers to reducing the need for specialist assessment and treatment hospitals and identify solutions for providing effective local services by April 2013;
- The Developing Care Markets for Quality and Choice programme will support local authorities to identify local needs for care services and produce market position statements, including for learning disability services;
- We will work with sector leaders on co-produced resources to support health and wellbeing boards on specific aspects of Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWSs). As part of this work, we will explore how, in responding to the issues raised in the Winterbourne View review, we will ensure that health and wellbeing boards have support to understand the complex needs of people with challenging behaviour;
- We will work with key partners to agree by April 2013 how Quality of Life principles should be adopted in social care contracts to drive up standards;

*Strengthening accountability and corporate responsibility*

- DH will review the regulatory requirements in respect of criminal records checks and whether providers should routinely request a criminal record certificate on recruitment from 2013 once the impact of the new service is understood;
- DH will immediately examine how corporate bodies and their Boards of Directors and financiers can be held to account for the provision of poor care and harm, and set out proposals during Spring 2013 on strengthening the system where there are gaps;

- We will consider both regulatory sanctions available to CQC and criminal sanctions. We will determine whether CQC's current regulatory powers and its primary legislative powers need to be strengthened to hold Boards to account.

*Improving the quality and safety of care*

- We have already committed to putting Safeguarding Adults Boards on a statutory footing (subject to parliamentary approval). DH will revise statutory guidance and good practice guidance to reflect new legislation and address findings from Winterbourne View, to be completed in time for the implementation of the Care and Support Bill;
- DH will, together with CQC, consider what further action may be needed to check how providers record and monitor restraint;
- With external partners, DH will publish by the end of 2013 guidance on best practice around positive behavioural support so that physical restraint is only ever used as a last resort where the safety of individuals would otherwise be at risk and never to punish or humiliate;
- We will work with CQC to agree how best to raise awareness of and ensure compliance with the Deprivation of Liberty Safeguards (DOLS) provisions to protect individuals and their human rights and will report by Spring 2014;
- We will update the Mental Health Act Code of Practice during 2014 and this will take account of findings from this review;
- We will produce a progress report by the end of 2013 on actions to implement the recommendations in *Strengthening the Commitment*, the report of the UK Modernising Learning Disability Nursing Review;
- Through the Whistleblowing Helpline, we aim to increase awareness of whistleblowing for staff within the health and social care sectors. The helpline will advise employers on embedding best practice policy and procedure and staff on how to raise concerns and what protection they have in law when they do so;
- We will explore with the Royal College of Psychiatrists and others whether there is a need to commission an audit of use of medication for this group. As the first stage of this, DH will commission by summer 2013 a wider review of the prescribing of antipsychotic and anti-depressant medicines for people with challenging behaviour to report;
- We will work with the National Valuing Families Forum, the National Forum of People with Learning Disabilities, ADASS, LGA and the NHS to identify and promote good practice for people with learning disabilities across health, housing and social care by June 2013;
- We will work with independent advocacy organisations and other key partners to:
  - identify the key factors to take account of in commissioning advocacy for people with learning disabilities or autism in hospitals so that people in hospital get good access to information, advice and advocacy including self advocacy that supports their particular needs; and
  - drive up the quality of independent advocacy, through strengthening the Action for Advocacy Quality Performance Mark and reviewing the Code of Practice for advocates to clarify their role.

*Measuring and monitoring progress*

- By March 2013, DH will commission an audit of current 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;
- We will work with the Information Centre and the NHSCB to develop measures and key performance indicators (eg on numbers of people in hospital, length of stay) to support commissioners in monitoring their progress from April 2013;
- We will develop a new learning disability minimum data set to be collected through the Information Centre from 2014/15;
- We will continue to collate a suite of information and evidence relating to people with learning disabilities and behaviour which challenges and the health inequalities they experience and report on these to the Learning Disability Programme Board;
- The cross-government Learning Disability Programme Board, chaired by the Minister of State for Care and Support will lead delivery of the programme of change by measuring progress against milestones, monitoring risks to delivery and challenging external delivery partners to deliver to plan, regularly publishing updates;
- We will work with the improvement team to monitor and report on progress nationally. We will publish a follow-up report one year on by December 2013 and again as soon as possible following 1 June 2014, to ensure that the steps set out in this Concordat are achieved.

**Forums and voluntary sector organisations**

*We, the undersigned who represent people who use services, self- advocates and families undertake to challenge statutory and public bodies in how they are delivering against these commitments.*

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# Transforming care:

## A national response to Winterbourne View Hospital

*Department of Health Review: Final Report*

Easy Read version

# What will you read about?



Words shown in **blue** will be explained in the 'Difficult words used' section at the end

Please see the Easy Read Concordat (or Agreement) for all the actions that will happen.

# Message from the Minister

What happened at Winterbourne View hospital was horrifying for both the patients and their families.

Like many people who watched the BBC Panorama Programme, I was shocked, angry and disappointed by the way people with learning disabilities or autism and who have mental health conditions or behaviour that challenges were treated. It was unacceptable.

This review was set up immediately after the Panorama Programme in May 2011. It learns from what happened at Winterbourne View hospital and sets out action to stop such abuse from happening again.

What happened at Winterbourne View hospital was criminal. Six former members of staff at Winterbourne View hospital were jailed for the terrible crimes they committed.

There was a clear failure by the hospital, but the Serious Case Review showed that there was a wider failure across the whole system.

When such failures happen, there should be consequences for everyone involved. The plans to change the law (or regulatory framework) will mean that Boards, Directors and Managers who run hospitals where abuse happens will face consequences. This will send out a strong message to Boards, Directors and Managers that the care and wellbeing of people they care for is their responsibility.

What happened at Winterbourne View hospital was terrible, but we must use it to push for change. This review is a key part of making that change happen.

**NORMAN LAMB**

## Part 1: Why did the review take place?


On 31st May 2011, a BBC Panorama television programme showed people with challenging behaviour being abused by staff at a private hospital called Winterbourne View.

This hospital is now closed.

The abuse that took place at Winterbourne View was criminal. The staff whose jobs were to care and help patients were shown to be abusing them.

- The patients experienced physical abuse. For example - they were pushed around.

- The patients also experienced emotional abuse. For example - they were shouted at.

Paul Burstow was the Minister of State for Care Services at the time that the programme was shown.

Paul Burstow asked Department of Health (DH) officials to carry out a full review into what happened at Winterbourne View hospital.

The aim of the review was to look into what happened at Winterbourne View hospital so that lessons can be learned.

**AND**

To look into how people with challenging behaviour are supported all over England.

As part of the review, Department of Health officials looked at reports and evidence from other reviews.

What reports and evidence did the Department of Health look at?

1. Evidence from the criminal proceedings.

2. The Castlebeck Ltd report

   Castlebeck Ltd was the owner of Winterbourne View hospital.

3. The Care Quality Commission's (CQC) review.

   The CQC inspected 150 hospitals and care homes that provide services for people with learning disabilities.

4. The **NHS** report.

This report looked into how people from Winterbourne View hospital came to be placed there.

5. The Serious Case Review by South Gloucestershire Council

The review gave a detailed picture of what happened at Winterbourne View hospital.

DH officials also spoke to different people to hear their views about how people with challenging behaviour are supported all over England. These people included:

- People with learning disabilities
- People with autism
- Families of people with learning disabilities/autism
- Commissioners
- Providers
- Workers


In June 2012, the Department of Health published an interim report.

In that report, we explained that we could not say anything about what happened at Winterbourne View hospital until after the criminal proceedings.

The criminal proceedings are now over.

This final report builds on the evidence set out in the interim report.

The 11 members of staff who abused patients at Winterbourne View have been sentenced for the criminal acts.

As the criminal proceedings are now over, this final report can now set out what we found. The report sets out:

- the facts about Winterbourne View;
- What happened to people who were at Winterbourne View;
- What needs to be changed in the system;
- Learn lessons for the future; and
- Look at what the Government needs to do.

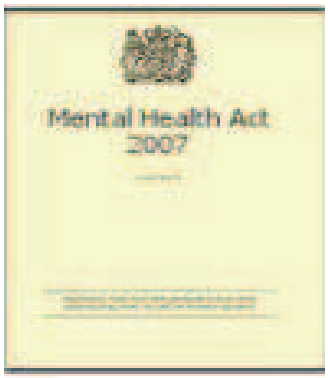
## Part 2: Winterbourne View hospital

Winterbourne View hospital was a private hospital. It was owned by Castlebeck Care Limited.

It was opened in December 2006.

The hospital was registered to provide assessment and treatment and rehabilitation for people with learning disabilities.

The hospital had enough beds for 24 patients with learning disabilities.




Most of the patients in Winterbourne View hospital had been placed at the hospital under the Mental Health Act.


A total of 48 patients had been placed at Winterbourne View hospital.

The patients in Winterbourne View hospital were placed there by different commissioners from all over England.

On average, it cost £3,500 per week to place a patient at Winterbourne View.


Almost half of the patients at Winterbourne View were placed far away from their homes.

One of the main reasons they were placed in Winterbourne View was to manage a crisis.

This suggests a lack of local services to support people with challenging behaviour.

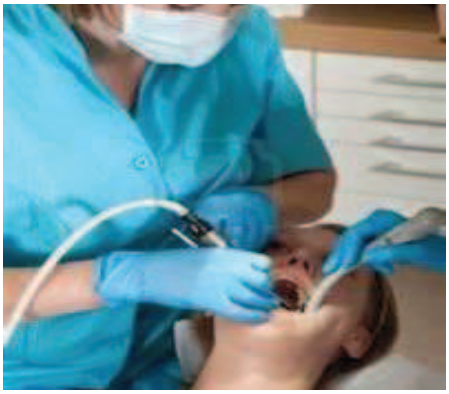

Also, the patients placed at Winterbourne View hospital were there for a very long time.

Some patients were there for more than 3 years.

From the evidence, it does not appear that there was much hurry to move patients on from Winterbourne View.


The number of times patients were restrained by staff at Winterbourne View hospital was very high and unacceptable.

For example - a family provided evidence that their son was restrained 45 times in 5 months.



The Serious Case Review provides evidence of poor quality care in Winterbourne View hospital.

For example:
Some people had poor dental health care.

The Serious Case Review says that for a lot of the time Winterbourne View hospital was open, families were not allowed to visit patients on the ward or in their bedrooms.

This made the abuse of patients even harder to spot.

The patients at Winterbourne View had very little access to advocacy.

Also, patients' complaints were not handled properly.

The abuse of patients at Winterbourne View hospital should have been noticed earlier.

But it was not.

## Castlebeck Care Limited

Castlebeck Care Limited had policies and procedures that seemed really good. But the policies and procedure were not put into practice.

For example:

The recruitment of staff did not appear to focus on quality. The job descriptions of staff did not ask for staff to have experience in supporting people with learning disabilities/autism and challenging behaviour.

Evidence also suggests that staff training at Winterbourne View was focused too much on the use of restraint.

## The safeguarding authority

South Gloucestershire Council were told about safeguarding issues in Winterbourne View but failed to identify a trend in the number of times they were contacted.

## The commissioners

The commissioners are the people who placed people at Winterbourne View.

They paid a lot of money to place people there and should have made sure the hospital provided quality care.

## The Care Quality Commission

Before the Panorama programme showed on television, a whistleblower told the Care Quality Commission that he was worried about the way patients at Winterbourne View were being treated.

The Care Quality Commission failed to respond to the concerns raised by the whistleblower.

## The Mental Health Act Commission

The Mental Health Act Commission were told about incidents at Winterbourne View and said there was a need to improve but did not follow up to make sure improvements had happened.

## The Police

29 incidents were reported to the police. 8 of the reported incidents concerned staff using physical restraint on patients.

The police didn't follow up the incidents because they believed the reasons given by staff at Winterbourne View.

Before the Panorama programme, the police successfully prosecuted one of the members of staff at Winterbourne View.

## Part 3: What happened to the people who were at Winterbourne View hospital?

The people who were at Winterbourne View hospital were treated very badly.

The Serious Case Review said that the patients who were at Winterbourne View should get support to deal with the abuse that took place at Winterbourne View hospital.

They said this support should be provided by commissioners.

In the Out of Sight report, a report written by Mencap and the Challenging Behaviour Foundation. Simon's mum said that:

- Simon is now living near his family.
- Simon now has his own flat.
- Simon has his own support team.
- Simon is both safe and happy.

The support that Simon is receiving costs less than Winterbourne View hospital.

It is sad that not all the people that were at Winterbourne View have had the same experience as Simon.

The Department of Health asked the NHS South of England to follow up on what happened to the 48 English patients who had been in Winterbourne View. This was done twice.

The feedback that the Department of Health received in March 2012 was:


- 22 patients were in hospital, and 26 were in social care supported places;
- Safeguarding alerts had been raised in relation to 19 of the 48 patients;
- 27 of the 48 patients needed a lot of support to deal with the abuse that took place at Winterbourne View.

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The feedback that the Department of Health received in September 2012 was:

- 32 people were in social care supported places, while 16 were in hospital.
- But Safeguarding alerts had been raised in relation to 6 people.

The Department of Health will continue to check on the people who were at Winterbourne View to make sure things improve for them.

# Part 4: How are people with learning disabilities and autism supported in England?


The terrible things that happened at Winterbourne View set off a wider review into how people with challenging behaviour are treated all over England.

By looking at the information from other reports and speaking to families and people with a learning disability and autism, the Department of Health was able to see how people with learning disabilities and autism are supported.  We did not like what we found.

We found that:


There are too many people with learning disabilities and autism in hospital, when they should not be.

This is because the right services to support people in the community have not been put in place.


Too many people with learning disabilities and autism are placed in hospital and are staying in hospital far longer than they should.

Hospitals are not homes, so this should not happen.

Too many people with learning disabilities and autism are sent far from their homes and families.

Government guidance says that people should be able to get the support and services they need locally, near to family and friends.

We also found many cases of:

- poor quality care
- Poor care planning around the needs of people.
- Lack of quality activities for people to do in the day
- Too much reliance on the use of restraint by staff

All of these things are wrong.  The right services to support people with learning disabilities and autism must be put in place.

## Part 5: The Big Goal: What we want to see

The report sets out the type of care that people with learning disabilities/autism and behaviour that challenges should get.

People should receive local personalised services that meet their needs.

This support should be planned from childhood.

People should be supported in the community, in their home or close to their home and family.

People should only go to hospital for assessment and treatment if it is necessary and they cannot get the support they need at home or in a community service.


People that do have to go into hospital for assessment and treatment should receive good quality care as near to their home as possible.


People should be moved on from hospitals as quickly as possible – either back home or on to other community support.

Commissioners who place people with learning disabilities/autism in hospital or community support settings should have clear responsibility for each person.

The commissioners should also make sure that people with learning disabilities/autism are able to see and speak to their families regularly.


There should be local services that stop people with learning disabilities from having a crisis.

If a crisis does happen then there should be local services to help people deal with the crisis.

## Part 6: How will we make change happen?


Everyone has a part to play in making things better for people with learning disabilities or autism and behaviours that challenge.

This is why the Department of Health and a number of organisations have come together to make change happen.

This plan will mean better outcomes for all people with learning disabilities or autism and behaviours that challenge.

Everyone who has signed this plan will work together to make change happen by October 2013.

The plan will ensure that:

Health and care commissioners will look at everyone with a learning disability who is in hospital now. If people do not need to be in hospital they will support them to move to community support by 1 June 2014. Before then if possible.


Every area will have a local joint plan for very good care and support services for people of all ages with challenging behaviour.

There will be national leaders to support local change.

The NHS Commissioning Board and the Local Government Association will start a new programme of work called the **development improvement programme.** This will provide national leadership to change services locally.

Planning good care starts with children so that there are good services when people grow into adults.

Making the care people get safer and better.

The Department of Health says it will be law to have Safeguarding Boards for Adults. This is about keeping people safe.

Everybody will make sure that safeguarding boards work to make children, young people and adults safe.

Over the next year everyone who has signed this agreement will help make the skills of the workforce better so that people get better care.


Organisations and their Directors are responsible for care being good and they will be asked to explain and held to account for poor care.

Laws about inspecting services will be stronger.

The Care Quality Commission (CQC) will use the law, or regulations, they already have to make sure service providers are doing the right thing.

CQC will carry on inspecting hospitals and care homes without letting providers know first. People with learning disabilities and family carers will be in the teams who do the inspecting.

We will check to make sure services get better.

The Learning Disability Programme Board, which is chaired by the Minister for Care and Support, will check all the actions in the agreement and report on what is happening.

There are many more actions that different organisations will carry out.

These actions are in a document called the Concordat or Agreement.

## Difficult words used:

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| **Assessment and treatment unit** | An Assessment and Treatment unit is like a small hospital.<br><br>Sometimes people go to assessment and treatment units when they are upset or disturbed or when there is a crisis and they are in danger of hurting themselves or other people to help them and find out what treatment they need.<br><br>People who work there include nurses, doctors, psychologists and therapists. |
| **Association of Directors of Children's Services** | The Association of Directors of Children's Services Ltd (ADCS) is the national leadership association in England for statutory directors of children's services and their senior management teams. |
| **Association of Directors of Adult Social Services (ADASS)** | This an organisation made up of Directors of Adults Social Services. There is also an organisation for Directors of Children's Services. |

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| **British Institute of Learning Disabilities (BILD)** | BILD is an organisation that supports people with learning disabilities and provides training, events, meetings, books and magazines for their members to help spread good practice about people with learning disabilities. |
| **CONCORDAT** | This is another word for a written agreement that different people agree to. |
| **Children and Young People's Outcomes Framework** | The Department of Health wrote this to say what is needed for children and young people to have good health and care. |
| **Clinical Commissioning Groups (CCGs)** | A Clinical Commissioning Group (CCG) is the name for the new health commissioning organisation which will replace Primary Care Trusts in April 2013. Commissioning organisations are responsible for planning and buying of healthcare to meet the needs of people. |

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| **Care Quality Commission (CQC)** | The Care Quality Commission makes sure there are good health services, and good social care for adults in England. They check up on services run by the NHS, local councils, private companies and voluntary organisations. |
| **Education, Health and Care Plans** | These are plans which mean there is good planning for children when they grow up and become adults. They cover important areas in one plan. |
| **Forums and voluntary sector organisations** | These are organisations like the National Forum for People with Learning Disabilities and the National Valuing Families Forum who speak for people with learning disabilities and the families who care for them. |
| **Healthwatch** | Healthwatch England is a national organisation from October 2012. Local Healthwatch will start in April 2013 to give a greater voice to people who live locally about health and social care. |

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| **Health and Care Commissioners** | These are people whose job it is to purchase health and care services. |
| **Health and Wellbeing Boards** | The Health and Social Care Act 2012 set up health and wellbeing boards. They are a forum where key leaders from the health and care system work together to improve the health and wellbeing of their local population and reduce health inequalities. |
| **Improvement Programme** | Local government and the NHS Commissioning Board will work together to lead local change. They will do this through a new development improvement programme which will be set up by end December 2012. |
| **Joint Health and Wellbeing Strategies** | Joint Health and Wellbeing Strategies are to do with being healthy and feeling well. They are plans between different groups to make things happen locally. |
| **Learning Disability Professional Senate** | The LD Senate has professionals like GPs, Nurses and Psychiatrists who look after people with challenging behaviour. |

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| **Local Government Association (LGA)** | The LGA works on behalf of councils to make sure local government has a strong voice in national government. |
| **Mandate** | The Mandate is a formal notice from DH to the NHS Commissioning Board that sets out the objectives for the Board to make care and healthcare better. |
| **NHS Commissioning Board** | This started as an independent organisation from 1 October 2012. It helps to set up Clinical Commissioning Groups (CCGs). It is part of the new health system and will take up its new work in full from April 2013. |
| **Health and Social Care Information Centre** | This is an NHS organisation that collects facts and figures about health and social care in England. |
| **NHS Serious Untoward Incident Investigations** | The NHS in the South of England also carried out a special review of what happened at Winterbourne. They are looking at what happened to patients at Winterbourne View after the hospital closed. |

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| **National Institute for Health and Clinical Excellent (NICE)** | The National Institute for Health and Clinical Excellence (NICE) helps healthcare professionals and other make sure the care they provide is good quality and is good value for money. |
| **People with challenging behaviour** | When we say 'People with challenging behaviour' we mean people with learning disabilities or autism and who have mental health conditions or behaviour that challenges. |
| **Providers** | These can be organisations run by the Government, charities or private companies. They provide services for people with learning disabilities. |
| **Personalisation** | This means people having choice and control over the health and care they receive so their particular needs are met. |
| **Quality of Health Principles** | An organisation called Changing our Lives worked with people with learning disabilities to say how they want to be treated in hospital. The principles will be included in NHS contracts with providers. |

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| **Serious Case Review (SCR)** | The local authority for Winterbourne View, South Gloucestershire Council, looked at what went wrong. They asked for reports from everyone like the NHS, the Care Quality Commission and Castlebeck Care. |
| **Skills for Care & Skills for Health** | These organisations support the people who work in adult social care in England. |
| **South Gloucestershire Council** | This is the local council for Winterbourne View. |
| **The National Quality Board** | Is made up of stakeholders who make sure there is good quality right across the NHS. The Board is an important part of the work to deliver high quality care for patients. |
| **The Department of Health** | This is a Government Department in charge of the policy and law to do with health and social care. |

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| **The Department for Eduction** | This is a Government Department in charge of policy and law to do with children and education. |
| **The Learning Disability Programme Board** | This Board includes people from Government Departments, organisations for people with learning disabilities, like the National Forum for People with Learning Disabilities, the National Valuing Families Forum and Mencap. |
| **The Children and Families Bill** | Once it has been agreed in Parliament, this Bill will be a law that brings one way to assess children. This is called a single assessment and covers education, health and social care. |
| **Think Local Act Personal (TLAP)** | Think Local, Act Personal is an organisation that works locally on personalisation. |
| **Whistleblowing** | Whistleblowing is when a worker reports things they see at work they think are wrong to other organisations who can do something about it. DH has set up a Helpline to make whistleblowing easier. |

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| **Winterbourne View** | This was a hospital run by a company called Castlebeck Care. The hospital was for people with learning disabilities, people with autism and people who may need support with their behaviour.<br><br>The hospital is now closed. |

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# Facing the commissioning challenge: responding effectively to people whose behaviour is challenging

**Sandy Bering**
Strategic Lead Commissioner/Consultant, NHS Trafford, UK

## Abstract
Securing better health and better care outcomes for people by effective use of public resources is at the heart of the commissioning agenda. Commissioning should ensure that the needs and wishes of people are well understood, and the market managed, so there are a range of local supports and provision available at a reasonable price. This is particularly important for people with intellectual disability whose behaviour is challenging, where effective clinically informed leadership is essential. Although models of good practice have been demonstrated for more than 20 years, making this happen on a wider scale remains the real challenge. Common wisdom about positive practice is not common practice in meeting identified needs. This paper aims to demystify the 'commissioning' role, and highlights the case for change in current practice, exploring some of the key barriers that must be addressed and suggesting ways to achieve better outcomes.

## Key words
learning disabilities; intellectual disability; challenging behaviour; commissioning; positive behavioural support

## Introduction
Securing better health and better care outcomes for people by effective use of public resources is at the heart of the commissioning agenda. As a result, good commissioners are able to understand both individual and local service needs over time. They should be able to shape services that are fair and of good quality, and that change to match individuals' assessed needs and wishes. They should also be able to use the resources they have in the most effective ways to ensure that each locality has the capacity to respond flexibly, including ensuring effective support for those who are seen as challenging. The Mansell Report (DH, 1993) noted that:

> *life for people with major disabilities supported by good services will often look quite ordinary, but this ordinariness will be the product of a great deal of careful planning and management.*

The commissioning task requires effective and informed leadership to ensure that such conditions exist.

Even though models of good practice have been demonstrated for more than 20 years, making such conditions happen on a wider scale remains a challenge. Evidence of what works in commissioning positive behavioural practice has not kept pace with identified need. Placement breakdowns continue to be too common a problem; many people remain excluded from services; clinically informed recommendations are ignored; assessment and treatment facilities too often become blocked as individuals are not able to move back home; many placements eventually found are of high cost and low value in meeting identified needs. The Cornwall Inquiry (Healthcare Commission, 2007) traced reported abuse of people with intellectual disability, including of people whose behaviour was challenging, to lack of focus and commitment by commissioners to act in informed ways.

Given this recognised challenge, why has commissioning practice so often failed? Why has there too often been a preoccupation with passive, reactive and/or short-term orientated 'fixes', and failure to ensure clear, effective, early interventions? Commissioning actions appear to have been preoccupied with immediate costs and activity targets, with too little attention to strategic long-term outcomes, even though guidance such as the Commissioning Framework for Health and Wellbeing (DH, 2007b) sets an alternative clear direction for a shift to personalised services, a strategic reorientation to promoting health and well-being, investing early and in childhood to reduce future ill-health and disability costs, and a stronger focus on results with better partnership working promoting social inclusion and tackling health inequalities.

More recently this required shift has been captured in the vision for World Class Commissioning, summarised as 'adding life to years and years to life within a better value for money framework'. This ambitious programme is based on

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an examination of best practice in the UK and other systems around the world, and aims to transform commissioning practice in public services with resulting improved quality, effectiveness and efficiency of services (DH, 2009b). Ensuring better strategic and operational commissioning for people with intellectual disability exemplifies this vision, and making it happen for people whose behaviour is challenging has been regarded as a critical 'acid' test (IDeA, 2008). This has been reinforced by a variety of key reports and policy guidance over the past decade.

This paper aims to demystify the elements of effective 'commissioning' roles, processes and the relationship of this work to positive outcomes in intellectual disability services, and to challenging behaviours. It highlights the case for a change in current common practice, explores some of the key barriers that must be addressed, and suggests key ways to achieve better outcomes.

## Commissioning in line with *An Ordinary Life* and the Mansell reports

More than 20 years ago, a key publication from the King's Fund set out a framework for developing high-quality services for people with challenging behaviour, *Facing the Challenge: An Ordinary Life for People with Learning Difficulties and Challenging Behaviour* (Blunden & Allen, 1987), followed by the supporting report *Meeting the Challenge* (Allen *et al*, 1991). Both demonstrated examples in a UK context of success, with all key necessary elements identified in line with international research findings:

- clear informed commissioning and clinical leadership with a focus, commitment and enthusiasm across local systems to a shared positive value base recognising that people with challenging behaviour have equal value, rights and need to live and participate fully in their local communities with access to effective support
- responsibility taken by lead commissioners, managers and clinicians to support people locally and design well co-ordinated person-centred supported home and day services, grasping 'local windows of development opportunity' with careful calculated risk taking and flexible supports, avoiding the 'easy ways out' of placing people presenting complex support needs with someone else or somewhere else away from their local communities
- use of positive clinical technical assistance including behavioural approaches adapted to the social context (Lovett, 1985), communication-enhancement interventions (Reichle & Wacker, 1993) and rapid access to skilled clinical advice and intensive practical change and crises management programmes (Emerson *et al*, 1987).

***Box 1***, below, sets out the key points about challenging behaviour with which commissioners should be familiar.

The Department of Health published the findings of a project group chaired by Professor Jim Mansell, *Services for People with Learning Disabilities and Challenging Behaviour or Mental Health Needs* (DH, 1993). This built on the King's Fund reports by identifying critical issues in effective local service developments, including the following.

- Improved understanding of the needs of children (and adults) with reputations for challenging behaviour placed out of area, and a focus on clear strategies enabling a return locally.
- Implementing programmes in early intervention and detection of emerging problem in childhood and at transitions.
- Services structured around individual needs, minimising the occurrence of challenging behaviour and with the resilience to cope with severe presenting challenges, including those related to mental health difficulties and

**Box 1: The key things commissioners should know about challenging behaviour**

- It is relatively common, present for 5–15% of service users and varied in presentation
- Some people are at greater risk so need targeted interventions
- It is damaging to people themselves, relationships, families/carers, services and society
- It often emerges in early childhood, persists over decades with 70–80% persistence over seven years, and so needs early effective intervention and understanding. Personal histories matter
- The factors causing and maintaining challenging behaviour are varied and complex, and include various mixes of biological-psychological-social factors and as such require responses from confident, skilled teams informed by comprehensive assessments and formulations that take into account individual disabilities and personal history and acknowledge that they may be expressions of desired ordinary life experiences, control communication, relationships and chronic negative behaviour patterns/habits
- Positive behaviour support strategies do work when delivered within coherent comprehensive support systems backed by competent, confident and capable staff, rather than naïve reliance on staff to react 'naturally' with little training
- Most people do not receive effective interventions, and many continue to receive no, ineffective or potentially damaging 'treatment', and also are excluded from local valued opportunities that then damage individuals further by over-reliance on medication, control and punishment
- Setting up challenging behaviour home/day units or just moving people does not work

offending behaviours, rather than 'place and hope' strategies that result in mis-matches.
- Careful design, provision and maintenance of local placements, recognising the impact of social context on challenging behaviour presentations since behaviours are a product of interactions between individual factors and the circumstances in which people live, rather than isolated pathological acts.
- Using the wide-ranging evidence base and knowledge about effective positive behavioural support strategies and programmes, and targeting prevention activities with enriched environments and able staff supported to promote adaptive behaviours.
- Organising long-term flexible support packages and accepting the need for complex multi-component intervention and support plans that need adjusting and review at regular intervals.
- Ensuring access to skilled, experienced clinical practitioners in local community support teams that support confident, committed, capable and competent social providers, avoiding artificial distinctions between health and social care, and able to provide high levels of practical, technical, clinical and regular emotional/de-briefing support for carers, avoiding exploitation of commitment and dedication.
- People generally feel more secure with fewer people to relate to, and have a greater sense of control over their environment and life, so grouping people with challenging behaviour together tends to create additional problems and should be avoided.
- Developing services that enable staff to connect with individuals whose behaviour is challenging, and then continue direct involvement, thereby developing a real sense of personal responsibility and commitment.
- Accepting that changing challenging behaviours takes time and effort and no one answer works for individuals at all times.
- Changing the continued 'reactive' focus dominant in supporting individuals to manage crises.
- Responding to emerging danger signs with crisis management and support, with rapid deployment of 'hands on' staff support, accessible on-call services, contingency relapse planning, respite/break options, access to alternative homes and jobs, training in managing physical interventions, skilled specialist interventions and, last resort, access to emergency beds.
- Completing regular structured service review and development programmes.
- Effective contracting for improved services by specifying service models shown to achieve good results such as supported homes, employment, education and leisure packages, what services will achieve, and key elements of the required models of care, including amount and quality of staff support, and external validation strategies of care quality and options for raising safeguarding concerns.
- Adopting comprehensive investment frameworks that recognise hidden costs such as responding to placement breakdowns, crises and other carer costs, and using joint funding approaches to emphasise inter-dependency between services, and strategies to strengthen local 'mainstream' services.

Mansell identified the way forward as that of strengthened commissioning combined with provision of effective clinical expertise (Allen *et al*, 2005; Carr *et al*, 1999; Donnellan *et al*, 1988; Emerson *et al*, 1999; Horner *et al*, 1990).

Although all this work has subsequently underpinned both the *Valuing People* (DH, 2001) and *Valuing People Now* (DH, 2009c) strategy commissioning and delivery programmes, there has been limited specific guidance on what clinicians and commissioners should do. Following recognition of continuing problems in designing, developing and delivering effective supports for people whose behaviour is challenging, the Mansell report was revised and brought up to date by the lead author (DH, 2007c). He confirmed that the recommendations of the original report remained relevant more than a decade later. Although good progress had been reported on many fronts since the publication of *Valuing People*, progress on challenging behaviour lagged behind. Failure to commission and develop appropriate services is continuing to lead to damaging outcomes for individuals, and is a serious cost to society. Mansell noted that the main reason for this concerned poor, and at times ill-informed, commissioning leadership, together with a general failure to introduce positive behavioural support practices.

In terms of challenging behaviour, the agenda is clear: commissioning should follow the recommendations of *Facing the Challenge* and the Mansell report.

## Commissioning principles

The central challenge for all commissioners remains balancing effective and efficient service delivery, improved outcomes for users of services, higher quality and cost-effectiveness. Commissioning should ensure that the needs and wishes of people from the local area are well understood and the market managed so there are a range of local supports and provision available at a reasonable price. This requires a connection between commissioning plans and operational micro-commissioning, decision-making practice where individual care packages are agreed and reviewed.

In its simplest form, commissioning is an on-going cyclical process to understand the needs and wishes of individuals, using assessments and research to detail priorities and choices which lead to determining how best to deliver the support and to allocate the funds it requires. Plans are then developed, monitored and evaluated to ensure the



quality of the service. To be effective, this process needs to be inclusive. However, beneath those words lies a more complex agenda and a continuous process that has been summarised as the eight-step commissioning cycle (DH, 2007b) – ***Figure 1***, below.

The process, done well, includes a range of activities, such as knowing what services people need to live a good life, using this knowledge to plan changes for localities, taking action to change services where they are not good enough, funding services to meet individual needs, checking that outcomes from services are of good quality, and changing services and plans if needed. This then requires a clear, articulated vision and commitment to achieving meaningful long-term outcomes that connect with the needs and aspirations of local people (a strategic commissioning plan), understanding needs, demand and supply over varying time-frames, effective and efficient use and deployment of resource, and financial planning linked to service development and changes in delivery patterns.

A detailed intellectual disability commissioning assessment framework was developed by the Care Quality Commission (and its three predecessor regulatory bodies, the Healthcare Commission, CSCI and the Mental Health Act Commission, 2008) in response to collective concerns over the quality of commissioning practice and the widely reported negative service experiences of people with intellectual disability and complex needs, including those whose behaviour was challenging. The key elements of the framework enable local review of progress against the priorities implicit in *Valuing People Now* (DH, 2009c), and support the required new World Class Commissioning competencies and roles for commissioners (DH, 2008b). Some of the key elements of this approach have been captured as a person-centred commissioning pathway approach (IDeA, 2008).

The CQC (2009) has now recognised that commissioning plays a key part in ensuring that outdated care and support are sustained. Key strategic development priorities have now been identified to enhance the quality of outcomes for people with intellectual disability who use services: ensuring that care is centred on people's needs and protects their rights, championing joined-up care so that health and social care are more co-ordinated, acting swiftly to help eliminate poor care, ensuring and promoting high-quality care, and regulating effectively in partnership.

## Commissioning for challenging behaviour – key challenges

In February 2009 the Parliamentary and Health Service Ombudsman and Local Government Ombudsmen reported on the six individual cases highlighted in *Death by Indifference* (Mencap, 2007) of people with intellectual disability who died prematurely while in the care of the NHS. In addition to their conclusions on these individual cases, the report recommended that all NHS and social care organisations should:

- urgently review the effectiveness of the systems they have in place to enable them to understand and plan to meet the full range of local needs
- urgently review the capacity and capability of the services they provide and/or commission to meet the additional and often complex needs of people with intellectual disability, including those who present challenging behaviours
- report accordingly to their Boards by March 2010.

**Figure 1: The eight-step commissioning cycle**

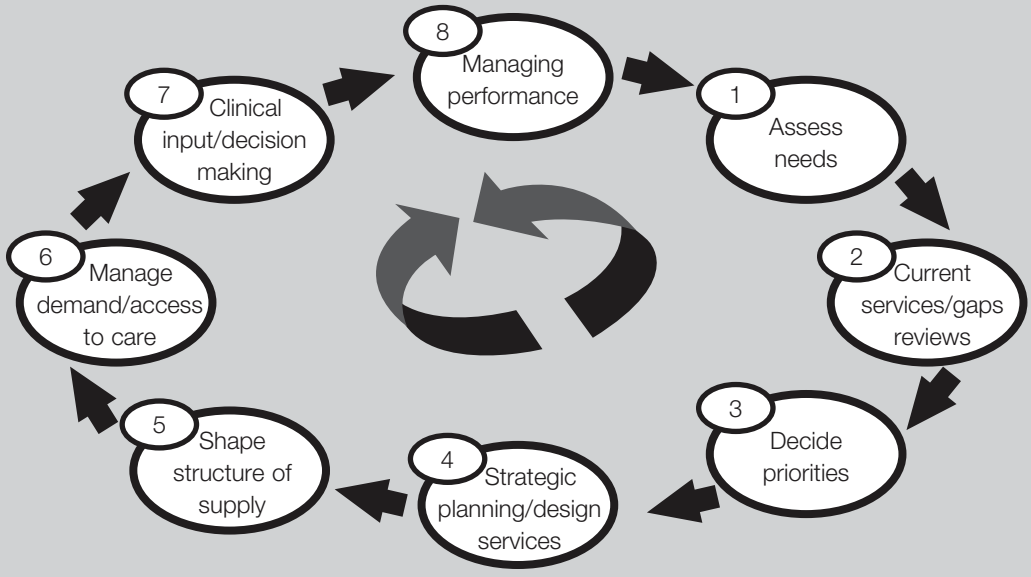
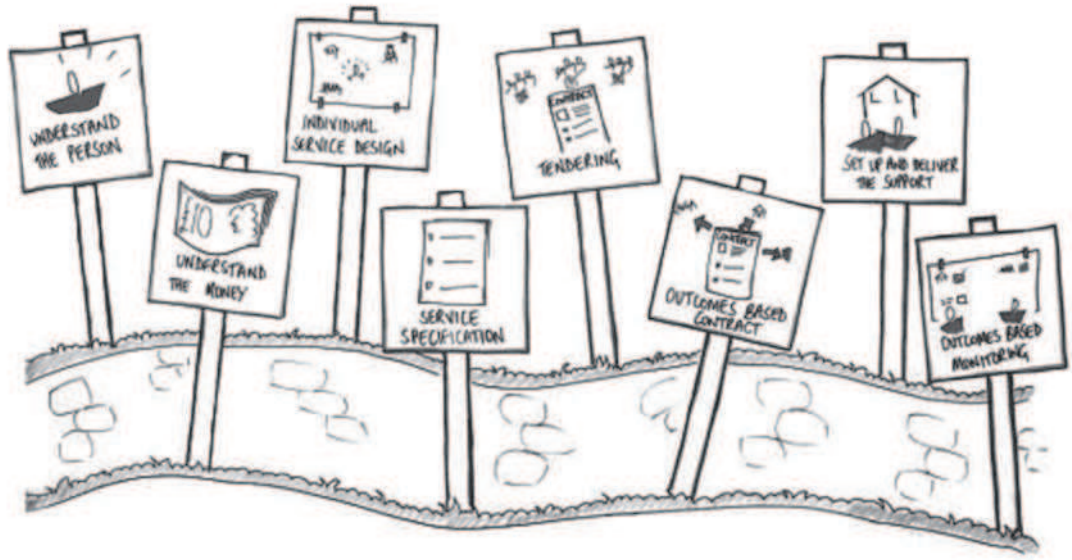


**Figure 2: A person-centred commissioning pathway approach**




The findings of the Joint Commissioning Review for People with Learning Disabilities and Complex Needs (2009), carried out by the Healthcare Commission, Commission for Social Care Inspection and Mental Health Act Commission, highlighted:

- concerns about broader commissioning skills and practice
- continued negative professional values and attitudes
- poor forward planning for people with intellectual disability to prevent crisis
- lack of person-centred care plans, poor care planning and care
- over-reliance on poor-quality out-of-area placements with limited local services
- negative treatment of people whose behaviour challenges
- concerns about excessive physical interventions and restraint rather than proactive strategies involving antecedent control and ecological changes
- growth of large traditional service models in the private sector
- lack of regular monitoring of placements and support for quality outcomes
- poor practice in capacity, consent and deprivation of liberty issues
- increased burden on family carers
- very few people getting annual health checks and support in primary care
- people and their families having bad experiences while in general hospitals
- limited progress in securing positive support from mental health services
- lack of involvement of people in delivery, training and development of services.

Other distinct commissioning challenges have been confirmed by the recent World Class Commissioning Guidance on Commissioning for People with Learning Disabilities (DH, 2009b), including managing the challenges of lead social care commissioner arrangements, legal requirements, person-centred care, information sharing, promoting access to services, consent and capacity issues, effective communication, diagnostic overshadowing, knowledge and skills, and resettlement and campus closure plans.

The recent transfer to local authorities of responsibility for past PCT-led social care commissioning and funding (DH, 2009b) for people with intellectual disability has been designed to enable PCTs to focus better on meeting the health needs of people with intellectual disability (now defined as responsibility for health care, including specialist and mainstream services, forensic support and continuing health care).

This action has been complemented by the guidance on *Commissioning Specialist Health Services* (DH, 2007d), which requires an effective and identifiable strategic presence within PCTs to inform and support the commissioning and delivery of services in ways that address the needs of people with intellectual disability. It also confirmed the particular need to enhance local specialist support for people, to reduce the number of poor-quality, high-cost out-of-area placements.

Nevertheless, too little attention and value have been focused on enabling the availability of well-functioning community learning disability teams in line with *Commissioning Specialist Adult Learning Disability Health Services: Good Practice Guidance* (DH, 2007d) and professional practice guidelines such as *Challenging Behaviour: A unified approach* (RCPsych *et al*, 2007).

Many non-clinical experienced and social-orientated commissioners lack experience in commissioning person-centred support for complex needs, which has too often resulted in support for risk-averse cultures. This has then appeared to pressure local services into being unwilling to sign off risk assessments that would enable local placement of people who challenge. As a result, too often choice and normalisation principles have been confused with the need for balance with effective structure, boundaries and clinical support involving known, successful, positive behavioural technologies (Emerson & McGill, 1989; LaVigna & Willis, 2005) and person-centred essential planning principles (Lovett, 1985; Smull, 1995), thereby really 'learning to listen' to the 'message value' underpinning challenging behaviour presentations (Lovett, 1996).

The lead commissioning role of local authorities should not be mistaken for the removal of any continuing responsibility and effective involvement of PCT commissioners and other clinicians in informing necessary local service responses to challenging behaviours and health needs. However, too often commissioning remains primary-led by social care practitioners ill-equipped and unsupported in terms of clinical confidence, knowledge and experience of managing and changing challenging behaviours. High on the agenda to respond to this, local commissioners need to think and act both strategically and pragmatically, overcoming the tension between various priorities and competing targets that sometimes conspires to create boundaries to effective partnership at the social–health commissioning interface.

The separation of commissioner and provider roles has also stopped many skilled intellectual disability professionals and other key stakeholders, able to provide important information at a number of points in the commissioning cycle, from doing so. In fact, at times lack of clinical engagement may well have contributed to some ineffective commissioning decisions with respect to challenging behaviours, when well-presented, high-cost but ineffective services with a lot of window dressing have become confused with effective positive behavioural supports.

The emergence of the personalisation agenda in health and social care will also bring new challenges for commissioners, as it requires commissioners to think about care and support services in a different way by challenging all existing systems, processes, staff and services to put people first (DH, 2007a), together with more effective market management and the stimulation of competition that has grown in recent years. The principle factor in managing the local market should be for commissioners to procure services from providers who are best placed to deliver the needs of patients. As part of this process, commissioners now need to develop better specifications for contracts for individual support and care pathways, and then place greater emphasis on effective outcome-based contract management.

Finally, over the coming years, it is clear that commissioners will be operating in a intensely cold financial climate, with reduced budget allocations, increasing focus on achieving savings, and a need to prioritise investment on the essential clinically- and cost-effective services (NHS Confederation, 2009). New developments will be scrutinised even more closely, to ensure that they are evidence-based and will be of direct benefit to users of services and the wider community. Commissioners will need to employ new approaches and create opportunities to engage service users and carer experts by experience in developing pragmatic solutions.

## Putting the jigsaw together: commissioning for challenging behaviour

I am fortunate in having been afforded a range of experiences over the past 25 years as an assistant/support worker, clinician, manager and commissioner that have endorsed the value of each of the pieces of the emerging commissioning jigsaw.

For example, experience suggests that effective commissioning and service delivery rely on the sustained commitment and skills of individuals; negative changes often result from small yet significant changes to the context (such as shifts in leadership, local priorities or team composition). Supporting positive behavioural support programmes requires both strategic attention to system-wide interventions and supporting key anchors, allies and assistants. This latter point is critical, as too often personal factors are down-played, with the good intention of managers to implement mechanistic service systems that reduce reliance on personality factors. Clearly, while such an approach is understandable, it is bound to ensure attainment of only minimum service standards rather than true person-centred, excellent supports.

Based on a review of effective commissioning and clinical practice experience in Birmingham, Sheffield, Liverpool, Cheshire and Trafford the following priorities exist.

- Establish senior, local, clinically informed strategic commissioning and operational leadership posts, usually focused on enabling positive outcomes for vulnerable people rather than intellectual disability alone.
- Begin with a local person-centred needs assessment process to identify proactively all known local individuals with severe reputations for presenting challenging behaviours, then develop detailed personal profiles and functional analyses of challenging behaviour. Follow up proactively by combining the evidence on the wider number, health needs and

experiences of people and those presenting complex needs to prioritise investment decisions.
- Enable an effective, robust, person-centred planning process and formalise links between the outcomes of individual person-centred plans and strategic development decisions for services and local strategic needs analyses.
- Focus on shaping joint early-intervention programmes with children's services, including enhanced behavioural support and transition support pathways, and providing a range of Aiming High flexible, planned/crisis, short-break options.
- Identify and share best practice in the creative use of funds to help create cultures that sustain positive support arrangements within budgets.
- Take stock of current services, looking at costs and effectiveness, deficits in provision and unmet need, and key workforce development needs.
- Enable regular, reflective, solution-focused dialogue with providers and service users at multiple levels to identify what has worked well and where there have been problems.
- Shape markets to match local needs, with greater flexibility in tendering and contract processes to ensure they work well for people using the services.
- Initiate tendering and preferred provider frameworks, and decide on the providers who are best able to meet needs and where appropriate decommissioning may be needed.
- Complete clear service specifications for individuals, group services and projects.
- Facilitate regular commissioner-led contract and service development review meetings to monitor effectiveness and tracking of progress for real person-centred outcome changes and positive stories, as well as performance data, by honest communication between commissioners, individuals who use services and support providers.

**Box 2: Completing the jigsaw of positive commissioning responses to challenging behaviours**

- **Person-centred and clinician-informed commissioning**, focusing on needs assessment, prevention and early identification/intervention and proactive community development, ensuring that interesting options are matched to individuals' needs and personal champions who truly care for people and act as anchors
- **Better support for children and families integrated with children and family services commissioners**, focusing on practical positive family-centred behaviour support plans for young children to disrupt the establishment of negative habits and rituals, effective types of support to prevent or reduce challenging behaviour in childhood, and working with commissioners for children's services to tackle 'upstream' problems and ensure transition is well managed
- **More and effective support for families**, through better access to information, training, support and respite/short breaks, and integrated structured interventions with schools and through the transition process
- **Effective expert care management and resource allocation panels**, with all people with intellectual disability and complex needs having a named care manager, health facilitator or navigator whom they have met, who actively monitors how their needs are being fulfilled and offers support should they wish to raise concerns; wider systems planning ahead, based on clear, accurate, person-centred summary profiles or plans with simple written records of history, key preferences, helpful and unhelpful responses, to inform the design of capacity to cope with changing demands, rather than waiting until crises occur
- **Competent health and social care providers** with effective managers/leaders, and access to supported home, workplace and lifestyle opportunities conducive to learning, joy and experiencing a wide variety of activities and relationships; recognising how challenging behaviour is maintained by environmental processes, interventions should take place in normal settings, with personalised routines and managed expectations of carers to reduce unreasonable pressures and stress
- **Specialist clinical capacity**, competent clinicians and community support teams, skilled and accessible ongoing positive behavioural support, practical emotional support, interventions that work in natural settings, and bio-psycho-social programmes
- **Effective interfaces** with specialist child and adolescent mental health, disability and adult mental health, continuing care, safeguarding services including Aiming High for Disabled Children, early intervention teams, transition, *Mental Capacity Act*, Green Light Toolkit protocols, crisis resolution, assertive outreach and emergency support services, secure services and PCT/locality authority resource allocation panels
- **Long-term resource deployment**, including confident, competent staff to support effective ways of working and sufficient respite break opportunities and supervision and training
- **Funding, procurement and contracting mechanisms**
- **Emergency support options**, providing coping strategies to deal with presenting challenging behaviours, managing them with low-arousal responses, enabling access to psychiatric support and short-term alternative places for support as part of integrated care pathways



- Ensure links to clinical and corporate governance by appropriate reporting lines, accountability, safeguarding mechanisms, complaints management systems and training/development activities.

***Box 2***, opposite, summarises how the 'jigsaw' can be completed.

Mansell has noted that:

> *… since cost is sometimes given as a reason why adequate services for this group of people are not developed, it is worth noting at the outset that these services were all developed within the existing resource framework available to their host agencies. Resources are a question of priorities as well as of the amount available* (DH, 2007c).

At a time when commissioners are faced with increasing demands and financial constraints, they should not resort to traditional group services, but support personalisation even more, and focus activities to ensure they make a real difference to people. Only then can high-quality commissioning lead to high-quality outcomes for people whose behaviour is challenging.

It is up to effective commissioners to rise to the challenge and make this a reality everywhere, with strategic analyses of need, investments and action involving positive behavioural support strategies.

## Summary points

- Securing better health and better care outcomes for people by effective use of public resources is at the heart of the commissioning agenda.
- Commissioning should ensure that the needs and wishes of people are well understood and the market managed so there are a range of local supports and provision available at a reasonable price.
- This is particularly important for people with intellectual disability whose behaviour is challenging, where clinically-informed leadership is essential.
- Although models of good practice have been demonstrated for more than 20 years, making it happen on a wider scale remains the real challenge.
- Common wisdom about positive practice is not common practice in meeting identified needs.
- To respond to this challenge, commissioners will need:
  - to work together more effectively to secure and deploy technical commissioning expertise/capacity and develop effective positive behavioural supports
  - to recognise that effective commissioning requires development of deeply embedded, sustained and trusting relationships with all stakeholders – not just technical skills
  - to ensure there are sufficient incentives for individuals and teams of the right calibre to take on the necessary leadership roles across systems
  - to invest heavily in preserving and improving relationships with partners, and consider all opportunities to combine resources
  - as a result, to respond positively with what we know works in effective commissioning practice as outlined above.

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