Nottinghamshire County Council

Report to the Health and Wellbeing Board

2nd October 2013

Agenda Item: 8

REPORT OF SERVICE DIRECTOR, PERSONAL CARE AND SUPPORT YOUNGER ADULTS

THE NOTTINGHAMSHIRE RESPONSE TO 'TRANSFORMING CARE; A NATIONAL RESPONSE TO WINTERBOURNE VIEW HOSPITAL.

Purpose of the Report

1. To inform Board members of the local response to the Department of Health report, 'Transforming Care; A National Response to Winterbourne View Hospital', and the subsequent Winterbourne View Concordat.

2. To seek approval for the continued work to develop alternative services for people who are inappropriately placed in hospitals and the development of local services to prevent future inappropriate placements, together with an agreed shared funding responsibility.

Information and Advice

3. In May 2011 an investigation by the BBC Panorama programme revealed criminal abuse of people with learning disabilities at Winterbourne View, a Castlebeck assessment and treatment hospital near Bristol. As a result of criminal proceedings, eleven care workers admitted 38 charges of either neglect or ill-treatment of people with learning disabilities.

4. In December 2012, the Department of Health (DH) report **Transforming Care: A National Response to Winterbourne View Hospital** was published based on a number of reviews and investigations which had been undertaken by the Police, the CQC and local services. The report identifies a range of actions required at a national and local level to drive up the quality of support provided to people with learning disabilities, particularly those that are identified as having 'challenging behaviour' so they can receive high quality healthcare and be supported to live in the community. At the same time a national Concordat Program of Action was published backed up by a joint improvement programme led by The Local Government Association (LGA) and the NHS England.

5. The DH report found

   - **Patients stayed at Winterbourne View for too long and were too far from home** – the average length of stay was 19 months. Almost half of patients were more than 40 miles away from where their family or primary carers lived.

   - **There was an extremely high rate of 'physical intervention'** – well over 500 reported cases of restraint in a fifteen month period.

- **Multiple agencies failed to pick up on key warning signs** – nearly 150 separate incidents – including A&E visits by patients, police attendance at the hospital, and safeguarding concerns reported to the local council – which could and should have raised the alarm.

- **There was clear management failure at the hospital** – with no Registered Manager in place, substandard recruitment processes and limited staff training.

- **A 'closed and punitive' culture had developed** – families and other visitors were not allowed access to the top floor wards and patient bedrooms, offering little chance for outsiders to see daily routines at the hospital.
- The Review also exposed wider concerns about how people with learning disabilities or autism and with a mental health condition or challenging behaviours were being treated in England:
- **Inappropriate placements** – too many people are being placed inappropriately in hospitals for assessment and treatment, and staying there for long periods.

- **Inappropriate care models** – too few people are experiencing personalised care that allows them to be in easy reach of their families, or their local services.

- **Poor care standards** – there are too many examples of poor quality care, and too much reliance on physical restraint.

6. At the same time the DH established a national Concordat Program of Action backed up by a joint improvement programme led by The Local Government Association (LGA) and the NHS England. The programme of action proposed a series of measures to improve care for people with challenging behaviour;

    - any adult who is in a specialist autism or learning disability hospital setting will have their care reviewed by 1 June 2013; and

    - if they would be better off supported in the community then they should be moved out of hospital as quickly as possible, and no later than 1 June 2014

    - The Department of Health will examine how organisations and their Boards of Directors can be held to account for the provision of poor care or harm, and set out proposals in the Spring to strengthen the system where there are gaps.

    - the CQC will tighten inspection and regulation of hospitals and care homes for vulnerable groups, with more unannounced inspection and greater involvement of service users and their families; and

    - the CQC will hold organisations to account more vigorously for any failures to provide good quality care in line with the legal requirements.

    - new guidance will be published on training standards, codes of conduct, better commissioning practices and a code of ethics by various national bodies in 2013;

    - stronger rules on social services departments' responsibilities for safeguarding issues are included in the draft Care and Support Bill; and

- the Department of Health will work with professionals, providers, people who use services and families to develop and publish by end 2013 guidance on best practice so that physical restraint is only used as a last resort where someone's safety is at risk and never to punish or humiliate.

- the NHS and councils are expected to work more closely on joint plans in future, with pooled budgets to ensure adults with challenging behaviour get the support they need; and

- a new NHS and local government-led joint improvement team, funded by the DH, will help guide local teams, supported by a Concordat pledging commitment from over 50 national partners to raise standards.

- The DH will develop a range of measures and key performance indicators to help local councils assess the standard of care in their area; and

- The Learning Disability Programme Board, chaired by the Minister for Care and Support, will monitor progress and publish milestones.

7. The key message is that people should receive support locally, near to family and friends. Progress in this area will therefore be dependent on developing a range of responsive local services which can prevent admissions to hospital or other large institutional settings. All actions should be appropriately informed by the views and needs of people with challenging behaviour and their families.

8. The DH have directed that CCGs should work closely with local authorities to ensure that vulnerable people receive safe, appropriate, high quality care and that there is a substantial reduction in reliance on inpatient care for these groups of people. Where specialist support is required the default position should be to put this support into the person's home through specialist teams and services, including crisis support.

9. Within Nottinghamshire a joint health and social care project team working across all CCG areas has commenced work to meet the requirements of the programme. The project group are tasked with reviewing all patients who are in inpatient care, locked or unlocked rehabilitation, or Assessment and Treatment Units. Liaison has taken place with regional specialised commissioning services in relation to patients in low, medium and high secure services to facilitate discharge of patients in these settings to the community but it is recognised the responsibility for carrying out the assessments of these patients sits with specialised services.

10. The team are overseeing the delivery of person centred plans for each individual that include clear discharge plans. On the basis of this planning the team will recommend development of appropriate and sustainable community placements for the individuals identified. Supported living schemes are being progressed in Ashfield, Huthwaite, Hucknall, Mansfield, Newark and Worksop. The aim is to provide core and cluster flats where service users with challenging needs have independent accommodation with access to on-site support from suitably qualified staff. Where supported living is not deemed suitable for an individual, residential care options will be pursued.

11. The team are also tasked with Identifying current resources available locally to support the service users on discharge from hospital and develop a plan for additional resources required to meet the objective of supporting people with learning disabilities in the community in the longer term. This includes identifying the funding required to meet the above objectives including consideration of pooled budget arrangements

12. The table below indicates key actions required and the timelines outlined in final Department of Health Report: together with an update on local progress

	Key Action	**By When**	**Progress to date**
1	All Primary Care Trusts to develop local registers of all people with challenging behaviour in NHS-funded care	1st April 2013	Registers of patient identifiable information cannot be held by CCGs at present and so it has been proposed that the Healthcare Trust maintain the register of inpatients with Continuing Care needs maintaining the register for patients in the community.
2	Health and care commissioners, working with service providers, people who use services and families to 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.	1st June 2013	35 assessments and associated documentation to inform the future planning of services for individual patients – this has been completed and signed off by end of June 2013. Clear discharge plans developed for all patients not deemed to be ready for discharge prior to 1st June 2014
3	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.	April 2014	The capacity within local services to provide on-going support and monitoring to these and other complex patients requiring support in the community is being scoped to ensure a decrease in the use of out of area hospital beds.
4	Everyone inappropriately in hospital will move to community-based support	June 2014	25 patients have been reviewed as being ready to return to the community by June 2014. For these people planning is being undertaken to provide them with accommodation and individual support to meet this timescale.
5	Health and care commissioners should use contracts to hold providers to account for the quality	From April 2013	Current commissioning and contracting arrangements will be reviewed to ensure that

	and safety of the services they provide		accountability for quality is clearly defined

13. The DH report makes clear that where commissioning and funding responsibility transfers from the NHS to local government, councils should not be financially disadvantaged. The NHS should agree locally how any new burden on local authorities will be met, whether through a transfer of funding or as part of a pooled budget arrangement. The strong presumption is in favour of pooled budget arrangements with local commissioners offering justification where this is not done. Pooled budgets can be established under Section 75 of the NHS Act 2006 where a Local Authority and CCGs consider that this would enable better integrated care and provide an efficient way of working.

14. Health and Wellbeing Board is asked to consider how financial responsibility should be shared. The options are

    a) A simple transfer of funding from CCGs to the Council equal to the current cost of services and any savings made by the CCG from no longer accommodating people in hospital and moving them to community settings.
    b) A pooled budget. This could be confined to the current cohort of people being reviewed, to all people with a learning disability who challenge services, or for all learning disability services across the county currently funded by health and social care commissioners.

15. A pooled budget could deliver certain opportunities: such as:

- Facilitating a co-ordinated network of health and social care services, eliminating gaps in provision;
- Ensuring the best use of resources by reducing duplication and achieving greater economies of scale (giving both partners a vested interest in ensuring spend is committed in the most effective way);
- Forecasting of need that takes place when constructing the pooled fund will enable money to be more effectively targeted, with less wastage, on delivering local services which fit needs.
- Generating economies of scale. For example pooled funding arrangements could encourage commissioning practices that promote the rationalisation of suppliers and drive down costs. Pooled funding might therefore drives economies through scale *and* through greater power in the market.

16. A pooled budget could also deliver certain challenges, for example;

- There may be considerable cost from administering joint budgets
- Even where there are joint budgets often organisations prefer to keep some separation over their own element of the budget, denying a true joining up of budgets.
- There is no definitive evidence that pooled budgets lead to improved outcomes for service users or any savings over the long term (and there may be costs in the short term)
- Budgets would need to be pooled across up to 6 organisations

17. A limited pooled budget just for people with challenging behaviour could be calculated by scoping the current spend of commissioners and this would facilitate the ending of perverse incentives to reduce spend that may impact negatively on the other partner.

18. In many areas pooled budgets have already taken place, although in some areas disaggregation has already taken place due to perceived costs associated with managing pooled budgets. However a fully joined up pooled budget does have the potential to deliver many of the potential advantages outlined above.

19. A national Programme Board Stocktake report was completed in July of this year (see attached at **appendix1**). The stocktake identified the most significant risk to completing the actions required relates to the very tight timescale for developing suitable accommodation options. Most of the reviews of the 25 people ready to leave by June 2014 have suggested that supported living is the most appropriate housing option. To house 25 people with challenging behaviour by June 2014 is a very difficult and complex task.

20. There are multiple issues around compatibility of service users, some service users are offenders who cannot live in certain areas, there is a lack of capital to develop housing, planning permission can delay or derail completely new schemes and there is a lack of willing housing providers. Even where these hurdles are overcome building or converting properties can take a long time.

21. Following the stocktake submission, Coun Bosnjak, Chair of the Health and Wellbeing Board wrote to Chris Bull, Chair of the national Improvement Programme to enquire if additional capital investment would be forthcoming to aid the development of accommodation.

22. A further issue which may cause delays in people moving to their preferred or most appropriate accommodation is the application of the Deprivation of Liberty safeguards. For some of the individuals assessed as being able to be supported in the community, a Deprivation of Liberty application would need to be made. This is likely to incur significant delays due to the need for an order being agreed through the Court of Protection. A similar recent case within the county took over a year to resolve through the Court.

23. There may be some service users who can move to appropriate accommodation but for whom the above factors lead to a delay in them moving beyond June 2014. In order to meet the June 2014 deadline of the service users leaving hospital they might be asked to move to accommodation that does not fully suit their needs. This decision should take into consideration the potential consequences of moving the patient to a less than ideal placement for a period as oppose to having an extended stay in hospital. Both courses of action will have costs and benefits that will require consideration. The Board may wish to consider whether it would prefer to see interim care and accommodation to be provided or delayed transfers from hospital in these circumstances.

24. The case scenario below provides an example of the nature of needs which are present with people currently being reviewed for a move from hospital accommodation.

Mr X had a difficult childhood that included emotional neglect and abuse. He did not always attend school. He has a moderate learning disability, including significant communication problems, as well as mental ill health.

After leaving school Mr X began to lead a chaotic lifestyle, abusing alcohol as well engaging in criminal activity such as theft, violence and using fake firearms to intimidate members of the public. He was accommodated in residential care but this broke down due to assaultive behaviour and issues around mental illness and criminal behaviour.

Mr X was subsequently put on a section of the mental health act and was eventually moved to a secure hospital to undertake a period of treatment and containment. Over a period of 5 years significant clinical assessment has taken place determine what factors maintain Mr X's behaviours of concern. A multi-element therapeutic approach has been used, where Mr X has engaged with occupational therapy, psychology, psychiatry, speech and language therapy and the direct contact of skilled nursing staff.

There has been significant improvement in Mr X's mental health, and he has been supported to develop daily living skills, such as cooking, general housework, shopping and planning and seeking help. He will require a further period of 6 months support to implement incremental access to the wider community to ensure his safety skills are in place and can be maintained before he moves back to the community.

Reason/s for Recommendations

25. This report outlines the work taking place to implement the required actions resulting from the DH report, Transforming Care, A National Response to Winterbourne View Hospital; and the Winterbourne View National Improvement Programme

Statutory and Policy Implications

26. This report has been compiled after consideration of implications in respect of finance, equal opportunities, human resources, crime and disorder, human rights, the safeguarding of children, sustainability and the environment and those using the service and where such implications are material they are described below. Appropriate consultation has been undertaken and advice sought on these issues as required.

Financial Implications

27. The current cost of providing care to people accommodated in locked rehabilitation hospitals is estimated to be £2,600 per week. The cost of people accommodated in low / medium secure settings is unknown, being funded as part of a regional block contract. The future care costs of accommodating people in community settings with appropriate care and support remains unclear and will not be fully known until each individual care and support plan has been completed at the point of discharge.

28. However, evidence from similar transfers of care previously undertaken such as the Campus re-provision programme would show that community alternatives are likely to be more costly

than the existing hospital based care. It is also estimated that whereas the current cost of care is 100% health funded, alternative provisions are likely to incur an element of social care funding requirements which again cannot be estimated until full assessments have been undertaken of Continuing Health Care needs. The guidance states that existing NHS funding should be fully reutilised for the provision of new services (this may not be possible for funding allocated to the regionally commissioned services) but It may be prudent to suggest that this is likely to be insufficient to meet future needs.

RECOMMENDATION/S

It is recommended that the Health and Wellbeing Board

1) note the content of the report.
2) approve in principle the establishment of a pooled budget to meet the needs of the people who will move from hospital to more appropriate community based support, subject to further work to scope the size of the pool, develop an appropriate management arrangement and develop risk sharing agreements.
3) agree to interim placements being made for individuals whose preferred accommodation and support cannot be provided within the prescribed time frame of 1st June 2014
4) agree to receive an update report in January 2014 to include progress on the development of pooled budget arrangements.

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Constitutional Comments (NAB 12.09.13)

29. The Health and Wellbeing Board has authority to approve the recommendations set out in this report by virtue of its terms of reference.

Financial Comments (KAS 23.9.13)

30. The financial implications are contained within paragraphs 27 and 28 of the report.

Background Papers

Except for previously published documents, which will be available elsewhere, the documents listed here will be available for inspection in accordance with Section 100D of the Local Government Act 1972:

Electoral Division(s) and Member(s) Affected
All.