Agenda Item No: **9**

Wolverhampton City Council **OPEN INFORMATION ITEM**

Health Scrutiny Panel Date **18 JULY 2013**

Originating Service Group(s) **JOINT COMMISSIONING UNIT**

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Title **TRANSFORMING CARE: A NATIONAL RESPONSE TO WINTERBOURNE VIEW HOSPITAL; WOLVERHAMPTON RESPONSE**

RECOMMENDATION

That the Panel receives this report regarding Winterbourne View Hospital and Wolverhampton's response to transforming care: A National Response to Winterbourne View Hospital.

1. PURPOSE

1.1 To describe the findings of the investigations into the abuse of patients with learning disabilities at Winterbourne View Hospital and to summarise local work to date to respond to the National report Transforming Care: A National Response to Winterbourne View Hospital.

2. BACKGROUND

2.1 Winterbourne View, an independent hospital provided by Castlebeck Care, was featured in a Panorama documentary in 2011 and showed adults with learning disabilities and autism being assaulted and mistreated by staff. Initially brought to the attention of the TV programme makers by a whistle blower, an undercover reporter spent five weeks at Winterbourne View as a paid care worker and filmed his observations of systematic bullying, ill treatment and abuse of patients by staff.

2.2 Eleven members of staff identified in the programme were subject to criminal investigations and were subsequently convicted. Six staff members were given custodial sentences.

2.3 South Gloucestershire Safeguarding Adults Board commissioned a Serious Case Review which was undertaken by Margaret Flynn and published in August 2012. In addition to this the Government asked the Care Quality Commission (CQC) to implement an immediate programme of unannounced inspections of hospitals providing assessment and treatment for people with learning disabilities and behaviours that challenge. CQC carried out 150 inspections and an initial report was produced in June 2012. The Department of Health also facilitated and co-ordinated a number of other work streams leading to a final report and partnership wide Concordat, published in December 2012. The Executive Summary from the final report is contained with Appendix 1.

2.4 Between now and June 2014 all Local Authorities and PCTs/CCGs must take action to transform the way services are commissioned and delivered to stop people being placed in hospital inappropriately, provide the right model of care, and drive up the quality of care and support for all people with behaviour that challenges. It is envisaged that significantly fewer inpatient and institutional-type beds (e.g. residential and nursing) will be purchased in the future.

The Concordat: Programme of Action which accompanies the report sets out the requirements for each local area. The key actions are to:

- Develop and maintain a local register of all people with learning disabilities or autism who have mental health conditions or behaviour that challenges in NHS-funded care (including hospital placements) no later than 1 April 2013

- Review all current hospital placements (inpatient learning disability and/or autism), ensuring that there is a first point of contact for each person. These reviews should include agreeing a personal care plan for each individual based around their and their families' needs and agreed outcomes, and must be completed by 1 June 2013. Independent advocacy must be provided where appropriate to enable people to express their views

- Support everyone inappropriately placed in hospital to move to community-based support no later than 1 June 2014

- Develop a locally agreed joint strategic plan for high quality care and support services for people of all ages with behaviour that challenges, that accords with the model of good care put forward in the DH final report. These plans should include children's services, mainstream mental health services, police and offender management teams and housing to ensure that a new generation of inpatients does not take the place of people currently in hospital. This joint plan must be produced by April 2014 and will include plans to develop a range of local and responsive services to prevent admission and enable current inpatients to be supported positively in community placements

- The DH report also expects each local area to review people with behaviour that challenges who are placed in large-scale residential care, particularly those who are placed away from their home area. This group should be identified and reviewed in the same way as people in hospital settings.

2.5 We have established a Winterbourne Action Group which meets monthly and oversees the Concordat and local programme of action and includes representation from across services and represents the all-age responsibility to agree a joint plan.

2.6 The review of the abuse of patients at Winterbourne underpins the need to ensure that we are committed to co-produced, co-developed, co-evaluated services for people with learning disabilities and their families. We have therefore arranged for Changing Our Lives (an independent self-advocacy organisation which facilitates the People's Parliament in Wolverhampton) to join the steering group as a critical friend and to support us to co-produce work going forwards.

3. LOCAL RESPONSE TO DATE

3.1 Wolverhampton currently commissions 5 Assessment and Treatment places for people with learning disabilities, these all being provided by Black Country Partnership Foundation Trust (BCPFT) as part of the mental health contract. They are all at Pond Lane, in Parkfields, Wolverhampton. We have rarely purchased out-of-city Assessment and Treatment services for people with learning disabilities.

3.2 We know of all the adults with a learning disability placed outside of the City in residential, nursing and hospital environments and recognise the need to ensure timely and robust reviews.

3.3 The Joint Commissioning Unit (JCU) have been working with Black Country Commissioners and colleagues across the West Midlands region to ensure that we have robust ways of monitoring and safeguarding people placed in Assessment and Treatment facilities.

3.4 The JCU has worked with the Provider (BCPFT) to ensure that we have rigorous Safeguards in place for people with learning disabilities who use their services. This work is on-going but has taken into account the learning from the serious case review, the CQC inspections of 150 Assessment and Treatment hospitals and our own internal monitoring and review processes. It has included:-

- Monthly meetings with the Provider to monitor delivery of the contract and to include monitoring of the delivery of their Action Plan post their CQC inspection. This Action plan is updated and reported to the Commissioner on a monthly basis and is now reporting Green on all areas

- Re-negotiation of the Key Performance Indicators to include bi-annual patient-led audits (facilitated by Changing Our Lives, an independent advocacy organisation) and annual satisfaction questionnaire to be sent to people who have used the service and family carers. We have also agreed CQUINS and a programme of service development for 2013/4.

- Monthly monitoring meetings with the Provider to discuss complaints, compliments, serious incidents, safeguarding referrals, use of restraint (physical interventions), service reviews/visits from CQC, delayed discharges, the use of the MCA and DOLS. These meetings are then reported into the Clinical Quality Review and Contracts meetings as appropriate

- A report was taken to the Wolverhampton Safeguarding Vulnerable Adults Board in September 2012 following the publication of the serious case review. Following this, a Joint workshop of the Wolverhampton Safeguarding Vulnerable Adults Board and the Wolverhampton Learning Disability Partnership Board took place in January 2013 to progress the findings of the serious case review and to ensure a joined up approach is continued to ensure safety and quality for people with learning disabilities in care settings

- A commitment has been expressed through our commissioning intentions to reduce the number of inpatient beds we commission in favour of developing an intensive support team which will be able to offer intensive assessment and treatment within a person's usual living environment, if this is appropriate

- Funding has been identified to develop a mental health liaison post within mainstream mental health services, to ensure that wherever possible people with learning disabilities can access the same services as the general population whenever this is appropriate and with reasonable adjustments being made to ensure that their care is effective

- All of the Concordat actions to be delivered by June 2013 have been delivered within the timescales set. This has included developing the register of people with learning disabilities and/or autism who are in NHS funded care. This register is being maintained within the Joint Commissioning Unit. All of the people on this register have been reviewed jointly and in a manner which reflects best practice - there were 7 people on this register

- Wolverhampton has responsibility for 14 adults who are in secure hospitals. The responsibility for reviewing these people is with the NHS Local Area Teams. These reviews have all also been completed, and regular meetings are held between commissioners, the NHS Local Area Team and the community Learning Disability Team to ensure that discharge to the least restrictive settings is proactively sought

- Wolverhampton has also developed a register of people who are in large-scale accommodation in order to review them and ensure that they are appropriately placed and to consider community-based alternatives - these reviews are being staggered throughout the year in line with guidance.

- Wolverhampton has responsibility for one young person who has autism and behaviour that challenges and is placed in a CAMHS hospital service. The NHS Local Area Team are responsible for reviewing this young man in the same way as other patients in secure care.

- Information from all of the reviews is being collated such that it can be used to develop the Joint Plan and future commissioning intentions. It is anticipated that we will develop the joint plan from September 2013, as most of this information will be available by then.

4. FINANCIAL IMPLICATIONS

4.1 The Concordat is set to be delivered within current resources. A small amount of extra financial support (£70,000) has been awarded via the CCG to enable the Provider Trust (BCPFT) to increase its community support as a short-term measure whilst services are redeveloped.

[MK/08072013/T]

5. LEGAL IMPLICATIONS

5.1 Services for persons with learning disability are provided in accordance with the Council's statutory duties as a Social Services Authority under Section 7 of the Local Authority Social Services Act 1970 which also provides for Social Services functions to be exercised in accordance with guidance issued by the Secretary of State.

[FD/04072013/D]

6. EQUAL OPPORTUNITIES IMPLICATIONS

6.1 There are equalities implications in this programme of work as the activity will support some of the most vulnerable adults in Wolverhampton. An Equality Analysis will be undertaken to reflect the work required by the Concordat and the outcomes achieved. Current drivers emphasis the need for to promote well-being, and in order to achieve this to we need to focus more systematically on the potential for developing services which effectively prevent and intervene earlier. A range of good quality local support services should reduce the need for people to be moving to out-of-city placements, into hospital settings or into Secure Services.

7. ENVIRONMENTAL IMPLICATIONS

7.1 There are no environmental implications arising out of this report.

8. SCHEDULE OF BACKGROUND PAPERS

Appendix 1 Transforming care: A national response to Winterbourne View Hospital Department of Health Review: Final Report

Appendix 1

Transforming care: A national response to Winterbourne View Hospital Department of Health Review: Final Report

Executive summary

1.
The abuse revealed at Winterbourne View hospital was criminal. Staff whose job was to care for and help people instead routinely mistreated and abused them. Its management allowed a culture of abuse to flourish. Warning signs were not picked up or acted on by health or local authorities, and concerns raised by a whistleblower went unheeded. The fact that it took a television documentary to raise the alarm was itself a mark of failings in the system.
2.
This report sets out steps to respond to those failings, including tightening up the accountability of management and corporate boards for what goes on in their organisations. Though individual members of staff at Winterbourne View have been convicted, this case has revealed weaknesses in the system's ability to hold the leaders of care organisations to account. This is a gap in the care regulatory framework which the Government is committed to address.
3.
The abuse in Winterbourne View is only part of the story. Many of the actions in this report cover the wider issue of how we care for children, young people and adults with learning disabilities or autism, who also have mental health conditions or behaviours described as challenging.
4.
CQC's inspections of nearly 150 other hospitals and care homes have not found abuse and neglect like that at Winterbourne View. However, many of the people in Winterbourne View should not have been there in the first place, and in this regard the story is the same across England. Many people are in hospital who don't need to be there, and many stay there for far too long – sometimes for years.
5.
The review has highlighted a widespread failure to design, commission and provide services which give people the support they need close to home, and which are in line with well established best practice. Equally, there was a failure to assess the quality of care or outcomes being delivered for the very high cost of places at Winterbourne View and other hospitals.
6.
For many people however, even the best hospital care will not be appropriate care. People with learning disabilities or autism may sometimes need hospital care but hospitals are not where people should live. Too many people with learning disabilities or autism are doing just that.
7.
This is the wider scandal that Winterbourne View revealed. We should no more tolerate people with learning disabilities or autism being given the wrong care than we would accept the wrong treatment being given for cancer.
8.
Children, young people and adults with learning disabilities or autism, who also have mental health conditions or behaviours described as challenging can be, and have a right to be, given the support and care they need in a community-based setting, near to family and friends. Closed institutions, with people far from home and family, deny people the right care and present the risk of poor care and abuse.
9.
The Department of Health review drew on:

a criminal investigation with 11 individuals prosecuted and sentenced;

the Care Quality Commission review of all services operated by Castlebeck Care, the owners of Winterbourne View, and the programme of inspections of 150 learning disability hospitals and homes;

the NHS South of England reviews of serious untoward incident reports and the commissioning of places at Winterbourne View hospital; an independent Serious Case Review commissioned by the South Gloucestershire Safeguarding Adults Board, published on 7 August 2012; and

the experiences and views of people with learning disabilities or autism and mental health conditions or behaviours described as challenging, their families and carers, care staff, commissioners and care providers.

10. An interim report was published on 25 June 2012. This final report of the review can be published now that the criminal proceedings have concluded.

Programme of Action

11.

This report sets out a programme of action to transform services so that people no longer live inappropriately in hospitals but are cared for in line with best practice, based on their individual needs, and that their wishes and those of their families are listened to and are at the heart of planning and delivering their care.

12.

The Government's Mandate to the NHS Commissioning Board1 says:

"The NHS Commissioning Board's objective is to ensure that CCGs 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." (para 4.5)

13.

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

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

by April 2014 each area will have a locally agreed joint plan to ensure high quality care and support services for all children, young people and adults with learning

1 http://www.dh.gov.uk/health/2012/11/nhs-mandate/

disabilities or autism and mental health conditions or behaviour described as challenging, in line with the model of good care set out at Annex A;

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

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

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

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

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

14.

A full account of these actions, together with a range of further actions to support improvement of services – including, for instance, steps to improve workforce skills, and strengthening safeguarding arrangements – is set out in Parts 4-8. A timeline of the detailed actions is at Annex B.

15.

Alongside this report, we are publishing a Concordat agreed with key external partners. It sets out a shared commitment to transform services, and specific actions which individual partners will deliver to make real change in the care and support for people with learning disabilities or autism with mental health conditions or behaviour that challenges.

16.
This report focuses on the need for change, but there are places which already get this right. This shows that the change we intend to make is achievable. Alongside this report, we are publishing examples of good practice which demonstrate what can – and should be – done for all.