Report to the Shadow Health and Well-Being Board

Report Title: **Transforming Care: A National Response to Winterbourne View Hospital Thurrock Implementation**
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Shadow Health and Well-Being Board Date: **14th March 2013**

Section 1
Recommendations for the Board

The purpose of this report is to inform the Shadow Health and Well Being Board about the Department of Health Report Transforming Care: A National Response to Winterbourne View Hospital, (2012) and the implementation of the actions required with in the report by the CCG in partnership with Thurrock Council.

Section 2
Background Information

In May 2011 the BBC television programme Panorama exposed the abuse of people with learning disabilities at Winterbourne View Hospital. Winterbourne View was a privately run hospital providing services to people with Learning Disability or Autism with behaviour that challenges services. As a result of the BBC Programme a review was commissioned and the report **Transforming Care: A National Response to Winterbourne View Hospital** was published by the Department of Health in December 2012

The report highlights some key system failures that allowed a catalogue of abuse to take place.

The people who were patients at Winterbourne View hospital were placed by Primary Care Trust and Local Authority Commissioners and practitioners from all over the country, often using the powers under the Mental Health Act. It became clear and is detailed in the report that professionals did not appropriately monitor and review to ensure the person they placed was safe, being cared for appropriately or being worked with to be moved on from the hospital. Statutory organisations and CQC did not talk to each other, share concerns or visit regularly.

The report highlights that between January 2008 and May 2011 the following occurred at Winterbourne View Hospital:

- 78 visits to A&E by patients
- 29 incidents involving the police
- 40 safeguarding alerts

The lack of involvement by placing authorities meant that most incidents were seen in isolation so patterns of abuse were not detected.

The Serious Case Review that followed highlights evidence of torture and abuse, exceptionally poor health care for the patients many patients being given anti-psychotic and anti-depressant drugs without a clear prescribing policy. Another key area of concern was that families and other visitors were not allowed access to the wards to visit patients creating a closed environment with little outside monitoring.

People who were patients at the hospital were not listened too, did not have advocacy support and were systematically abused. Individuals who were placed at Winterbourne View were often left there for lengthy periods of time. Commissioners often felt a person had been placed solving the immediate problem of what to do with some one who presented extreme challenges and rather than immediately starting the planning for discharge they were just left. The average length of stay was 19 months but many stayed over 3 years.

The Department of Heath report describes the abuse that was experienced by the people who were patients at Winterbourne View; it details the failure of Castlebeck Care Ltd to manage the hospital and the failure of the commissioning and monitoring organisations to safeguard the individuals that were placed there.

The report then goes on to explain the expectations of the Department of Health and other partners to ensure that the abuse at Winterbourne View Hospital is never repeated. The immediate response was to audit current provision for those with learning disability, severe challenging behaviour and associated mental health problems. CQC undertook over 150 inspections of a range of services provided to learning disabled people. The results of many of those inspections were shocking; too many people were in assessment and treatment beds, far away from home experiencing very poor quality of care.

The guiding principle throughout the report is that people must receive the right care in the right place and only go to hospital if it is genuinely the most appropriate option.

To ensure that this system wide failure does not occur again the Department of Health states that a number of measures must be put in place, firstly strengthening accountability and corporate responsibility for quality of care. The primary responsibility for the care rests with the providers. Therefore the owners, Boards of Directors and senior managers of organisations must be held to account and can not negate their responsibilities. There are requirements set out in law that must be followed and enforced. The report states that CQC must take steps to strengthen the way it uses its existing powers to hold organisations to account for failures to meet legal obligations

to service users.

The actions that are required to be implemented are far reaching creating a fundamental change to process and models of care within the health and wider care economy. The model of care proposed describes a person centred approach that treats people with dignity and respect focusing on an individuals human rights. The key principles for this model of care, for service delivery where assessment and treatment is provided, are based on the Mansell Report published in 1993 and revised in 2007.This report highlighted and recommended how care and support should be provided for people with learning disabilities who experience behaviour that challenges. The key principles of this model are attached.

Implementation

The timetable of actions within the Winterbourne View Report focus on every aspect of care and support provided within and outside assessment and treatment services and secure accommodation. The implementation will be monitored nationally through the newly created Learning Disability Programme Board. There are 63 actions incorporating the creation of national guidance including statutory guidance regarding children in long term residential care and the revision of the statutory guidance Working Together to Safeguard Children, frameworks for care, inspection and enforcement, legal duties, advocacy principles, workforce development, commissioning guidance, communication frameworks, together with work with providers. There will be contributions form the Royal College of Psychiatry, the Royal College of Speech and Language Therapists and the Royal College of Social Work. Every aspect of service development is being reviewed and revised. There is a key work stream to be undertaken by the police to develop a process to trigger early identification of abuse. A further pivotal role will be the importance of the Local Authority Contacting and Commissioning services offering expertise and guidance to the implementation of this agenda.

There is also a clear focus on the people who currently receive services and the need to ensure their care, support and safety.

Thurrock implementation

A Winterbourne Steering Group has been established with representation from the 4 CCG's and the 3 local authorities, Southend, Essex and Thurrock covering the South Essex locality, a detailed action plan has been drawn together to ensure the delivery of the recommendations of the Winterbourne report.

The initial focus, as in every area in the country, is on the people who are currently placed in assessment and treatment units and secure accommodation.

In Thurrock we are already aware of all the people who are placed in assessment and treatment beds and secure accommodation as directed by

the national report, they will all be reviewed by the end of March however all the people have been regularly reviewed whilst placed. The next piece of work will be to take a multi disciplinary approach to developing person centred individual plans for each person to ensure that they are able to move on to accommodation and support that will meet their needs, the plan must be drawn together by June 2013 and implemented at the latest by June 2014.

In Thurrock we have 8 people who have learning disabilities and challenging behaviour and are currently placed in health funded placements either assessment and treatment or secure accommodation. We have named care managers within social care to ensure a joint approach to reviewing and planning. The Winterbourne steering group will monitor all the reviews and care planning and oversee any commissioning that may be required to support people to return to their localities. Currently the cost to Health for these 8 Thurrock people is £1.4 million per year.

A comprehensive list of children and young people with learning disabilities and behaviour that challenges funded through health across South Essex is currently being drawn together and all the children on that list will be reviewed using the same principles, we have established positive links to children's services to ensure that they are included in this work.

The progress for our Thurrock Service users will also be monitored through a Thurrock Local Authority Winterbourne Task and Finish Group which is being established including Children's services. Progress reports will be regularly given to the Adult Safeguarding Board, the Children Safeguarding Board, the Learning Disability (soon to be Disability) Partnership Board and the Health and Well Being Board as directed by the actions within the national report.

The Task and finish group will also over see the implementation of the national direction noted above ensuring an integrated system to commission, monitor and review is in place in partnership with the CCG

The CCG is expected to deliver the following

- CCG's will be expected to maintain local registers, and review individual's care with the Local Authority, including identifying who should be the first point of contact for each individual.

- The NHSCB will hold CCG's to account for their progress in transforming the way they commission services for people with learning disabilities/autism and challenging behaviours

- The strong presumption will be in favour of pooled budget arrangements with local commissioners offering justification where this is not done

- CCG's should 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.

- Health and care commissioners should use contracts to hold providers to account for the quality and safety of the services they provide

- 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

We are clear this has to be a joint approach which will not only apply to health funded services but the principles of good practice and service development will be embedded across all adult and children's services to ensure that the outcome will be the redesign of care and support for children and adults with learning disabilities or autism and mental health conditions or behaviours viewed as challenging. These principles will be part of the work through, the refreshed CAMH's strategy, the Transition strategy the Autism strategy and the mental health strategy. The transformation of local services in Thurrock through the asset based community development work and the pilot of local area coordination will be key to broaden out this approach and include these principles.

The Model of Care

The key principles are:

For people:

- I and my family are at the centre of all support – services designed around the person highly individual and person centred
- My home is in the community – the aim is 100% of people living in the community supported by local services
- I am treated as a whole person
- Where I need additional support this is provided to me as locally as possible

For services:

- Services are for all including those individuals with the greatest level of challenges
- Services follow a life course approach i.e. planning and intervening early, starting from childhood and including crisis planning
- Services are provided locally
- Services focus on improving quality of care and quality of life
- Services focus on individual dignity and human rights
- Services are provided by skilled workers
- Services are integrated including good access to physical and mental health services as well as social care
- Services provide good value for money
- Where inpatient services are needed planning to move back to community services starts from day one of admission

Outcomes:

High quality services will mean that people with learning disabilities or autism who experience behaviour that challenges will be able to say:

- I am safe
- I am treated with compassion, dignity and respect
- I am involved in decisions about my care
- I am protected from avoidable harm, but also have my own freedom to take risks
- I am helped to keep in touch with my family and friends
- Those around me and looking after me are well supported
- I am supported to make choices in my daily life
- I get the right treatment and medication
- I get good quality general health care
- I am supported to live safely in the community
- Where I have additional care needs, I get the support I need in the most appropriate setting

- My care is regularly reviewed to see if I should be moving on.