WINTERBOURNE VIEW ACTION PLAN UPDATE

Update September 2014

Work on the action plan continues to be progressed, particularly in the following areas;

1) Development of a joint framework to establish trigger points for the escalation of care quality and safeguarding issues This includes collection and triangulation of information about issues of concern and an effective pathway to review and act on issues and link to the Adults Safeguarding Board
2) Development of a Quality Assurance process to ensure new care placements made by both health and social care are routinely checked for issues of concern and safety
3) Development of a revised specification for the health element of the Community Team for People with Learning Disabilities AND
4) Plans continue to progress to return the final 2 of the 9 Ex Winterbourne View patients back to appropriate placements in the local area.

A new CQC report - 3 Lives: What have we learned, what we need to do

The Health and Wellbeing Board are also asked to note that a further national report was published in June by CQC and the Challenging Behaviours Foundation. This highlights the continuing issues and concerns raised through the CQC inspection programme of services for people with learning disabilities. It discusses 3 cases.

It is relevant to consider the story of one of these - Lisa. During the inspection of an assessment and treatment unit, no one had set eyes on Lisa. The inspector insisted on pursuing her case and discovered that she was kept in a locked area, slept on a beanbag, never went out and staff interacted with her through a small letterbox style "hatch". For example, her food was passed to her through this hatch, and her hair was brushed through this hatch.

She lived like this for nine years detained under the Mental Health Act, with no therapeutic input and at an average cost of £1,800 per day. Following the inspection Lisa has now moved to a new service and is doing well, but there is considerable work to do to undo the damage caused by living in solitary confinement for so long.

The report concludes that we all have a responsibility to learn and change to ensure that behaviours and practices are in place to prevent more people from suffering from poor, damaging and brutalising services. I hope the Health and Wellbeing Board will take this opportunity to renew its commitment to the Winterbourne View Concordat and to working together to develop an integrated approach to the commissioning and delivery of high quality learning disability services for the people of Wiltshire.

Dugald Millar
Interim Head of Specialist Commissioning
28th August 2014