

Beyond Winterbourne View

Implications for Dudley



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Beyond Winterbourne View

Implications for Dudley

“The abuse of patients at Winterbourne View hospital was appalling, and those directly responsible have rightly been dealt with by the Courts. This report into the events at Winterbourne View shows clearly that there have also been many faults in the wider care system

Children and adults with learning disabilities or autism and who have mental health conditions or behaviour regarded as challenging have too often received poor quality and inappropriate care.

We know there are examples of good practice around the country, but we also know that too many people are admitted to hospital unnecessarily in hospital and they are staying there for too long.

This must stop”

Beyond Winterbourne View

Implications for Dudley

What this presentation covers

- Background to Winterbourne View
- Brief summary of key findings, recommendations and actions from a range of different reviews and reports
- Provide an update based on the recently published DoH Final Report and Concordat
- Hopefully provide you with some personal insight from my role as National ADASS Lead for the Winterbourne Review
- Provide opportunity for questions and discussions from the floor

Beyond Winterbourne View

Background

The BBC's Panorama investigation was aired on 31st of May 2011 and uncovered serious physical and mental abuse of patients being perpetrated by staff at Winterbourne View Hospital



As a result, several immediate responses were set in train:

- A criminal investigation was launched culminating in 11 individuals being prosecuted, leading to convictions and sentencing on the 26th of October 2012
- The CQC reviewed all services operated by Castlebeck Care, the owners of Winterbourne View, and undertook a programme of inspections of 150 learning disability hospitals and homes.
- The NHS South of England reviewed serious untoward incident reports and the commissioning of places at Winterbourne View
- An independent Serious Case Review was commissioned by South Gloucestershire Safeguarding Board and published on 7th August 2012

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Compendium of Key Findings, Recommendations and Actions

Compendium of Key Findings, Recommendations and Actions presented at the The National Children and Adult Services Conference 2012 in Eastbourne

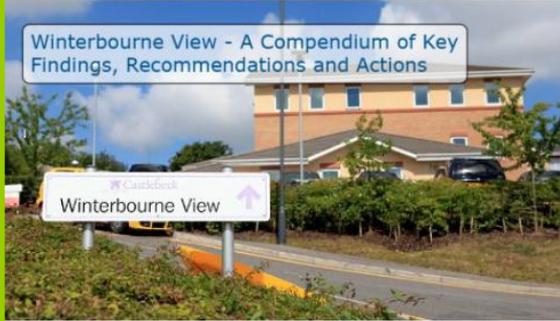
This consisted of content from the following documents and reviews

- CQC review from June 2011 into learning disability services from within the NHS, private care and social care services
- CQC Internal Management Review from July 2011 into the regulation of Winterbourne View
- Department of Health's Interim Review of Winterbourne View

The DoH Final Report was delayed until criminal proceedings had been completed.

- Serious Case Review carried out by South Gloucestershire Council

The National Children and Adult Services Conference 2012



Winterbourne View - A Compendium of Key Findings, Recommendations and Actions

“Even now, without the Winterbourne View Serious Case Review, there is compelling evidence that some people with learning disabilities and autism are being failed by health and care.

Around the country there are excellent examples of personalised care, focused on supporting people in their community, but that excellence is not universal.

There is insufficient focus on personalised care planning and too often the care which people receive is poor quality”

Winterbourne View Department of Health Interim Review

Local Government Association
ADCS
adass
24th to 26th October 2012 – Eastbourne

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Key Findings

- Too many people are placed in in-patient services for assessment and treatment (A&T) and are staying there for too long.
- This model of care goes against government policy and has no place in the 21st century.
- People should have access to the support and services they need locally – near to family and friends – so they can live fulfilling lives within the community.
- Winterbourne View was an extreme example of abuse, but we have found evidence of poor quality of care, poor care planning, lack of meaningful activities to do in the day and too much reliance on restraining people.
- All parts of the system – those who commission care, those who provide care and individual staff, the regulators and government – have a duty to drive up standards. There should be zero tolerance of abuse.

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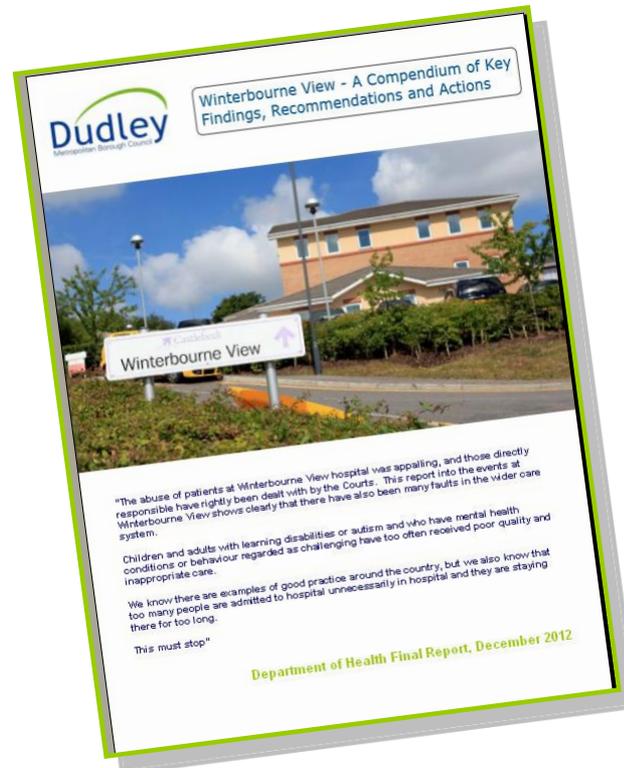
Key Recommendations

- Only local action can guarantee good practice, stop abuse and transform local services.
- Listen to people with learning disabilities and their family carers in developing person-centred approaches across commissioning and care
- Build understanding of the reasonable adjustments needed for people with learning disabilities who have a mental health problem so that they can make use of local generic mental health beds
- Commission the right model of care to focus on the needs of individual people, looking to avoid the factors which might distress people and make behaviours more challenging, building positive relationships in current care settings
- Focus on early detection, prevention, crisis support and specialist long term support to minimise the numbers of people reaching a crisis which could mean going into hospitals
- Work together to plan carefully and commission services for the care of children as they approach adulthood to avoid crises; and Commission flexible, community-based services.

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Compendium of Key Findings, Recommendations and Actions

The updated version which we will circulate following the official publication of the Department of Health's Final report now includes content from that report and the accompanying Concordat the anticipated content of which I will now cover in more detail.



Department of Health Final Report

Key Findings

- The abuse at Winterbourne View hospital was criminal
- 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
- Steps have been taken to respond to these failings – and further steps are set out in the report notably to tighten up the accountability of management and corporate boards for what goes on in their organisations.
- The abuse was only the beginning of the story - many of the actions in the report cover the wider issue of how as a country we care for people with learning disabilities or autism, who have what is often described as challenging behaviour.
- Aside from the poor care and abuse, many of the people being treated there should not have been there in the first place. They had been sent there – to a closed hospital setting – for what should have been short-term assessment, but some had been left there for much longer

Department of Health Final Report

Key Findings

- Inspections of similar establishments around the country revealed a similar story
- There were excellent examples of high quality services keeping people safe and help them lead the lives they want to lead.
- However, all too often, people were being wrongly placed in hospital settings and there was a failure to design, commission and provide services which give people the support they need, 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
- The result is that far too many people are in hospital when they should not be, and they are staying there for too long – in many cases for years.
- Far too many are sent a long way from their home and families.
- Many Hospitals and care homes are not offering the quality of care that people have a right to expect.

Department of Health Final Report

Key Findings

- Even where hospitals are run to the highest standards, they are still, for many people, the wrong place, offering the wrong sort of care.
- People with learning disabilities or autism may sometimes need hospital care; but hospitals are not where people should live.
- This is a wider scandal, on a national scale, that Winterbourne View revealed, and it is unacceptable.
- We should no more tolerate that people with learning disabilities or autism are being given the wrong care- against best practise that has been established for many years – that we would accept the wrong treatment being given for cancer.
- People with challenging behaviours can be, and have a right to be, offered the support and care that they need in a community-based setting, as near as possible to family and other connections.
- Closed institutions, with people far from home and family members, not only deny people the right care but present the risk of a culture of poor care and abuse.

Department of Health Final Report

The Government's Mandate

The Government's Mandate to the NHS Commissioning Board sets out;

“The NHS Commissioning Board’s objective is to ensure that CCG’s 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”

Department of Health Final Report

Programme of Action

The Department of Health report sets out a plan of action, contained within the Concordat, to ensure that we move urgently to a position where people are no longer inappropriately treated in hospitals but are cared for in line with best practice;

- Where there is clear accountability for ensuring people get the right care, and for the quality of that care wherever it may be;
- Where the needs and wishes of people who need support, and their families and carers, are listened to and are at the heart of the planning and delivery of care

Winterbourne View Review

Concordat : Programme of Action

The Concordat will be officially launched along side the DoH Final Report early next week

We understand that the Concordat will contain 7 Key actions for a range of partners across Government and Health & Social Care Providers and Regulators

These are as follows :

Winterbourne View Review

Concordat : Programme of Action

- 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
- 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.
- There will be national leadership and support for local change.
- Planning will start from childhood improving the quality and safety of care
- Accountability and corporate responsibility for the quality of care will be strengthened
- Regulation and inspection of providers will be tightened
- Progress in transforming care and redesigning services will be monitored and reported:

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Concordat : Programme of Action

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:
 - 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.

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Concordat : Programme of Action

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:

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.

Winterbourne View Review

Concordat : Programme of Action

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 will be part of the Joint Health and Well-Being Strategy for implementation from April 2014.
- The strong presumption will be in favour of supporting this with pooled budget arrangements with local commissioners offering justification where this is not done.

Winterbourne View Review

Concordat : Programme of Action

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 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 in three months, with the Board and leadership arrangements in place by the end of December 2012. DH will provide funding to support this work.

Winterbourne View Review

Concordat : Programme of Action

Planning will start from childhood:

- DH will work with the Department for Education (DfE) through the Children and Families Bill to introduce from 2014, a new single assessment process for every child and young person up to age 25 with special education needs or a disability, with an Education, Health and Care Plan (subject to parliamentary approval).
- 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

Winterbourne View Review

Concordat : Programme of Action

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.

Winterbourne View Review

Concordat : Programme of Action

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.

Winterbourne View Review

Concordat : Programme of Action

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.

Winterbourne View Review

Concordat : Programme of Action

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 the Concordat, are achieved.

Further information on each of these commitments and the implications for particular agencies will be circulated in document following the official launch of the DoH's final report and Concordat early next week

Beyond Winterbourne View

Key Challenges

- Leadership
- Accountability
- Partnership
- Direction
- Responsibility

