South Tees Hospitals NHS
NHS Foundation Trust

Meeting / Committee:	Board of Directors	**Meeting Date:**	26 March 2013

This paper is for: (Only 1 column to be marked with x as appropriate)	Action/Decision	Assurance X	Information

Title:	South Tees Hospital NHS Foundation Trust response to the Transforming care: A national response to Winterbourne View Hospital' final report (DH, December 2012).

Purpose:	The purpose of this report is to provide the Board with a service provision response to the DH 'Transforming care: A national response to WinterbourneViewHospital' final report (December 2012). This report acknowledges the key points identified by the DH that resulted in the failings of Winterbourne View Hospital to safeguard its service users and the implications of these key points for an acute Trust.

Summary:	The paper provides information on: • Assurances that there are sufficient policies and processes in place and a standard of practice to ensure that people with learning disabilities or autism, who also have mental health conditions or challenging behaviour, are safeguarded from abuse whilst in receipt of Trust services. The key points from the DH report have been categorised into the following themes: 1. Skilled and competent workforce 2. Accountability at Board and senior management level. 3. Safeguarding activity 4. Recruitment of workforce 5. Lawful restraint 6. Transitional process This report identifies the Trusts current status and areas for development in relation to these themes.

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	Learning Disabilities		

Recommendation:	The Board of Directors is asked to receive the report

Implications (mark with x in appropriate column(s)	Legal	Financial	Clinical	Strategic	Risk & Assurance
					x

1. INTRODUCTION

The Department of Health produced the final report; Transforming care: A national response to WinterbourneViewHospital (December 2012) in response to criminal abuse at Winterbourne View hospital revealed by the BBC Panorama programme in May 2011. The report identified that staff routinely mistreated and abused patients, and that the management allowed a culture of abuse to flourish by not appropriately responding to warning signs and concerns raised by a whistleblower.

The DH report additionally identifies weaknesses in the current system's ability to hold the leaders of care organizations to account and the provision of support and care for people with learning disabilities or autism, who also have mental health conditions or challenging behavior to be inappropriately assigned in relation to environment and location. These key areas for development are out of the remit of an NHS provider and therefore are not further discussed within this report.

The key principles of high quality services for people with learning disabilities and behaviour which challenges are set out in the DH report, this report in recognition of these principles, is provided following a review of current Trust practice, protocols and policies to offer assurances to the commissioning body that people with learning disabilities or autism, who also have mental health conditions or challenging behavior, whilst in receipt of Trust services are safe and protected from harm, their health and well-being are supported, their care needs are met and they are supported to make decisions about their daily lives.

2. KEY POINTS FROM FINDINGS/THEMES

The key points from the DH report which have implications in relation to the responsibilities for acute health service providers have been categorised into the following themes:

Theme 1 Skilled and competent workforce

Key Points:

- Poor quality healthcare, with routine healthcare needs not being attended to.
- Concerns about the quality of person centred planning, involvement of people and families in developing their care plan, and in ensuring personalised care and support.
- Where an individual lacks capacity and does not have a family to support them, the procedures of the Mental Capacity Act (2005) should be followed to ensure that decisions made are in her/his best interest and, if appropriate, an Independent Mental Capacity Advocate appointed.
- A failure to listen to people with challenging behaviour and their families, a sadly common experience and totally unacceptable. It leaves people feeling powerless.
- It is clear that there is a very wide variety in the quality and accessibility of information, advice and advocacy, including peer advocacy and support to self-advocate.
- It is crucial that staff who work with people with challenging behaviour should be properly trained in essential skills to ensure that non-professional members of the workforce (i.e.

bands 1-4) receive continuing development and training to provide a skilled and highly motivated workforce.

Theme 2 Accountability at Board and senior management level

Key Points:

- Winterbourne View revealed weaknesses in the system's ability to hold the leaders of care organisations to account. There is a need to tighten up the accountability of management and Corporate Boards for what goes on in their organisations.

- Failure to assess the quality of care or outcomes. There are weaknesses in the system of accountability where leaders of organisations are not fully held to account for poor quality or for creating a culture where neglect and even abuse can happen.

- We should no more tolerate people with learning disabilities or autism being given the wrong care than we would accept the wrong treatment being given for cancer. The accountability of Boards of Directors and Managers will be strengthened for the safety and quality of care which their organisations provide.

- Managers at the hospital had a number of opportunities to pick up indications that there were real problems at Winterbourne View, but failed to do so.

- It is vital that people who make complaints about their care, or the care of a family member are listened to and are given the support (including advocacy as appropriate) and advice they need to make that complaint. This includes complaints about abuse and disability hate crime.

- It is not sufficient to have a well-trained workforce. There also needs to be good clinical and managerial leadership.

- Although structurally a learning disability nurse-led organisation, it is clear that Winterbourne View had, by the time of filming by Panorama, become dominated to all intents and purposes by support workers rather than nurses.

- Boards should ensure they have proper governance arrangements in place and take seriously their corporate responsibilities towards the people for whom they provide care.

- There can be no excuse for Directors or managers allowing bullying or the sort of abusive culture seen in Winterbourne View.

- There must be robust consequences for senior managers or Boards of Directors of services where through neglect the organisations they lead provide poor quality of care or where people experience neglect or abuse.

    - Boards are expected to demonstrate good practice and comply with further legal requirements, which include:
    - Ensuring that systems and processes are in place to make certain essential requirements are being met and that they deliver high quality and appropriate care.
    - The Boards of care providers should understand the quality of the care and support services they deliver.
    - Organisations must identify a senior manager or, where appropriate a Director, to ensure that the organisation pays proper regard to quality, safety, and clinical governance for that organisation.

Theme 3 Safeguarding activity

Key Points:

- There was a failure to respond to and act on warning signs of abuse.
- NHS Accident and Emergency (A&E) staff need to be alert to adult safeguarding issues and have a clear understanding of what to do with any safeguarding concerns. There were multiple attendances at A&E for Winterbourne View residents – but no process in place for linking these.
- A failure by the provider to focus on clinical governance or key quality markers which is striking, and a sign of an unacceptable breakdown in management and oversight within the company.
- The CPS emphasised that what happened at Winterbourne View was Hate Crime.
- Events at Winterbourne View flagged the need to prioritise strengthening adult safeguarding arrangements.

Theme 4 Recruitment of workforce

Key Points:

- Approaches to staff recruitment and training did not demonstrate a strong focus on quality. For example, staff job descriptions did not highlight desirability of experience in working with people with learning disabilities or autism and challenging behaviour – nor did job descriptions make any reference to the stated purpose of the hospital
- Recruiting, training and managing the workforce is the responsibility of providers. The events at Winterbourne View highlighted that there are too many front-line staff who have not had the right training and support to enable them to care properly for people with challenging behaviour.

Theme 5 Lawful restraint

Key Points:

- The very high number of recorded restraints, high staff turnover, low levels of training undertaken by staff, the high number of safeguarding incidents and allegations of abuse by staff that were not investigated to any meaningful extent.
- Deep concerns were raised about over-use of antipsychotic and antidepressant medicines. Health professionals caring for people with learning disabilities should assess and keep under review the medicines requirements for each individual patient to determine the best course of action for that patient, taking into account the views of the person if possible and their family and/or carer.
- Services should have systems and policies in place to ensure that this is done safely and in a timely manner and should carry out regular audits of medication prescribing and management, involving pharmacists, doctors and nurses.
- Physical restraint should only ever be used as a last resort and never used to punish or humiliate.

Theme 6 Transitional process

Key points:

- Children and young people with challenging behaviour can face particular difficulties and crises as they move from child to adult services. Integrating care and support around their needs and ensuring that they have access to the services identified in their agreed care plan is vital.

3. CURRENT PRACTICE/ASSURANCE

Current status of practice and policy to offer assurances that the failings of Winterbourne View Hospital to safeguard its service users would not be replicated within the provision of South Tees Hospital NHS Foundation Trust services are presented in the following thematic format.

Theme 1 Skilled and competent workforce

The Trust has a 3 year training strategy to achieve 100% of Trust staff attending level one Safeguarding Vulnerable Adults training by October 2014.

Safeguarding Vulnerable Adults Level 1 training: 90 minute sessionsare delivered by the Specialist Nurse for Safeguarding Vulnerable Adults or accessible via e-learning programme for all Trust staff to meet the minimum competencies for Safeguarding Adults Boards. Training is mandatory 3 yearly and is delivered on the mandatory training programme.

Senior staff (Band 7 and above) are required to attend Safeguarding Vulnerable Adults SAM 1 training: 2 day accredited course provided through Teesside University for Clinical Managers and above. Training is a standalone accredited course. This course is however currently under review by the Teeswide Safeguarding Adults Training Group.

Mental Capacity Act (2005) & Deprivation of Liberty Safeguards training Level 1:90 minute sessionsare available delivered or via e-learning for clinical staff to understand the principles of the legislation and responsibilities of health staff under it. Training has a 3 yearly update. IMCA provider presents their service on the delivered session.

Mental Health Act training: 3 hour training session delivered by Tees Esk and Wear Valley Mental Health Trust to all Trust staff identified as designated staff to act on behalf of hospital managers to ensure that patients being detained to the Trust have their rights upheld. Training has a yearly update.

Learning disability training: 1 hour session delivered by Liaison Nurse, adults with learning disabilities to increase knowledge and understanding to help care and support patients with learning disabilities. Available to all Trust staff and allied agencies i.e. Carillon.

All staff can access to the following policies to offer relevant guidance in practice:

- G13 Consent to examination and treatment policy
- G39 Reporting concerns at work policy-whistle blowing policy
- G60 Incident Reporting and investigating policy
- G61 Mental Capacity Act (2005) and Deprivation of Liberty Safeguards policy
- G62 Safeguarding Vulnerable Adults policy

- G80a Guidelines and standards for patient record keeping policy
- G141 Mental Health Act (1983) as amended (2007) policy

The Trust provides specialist support and advice for staff in relation to the support and care for people with learning disabilities or autism, who also have mental health conditions or challenging behavior, which is provided through the following roles:

- Liaison Nurse, Adults with Learning Disabilities
- Specialist Nurse Safeguarding Vulnerable Adults
- Clinical Educator for Dementia (2)
- Challenging behaviour nurse (based within the Division of Acute Medicine)
- Patient Safety Management team (on call out of hours)
- 24 hour support from the Mental Health Act Office/on call team (Tees Esk Wear Valley Mental Health Trust)

Theme 2 Accountability at Board and senior management level

- **Board – Director of Nursing & Patient Safety is the Board lead for Safeguarding Vulnerable Adults**

CQUIN targets in place to identify patients with a learning disability and evidence reasonable adjustments being made to support patients, family and carers.

CQUIN targets in place to identify an assurance framework for monitoring compliance with the best interest decision making process in patients with a diagnosis of a learning disability or dementia.

The Safeguarding Vulnerable Adults Steering Group report to the Board via the Risk and Assurance Subgroup.

The Trust Board receives annual report regarding Six Lives Action Plan.

The Trust Board receives a Safeguarding Vulnerable Adults report bi-annually.

The Trust is a member of the Tees-wide and North Yorkshire Adult Safeguarding Boards and associated Committees and Practice groups.

- **Divisional**

The Trust has an e-rostering system in place to ensure that sufficient skill levels to meet client group needs are rostered on any given shift. Divisions are monitored and accountable to the Board for ensuring that an adequate skill set is provided for patient management within a given clinical area.

There are standardised weekly quality of care monitoring within clinical areas which are led by divisional clinical matrons and senior nurse.

The divisional quality of care is scrutinised through the Performance Review and Nursing and Midwifery Strategy Review processes.

Substantiated cases of abuse against Trust practice are reported through and scrutinised by the Integrated Governance Committee and Performance Review respectively.

There is divisional representation on the Trust Partnership Board and Safeguarding Steering group.

Theme 3 Safeguarding activity

The Trust has internal processes which adhere to the Tees-wide and North Yorkshire Safeguarding Adults Boards processes identified within the Trust G62 Safeguarding Vulnerable Adult Policy.

The Trust has a robust governance structure in place; all clinical incidents reported internally, complaints and PALS received externally are reviewed as to meeting safeguarding alerting criteria by Specialist Nurse Safeguarding Vulnerable Adults and alerted into the Local Authority appropriately.

The G62 Safeguarding Vulnerable Adults policy and process are identified within the level one safeguarding vulnerable adults delivered training programme.

Trust G39 Reporting concerns at work policy-whistle blowing policy is identified within level one safeguarding vulnerable adults delivered training programme.

Safeguarding activity is reported and analysed in a quarterly report for discussion re lessons learned and actions required. This analysis is broken down to divisional level which evidences a consistent majority of safeguarding reporting occurring front of house from within the Accident and Emergency Departments.

All Trust divisions are represented within the Safeguarding vulnerable adults steering group at which safeguarding activity is an agenda item. A transparency of Trust incident reporting is provided to partnership members who are active members of this group. Information and actions identified within this group are disseminated through divisions by divisional Steering Group member.

Specialist Nurse Safeguarding Vulnerable Adults acts in an advisory, supportive capacity for Trust staff in identifying safeguarding alerts and adherence to reporting protocols.

On call patient safety managers act in an advisory, supportive capacity for Trust staff in identifying safeguarding alerts and adherence to reporting protocols out of office hours.

Theme 4 Recruitment of workforce

The Trust recruitment processes and Criminal Record Bureau (CRB) checks are carried out in compliance with NHS check standards and legal and national requirements in relation to the safeguarding of vulnerable adults.

There are processes in place for the Director of Human Resources or designated deputy to inform the Independent Safeguarding Authority (ISA) where deemed appropriate following agreement with identified safeguarding and Human Resources lead at a senior level.

Theme 5 Lawful restraint

Guidance for staff on lawful restraint is identified within the trust G61 Mental Capacity Act (2005) & Deprivation of Liberty Safeguards policy.

Training on lawful restraint is included as part of the Mental Capacity Act (2005) & Deprivation of Liberty Safeguards level one training.

Best Practice Capacity Assessment and Best Interest Decision document available for all staff within G61 Mental Capacity Act & Deprivation of Liberty Safeguards policy to document any proportionate restraint used within clinical areas.

G141 Mental Health Act (1983) as amended 2007 policy in place to guide Trust staff through detention process. The Trust has a team of designated managers to support staff to promote the identification of a person's rights of individuals detained to the Trust.

Theme 6 Transitional process

The Trust has a process in place in which the transition team identifies individuals with a learning disability at the age of 14 years to be signposted to adult services.

A Specialist Consultant is identified in this process that becomes active in the care planning for meeting the individual's health needs.

There is an individual orientation to the adult service department for familiarisation with environment and staff.

4. FUTURE DEVLOPMENTS

The Trust continues to strive to develop services to ensure that a consistent high quality of services are delivered to people with learning disabilities and behaviour which challenges and other vulnerable groups within today's society. The following areas have been identified for future development within Trust services:

- Increase staff resources to deliver safeguarding vulnerable adults training and support (business case to increase resources for safeguarding adult team currently under consideration).

- Work with partner agencies to increase provisions of SAM 1 training; currently the Trust is providing approximately 10 places annually, this is considered insufficient to meet Trust services requirement.

- Mental Capacity Act (2005) & Deprivation of Liberty Safeguards level one training to be identified as a mandatory requirement by the Trust for all clinical staff (this is expected for April 2013).

- The Trust to produce a policy specifically focused in restraint to guide staff in practice.

- The Trust to produce a policy to guide staff in practice in covert administration of medication policy (policy currently in ratification process).

- Trust audit and subsequent action plan of the use of antipsychotic medication prescription and administration to include use of antipsychotics for patients with dementia and learning disabilities.

- Learning disability training to be identified as mandatory. Session to be reviewed to increase objectives including specialised training including postural care and support from drama group.

- Learning disability link staff for to be identified within clinical areas.

- A review of job descriptions to include the desirability of experience in working with people with learning disabilities or autism and challenging behaviour

It is also recognised that in the future the Trust will be required to develop services in response to future legal and contractual requirements directed by bodies external to the Trust.

5.CONCLUSION

This report has been produced to provide assurance to the commissioning body that the Trust when providing services to people with learning disabilities or autism, who also have mental health conditions or challenging behavior, keep them safe and protect them from harm, supporting their health and well-being, meet their care needs and support the individual to make decisions about their daily lives.

The Trust recognises that whilst it is presently in a position to offer such assurances, it must never become complacent with regards to recognising and appropriately responding and reporting when policies, procedures or practice do not promote the rights of a vulnerable individual or safeguard them from harm.

The Trust offers a commitment to welcome external scrutiny and to continue to internally monitor and develop policy and procedures to ensure a transparent service that promotes the dignity and rights of all vulnerable adults and safeguard them from harm. In the event of an incident in which expected safeguarding practice does not occur, the Trust will strive to sustain a workforce culture that will report the incident into the safeguarding procedures for external investigation.