TRAFFORD COUNCIL

Report to: Health & Well Being Board
Date: 28th May 2013
Report for: Information
Report of: Executive Member for Community Health and Wellbeing

Report Title

Update on Trafford Response to the Winterbourne View Concordat and Review Recommendations

Summary

A recent communication by the Minister of State for Care and Support, Norman Lamb MP urged Health and Well Being Boards to seek a progress and assurance report on the Winterbourne View Concordat and review recommendations.

This report provides an update on the current action plans in place with respect to the actions required by CCGs and Local Authorities with regard to the recommendations from the DH Report into Winterbourne View, and nationally defined priorities noted in the NHS Mandate and Everyone Counts planning guidance.

This update makes use of the feedback from discussions with the Trafford LD Partnership Board and Safeguarding Board, and joint action plans agreed through the Health and Well Being Board. This work is in line with outcome of externally validated reviews of current performance in the key areas to meet the defined responsibilities in relation to commissioning high quality sustainable mental health and learning disability services. This includes reference to actions necessary to ensure safe, sound and supportive services to vulnerable people and their carers, at a time when transformational local and city-region wide change is being effected across health and social care systems.

As such it is important to note that the Trafford approach to commissioning specialist health services has been identified as an exemplar for the national programme concerned with establishing best practice service specifications and improvement plans.

Further work is continuing to agree longer-term CCG collaborative and shared programmes to meet the identified local and national priorities in line with the planned agreement for the Association of Greater Manchester CCGs. Support has been continuing through the reconfigured Mental Health Network and Cluster Mental Health/LD Leads to those localities and work streams identified as needing additional specialist input through active dialogue with local CCG leads.

Continued support is requested for this work and approach to collaborative commissioning across Trafford and Greater Manchester, as well as the specific feedback to be provided to both the SHA and NCB LAT with regards to progress in meeting the required actions to prevent a repetition of the events at Winterbourne View, and more effective local responses to challenging behaviour.

Currently the CCG and Council are reviewing the progress to meet the national target for completion of a comprehensive refreshed local challenging behaviour support plan and check all individual reports completed/reviewed for the small number of people in WV-type placements as required by end May 2013.

Recommendations

1. The HWB receives the progress update on the Winterbourne View Concordat and review report recommendations.

Contact person for access to background papers and further information:

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Update on Trafford Response to the Winterbourne View Concordat and Review Recommendations

1 Background

The NHS Mandate and Everyone Counts planning guidance for the NHS makes clear that it wants to ensure people with mental health and learning disabilities benefit in relation to the defined key NHS Outcomes. Specifically:

- The NHS is being asked to reduce the number of early deaths from those illnesses that can be prevented through better early diagnosis and treatment, such as cancer and heart disease, so that more people can enjoy a long and healthy old age. Too many people die too soon from illnesses that can be prevented or treated, and there are persistent inequalities in life expectancy and healthy life expectancy between communities. One specific group recognized as requiring particular attention are people with learning disabilities, in line with the results of the Confidential Inquiry into Premature Deaths of people with learning disabilities. This includes:
    - earlier diagnosis of illness
    - ensuring that everyone has the same access to the best available care
    - reducing unjustified variation in avoidable mortality
    - focusing on preventing illness, with staff using every contact they have with people as an opportunity to help people stay in good health.

- The NHS will make sure people experience better care, not just better treatment, so that everyone can expect to be treated with compassion, dignity and respect whenever they come into contact with the NHS. Quality of care is as important as quality of treatment

- No one going in to hospital should have to worry about being left in pain, unable to eat or drink, or go to the toilet. And those who have relatives or friends who need support should have peace of mind that they will be treated with compassion, respect and dignity – whether in hospitals, at home or in residential care.
    - In incidents of major failings in care, it is frequently older and vulnerable people and those with complex conditions who bear the brunt – people who are less likely or less able to complain. This is at the heart of the Winterbourne View Review and Concordat recommendations

- The NHS Commissioning Board is being asked to do a range of things to help improve people's experience of care. This includes:
    - making rapid progress in measuring and understanding how people really feel about the care they receive and taking action to address poor performance
    - asking people whether they would recommend their place of treatment to a family member or friend
    - ensuring timely access to services by upholding the rights and commitments set out in the NHS Constitution

- The NHS will provide safe care, so that everyone is treated in a clean and safe environment and people are at a lower risk of avoidable health problems

The key pertinent objectives and outcome indicators agreed to judge CCG progress include:

- Higher standards and reduced extent of harm or death caused or contributed to by NHS (e.g. LD Health Self Assessment Framework and Winterbourne View action plans)

The government published its final report into the events at Winterbourne View at the end of 2012. The report sets out a programme of action to transform services so that vulnerable people no longer live inappropriately in hospitals and are cared for in line with best practice. This brief update report and

attachments with respect to the agreed local action plans in line with this agenda, and to inform the QIPP service delivery challenges and local commissioning plans.

2 The Winterborne View Review and Report

Summary of Programme

Completion Date	Action
Spring 2013	the department will set out proposals to strengthen accountability of boards of directors and senior managers for the safety and quality of care which their organisations provide
June 2013	all current placements will be reviewed, everyone in hospital inappropriately will move to community-based support as quickly as possible, and no later than June 2014
April 2014	each area will have a joint plan to ensure high quality care and support services for all people with learning disabilities or autism and mental health conditions or behaviour described as challenging, in line with best practice

As a consequence of the programme it is anticipated that there will be a dramatic reduction in hospital placements for people with learning disabilities, mental health and autistic spectrum conditions.

The Care Quality Commission will strengthen inspections and regulation of hospitals and care homes for this group of people, including unannounced inspections involving people who use services and their families.

A new NHS and local government-led joint improvement team will be created to lead and support this transformation in line with identified best commissioning practice and principles

Concordat.pdf

easy-read-of-final-report.pdf

Facing_the_Commissioning_Challenge_-_C

This programme is backed by a concordat signed by more than 50 partners, setting out what changes they will deliver and by when. The government will publish a progress report on these actions by December 2013.

The Report

The final report into the events at Winterbourne View Hospital states that staff routinely mistreated and abused patients, and management allowed a culture of abuse to flourish. The warning signs were not picked up, and concerns raised by a whistleblower went unheeded.

The report also reveals weaknesses in the system's ability to hold the leaders of care organisations to account. In addition, it finds that many people are in hospital who don't need to be. People with learning disabilities or autism, who also have mental health conditions or challenging behaviour can be, and have a right to be, given the support and care they need in the community, near to family and friends.

The aim of the review was to:

- Look into what happened at Winterbourne View hospital so that lessons can be learned
- Look into how people with challenging behaviour are supported all over England

- As part of the review, Department of Health officials looked at reports/evidence from other reviews
- They looked at what reports and evidence the Department of Health looked at?
- They looked at evidence from the criminal proceedings.
- They looked the Castlebeck Ltd report

The CQC inspected 150 hospitals and care homes that provide services for people with learning disabilities.

The NHS report looked into how people from Winterbourne View hospital came to be placed there.

There was a Serious Case Review by South Gloucestershire Council.

The review gave a detailed picture of what happened at Winterbourne View hospital.
Department of Health officials also spoke to different people to hear their views about how people with challenging behaviour are supported all over England. These people included:
- People with learning disabilities
- People with autism
- Families of people with learning disabilities/autism
- Commissioners
- Providers
- Workers

In June 2012, the Department of Health published an interim report. In the interim report it was explained that information about what happened at Winterbourne View hospital couldn't be discussed until after the criminal proceedings.

The 11 members of staff who abused patients at Winterbourne View have been sentenced for the criminal acts.

The final report builds on the evidence set out in the interim report. As the criminal proceedings are now over, the final report can set out findings. The report sets out:
- The facts about Winterbourne View
- What happened to people who were at Winterbourne View
- What needs to be changed in the system
- Learn lessons for the future
- What the Government needs to do

About Winterbourne View

Winterbourne View hospital was a private hospital. It was owned by Castlebeck Care Limited and was opened in December 2006.

The hospital was registered to provide assessment and treatment and rehabilitation for people with learning disabilities.

The hospital had enough beds for 24 patients with learning disabilities. Most of the patients in Winterbourne had been placed at the hospital under the Mental Health Act.

A total of 48 patients were placed at Winterbourne. The patients in Winterbourne were placed there by different commissioners from all over England.

On average, it cost £3,500 per week to place a patient at Winterbourne View. Almost 50% of the patients at Winterbourne View were placed far away from their homes.

One of the main reasons individuals were placed in Winterbourne was to manage a crisis, the patients placed at Winterbourne were there for a very long time; some patients were there for more than 3 years.

This suggested a lack of local services to support people with challenging behaviour. Evidence gathered as part of the review demonstrated that it does not appear that there was much hurry to move patients on from Winterbourne.
The number of times patients were restrained by staff at Winterbourne was unacceptably high, for example - a family provided evidence that their son was restrained 45 times in 5 months.

The Serious Case Review provides evidence of poor quality care in Winterbourne View hospital, for example some people had poor dental health care.

The Serious Case Review found that for a lot of the time Winterbourne was open families were not allowed to visit patients on the ward or in their bedrooms. This made the abuse of patients even harder to spot.

The patients at Winterbourne View had very little access to advocacy; also patients' complaints were not handled properly.

The abuse of patients at Winterbourne View hospital should have been noticed earlier.

Castlebeck Care Limited

Castlebeck Care Limited had very good policies and procedures; however these were not put into practice. An example of this is in relation to the recruitment of staff, recruitment did not appear to focus on quality. The job descriptions of staff did not ask for staff to have experience in supporting people with learning disabilities/autism and challenging behaviour.

Evidence also suggests that staff training at Winterbourne was focused too much on the use of restraint.

The Safeguarding Authority

South Gloucestershire Council were told about safeguarding issues at Winterbourne but failed to identify a trend in the number of times they were contacted.

The Commissioners

Commissioners failed to ensure that the support they were purchasing was of a high quality and met people's needs.

The Care Quality Commission

A whistle-blower told the Care Quality Commission that he was worried about the way patients at Winterbourne View were being treated. The Care Quality Commission failed to respond to the concerns raised by the whistle-blower.

The Mental Health Act Commission

The Mental Health Act Commission were told about incidents at Winterbourne and said there was a need to improve but did not follow up to make sure improvements had happened.

The Police

29 incidents were reported to the police, of these, 8 incidents concerned staff using physical restraint on patients. The police didn't follow up the incidents because they believed the reasons given by staff at Winterbourne View.

Trafford's Key Actions and Timescales

Timescales	Action	Local Progress and Plans
Initiating in April 2013	There should always be a presumption that services are local and people remain in their communities	Approximately 2-5 people are placed in hospitals, this information will be clarified by the CLDT and Health Commissioner as some are in secure services not subject to the Review . A strategy will be produced which will support the operational team to move people back to their community.
Initiating in April 2013	There will be a substantial reduction in reliance on inpatient care	In Trafford there is little reliance on in-patient services. A system is in place for A&E staff to alert Adult Safeguarding of anyone going into hospital, individuals are flagged when entering the service and a liaison nurse is notified
Beginning of June 2013	All current placements reviewed	CLDT Manager has been asked to confirm the total number of out of borough placements. A programme will be devised to visit each placement over the next 3-4 months – including secure and non-inpatient services. We will use the Formal Out Of Area Protocol and will approach commissioners in other authorities to ask them to share information in relation to our placements.
End of April 2014	Each area will have locally agreed joint plan to ensure high quality care and support services for everyone with learning disability or autism and mental health conditions or behaviour described as challenging	Health and Care Commissioners will produce a locally agreed plan, endorsed by key stakeholders, which ensures high quality services
End of June 2014	Transformational programme of action so people no longer live inappropriately in hospital	Commissioners will ask Operational Teams to produce a timetable of when individuals were last reviewed; a programme of reviews will then be produced based on this information. Contact in these areas will be made via Health and Care Commissioners to ensure a more formal approach to moving individuals. Trafford Council and NHS Trafford are much more proactive than other areas when working with providers and checking care is appropriate and of a high quality, this approach will be strengthened through a partnership approach and transformational strategy

3 Progress Update

To date the Winterbourne View Concordat: Programme of Action requires the CCG to complete several key actions (all of which have now been confirmed by NHS Trafford). That is:

- Primary Care Trust/CCG to develop registers of all people with a learning disability or autism who have mental health conditions or behaviour that challenges in NHS funded care as soon as possible and certainly on later than 1 April 2013, handing over the registers to Clinical Commissioning Group's who will have responsibility for maintaining the local register from 1 April 2013 and confirming between the Clinical Commissioning Group and Local Authority the nominated lead commissioner.

  - Confirmation that arrangements are in place to ensure a register of all people with a learning disabilities or autism who have a mental health condition or behaviour that challenges in NHS funded care is available by 28 February 2013 in order to be handed to Clinical Commissioning Group's.

  - Name and contact details of the nominated lead within the Clinical Commissioning Group who will hold and maintain the register from 1 April 2013.

  - By 1 June 2013, working together with service provider, people who use services and families, review the care of all people in learning disability or autism inpatient beds to agree a personal care plan for each individual based on their and their families' needs and agreed outcomes, putting 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.

  - Confirmation that a review has taken place since 1 November 2012 or is planned to take place by 31 May 2013 for all people in learning disability or autism inpatient beds identified on your register; The content of the review should include:

    - A personalised care plan;
    - Evidence of involving families and carers where appropriate;
    - A discharge plan;
    - A realistic estimated discharge date;
    - Highlighting whether the discharge is before or after June 2014;
    - An identified lead local commission;
    - Date of a comprehensive physical health check;
    - Identified appropriate and available independent advocacy to support the move on.

  - Confirmation of the number of people within local registers currently in learning disability or autism inpatient beds;

  - The number of people in learning disability or autism inpatient beds who have received an appropriate review between the 1 November 2012 and 28 February 2013;

  - The number of people in learning disability or autism inpatient units yet to be reviewed by 31 May 2013;

  - Confirmation that the capacity is in place to complete outstanding reviews by 31 May 2013.

6 Recommendations And Next Steps

The PCT/CCG is asked to note and confirm continued joint action to improve the life chances of local people with learning disabilities in Trafford, and their families/carers in line with national guidance, local needs assessment and best practice evidence/consultations with the LD Partnership Board and Safeguarding Board (e.g. to respond to the recognised health inequality outcomes, health service

assurance problems arising from the Winterbourne Review programme, and requirement to ensure through the New Health and Social Care Bill equity for Mental Health to that of Physical Health support).

7 Appendices

Appendix One – Full Action Plan

No.	Date	Action
1.	From June 2012	CQC will continue to make unannounced inspections of providers of learning disability and mental health services employing people who use services and families as vital members of the team.
2.	From June 2012	CQC will take tough enforcement action including prosecutions, restricting the provision of services, or closing providers down, where providers consistently fail to have a registered manager in place.
3.	From June 2012	CQC will take enforcement action against providers who do not operate effective processes to ensure they have sufficient numbers of properly trained staff.
4.	From November 2012	The cross-government Learning Disability Programme Board will measure progress against milestones, monitor risks to delivery and challenge external delivery partners to deliver to the action plan of all commitments. CQC, the NHSCB and the head of the LGA, ADASS, NHSCB development and improvement programme will, with other delivery partners, be members of the Programme Board, and report on progress.
5.	From December 2012	The Department of Health will work with the CQC to agree how best to raise awareness of and ensure compliance with Deprivation of Liberty Safeguards provisions to protect individuals and their human rights and will report by Spring 2014.
6.	From December 2012	The Department of Health will, together with CQC, consider what further action may be needed to check how providers record and monitor restraint.
7.	From December 2012	The Department of Health will work with independent advocacy organisations to identify the key factors to take account of in commissioning advocacy for people with learning disabilities in hospitals so that people in hospital get good access to information, advice and advocacy that supports their particular needs.
8.	From December 2012	The Department of Health will work with independent advocacy organisations to drive up the quality of independent advocacy, through strengthening the Action for Advocacy Quality Performance Mark and reviewing the Code of Practice for advocates to clarify their role.
9.	From December 2012	A specific workstream has been created by the police force to identify a process to trigger early identification of abuse. The lessons learnt from the work undertaken will be disseminated nationally. All associated learning from the review will be incorporated into training and practice, including Authorised Professional Practice.
10.	From December 2012	The College of Social Work, to produce key points guidance for social workers on good practice in working with people with learning disabilities who also have mental health conditions;
11.	From December 2012	The British Psychological Society, to provide leadership to promote training in, and appropriate implementation of, Positive Behavioural Support across the full range of care settings.
12.	From December 2012	The Royal College of Speech and Language Therapists, to produce good practice standards for commissioners and providers to promote reasonable adjustments required to meet the speech, language and communication needs of people with learning disabilities in specialist learning disability or autism hospital and residential settings.

13.	By end of December 2012	The Local Government Association and NHS Commissioning Board will establish a joint improvement programme to provide leadership and support to the transformation of services locally. They will involve key partners including DH, ADASS, ADCS and CQC in this work, as well as people with challenging behaviour and their families. The programme will be operating within three months and Board and leadership arrangements will be in place by the end of December 2012. DH will provide funding to support this work.
14.	By end December 2012	By December 2012 the professional bodies that make up the Learning Disability Professional Senate will refresh *Challenging Behaviour: A Unified Approach* to support clinicians in community learning disability teams to deliver actions that provide better integrated services.
15.	By January 2013	Skills for Health and Skills for Care will develop national minimum training standards and a code of conduct for healthcare support workers and adult social care workers. These can be used as the basis for standards in the establishment of a voluntary register for healthcare support workers and adult social care workers in England.
16.	By February 2013	Skills for Care will develop a framework of guidance and support on commissioning workforce solutions to meet the needs of people with challenging behaviour
17.	By March 2013	The Department of Health will commission an audit of current services for people with challenging behaviour to take a snapshot of provision, numbers of out of area placements and lengths of stay. The audit will be repeated one year on to enable the learning disability programme board to assess what is happening.
18.	By March 2013	The NHSCB will work with ADASS to develop practical resources for commissioners of services for people with learning disabilities, including: □□model service specifications; □□new NHS contract schedules for specialist learning disability services; □□models for rewarding best practice through the NHS; commissioning for Quality and Innovation (CQUIN) framework; and □□a joint health and social care self-assessment framework to support local agencies to measure and benchmark progress.
19.	By March 2013	The NHSCB and ADASS will develop service specifications to support CCGs in commissioning specialist services for children, young people and adults with challenging behaviour built around the model of care in Annex A
20.	By March 2013	The Joint Commissioning Panel of the Royal College of General Practitioners and the Royal College of Psychiatrists will produce detailed guidance on commissioning services for people with learning disabilities who also have mental health conditions.
21.	By March 2013	The Royal College of Psychiatrists will issue guidance about the different types of inpatient services for people with learning disabilities and how they should most appropriately be used.
22.	By 1 April 2013	The NHSCB will ensure that all Primary Care Trust develop local registers of all people with challenging behaviour in NHS-funded care.
23.	By 1 April 2013	The Academy of Medical Royal Colleges and the bodies that make up the Learning Disability Professional Senate will develop core principles on a statement of ethics to reflect wider responsibilities in the health and care system.
24.	By 1 April 2013	The National Quality Board will set out how the new health system should operate to improve and maintain quality.
25.	By 1 April 2013	The Department of Health will work with key partners to agree how Quality of Life principles should be adopted in social care contracts to drive up standards.
26.	From 1 April 2013	The NHSCB will make clear to CCGs in their handover and legacy arrangements what is expected of them in maintaining local registers, and reviewing individual's care with the Local Authority, including identifying who should be the first point of contact for each individual.
27.	From April 2013	The NHSCB will hold CCGs to account for their progress in transforming the way they commission services for people with learning disabilities/autism and

		challenging behaviours.
28.	From April 2013	Health Education England will take on the duty for education and training across the health and care workforce and will work with the Department of Health, providers, clinical leaders and other partners to improve skills and capability to respond the needs of people with complex needs.
29.	From April 2013	CQC will take action to ensure the model of care is included as part of inspection and registration of relevant services from 2013. CQC will set out the new operation of its regulatory model, in response to consultation, in Spring 2013.
30.	From April 2013	CQC will share the information, data and details they have about providers with the relevant CCGs and local authorities.
31.	From April 2013	CQC will assess whether providers are delivering care consistent with the statement of purpose made at the time of registration.
32.	From April 2013	Monitor will consider in developing provider licence conditions, the inclusion of internal reporting requirements for the Boards of licensable provider services to strengthen the monitoring of outcomes and clinical governance arrangements at Board level.
33.	From April 2013	The strong presumption will be in favour of pooled budget arrangements with local commissioners offering justification where this is not done. The NHSCB, ADASS and ADCS will promote and facilitate joint commissioning arrangements.
34.	From April 2013	The NHSCB will ensure that CCGs 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.
35.	From April 2013	Health and care commissioners should use contracts to hold providers to account for the quality and safety of the services they provide.
36.	From April 2013	Directors, management and leaders of organisations providing NHS or local authority funded services to ensure that systems and processes are in place to provide assurance that essential requirements are being met and that they have governance systems in place to ensure they deliver high quality and appropriate care.
37.	From April 2013	The Department of Health, the Health and Social Care Information Centre and the NHSCB will develop measures and key performance indicators to support commissioners in monitoring their progress.
38.	From April 2013	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.
39.	From April 2013	The Department of Health will work with the LGA and Healthwatch England to embed the importance of local Healthwatch involving people with learning disabilities and their families. A key way for local Healthwatch to benefit from the voice of people with learning disabilities and families is by engaging with existing local Learning Disability Partnership Boards. LINks (local involvement networks) and those preparing for Healthwatch can begin to build these relationships with their Boards in advance of local Healthwatch organisations starting up on 1 April 2013.
40.	By Spring 2013	The Department of Health will immediately examine how corporate bodies, their Boards of Directors and financiers 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. We will consider both regulatory sanctions available to CQC and criminal sanctions. We will determine whether CQC's current regulatory powers and its primary legislative powers need to be strengthened to hold Boards to account and will assess whether a fit and proper persons test could be introduced for board members.
41.	From Spring 2013	CQC will take steps now to strengthen the way it uses its existing powers to hold organisations to account for failures to provide quality care. It will report on

		changes to be made from Spring 2013.
42.	By 1 June 2013	Health and care commissioners, working with service providers, people who use services and families, will review the care of all people in learning disability or autism inpatient beds and agree a personal care plan for each individual based around their and their families' needs and agreed outcomes.
43.	By Summer 2013	Provider organisations will set out a pledge or code model based on shared principles - along the lines of the Think Local Act Personal (TLAP) Making it Real principles
44.	By Summer 2013	The Department of Health, with the National Valuing Families Forum, the National Forum of People with Learning Disabilities, ADASS, LGA and the NHS will identify and promote good practice for people with learning disabilities across health and social care.
45.	By summer 2013	The Department of Health will explore with the Royal College of Psychiatrists and others whether there is a need to commission an audit of use of medication for this group. As the first stage of this, we will commission a wider review of the prescribing of antipsychotic and antidepressant medicines for people with challenging behaviour.
46.	By June 2013	The Department of Health and the Department for Education will work with the independent experts on the Children and Young People's Health Outcomes Forum to prioritise improvement outcomes for children and young people with challenging behaviour and agree how best to support young people with complex needs in making the transition to adulthood.
47.	In 2013	The Department of Health and the Department for Education will develop and issue statutory guidance on children in long-term residential care.
48.	In 2013	The Department of Health and the Department for Education will jointly explore the issues and opportunities for children with learning disabilities whose behaviour is described as challenging through both the SEN and Disability reform programme and the work of the Children's Health Strategy.
49.	In 2013	The Department of Health will work with independent advocacy organisations to drive up the quality of independent advocacy.
50.	In 2013	The Department for Education will revise the statutory guidance *Working together to safeguard Children.*
51.	In 2013	The Royal College of Psychiatrists, the Royal Pharmaceutical Society and other professional leadership organisations will work with ADASS and ADCS to ensure medicines are used in a safe, appropriate and proportionate way and their use optimised in the treatment of children, young people and adults with challenging behaviour. This should include a focus on the safe and appropriate use of antipsychotic and antidepressant medicines.
52.	By December 2013	The Department of Health will work with the improvement team to monitor and report on progress nationally, including reporting comparative information on localities. We will publish a follow up report by December 2013.
53.	By end 2013	The Department of Health with external partners will publish guidance on best practice around positive behaviour support so that physical restraint is only ever used as a last resort where the safety of individuals would otherwise be at risk and never to punish or humiliate.
54.	By end 2013	There will be a progress report on actions to implement the recommendations in *Strengthening the Commitment* the report of the UK Modernising learning disability Nursing Review.
55.	By end 2013	CQC will also include reference to the model in their revised guidance about compliance. Their revised guidance abut compliance will be linked to the Department of Health timetable of review of the quality and safety regulations in 2013. However, they will specifically update providers about the proposed changes to our registration process about models of care for learning disability services in 2013.

56.	From 2014	The Department of Health will work with the Department for Education to introduce a new single assessment process and Education, Health and Care Plan to replace the current system of statements and learning difficulty assessments for children and young people with special educational needs; supported by joint commissioning between local partners (subject to parliamentary approval). The process will include young people up to the age of 25, to ensure they are supported in making the transition to adulthood.
57.	By April 2014	CCGs and local authorities will set out a joint strategic plan to commission the range of local health, housing and care support services to meet the needs of people with challenging behaviour in their area. This could potentially be undertaken through the health and wellbeing board and could be considered as part of the local Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy (JHWS) processes.
58.	No later than 1 June 2014	Health and care commissioners should put plans into action as soon as possible and all individuals should be receiving personalised care and support in appropriate community settings no later than 1 June 2014.
59.	In 2014	The Department of Health will update the Mental Health Act Code of Practice and will take account of findings from this review.
60.	By December 2014	The Department of Health will publish a second annual report following up progress in delivering agreed actions.
61.	From 2014/15	The Department of Health will develop a new learning disability minimum data set to be collected through the Health and Social Care Information Centre.
62.	By Summer 2015	NICE will publish quality standards and clinical guidelines on challenging behaviour and learning disability.
63.	By Summer 2016	NICE will publish quality standards and clinical guidelines on mental health and learning disability.

Appendix Two: Winterbourne View Update - October 2012 Following Second Panorama Programme

Introduction

Winterbourne View was a private hospital for people with learning disabilities and challenging behaviour.

The hospital was run by Castlebeck, a private company, but it was funded by public money.

The hospital was not based in a community; instead it was on an industrial estate where there were no other houses.

In 2011 a BBC Panorama programme aired distressing coverage of the failings of the Castelbeck Service, Winterbourne View.

It uncovered violent and systematic institutional abuse of adults with learning disabilities through undercover filming over the course of 16 shifts.

The coverage also, perhaps more disturbingly, highlighted the shortcomings of the Care Quality Commission, and their failure to do something about it even though there had been three allegations of abuse from a senior nurse whistle-blower.

It was also concerning because CQC had failed to raise the issues highlighted by Panorama on any of their inspection visits to the service. This made people think that CQC's inspection visits were not very good.

In response to Castlebeck Trafford's Director of Commissioning called for a review which focused on the quality of learning disability services in Trafford.

The review meant that unannounced visits were undertaken on all services which looked to assure the Council, the individuals who use services and their families that institutional abuse and bad practice was not happening in Trafford.

The review was positive with no areas of major concerns noted. Following the review a robust quality monitoring process has been put in place by Trafford Council.

A year after the first programme aired, Panorama have revisited the story in October 2012.

A Year On…

Simon's Story

The programme followed the story of a man called Simon who lived at Winterbourne View.

He is only now telling his family about the terrible things which happened to him when he lived at Winterbourne View, these are things like being hit and restrained by the people who worked there, having his head put down the toilet and being put in a cold shower.

Simon lived in the community for 16 years but a change in his behaviour meant that the care home he lived at said that they needed additional staff to support him; they said they needed £600 more a week.

Wiltshire Council, who would need to pay for this extra support, asked doctors to assess Simon's behaviour, but instead of doing this at home, they wanted to do this at Hospital, the family were told that if they refused this then Simon would be sectioned and would be taken to hospital forcibly.

So after 16 years of living in a community based home Simon was moved to a number of secure hospitals where he was being physically restrained on a regular basis.

Simon had been away from his home for 9 months, he was living at Postern House - a hospital ran by a NHS Trust – he told an advocate that he had been hit by a staff member. The BBC had accessed records about 3 incidents which had happened there – one where he had been "frogmarched" with his arm behind back to his room – another incident he had been restrained inappropriately and a person had lay across his chest, and a third incident where he got a cut on the head – the family were only aware of one of these incidents.

Postern House investigated but did not involve the family or the advocate, a few days later Simon moved to Winterbourne View. 2 people were disciplined over one of these incidents.

Simon is now back where he wants to be, in the community a few miles from his mum, costing £1,400 a week less than Winterbourne, getting the care he wants, with his friends and family close to him.

Simone's Story

Simone went to another hospital after Winterbourne – Postern House.

For the first few weeks she was very calm, however there were instances of restraint recorded, one day she was restrained on 12 separate occasions.

Simone's family received a letter from Wiltshire about a safeguarding concern, this was in relation to how she was supported by staff when she was upset and agitated, the family were given no further details but they were told that 4 members of staff had been suspended.

In a matter of weeks Simone was moved, this decision was taken following an attack on two members of staff, Simone was moved 400 miles away to another hospital – her family are unable to see her.

What Happened After Winterbourne

Change was promised – Winterbourne was closed and CQC inspected all similar establishments.

There was a Serious Care Review that looked at Winterbourne in detail, it concluded that
- Professional let people down
- Safeguarding let people down
- Police let people down
- Commissioners let people down

Even though all of these people missed things a lot of the responsibility lies with the provider, Castelbeck, as it promoted an unworkable management structure, and acknowledges that there was limited executive oversight. This means that the people who were in charge of making sure the service was good did not do their job.

The Serious Case Review said that is was not confident that those in charge of Castlebeck learnt any lessons

Castelbeck have said they changed their structure and invested over £8million pounds in a "turnaround programme"

Financially, Winterbourne was one of Castlebeck's best performing homes, with 24 beds it turned over £3.7million a year, with an average weekly fee of for patients of £3.5k

The judge who looked at the cases of the staff arrested in connection with Winterbourne said that Castlebeck was an organisation run with profit in mind with no regard for residents and staff.

Castlebeck deny that profit came before welfare – however the inquiry have found it hard to find out where public money was spent – when they asked for information about what was spent on things like activities or staff development they were told it was commercially sensitive information.

Following the closure of Castlebeck at least 19 of the 51 patients have had alerts raised about them, although this does not mean that they have come to harm. Just under half of the patients have been moved to another hospital.

This report has found that patients were left traumatised - because they were abused in places where we all should feel at their safest like our bedrooms – this is an appalling legacy

What Trafford have learnt – what are we still learning?

Quality and Values
It would be silly to say that it isn't possible for another Castlebeck to happen

We are doing all we can to recognise areas of good practice and to share these with other areas

We are doing all we can to challenge and stop bad practice under our safeguarding processes

We are giving people a voice when it comes to telling us about their services

Trafford continue to monitor its learning disability services to make sure that the culture of staff and services promote people's dignity, choice and independence

For all new services commissioned since Winterbourne we have asked specific questions about what people have learnt and changed as a result of what happened

Physical Intervention

There were 129 instances of physical restraint at Winterbourne reported to CQC in the first 3 months of 2011.

The Castlebeck training was done by an internal member of staff; there have been a number of criticisms of the advice given by the training officer.

Trafford Council monitor what training is accessed by providers and what the quality of this is through regular contact, Trafford also offer training to provider through Trafford's Training Consortium.

Trafford Council are revisiting the process it uses to ensure that Physical Intervention is only used as a final resort, and in these instances it is legal, the least invasive and individual to the person.

The Future…

It is felt nationally that the Government needs to do more than just give "guidance" the government is publishing it's finding's later in the year.

There is a term called "warehousing" which some professionals use to describe what happens when people are placed in hospitals. When it comes to Challenging Behaviour, hospitals, which should be the last resort, are used too frequently. This is not the case in Trafford.

It is reported that there has been an "out of sight, out of mind" mentality. This means that because people didn't see what was happening at Winterbourne, they didn't care. This is not the case in Trafford, we have a dedicated team ensuring that services are good quality and who support services who are struggling. People receive a face to face review once a year even if they are placed out of area.

For years it has been widely encouraged that people with learning disabilities live in the community – in Trafford we strongly believe this and will continue to ensure that people live where they are part of the community, contributing to it and being respected as citizens.

Winterbourne is a stark reminder of what can go wrong when commissioners and practitioners don't have good relationships with service providers; we have the strongest approach we have ever had in Trafford to make sure that we have good relationships with providers and to make sure that people are safe and well supported.

Appendix Three: Trafford LD Partnership Board Summary Presentation and Feedback

Winterbourne_for_LDPB

Trafford LD Partnership Board Su

Appendix Four: Greater Manchester LD Health Self Assessment Validation Ratings

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