14 January 2014	**ITEM: 5**
Health and Well-being Overview and Scrutiny Committee	
Winterbourne View Review Findings and Action Plan	
Report of: Catherine Wilson, Service Manager Commissioning and Service Development	
Wards and communities affected: All	**Key Decision:** Non-key
Accountable Head of Service: Roger Harris, Director Adults Health and Commissioning	
Accountable Director: Roger Harris, Director Adults Health and Commissioning	
This report is public	
Purpose of Report: The purpose of this report is to inform the Health and Well Being Overview and Scrutiny Committee about the Department of Health Report Transforming Care: A National Response to Winterbourne View Hospital, (2012) and the implementation of the actions required within the report by the CCG in partnership with Thurrock Council.	

EXECUTIVE SUMMARY

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 any where else. 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 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 the quality of their care, support and safety.

Thurrock implementation

A Winterbourne Steering Group has been working for the last year 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, has been on the people who are currently placed in assessment and treatment units and secure accommodation.

In Thurrock we are aware of all the people who are placed in assessment and treatment beds and secure accommodation as directed by the national report, they have all been reviewed and plans are at various stages for each person to ensure they are able to move on by April 2014. There is one person who currently and beyond April 2014 will need hospital support and care. In Thurrock we have 9 people who have learning disabilities and challenging behaviour and are currently placed in health funded placements either assessment and treatment or secure

accommodation. Currently the cost to Health for these 9 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 has been drawn together and all the children on that list are being

Progress with this and the wider agenda of service improvement is being monitored through The Adult Safeguarding Board, The Disability Partnership Board and the Health and Well Being Board

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 have implement a joint health and social care self assessment framework to monitor progress of key health and social care inequalities. This has been implemented Nationally. In Thurrock this has been completed and submitted. Some significant health and social care data has been difficult to obtain this year however it has ensured that next year we will have as far as possible systems in place to collect the information. It has been acknowledged nationally that data collection has been difficult. In March 2014 a collation of the national data will be published to support further development of good practice.

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.

In June 2013 Thurrock submitted the Winterbourne Stocktake which had been requested by the National Winterbourne Programme Board to provide a consistent national view of progress with the recommendations of the Department of Health Report: Transforming Care: A National Response to Winterbourne View Hospital, (2012). The Programme Board has asked that each Health and Well Being Board and CCG is aware of and agrees the contents of the stocktake document.

The stocktake for Thurrock is a very positive one; it clearly confirms the robust joint working relationships between Thurrock Council and Thurrock CCG around Winterbourne and the partnership approach across South Essex.

One area of concern was as highlighted above the failure of the SCG to commit to funding following the person once they are discharged from long stay hospital care. It is clear that this poses financial risks to the CCG and the Council. Work is being undertaken to address this issue through NHS East of England.

The stocktake highlighted the good practice and partnership working between the CCG and Thurrock Council and that all areas of the National Report are being addressed in Thurrock.

1. RECOMMENDATIONS:

1.1 That the Health and Well-being Overview and Scrutiny Committee are aware of the Winterbourne view report and recommendations

1.2 That the Health and Well-being Overview and Scrutiny Committee are aware of the progress to date in Thurrock

2. INTRODUCTION AND BACKGROUND:

2.1 The background information is included within the Executive Summary for ease of reference for Health and Well-being Overview and Scrutiny Committee Members so that a full and detailed explanation of what lead to the Department of Health Report: Transforming Care: A National Response to Winterbourne View Hospital, (2012) is clear together with the expectations for Local Authorities and Clinical Commissioning Group to deliver the recommendations of that report.

3. ISSUES, OPTIONS AND ANALYSIS OF OPTIONS:

3.1 N/A

4. REASONS FOR RECOMMENDATION:

4.1 To ensure that the Health and Well-being Overview and Scrutiny Committee are fully informed regarding the Department of Health Report: Transforming Care: A National Response to Winterbourne View Hospital, (2012) and the subsequent agenda for change regarding long term support for people with Learning Disability or Autism with behaviour that challenges services.

4.2 To ensure that the Health and Well-being Overview and Scrutiny Committee are fully aware of the progress to date in Thurrock regarding the Winterbourne View Report recommendations.

4.3 To highlight the positive joint working between Thurrock CCG and Thurrock Council with regard to this significant piece of work.

5. CONSULTATION (including Overview and Scrutiny, if applicable)

5.1 Not applicable for this report.

6. IMPACT ON CORPORATE POLICIES, PRIORITIES, PERFORMANCE AND COMMUNITY IMPACT

6.1 The implementation of the recommendations of the Winterbourne View Report will have a significant and positive impact on Thurrock residents who have learning disabilities, autism and behaviour that may challenge services. This will be in the longer term to deliver more locally based higher quality services where services are required and to support people within their local communities where ever possible. 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, this is the guiding principle of our work in Thurrock.

7. IMPLICATIONS

7.1 **Financial**

Implications verified by: **Mike Jones**
Telephone and email: **01375 652772**
mxjones@thurrock.gov.uk

There may be financial implications regarding funding care and support for people who move from long stay hospital care. This has been recognised and considered within the current budget and will be monitored closely.

7.2 **Legal**

Implications verified by: **Dawn Pelle**
Telephone and email: **020 8227 2657**
dawn.pelle@bdtlegal.org.uk

There are no direct legal implications within the context of this report.

7.3 **Diversity and Equality**

Implications verified by: **Samson DeAlyn**
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The Winterbourne agenda is key to ensuring equality of opportunity for citizens of Thurrock and the Diversity Team would want to monitor that the recommendations of the Winterbourne View Report are delivered appropriately focusing on individual need including all aspects of an individuals life and support needs.

7.4 **Other implications (where significant) – i.e. Section 17, Risk Assessment, Health Impact Assessment, Sustainability, IT, Environmental**

N/A

BACKGROUND PAPERS USED IN PREPARING THIS REPORT (include their location and identify whether any are exempt or protected by copyright):

APPENDICES TO THIS REPORT:

- N/A

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