

# Croydon Council

For General Release

<b>REPORT TO:</b>	<b>ADULT SOCIAL SERVICES REVIEW PANEL</b> <b>2 October 2013</b>
<b>AGENDA ITEM NO:</b>	<b>7</b>
<b>SUBJECT:</b>	<b>Action plan following Winterbourne abuse enquiry</b>
<b>LEAD OFFICER:</b>	<b>Hannah Miller, Executive Director Adult Services Health and Housing</b>
<b>CABINET MEMBER:</b>	<b>Councillor Margaret Mead, Cabinet Member for Adult Services and Health</b>
<b>WARDS:</b>	<b>All</b>
<b>CORPORATE PRIORITY/POLICY CONTEXT:</b> <p>On 31 May 2011 Panorama broadcast a program evidencing shocking abuse of patients with a learning disability at Winterbourne View private hospital in South Gloucestershire. The abuses uncovered have led to criminal convictions.</p> <p>A number of enquiries followed the initial exposé. In December 2012 the department of health produced a report 'Transforming Care: a national response to Winterbourne View Hospital'.</p> <p>There is a clear expectation that each local area - council, health and other agencies develop an action plan to ensure that the type of abuses that occurred at Winterbourne will not be repeated elsewhere and that our services for people with a learning disability and behaviours that challenge maintain high quality, safety, dignity and care.</p>	
<b>FINANCIAL IMPACT</b> <p>There is no specific financial impact related to this report.</p>	

## 1. RECOMMENDATION

1.1 The Panel is asked to note the content of the Winterbourne Action plan and stocktake which will be monitored to ensure effective implementation across all agencies.

## 2. EXECUTIVE SUMMARY

The Department of Health review drew on:

- a criminal investigation with 11 individuals prosecuted and sentenced;
- the Care Quality Commission review of all services operated by Castlebeck Care, the owners of Winterbourne View, and the programme of inspections of 150 learning disability hospitals and homes;
- the NHS South of England reviews of serious untoward incident reports and the commissioning of places at Winterbourne View hospital;
- an independent Serious Case Review commissioned by the South Gloucestershire Safeguarding Adults Board, published on 7 August 2012;
- and the experiences and views of people with learning disabilities or autism and mental health conditions or behaviours described as challenging, their families and carers, care staff, commissioners and care providers.

This report sets out a programme of action to transform services so that people no longer live inappropriately in hospitals but are cared for in line with best practice, based on their individual needs, and that their wishes and those of their families are listened to and are at the heart of planning and delivering their care.

The Government's Mandate to the NHS Commissioning Board<sup>1</sup> says:

*"The NHS Commissioning Board's objective is to ensure that CCGs 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."*

The department of health report demands fundamental changes that include:

- That all current placements will be reviewed by 1 June 2013, and everyone inappropriately in hospital will move to community-based support as quickly as possible, and no later than 1 June 2014; that by April 2014 each area will have a locally agreed joint plan to ensure high quality care and support services for all children, young people and adults with learning disabilities or autism and mental health conditions or behaviour described as challenging, in line with a prescribed model of good care
- that there will be a dramatic reduction in hospital placements for this group of people and the closure of large hospitals;
- that a new NHS and local government-led joint improvement team, with funding from the Department of Health, will be created to lead and support this transformation;
- that the DH will strengthen accountability of Boards of Directors and Managers for the safety and quality of care which their organisations provide, setting out proposals during Spring 2013 to close this gap;
- that CQC will strengthen inspections and regulation of hospitals and care homes for this group of people. This will include unannounced inspections involving

- people who use services and their families, and steps to ensure that services are in line with the agreed model of care; and
- that the DH, with the improvement team, will monitor and report on progress nationally.

Alongside this report, the DH published a Concordat agreed with key external partners. It sets out a shared commitment to transform services, and specific actions which individual partners will deliver to make real change in the care and support for people with learning disabilities or autism with mental health conditions or behaviour that challenges.

### **3. DETAIL**

The Croydon multi- agency action plan which resulted from the Winterbourne View reports and concordat has sought to capture all the recommendations for good practice identified and to ensure implementation. The action plan has been developed in conjunction with key agencies including the clinical commissioning group, Croydon health services, the police, learning disability commissioners and the joint learning disability team.

In addition to the action plan the learning disability commissioner, Mike Corrigan, is leading on completion of a stocktake report which has been requested by the Local Government Association and NHS England. The intention is to enable local areas to assess their progress in the joint implementation of improvement actions, following the Winterbourne concordat, to share information and disseminate good practice and to identify what support is required from the Joint Improvement programme so that resources can best be targeted.

### **4. CONSULTATION**

There has been wide consultation across key partner agencies. The stocktake and action plan will be monitored locally via the Croydon Adult Safeguarding board and best practice subgroup and also by the Health and Wellbeing board and nationally by the local government association and NHS England.

### **5. FINANCIAL AND RISK ASSESSMENT CONSIDERATIONS –**

5.1 There are no specific financial considerations attached to this report.

(Approved by: Paul Heynes, Head of Finance – DASHH, Interim Chief Executives Department on behalf of the Director of Finance)

## **6. COMMENTS OF THE COUNCIL SOLICITOR AND MONITORING OFFICER**

- 6.1 The Solicitor to the Council comments that there are no legal issues arising from the report

*(Approved by: J Harris Baker, head of social care and education law and deputy monitoring officer on behalf of the Council Solicitor & Director of Democratic & Legal Services)*

## **7. HUMAN RESOURCES IMPACT**

- 7.1 There are no immediate HR considerations that arise from this report for LBC staff.

Approved by: Michael Pichamuthu Strategic HR Business Partner on behalf of the Director of WCR

## **8. EQUALITIES IMPACT**

- 8.1 This report is concerned with people who are protected under the equalities act due to a number of protected characteristics including learning disability, mental illness and who are vulnerable adults. Implementation of the action plan and stocktake and continuing work by all agencies will help to strengthen service delivery for these individuals.

## **9. ENVIRONMENTAL IMPACT – None**

## **10. CRIME AND DISORDER REDUCTION IMPACT – None**

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**CONTACT OFFICER:** Kay Murray, head of professional standards ex 86711  
**BACKGROUND DOCUMENTS:** 1. Winterbourne View action plan 2. Winterbourne View stocktake – NHS England and Local Government Association