Agenda Item No. 7

Dudley Health & Wellbeing Board 26th September 2013

Report of the Director of Adult, Community and Housing Services and the Chief Officer, Dudley Clinical Commissioning Group

Quality & Safety – update on Dudley response to Winterbourne View Report

Purpose of Report

1. As part of its overall leadership on Quality and Safety issues in Dudley, to update the Health and Wellbeing Board on developments relating to response in Dudley to the implications of the Winterbourne View.

Background

2. Dudley Health and Well Being Board received a Report at its meeting of 29th April 2013 on the response of the Dudley Safeguarding Adults Board and the Learning Disabilities Partnership Board to initial activity in Dudley to the Winterborne View report.

3. Winterbourne View Hospital was a private hospital for adults with learning disabilities and autism, mostly accommodating patients detained under the provisions of the Mental Health Act 1983.

4. On 31st May 2011 BBC Panorama uncovered serious physical and mental abuse of patients, which was being perpetrated by staff at the hospital. The investigation led to the prosecution of eleven staff members; the commissioning of a Serious Case Review by South Gloucestershire, and the Care Quality Commission's review of 150 learning disability hospitals and homes. The final Department of Health report and the Concordat outlining the actions were published in December 2012. The Director of Adult, Community and Housing Services, Andrea Pope-Smith, has represented the Association of Directors of Adult Social Services on this strand of work at a national level.

5. Amongst its finding, the national review:

    a. Found that too many people are placed in in-patient services for assessment and treatment, and remain there for too long. These units were often far from the patient's home and family.
    b. recommended that people should have access to the support and services they need locally, which should evidence long term support to families, which is preventative.
    c. With regard to Safeguarding, The South Gloucestershire Serious Case Review highlighted a range of concerns which needed to be considered nationally It was judged that the safeguarding process which was followed did not

sufficiently challenge other professionals' attitude, or the hospital's failure to produce reports when investigating concerns. The review also found that other alerts existed which should have also raised concerns i.e. use of advocacy services, attention to complaints and the frequency with which patients were restrained or absconded.

d. Asserted that Winterborne View failed in the recruitment, training and retention of staff, and that staff had not attended adequately to the mental and physical needs of patients.
e. The following 150 inspections of Treatment & Assessment Centres (CQC) highlighted similar concerns across these services nationally

Update since April 2013

6. In line with local, regional and national frameworks and agreed actions, specific local plans and progress has been made under the auspices of::

    a. All local authorities and CCG's are required to provide a Joint Strategic local Plan out lining current positions and plans for improvement relating to the requirements in the DH Report 'Transforming Care' and the Post Winterbourne View Concordat
    b. Dudley has established a Learning Disabilities Partnership – based on the WInterborne View Concordat actions which will be monitored at the Joint Learning Disability Commissioning Group and will include:
        i. The responsibility of the Clinical Commissioning Group to develop local registers of all people with challenging behaviour in NHS funded care; (this has been completed)
        ii. the NHS and Councils to ensure that systems and processes are in place to provide assurance that essential requirements are being met with governance systems in place to ensure they deliver high quality and appropriate care;
        iii. presumption in favour of pooled budgets;
        iv. use of contracts for holding providers to account;
        v. development of a quality assurance framework;
        vi. the review of care arrangements and update support plans for individuals with learning disabilities in NHS funded placements by June 2014; (These Reviews have been completed and plans are in place for those who will be ready for discharge to return to Dudley. All have workers allocated from Community Learning Disability Team.) A further cohort of 85 people with learning disabilities who have complex needs have been included on the database and are in the process of being reviewed as part of this process.
        vii. ensuring that there is a joint commissioning plan for learning disabilities in the area; There is an existing Joint Commissioning plan in place but

this is in the process of being refreshed to include post Winterbourne View actions.

viii. updating advice and advocacy support as needed; and

ix. starting planning for people with a learning disability from childhood

x. The completion of the national Stock Take (Joint Improvement Board) the NHS 'Count Me In Census' and the new Self Assessment Framework for LD (Joint health & social care)

c. Dudley Safeguarding Adults Board – has integrated its actions in response to Winterborne into its current Business Plan for 2013/14. This is available at the end of the Dudley Safeguarding Adults Board Annual Report which is being considered at the Meeting today The main areas for action following formal consideration of the Winterbourne Reports and their implications for safeguarding adults in Dudley are:

i. Assessment and Treatment – actions include agreeing a protocol for regular reporting to Board on follow up actions; identifying patterns of safeguarding issues linked to assessment and treatment units; and involving people with Learning Disabilities and family carers in safeguarding process to consider and address their desired outcomes and concerns
ii. Commissioning and Safeguarding – actions include identifying trends, and methods to monitor, investigate and respond; and information sharing and response partnership with CQC
iii. Restraint and control: - actions include scoping Methods of restraint being used in local services, how these are recorded and identified in the context of safeguarding referrals and how these are reported to the Safeguarding Board

7. Although there is more work to do as per the Action Plan (such as consolidating work on control and restraint and agreeing definitions) Progress has been made through a range of actions to date including:

- report from the Learning Disability Partnership Board having been made to the Safeguarding Board on implications for Winterborne in Dudley
- West Midlands Police presented an initial report on use of control and restraint amongst partners
- The Safeguarding Adults Training Strategy has changed to focus more on prevention and use of Mental Capacity Act
- A report on advocacy and how advocacy is used within safeguarding and with a view to further improvements
- Consideration of use of Deprivation of Liberty Safeguards in Dudley

8. Through its sector-led improvement work, the Winterborne View Joint Improvement Programme supported by the Local Government Association and the NHS

Commissioning Board required responses to a "stocktake" of local and regional responses. This adds to the performance and outcomes management environment for learning disability services locally and in addition stocktake outcomes will be monitored through a regional group where feedback will be provided on 27th September 2013.There will also be national feedback and analysis. The work is being overseen by the Minister for Care Services, Norman Lamb.

9. As described in the Report to the Health and Well Being Board of April 2013, a number of assurance arrangements are in place in Dudley which include bi-monthly meetings amongst regulatory, commissioning and assessment partners from the Council, the Clinical Commissioning Group and the Care Quality Commission.

11. The Annual Learning Disability Self Assessment process provides a comprehensive data set for the Partnership Board on a range of issues to provide assurances to Board members regarding the services commissioned and provided to people with a learning disability within Dudley. In addition the Board will receive quarterly data sets covering a range of subjects including safeguarding An annual Learning Disabilities Self-Assessment is also underway to be returned to the Department of Health by the end of November 2013

12. Other national developments - In te context of considering this report on local response to the Winterborne View Report, the Dudley Health and Well-being Board will wish to note two national pieces of work which are also impacting locally.

13. Confidential Inquiry - As part of a response to Mencap's 2007 report, *Death by Indifference*, the Department of Health established a Confidential Inquiry into premature deaths of people with learning disabilities and findings were reported earlier this year.

14. It reviewed the deaths of 247 people with learning disabilities within 5 Primary Care Trusts in the South-West of England. It also reviewed the deaths of 58 people without learning disabilities to place the findings in context.

15. The study reveals that the quality and effectiveness of the health and social care given to people with learning disabilities was deficient in a number of ways. Key recommendations have been made which will lessen the risk of premature death amongst people with learning disabilities. The Department of Health has recently issued a formal response to the findings of the Confidential Inquiry and recognises that we all have a part to play in reducing premature deaths of people with learning disabilities. There will representation from Dudley at events being organised by the Confidential Inquiry team this autumn.

16. "Six Lives Progress Report" – First published in March 2009, 'Six Lives' was the Ombudsmen's report looking at the care given to six people with learning disabilities who died. 'Six Lives.' A Progress report was published this year and found both positive things and things which still need to be improved and link to the outcomes of the Winterborne View Reports.

17. Positively, people with learning disabilities and their carers described some hospitals and GP practices as having improved their care and treatment of people with a learning disability a lot in recent years. Reasonable adjustments were thought to be made and staff seem to have a more positive attitude towards people with a learning disability. It is perceived that greater involvement of people with a learning disability and their families/carers takes place and there has been wider employment of learning disability nurses. Overall, the progress report states that people in hospitals do what the law says in the Mental Capacity Act.

18. However, the Report also finds that it takes too long to find out what is wrong with someone with a learning disability and start treatment. Annual health checks are not always done properly and it is felt that People with learning disabilities are not given information in a way they can understand. The Reports findings include the perception that people who work in hospitals do not always realise when someone with a learning s disability is in pain and people with learning disabilities are not always included in decisions about their care.

Finance

19. The Council, in accordance with our lead responsibility, funds most of the partner agency activities with regard to Safeguarding. The Council also funds most of the joint agency training programme through the Social Care Training Grant and the Mental Capacity Act grant. The Learning Disability Development Fund has commissioned an advocacy contract to work with people with complex needs.

Law

20. The main legislation currently governing adult protection is contained in sections 21, 26 and 28 of the National assistance Act 1948, the Community care Act 1991, the Mental Health Acts 1983 and 2007, the Mental Capacity Act 2005 and the Human Rights Act 1998.

Equality Impact

21. The Safeguard and protect policy and Procedures are consistent with the equal Opportunities Policy of the Council.

Recommendation

22. The Health and Wellbeing Board is asked to consider and comment update on the response to Winterborne View in the context of its overall concern for Quality and Safety ion the Borough and the services used by people in Dudley. .

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