Health and Wellbeing Board
North Yorkshire

North Yorkshire

Shadow Health and Well Being Board

28 November 2012

Winterbourne View

1. Purpose:-

1.1. The purpose of this report is to brief the Board of the current position with regard to the North Yorkshire response to the Interim Department of Health (DoH) Report in response to events at Winterbourne View in 2011, to identify possible risks and to recommend further actions.

2. Background:-

2.1. Following the serious incidents exposed at Winterbourne View in 2011 there has been a significant level of scrutiny and activity to ensure that there is a comprehensive stakeholder response, and to develop an improvement framework for the future.

2.2. The following reports have now been published:

- CQC LD Review – National Overview (150 inspections).
- Interim Report - DoH (June 2012).
- Serious Case Review – Winterbourne View (South Gloucestershire Council).
- Internal Management Review – NHS.
- Internal Management Review – CQC.

2.3. The final DoH report will be published in November 2012.

2.4. The DoH published an interim report of the review into the events at Winterbourne View hospital in July 2012. The Minister for Care Services, Paul Burstow, set up the review to establish the facts and bring forward actions to improve the care and outcomes of people with learning disabilities or autism. A letter from David Nicholson, NHS Chief Executive and David Behan, Director General Social Care, Local Government and Care Partnerships highlights action to be taken forward by NHS bodies and local authorities as set out in that report. This was a follow up to a letter from the DoH on 2 February 2012. .

2.5. The main findings set out in the interim report are that:

2.5.1. There are too many people in in-patient services for assessment and treatment and they are staying there for too long. This model of care has no place in the 21st century;

2.5.2. Best practice is for people to have access to the support and services they need locally to enable them to live fulfilling lives integrated within the community;

2.5.3. In too many services there is robust 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;

2.5.4. All parts of the system– commissioners, providers, workforce, regulators and government – must play their part in driving up standards of care and demonstrating zero tolerance of abuse. This includes acting immediately where poor practice or sub-standard care is suspected.

2.6. The key objectives for the actions are to:

2.6.1. Improve commissioning across health and care services for people with behaviour which challenges with the aim of reducing the number of people using inpatient assessment and treatment services;

2.6.2. Clarify roles and responsibilities across the system and support better integration between health and care;

2.6.3. Improve the quality of services to give people with learning disabilities and their families choice and control;

2.6.4. Promote innovation and positive behavioural support and reduce the use of restraint;

2.6.5. Establish the right information to enable local commissioners to benchmark progress in commissioning services which meet individuals' needs, improve the quality of care, and reduce the numbers of people in in-patient services for assessment and treatment;

2.6.6. It was clear from this letter that PCTs and local authorities need to work together to assure themselves that they are continuing to take all action needed to improve outcomes for people with learning disabilities in preparation for the outcomes of the final report into the events at Winterbourne View, which will be published in the autumn.

3. <u>Actions to date:-</u>

3.1. A draft action plan has been produced which aims to match the current position of Health and Adult Services and NHS North Yorkshire and York against the five local actions required from the 25 June letter and the four actions from the 2 February letter. The plan evidences progress to date against each of the local actions and identifies where risks may remain. It also includes information on the:

3.1.1. 14 actions identified at a national level to help achieve these objectives and to drive good practice and focus on improving outcomes for individuals with learning disabilities or autism and behaviour which challenges; and

3.1.2. Six Lives action plan updated in February 2012 following the letter referred to above.

3.2. HAS and PCT Commissioners are currently drafting a joint commissioning statement which will be presented to the CCG and CSU with the proposal of developing integrated teams/models.

3.3. A workshop took place on 16 November which looked at the government reports and inspection findings and checked how we are doing locally. The aim of this workshop was to check what has happened in North Yorkshire so far and make a plan for what needs to happen locally. This is a joint workshop between the

Learning Disability Partnership Board and Safeguarding Adults Board, facilitated by Inclusion North.

3.4. The Safeguarding Adults Board continues to have the Winterbourne View and the Enhanced Commissioning Framework on its agenda. It is clear that there is a significant safeguarding element to the recommendations although they are wider than the remit of the Safeguarding Adults Board.

4. Key Issue/Risks identified

4.1. There is a clear expectation from the Board that health commissioners should lead on this area of work so the main risk comes from changes to health and risk from structural fragmentation of commissioning roles and a move away from specialist commissioning posts. There is a risk that there is no Learning Disability lead currently identified in the Clinical Support Unit.

4.2. The risks associated with the key local action areas are:

4.2.1. Lead Commissioner - ensuring that the DoH Out of Area Placement Protocol / Enhanced Commissioning Framework (ECF) Project Plan are implemented. The key areas being addressed from the ECF are data quality, reviews and out of county placements;

4.2.2. Effective communication in reviewing placements – a countywide risk management /enablement panel needs to be put in place.

4.2.3. Clear multi-agency approach to safeguarding – the transfer of PCT responsibilities to Clinical Commissioning Groups (CCGs) and Clinical Support Unit present the greatest risk as this impacts both on strategic responsibilities for safeguarding and for learning disabilities commissioning;

4.2.4. Joint strategies for commissioning – there is a need to establish a joint CCG / Local Authority integrated commissioning model, perhaps through development of lead CCG arrangements. This could address the oversight of the Enhanced Commissioning Framework project plan.

4.2.5. Person centred commissioning – the risk is not associated with an individual; it is associated with changes to health and risk from structural fragmentation of commissioning roles and a move away from specialist commissioning posts;

4.2.6. Reasonable adjustments for people with learning disabilities to use generic mental health beds - consideration needs to be given to the terms of the current contracts with Leed and Yorkshire Partnership Foundation Trust and Tees Esk and Wear Valleys NHS Trust;

4.2.7. Commissioning the ‘right model of care’ - There is currently no ‘right model of care’. The DH has identified that it will work with the NHS Commissioning Board Authority and ADASS to develop a clear description of all the essential components of a model service by March 2013. It is the local view that any Quality Framework should provide guidance on outcome focussed service development, measurement of quality against individually agreed outcomes and a risk enablement tool to allow positive risk taking in a supportive environment;

4.2.8. Early detection and prevention to reduce the numbers reaching a crisis - there is evidence that the population of people with learning disabilities is under represented in populations attending routine health checks/screening programmes;

4.2.9. Transition planning – it is a clear priority that health commissioners need to be involved early in the transition process.

5. Consideration of the Report:-

5.1. Health and Adult Services Management Board considered this report on 31 October and resolved

5.1.1. To accept the draft Action Plan including the key issues/risks identified and the HASMB leads to take the actions forward;
5.1.2. To agree that the draft action plan is considered by the Safeguarding Adults Board & the Learning Disabilities Partnership Board;
5.1.3. To agree that the draft action plan should be considered by the Health and Wellbeing Board;
5.1.4. To recommend that the Safeguarding Adults Board leads this work until the Clinical Commissioning Groups are fully established.

5.2. The North Yorkshire Safeguarding Adults Board considered this report on 2 November and resolved

5.2.1. To note the draft Action Plan including the key issues/risks identified and the leads to take the actions forward;
5.2.2. To monitor the development of a joint commissioning model and receive a further report to the January meeting;
5.2.3. To consider the Winterbourne View Serious Case Review at the next meeting.

6. Recommendations:-

6.1. It is recommended that the Health and Wellbeing Board;

6.1.1. Note the draft Action Plan including the key issues/risks identified and the HASMB leads to take the actions forward;
6.1.2. Note that the draft action plan will be considered by the Safeguarding Adults Board & the Learning Disabilities Partnership Board;
6.1.3. Note that the Safeguarding Adults Board will oversee monitoring of this work until the Clinical Commissioning Groups are fully established.
6.1.4. Receive further report on this issue including the development of a joint commissioning model.

Report Sponsor:-
Helen Taylor, Corporate Director – Health and Adult Services
14 November 2012

Enclosures:-
Appendix 1 – Draft Action Plan.
Appendix 2 – Winterbourne View – ADASS update.