Avon and Wiltshire NHS
Mental Health Partnership NHS Trust

enabling and empowering people to reach their potential and live fulfilling lives

Summary Report – Trust Board Meeting (Part 1)	**Date: 30th January 2013**
Report Title: Report in response to DH report on Winterbourne View	
Agenda Item: 11	**Enclosures: Winterbourne View action plan v4 – January 2013.**
Sponsor: NCAS Director	**Presenter: NCAS Director**
Report Author: Head of Safeguarding	
Report discussed previously at:	*Mental Health Legislation and Safeguarding Management Group- 19/12/2012*

Purpose of the Report and Action required		
To update the Board on the release of the final government response to the recommendations arising from the Winterbourne View and to approve the updated AWP Winterbourne View action plan incorporating additional actions arising from the final report.	Approval	X
	Discussion	
	Information	

Executive Summary of Key Issues

The government published its final report "Transforming care: A national response to Winterbourne View Hospital" *Department of Health Review: Final Report* on the 10th December 2012, containing recommendations on models for LD services, commissioning oversight. access to mainstream mental health services for people with LD, and a review of the MHA Code of Practice

AWP is working with local Safeguarding Adult Boards, local authorities and commissioners to implement changes to monitoring and assurance in inpatient settings, and in particular of funded placements.

Further work is being undertaken internally and on a multi agency basis on changes in systems, management and monitoring of inpatient care and settings to manage risks that of inappropriate or abusive practice

The proposed actions in AWP are set out in this report and the attached updated Winterbourne View Action plan (version 4)..

Report in response to DH report on Winterbourne View

Which Strategic Objective does this paper address	
A sustainable value for money business	Y
Excellent service user access and experience	Y
Excellent partnership working with other organisations	Y
Effective engagement and improvement in staff satisfaction	N

Link to Fit for the Future Implementation Plan	
N/A	

Corporate Impact Assessment	
Quality and Safety implications	Compliance with Outcome 7 (Essential Standards)

Recommendations to other committees
None

Recommendation/Decision
The Board is recommended to **note** the report, and **approve** the attached Winterbourne View Action plan (version 4) and the actions set out in this report

Report in response to DH report on Winterbourne View

1. Purpose of the Report

1.1. To update the Board on the release of the final government response to the recommendations arising from the Winterbourne View and on the proposed actions within the updated AWP Winterbourne View action plan that incorporates the additional actions arising from the final report.

2. Background

2.1. South Gloucestershire's multi-agency Safeguarding Adults Board (SAB) published an independent Serious Case Review into the abuse of patients with learning disabilities at the Winterbourne View private hospital on the 7th August 2012.

2.2. The review was commissioned by the SAB following the disclosure last year of the abuse of adults with learning disabilities, mental health problems and autism at the 24-bed private hospital owned and operated by Castlebeck Ltd, and showed that the abuse at Winterbourne View Hospital resulted from serious and sustained failings in the management procedures of Castlebeck Limited.

2.3. It also identifies where other organisations' systems and procedures fell short in commissioning patient care, and in reviewing and safeguarding the wellbeing of patients before and during their stay at Winterbourne View hospital.

2.4. AWP had one patient placed at Winterbourne View; however the placement was only made four weeks prior to the exposure of abuse, and therefore CPA review procedures had not commenced in relation to the placement. There is no evidence that this particular patient was abused during this short stay.

2.5. Recommendations from the review at a national level include a call for greater investment in community-based care in order to reduce the need for in-patient admissions at assessment, treatment and rehabilitation units such as Winterbourne View Hospital.

2.6. The report highlights the need for outcome-based commissioning for hospitals detaining people with learning disabilities and autism and says that the use of 't-supine restraint' should be discontinued at such units. This method of restraint is not in use in AWP LD services.

2.7. The report also calls for notifications of concern, including safeguarding alerts, hospital admissions and police attendances, to be better co-ordinated and shared amongst safeguarding organisations to allow earlier identification of potential problems and earlier action to be taken.

2.8. The recommendations of the SCR will be taken forward in an action plan overviewed by all the local Safeguarding Adults Boards.

2.9. There are proposals to put forward primary legislation to safeguard adults at risk in 2014.

2.10. The government published its final report "Transforming care: A national response to Winterbourne View Hospital" *Department of Health Review: Final Report* on the 10th December 2012. This contains a range of recommendations in regard to models for LD

services, and commissioning oversight. In particular it makes various recommendations about access to mainstream mental health services for people with LD suffering from mental illness and also recommends a review of the MHA Code of Practice in light of Winterbourne View.

2.11. Transforming care: A national response to Winterbourne View Hospital is available at: https://www.wp.dh.gov.uk/publications/files/2012/12/final-report.pdf

3. Conclusion

3.1. AWP is working with local Safeguarding Adult Boards to develop and implement the actions arising from the various recommendations arising from this SCR. There is also further work underway with local authorities and commissioners to implement changes to monitoring and assurance in inpatient settings, and in particular of funded placements.

3.2. Further work is therefore being undertaken internally and on a multi agency basis to develop and implement changes in systems, management and monitoring of inpatient care and settings that can implement and build on the lessons identified in this SCR, other reports, and the DH final response to ensure that the measures in place in AWP identify and manage risks that might arise in relation to inappropriate or abusive practice

3.3. All current identified actions are identified in the attached updated Winterbourne View Action plan (version 4), that was considered and updated/amended at the Mental Health Legislation and Safeguarding management group on the 19/12/2012.

3.4. Regular update reports on the progress of the reports, recommendations and actions will be reported to the Mental Health Legislation and Safeguarding Management Group.

3.5. A short briefing on the action plan and DH response will be circulated through Communications via the Trust news/briefing system in due course following approval.

4. Decisions

4.1. The Board is asked to note the report, and to approve the actions set out in the attached Winterbourne View Action plan (version 4) and the further actions set out in the conclusion section of this report