

Workshop Outcomes

Learning from Previous Closure Programmes

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The current need for closure

Shortly after Winterbourne View was exposed on Panorama in 2011, a letter was sent to key Government officials setting out the changes that CB NSG members agreed needed to happen. Included within this was the managed closure of institutional services. Over the next four years, as little or no progress was made on reducing the numbers of in patients, we have promoted the need for a closure programme at various meetings and consultations, but it was ruled out by senior officials and Government Ministers.

In 2014, NHSE commissioned Sir Stephen Bubb to report on the lack of progress post Winterbourne. A closure programme was included within his recommendations, but NHSE did not commit to this in their formal response to his report. On 9th February 2015, at a meeting of the Public Accounts Committee to discuss the National Audit Office report, Simon Stevens was asked whether he was suggesting a closure programme, and he announced that “for some of these facilities, there will have to be”.

Summary

The facilitators of this workshop and many of those who attended were involved in the 1980s long stay hospital closures and the closure of campus facilities. The session began with Sue and Peter outlining ‘things we’ve done wrong’ and by the end of the session **a list was generated of key points that need to be considered around the issue of closure**. This list will be passed on to NHS and others. It includes the things you really have to attend to and be aware of during the process of reducing the number of people in ATUs and similar settings/services.

Introduction

Peter spent about 5 years in the late 80s/early 90s based in Kent as part of the special development team. It was NHS funded and set-up to support the resettlement of individuals with SLD from the long-stay hospitals in the South East of England whose behaviour significantly challenged services. He (and the team) supported areas to resettle specific named individuals. They helped to develop services for 22 people who were moving out of the long stay hospitals. There are many features of these services to reflect on, and learn from:

- Firstly is the incredible individualisation that occurred for each of those 22 individuals who were placed in specially designed services and their individual set of support was based on an extensive process of knowing the individual, involving family/existing carers and more formal assessments. In contrast someone who is currently involved in helping someone leave an

existing unit – they are trying to design a plan based on just one interview. If this is the typical plan for closure (hopefully not) it will mean disaster for community services and disaster for individuals who will end up going back to more restrictive settings in the longer term.

- The process is difficult and complex, individuals who are in these settings often have difficult and complex histories and they need considerable support. The process of developing and planning a new service of support in a community setting is a very skilled, lengthy and difficult process.
- Over the course of 5 years, of the 22 new sets of support, there were 3 breakdowns but I can guarantee that there were crises in all of them. You don't just take people from hospital, put them in a house in the community and leave them to get on with it. It's about supporting them and dealing with the inevitable problems and difficulties that will arise as well as proactively seeing them. The problems and difficulties are probably to do with the infrastructure issues discussed this morning: the lack of skilled and trained staff and the silos between different areas of support preventing people getting the support they need. We have to plan for that. The outcome is not just getting out of hospital but managing the crises, maintaining the placements and individuals receiving the necessary support.
- A final point is that **this process cannot be dealt with as something separate and special it needs to be about integrating what goes on – the rest of the support needs to be available locally for people with learning disabilities**. This is the biggest lesson learnt from the specialist team work – it was about **developing mainstream learning disability services as much as about as specialist provision**.

Sue spoke about her experience as Director of Nursing of 3 long stay hospitals in Hertfordshire as they closed. She freely admitted that she got lots wrong, with 1700 people in three hospitals, whilst managing the enormous changes. She also worked in the Valuing People Support Team closing hospitals, then campuses. There were difficulties in; the complexity of data, people who didn't want closure to happen but said they did, money (and using it well) and there being little written up about what works well. What particularly helps is people who are doing similar things talking about it and sharing what is and isn't working well (which is difficult if you want to appear successful).

The process we're talking about now isn't just about closure. There are lots of lessons to be learnt. Those involved in making decisions about these matters need to learn from the knowledge and history of the past, what went wrong and what's gone right.

Discussion

The discussions started from headings – what we thought might be a short-list with things to remind us all, in the heat of it action, what to think about.

How do we listen to all the issues presented and come up with solutions? Bring together what we've got so that the right people can do the right things to get the right support?

Closure is not an easy task and it needs to be different. The nonsense about people moving out by a certain date needs to stop. People need goals, otherwise it won't happen, but you can't just set arbitrary targets.

Heading	Original thoughts	Thoughts from discussion
Closure (the word)	<ul style="list-style-type: none"> • Helpful in galvanising and clarifying some of the task. • Energises people but can send people off on the wrong track – might not make it work for the generations to come • However it focusses people on that narrow function and goal rather than the wider developmental ones. • There is a need to come up with a good name for what is ahead that includes closure but evokes the challenge and development. 	<ul style="list-style-type: none"> • Would help to address the problem of something new (and just as inept) springing up in its place. • Some closure work and new provision at the same time. • Important to think of functions and 'succeed' in providing long term support • Don't want people to end up in 'step-down'/residential care • Prior to Simon Stevens announcement there was a belated push to discharge quickly and there is little evidence of where people are being discharged to, it's fundamental to know. (Allegation that campus closure led to growth in ATU's – the question remains about what people will get next). We don't want to have to close down something in a decade that springs up to replace ATUs. • The notion was if you speed up the assessments you speed up the discharges but it missed the point of the capacity issue in terms of what you discharge to. • We need a way of defining where people go, why and the outcomes for this. Care & Treatment Reviews are crude but a start and need to happen post-discharge (as happens in some areas). • There is an issue with assessments e.g. in long-stay hospitals little was done to tell of patients potential in community settings
Leadership and ownership	<ul style="list-style-type: none"> • Different levels, groups, functions • Nationally, regionally and locally this means a group of individuals with a range of skills and expertise, not one. • Professional leadership could be 	<ul style="list-style-type: none"> • Perhaps this is the only thing we need to talk about today. • At all levels, it criss-crosses • There is such a variation in quality • We need to ensure we won't lose-out if someone leaves • What should we say to NHSE about this? Someone asked a question about what happens if CCGs don't do it – nothing? Restraints and

	helpful?	<p>constraints in the system but how can we get leadership that will make things happen at CCG/LA level?</p> <ul style="list-style-type: none"> • The greater the voice of the user and carer the more likely there will be leadership – working the system, work by consensus. • To keep the focus – we need to empower user and carers to ask uncomfortable questions • In Peters specialist team work, regions were required to meet and discuss named cases, this was helpful in terms of leadership and in terms of finding out what was really happening to people. Not just 37 people have moved out but exactly where they are going.
Money	<ul style="list-style-type: none"> • What is available, capital and revenue (including dowry's?) • How you get it? • When you get it? • What has to be found locally and by whom? 	
Involvement/Co production/ working together	<ul style="list-style-type: none"> • Families of people who have lived in units and come out the other side and everyone else working together - even and especially when we don't agree. 	<ul style="list-style-type: none"> • No one person has all the answers. • Must try to move people out without causing more harm e.g. through the destruction of relationships. We have a relatively small number of people and this should be possible. • Legal framework to offer protection. • A key element is sustainability of the market – sufficient signals to social care, health care, housing to enable them to think through what kind of services we should think through.
A really good plan, that gets us going, helps and supports and doesn't turn into a list of process tasks.	<ul style="list-style-type: none"> • The outcome: We want people to have great lives • A multi layered plan that shows who contributes what when and how. 	<ul style="list-style-type: none"> • Need to ensure we don't let risk govern the process. • Regard to MHA/Criminal justice system issues. Need to tackle if we're here to protect or are we here to do no harm/help the patients? • Issue with restricted clients who can be discharged and are ready but can't go into the community due to a deprivation of liberty. • We have two institutions were they are ready to discharge and are waiting for the MoJ to agree DoL, mainly elderly men who were

		<p>probably convicted for sex offenses and they could probably be supported very safely in the community are 'stuck' and nobody is looking at it. Can't discharge from restriction order to DoL.</p> <ul style="list-style-type: none"> • If you have people who lack capacity no reason in law but a bit confusing. • Two or three fold difference in the regional rate of people being put on restriction order by the judiciary. • Gyles Glover paper in Tizard LDR.
Pace	<ul style="list-style-type: none"> • Balancing the importance of target dates with achieving good outcomes for people • E.g. Agreeing that an individual can miss the target date for good reasons and to ensure that the transition to a safe, appropriate community placement works well for the individual 	<ul style="list-style-type: none"> • In the past, some were ready to be discharged but were then detained under a section of the MHA but another psychiatrist came in and they came off their section. • Then you have a disjunction between who is clinical in charge and the current assessment 'a no man's land' (the job is not for the clinician in charge). • To get on the right page workforce, commissioning it takes time. • Cannot make it a tick-box exercise. It's hard to get a handle on exactly what is going on.
Data	<ul style="list-style-type: none"> • Counting the people- this is a subset of, the plan • It needs rigor, sense and an improvement in quality/outcome focused collection • No cut off to inclusion in the programme so some people are in the program and others out as they were admitted too late. • Clear definitions and fidelity of services to ensure no abusive or numbers gaming moves for individuals. The Mental health act is clearly part of this. 	<ul style="list-style-type: none"> • There is a danger of getting trapped into numbers games. For example recorded as being discharged from hospital but the patient has not moved (reregistering of services) • Actual outcomes for individuals need to be measured in all the domains that really matter – are you better, safer, having a better time. If you do this will have a better outcome, and not be hung-up on dogmatic rules (would also prevent issues such as the above) and this needs to start now.
Good information for people and families	<ul style="list-style-type: none"> • About the programme • Why and what the outcomes for the individual should be, including high quality 	

	<p>transition plans for any changes.</p> <ul style="list-style-type: none"> • Good detail about what the person will be doing day to day, how this is supported, including work and longer term plans. • Importance of stories-sharing what works and on a really good day sharing mistakes. I'm sharing a few here to get us started. 	
Advocacy	<ul style="list-style-type: none"> • High quality • Independent 	<ul style="list-style-type: none"> • Duty under care act • Really robust • Independent (no 'shut up or we'll defund you') • Circles around people (different models) • Families • Learning from long-term institutions, speaking with families I learnt of the awful guilt of parents, who made the most difficult harsh decision to give their loved-one over to a system which had been heavily advocated for and sold as the right thing for them. Then we rocked up and were told if I thought my son could live in an ordinary house, on an ordinary street I would never have let him go. Go away because you are hurting me too much. I can't believe you are right, you're talking nonsense. Get out. – We were arrogant, dismissive and demonised families. We cannot forget families, and the painful process they went through. E.g Orchard Hill.
Prevention	<ul style="list-style-type: none"> • Children and young people – the importance of early intervention and getting it right from the start • How to move from words to action within a wider program 	<ul style="list-style-type: none"> • Life-long, not just project-management of current problem.
Development of high quality community support	<ul style="list-style-type: none"> • A huge topic in itself but needs to be at the front in the plans and somehow in the overall name and 	<ul style="list-style-type: none"> • The institutions succeed in providing long-term support. The community support needs to be equally (hopefully better) support. • Discharging from hospital, getting

	<p>task.</p> <ul style="list-style-type: none"> Housing will be a significant and continuing issue as part of local housing plans 	<p>them out can transform a person and how they are (their behaviour).</p> <ul style="list-style-type: none"> Learning from Orchard Hill – people waiting for pads to be changed, thinking of individual quality of life. At Orchard Hill where you came from depended on the quality of support you were given after. The reality of what needs to be put in place really needs to be thought through honestly. Day centres, respite (they've been closing – they need somewhere to go).
Workforce and Skills	<ul style="list-style-type: none"> Person centred approaches could sometimes feel so important and complicated that some people spent lots of money and still were unable to get on with it in a good and skilful way. Possible parallel with PBS? support across networks and localities - from areas with expertise to those who are struggling and just starting to learn.(link with professional leadership) 	<ul style="list-style-type: none"> Skills following people (excluding institutionalised staff). We need to find a way of providing high skill levels more cheaply (e.g. by imparting skills to those 'cheaper' to employ – the front line staff). Frontline staff can learn a lot from psychologists, psychiatrists, speech and language therapists but there is no programme for that to happen. Enabling frontline staff to understand why people challenge (and keep going as staff change). Lots of ongoing support and safeguards. Outsourcing assessment. Workforce commissioning element. Commissioning can't just focus on right this person needs 2:1 support but they need psychiatrists, psychologists... multi-disciplinary teams. There were examples of good resettlement work with large community learning disability teams, with a subset of that team around each person. There were local , short-time crisis beds, but that infrastructure is gone. There needs to be a link between needs and skills – workforce must develop around needs of individuals. Identify skills needed. Do not mix skills with professions. Attitudes towards behaviour, understanding of it. Need a here and now – skills following people.
Ensuring it happens for people and	<ul style="list-style-type: none"> Link to leadership A really good plan will make this easier. Clear support when 	<ul style="list-style-type: none"> In the past the reasons for breakdowns were typically to do with: whether the services was any good at in the longer term helping

acting swiftly when it goes wrong in some way.	there are challenges, some of these will be legal, we should expect them.	people to live a structured live (an active support process), secondly was a lack of local management and professional support in the settings and where they were located
FINALLY GET CRACKING- PEOPLE CAN'T AND MUST NOT WAIT		

Agreed Actions: - How we get these things to have an impact and an influence to those who have the decision making position

Action	Who/how to take it forward
Write up the list of key learning as into a short paper and send to NHS England.	CBF
Planning for community development <ul style="list-style-type: none"> Commissioning the right skill set locally – skills set & advocacy. Identify the right skill set for individual and train frontline staff 	CBD
Influence Health Education England, Skills for Care and Skills for Health. As they are developing something and there are concerns about its fitness for purpose – write letter using comments from this workshop.	CBF to write to NHSE, ADASS & ADCS to ask how they are planning community development and how people can get involved.
Family carer advocacy <ul style="list-style-type: none"> Meeting commissioners who have never had to plan the type of service before Duty under care act – influence the opportunity 	All
NHSE – measure outcomes not numbers <ul style="list-style-type: none"> Can we formally ask about this and help develop – a potential route could be through a specific CB NSG discussion day. 	Proposal to be taken to CB NSG SG.