Tower Hamlets Health & Wellbeing Board – 6th February 2014

Winterbourne Review Update

The Winterbourne Report made recommendations to prevent the type of serious and systematic physical, emotional and institutional abuse of vulnerable people with a learning disability,as portrayed in a BBC Panorama documentary.

The abuse happened due to a range of factors, such as little contact with their families and no advocacyto act on their behalf. The Winterbourne staff were not well managed and a culture of institutional abuse developed, which was normalised by the staff who worked there. The report also noted that abuse was not identified by health and social care staff undertaking reviews or through Care Quality Commission inspections. In summary, the report concluded that all agencies had failed the people placed at Winterbourne.

Winterbourne actions require agencies to put in place measures so that people with learning disabilities and challenging behaviour are not put at future risk.

It is recommended that Health & Wellbeing Boards (HWBB) lead on ensuring thattheir local agencies comply with Winterbourne actions. These include the following:-

- People with a learning disability and challenging behaviour receive safe care
- Any patterns of abuse identified in assessment and treatment centres are acted upon immediately by all agencies working together
- That Council's and the NHS develop local services through joint commissioning of accommodation and care, especially for those people with a learning disability and challenging behaviour

The report highlighted that assessment and treatment centres can be used inappropriately to contain people with challenging behaviour for long periods of time when their remit is to help people recover or in the case of forensic units to be legally detained.

Tower Hamlets has made limited use of assessment and treatment centres and only when no other option was available and for those people where it was appropriate. Currently Tower Hamlets have 3 people in such centres (one of the lowest rates in the country) andwere highlighted in Parliament as promoting good practice in limiting the use of assessment and treatment centres. However,our local review has identified a lack of local provision of high support /extra care housing in order that people can continue to live in Tower Hamlets and access to support, employment and training opportunities for people with complex learning disabilities.

The Winterbourne Report required local authorities, NHS commissioners, providers and stakeholders to review all people currently living in assessment and treatment centres (hospitals) in England and Wales to ensure:

- Reviews were within specified timescales
- People with a learning disability were listened to
- People were seen and receiving personalised support and care
- Independent advocates were provided for each person with a learning disability
- Families/carers were helped to visit the person with a learning disability including arranging and funding transport arrangements if they were unable to do so.
- To ensure that there was clear and strategic leadership in place
- Health and social care jointly commissioned community support options for people with challenging behaviour and complex needs.

Tower Hamlets Actions

Tower Hamlets reviewed all people placed in out of Borough placements within the six month timescale, as required by Winterbourne and applied the Winterbourne actions as good practice.

1. Currently Tower Hamlets has 3 people in assessment and treatment centres. These are defined as people who are in hospital placements and include two people who are currently in the medium secure unit in Hackney. There are specialist beds in the forensic unit for male patients witha learning disability, which is beneficial for our population, but this local facility does not exist for females.

2. Reviews were completed for the 3 service users in assessment and treatment centres. In addition all cases funded by the NHS have been reviewed and the details passed to the Tower Hamlets Clinical Commissioning Group (CCG). The deadline of June 2013 for all reviews to have been completed was met and annual reviews are in planned.

3. All peoplewho require such placements are placed out of the Borough as there is limitedlocal specialist provision for people with learning disabilities and challenging behaviour.There is a long term strategy to aim to provide local supported housing and care support.

4. There is a challenging behaviour work stream of the Learning Disability Partnership Board that is identifying the unmet needs of people with challenging behaviour and learning disabilities. One of its key functions is to highlight this unmet need with health and social care commissioners, so local provision can be provided.

5. There have been some early discussions with other councils across East London, following a London wide stocktake of provision. This identified common areas of unmet need that could be commissioned effectively on a sub-regional basis, if cross borough funding agreements and location of provision could be agreed.

	Action	*Outcome*	*Time scale*	*Named responsible person/team*
Complete outstanding Reviews on Out of Borough placement	Reviews allocated to each care programme and performance reviewed in supervision	Completed	Monthly	All care programmes Each Manager reviewing outcomes and sign off
Minimise risks for LD service user living in residential care	All cases reviewed to ensure that no service users in any of the residential /nursing homes flagged for concerns	Visits addressing standards around • Safeguarding • Documentation • Discharge arrangements • Customer evaluation • Environment • Medication • Keyworker sessions • Personalisation	On going Care programme managers to review monthly- that reviews are compliant and signed off by the manager	Care program managers Service manager to check compliance on 5 random cases each month.
Safeguarding	To review numbers of safeguarding alerts in residential and nursing care as a proportion of the cohort all safeguarding cases	To prepare quarterly safeguarding reports and extract this information as a proportion of the whole	Every 4 months	Care Programme Managers and Service Manager Report to go governance meeting every 3 months
Personalisation	All cases to be reviewed considering if the service user can return to the Borough or nearer to	Review the numbers of people with LD moving on from residential and nursing care. This is an ongoing exercise	On going	Review as part of performance report for the

	home Care manager to actively explore this option with the service user and carers			CLDS service
PCTs to develop registers of all people with learning disabilities or autism and who have mental health conditions or behaviour that challenges in NHS funded care	PCT commissioners to identify all people with a learning disability or autism who have challenging behaviour,	31st March 2013/ completed (however assumes all service users are registered with a GP		PCT commissioners/ CCG commissioners
Review all LD in patients in assessments and treatment centres	a. To visit all inpatients Continuing care / health and residential and nursing care b. Personalised care plan c. Evidence of engagement and agreement with families and carers d. A discharge plan (including estimated discharge date) e. A named care co-ordinator f. An identified lead CCG g. Date of a comprehensive physical health check h. Identified independent advocacy to support the move on.	June 2013	Completed Completed Completed d)When required this will be completed as part of the discharge planning agreements completed Richard Fradgley Date of	CCG commissioners to report CLDS to action

			health check included in the review Advocates identified with SU agreement and/or if family do not act as the advocate	
Position statement to NHS Commissioning	Statement to include the following : 1. The number of people within your registers currently in learning disability or autism inpatient beds; 2. The number of people in learning disability or autism inpatient beds who have received an appropriate review between 1 November 2012 and 28 February 2013; 3. The number of people in learning disability or autism inpatient units yet to be reviewed by 31 May 2013; 4. Confirmation that the capacity to complete outstanding	Currently tendering for an Autism community team, we currently have 3 people who are in inpatient beds as specified. All service users have received an appropriate review There are no outstanding reviews of people with LD in inpatient units		

	reviews by 31 May 2013 is in place	There are systems and processes in place to ensure reviews happen in a timely fashion		

In addition, there is an expectation that the local NHS has an updated list of learning disability patients. The council andCCG are working to rationalise these lists and ensure that the information is shared, through the development of data sharing protocols and ICT alignment.

In addition to the Winterbourne actions, the council and the local NHS are working together to focus such activity to all people living in residential and nursing homes.

Recommendation

The HWBB is asked to note that Tower Hamlets is compliant with the specific Winterbourne actions, but to receive annual updates on future activity related to reviews of people within assessment and treatment centres and the longer term development of local provision of housing and care support.