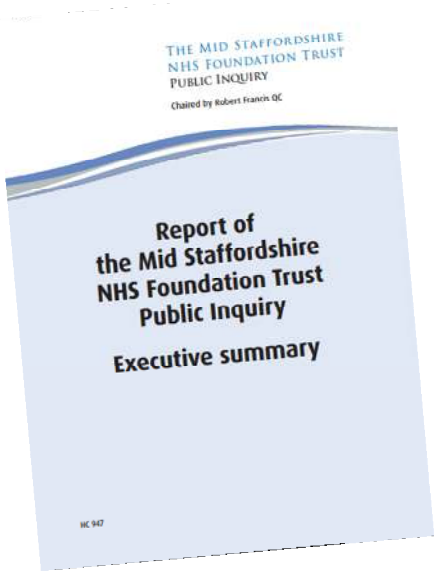
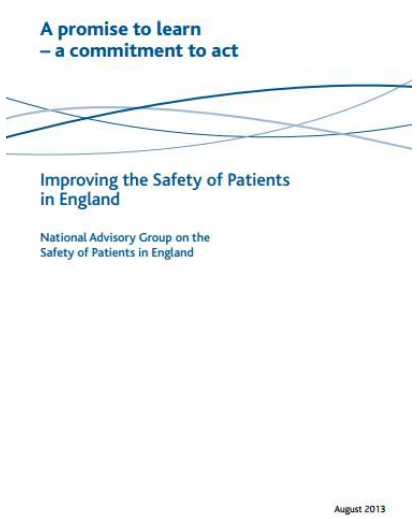
"Reflecting on Compassionate Care and National Reports – How do we Move Forward?

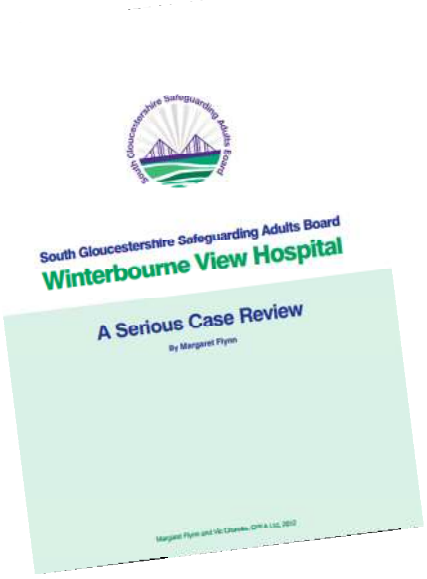
Dr Peter Carter OBE

Chief Executive and General Secretary

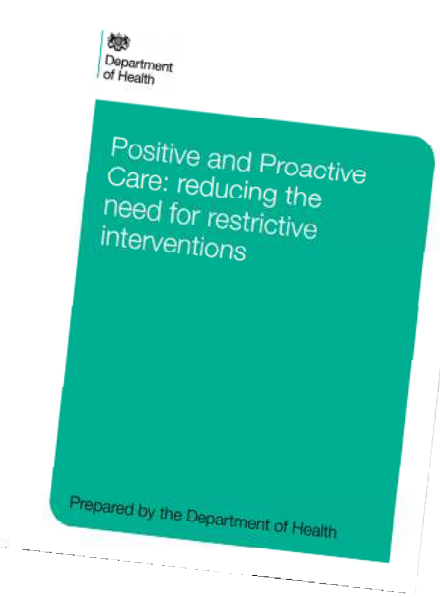

THE MID STAFFORDSHIRE
NHS FOUNDATION TRUST
PUBLIC INQUIRY
Chaired by Robert Francis QC
Report of
the Mid Staffordshire
NHS Foundation Trust
Public Inquiry
Executive summary
HC 947


A promise to learn
– a commitment to act
Improving the Safety of Patients
in England
National Advisory Group on the
Safety of Patients in England
August 2013


NHS
Review into the quality of
care and treatment provided
by 14 hospital trusts in
England: overview report
Professor Sir Bruce Keogh KBE
16 July 2013


South Gloucestershire Safeguarding Adults Board
Winterbourne View Hospital
A Serious Case Review
By Margaret Flynn


Stress
Leadership
Fatigue
Interventions
Dexterity
Awareness
Decision
The patient
Distraction
Teamwork
Work environment
Communications
Safety culture


Department of Health
Positive and Proactive Care: reducing the need for restrictive interventions
Prepared by the Department of Health

What is safety?

The people on this slide all have one thing in common.

Wayne Jowett
Mayra Cabrera
Joshua Titcombe
Connor Sparrowhawk

What they have in common is that they were all mortally harmed by systems whose avowed purpose was to keep them free from harm.

On the RCN website we try to answer that question.

What is safety?

It is the prevention of avoidable errors and adverse effects to patients associated with health care.

Staff ***practise*** patient safety when they apply safety science methods towards the goal of developing reliable systems of care.

So patient safety is ***both*** a ***characteristic*** of a healthcare system and a ***way*** of improving the quality of care.

"This is a story of appalling and unnecessary suffering of hundreds of people. They were failed by a system which ignored the warning signs and put corporate self-interest and cost control ahead of patients and their safety." Sir Robert Francis

290 recommendations including:

•The merger of the regulation of care into one body

•Senior managers to be given a code of conduct and the ability to disqualify them if they are not fit to hold such positions

•Hiding information about poor care to become a criminal offence as would failing to adhere to basic standards that lead to death or serious harm

•A statutory obligation on doctors and nurses for a duty of candour so they are open with patients about mistakes

•An increased focus on compassion in the recruitment, training and education of nurses, e.g. aptitude test for new recruits and regular checks of competence as is being rolled out for doctors

"In any organisation, mistakes will happen and problems will arise, but we shouldn't accept harm to patients as inevitable. By introducing an even more transparent culture, one where mistakes are learnt from, where the wonderful staff of the NHS are supported to learn and grow, the NHS will see real and lasting change." Don Berwick

•Recognise need for wide systemic change and abandon blame. Trust the goodwill and good intentions of the staff

•Reassert the primacy of working with patients and carers to achieve health care goals

•Use quantitative targets with caution. Such goals do have a role en route to progress, but should never displace the primary goal of better care

•Recognise that transparency is essential and expect and insist on it.

•Ensure that responsibility for functions related to safety and improvement are vested clearly and simply

•Give the people career-long help to learn, master and apply modern methods for quality control, quality improvement and quality planning.

IMPLEMENTING THE BERWICK REVIEW

Aim

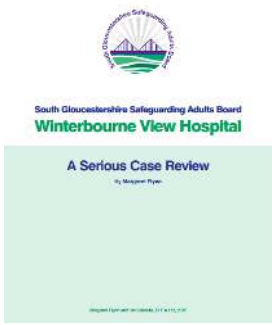
By the end of 2014, all recommendations of the Berwick Review relevant to my context will be fully implemented

Primary Drivers

- Hearing staff and patient voice
- Leadership behaviours
- Capacity and capability
- Measurement and transparency
- Organisational learning

Secondary Drivers

- Create a culture that values feedback
- Help staff learn to listen
- Establish ways to capture patient voice
- Share decision making and involve patients in service design
- Lead by example
- Empower and engage staff across hierarchies
- Value feedback and learning
- Give real time focus to operational capacity issues
- Create a culture of learning with senior advocates
- Design and establish a QI infrastructure and measures linked to strategy
- Build a critical mass of people with QI expertise at all levels, including patients
- Create capacity and opportunities to implement improvement
- Develop collective understanding of purpose of measurement
- Define measures that are meaningful locally at all levels
- Establish a system for reliable collection and reporting of data
- Build capability for analysis of data and for sharing learning
- Develop means for adoption and reliable spread of learning
- Develop teamwork and supportive culture
- Create time and resources for learning
- Create measurement systems for staff and team feedback

Hearing patient, carer and staff voices	Concerns about understaffing and use of restraint raised by some staff as early as 2009	No patient advocacy or response to written complaints	
Leadership behaviours	WVH operated wo registered manager for 7 months in 2008 and final 18 months	WVH became a “support worker led hospital”.	Castlebeck Ltd still did not assume control.
Capacity and capability	Training was “on the job”. Poor recruitment practices.	Most staff were unregulated support workers	Therefore they were not subject to code of conduct minimum training standard.
Organisational learning	Ignored: absconding patients, family concerns, requests to be removed, escalating self-injury	None of these were seen as indicators of failing service.	Also indifferent to inspectors’ reports; high levels of staff sickness and turnover

Panorama *Under cover care: the abuse exposed* aired on 30th May 2011

First arrests 1st June. First discussion HoC 7th June 2011

10 people charged 28th November 2011 (eleven are eventually convicted 6th August 2012).

DoH announces performance and capability review of CQC 23rd February 2012

Analysis of CQC reports: only 14% of people living in assessment and treatment units compliant with regulations according to Improving Health and Lives report . Doubt cast on CQC criteria 25th June 2012

Mencap and Challenging Behaviour Foundation publish "Out of Sight" report warns of risk of another WVH 7th August 2012

Winterbourne View Joint Improvement Prog set up. DoH report "Winterbourne View: Transforming care one on" admits slow progress to reduce number of people in secure hospitals/ assessment and treatment settings December 2013.
Only 1:10 had dates set to transfer according to DoH figures published March 2014

Government launches "Positive and Proactive Care".
RCN leads on developing guidance on use of restrictive practices April 2014

National group to develop national guide for how health and care provided for those with learning disabilities July 2014

Where are we now?

This timeline shows a selected chronology of events following the Panorama programme that first exposed the abuses at Winterbourne View in May 2011.

The overall picture is one of slow progress to the goal of reducing numbers of people living in settings apart from their families and communities.

A second Panorama programme updated the situation for people with learning disabilities in October 2012.

19 of the 51 patients who spent time at Winterbourne View before it was closed have since been the subject of further ‘safeguarding alerts’ over their wellbeing.

After being moved to another residential home in Wiltshire (8 hours drive from her parents) on one particular day Simone was restrained in a chair ten times and then twice on the floor – within just four hours.

Although his family was not informed at the time, Simon was the victim of three separate ‘incidents’ .

In the aftermath of this head injury, a meeting was held to which neither Simon’s mental health advocate nor his family were invited. Within days, Simon had been moved to Winterbourne View. Doctors had decided he was ‘dangerous’.

‘It was always assumed that it was Simon’s behaviour that was the problem,’ remembers his mother, Ann Tovey. ‘Professional people never seemed to consider whether it was because of something they were doing.’

Though, shockingly, his family were not told, Simon’s notes show that two people were disciplined over the first two incidents.

The situation must change.

There are many ways in which it can.

1) Developing organisational learning

2) Strengthening interagency response to hate crime

3) Support for active risk control for people in these units

4) Meaningful involvement of disabled people in service planning, implementation and reviewing

5) Develop learning disability nursing in the UK

Organisational learning

•Create systems for staff and team feedback
•Develop teamwork and supportive culture
•Develop means for adoption and spread of learning

Terry Bryan, former charge nurse at Winterbourne View, was a whistleblower in the case.

He described the archaic and degrading practices at WVH. The unit was “chaotic”. No risk management or care plans

The culture at WVH saw restraint methods as a means of coercion and control. The tipping point for Terry Bryan was when he refused to take part in the use of restraint.

Helene Donnelly was a whistleblower at Mid Staffs.

She now has a role now in her Trust from the Chief Executive, Stuart Poynor and the Trust Board, to act freely and with complete autonomy from the management team as another route for issues of concern to be raised at the highest level.

The Leicester HATE CRIME Project

Strengthening interagency response to hate crime

Leicester, Leicestershire and Rutland's health and hate crime leads are examining ways to improve health system response to hate crime

Multi-agency collaboration is establishing closer contact with local communities affected by hate crime including:

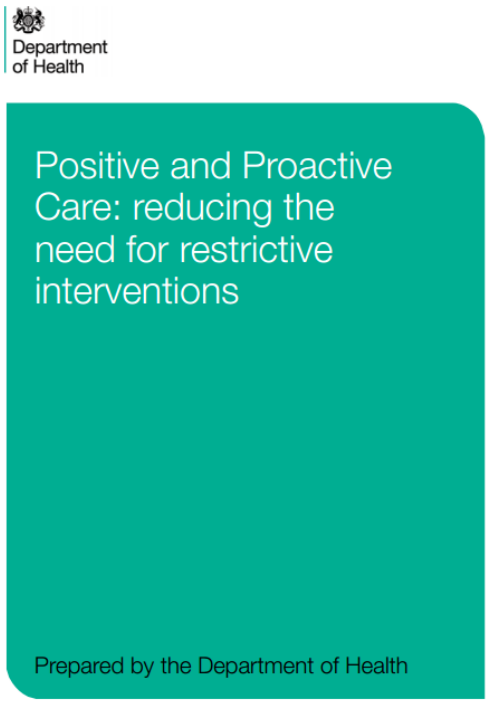
•Mapping out current health approaches

•Looking at best practice in other communities

•Building effective training and learning packages for improving staff understanding

•Improving recording systems in participating Trusts

The key output is the design of a ***hate crime pathway*** intended to help healthcare professional recognise their roles in identifying early signs of victimisation and to help prevent escalation



Support for active risk control for people in these units

The RCN led multi-professional consortium on developing guidance (DoH April 2014) around use of restrictive interventions:

Many restrictive interventions place people who use services, and to a lesser degree, staff and those who provide support, at risk of physical and/or emotional harm.

•offers framework within which adult health and social care services can develop a culture where restrictive interventions are only ever used as a last resort and only then for the shortest possible time

•identifies key actions that will better meet people's needs and enhance their quality of life, reducing the need for restrictive interventions.

•sets out mechanisms to ensure accountability for making these improvements, including effective governance, transparency and monitoring.

Department for Work & Pensions

Disabled People's User-Led Organisations Making a Difference:

Disability Hate Crime

Published by the Strengthening Disabled People's User-Led Organisations Programme
December 2012

Access Dorset
Nothing About Us Without Us!
Enhancing Everyday Lives in Dorset, Bournemouth and Poole

Meaningful involvement of disabled people in service planning, implementation and reviewing

The Disabled People's User-led Organisations (DPULO) initiative has produced *Making a difference: disability hate crime* (DW&P 2012).

Brings together case studies that show how disabled people's user led organisations (DPULOs) can make a difference to disability hate crime.

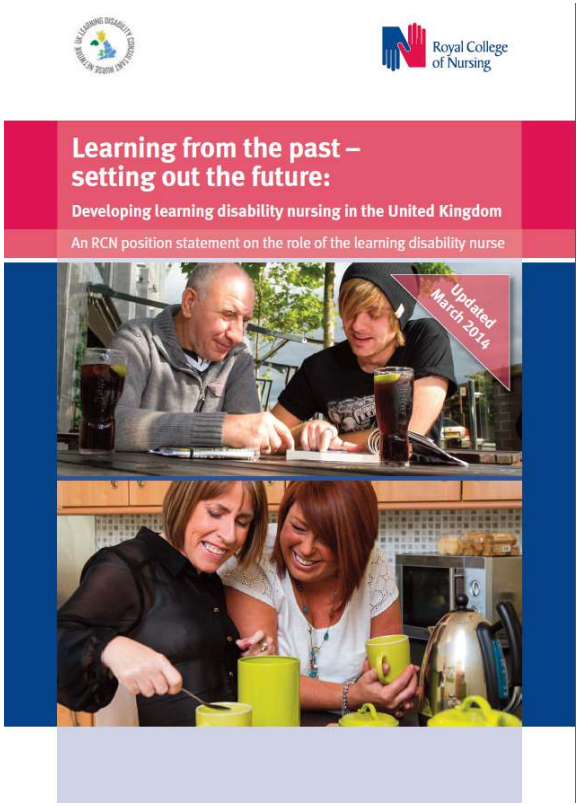
Identifies 10 options for action including:

•Identifying DUPLOs in your area, involving them in design and delivery of strategy

•Involve disabled people in you in-house training programmes and create opportunities for them to work alongside practitioners to provide a personal perspective

•Identify strategic partnerships to pool resources, funding, staff and good practice to address disability hate crime

•Look for opportunities to promote positive outcomes to encourage disabled people to provide information, intelligence and report all incidents



Develop learning disability nursing in the UK

The RCN has updated an action plan (March 2014) for developing learning disability nursing:

Education

RCN Learning Disability Forum will work in partnership with the Nursing and Midwifery Council to ensure the learning disability component of all pre-registration nursing programmes is fit for purpose

collaborate with education providers to review continuing professional development (CPD) opportunities for learning disability nurses wherever they may practice.

Workforce

The Forum will scope learning disability nurses (currently or previously registered) wherever they practice to establish an accurate workforce profile.

will develop an evidence base of the outcomes of learning disability nursing practice.

Leadership

Profile leaders in learning disability nursing wherever they may practice.

SOCIOLOGY OF HEALTH & ILLNESS

Sociology of Health & Illness Vol. 33 No. 4 2011 ISSN 0141–9889, pp. 602–617
doi: 10.1111/j.1467-9566.2010.01302.x

The violence of disablism

Dan Goodley and Katherine Runswick-Cole

Research Institute of Health and Social Change, Manchester Metropolitan University

Abstract This article addresses the multi-faceted nature of violence in the lives of disabled people, with a specific focus on the accounts of disabled children and their families. Traditionally, when violence and disability have been considered together, this has emphasised the disabled subject whom inevitably exhibits violent challenging behaviour. Recently, however, more attention has been paid to violence experienced by disabled people, most notably in relation to hate crime. This article embraces theories that do not put the problems of disablism or violence back onto disabled people but magnify and expose processes of disablism that are produced in the relationships between people, which sometimes involve violence. This, we argue, means taking seriously the role of social relationships, institutions and culture in the constitution of violence. Disabled children, we argue, are enculturated by the violence of disablism. We follow Žižek's advice to step back from the obvious signals of violence to 'perceive the contours of the background which generates such outbursts', and identify four elements of the violence of disablism which we define as real, psychoemotional, systemic and cultural. We come to the conclusion that violence experienced by disabled children and their families says more about the dominant culture of disablism than it does of the acts of a few seemingly irrational, unreasonable, mean or violent individuals. We conclude that there is a need for extensive cultural deconstruction and reformation.

Keywords: violence, disablism, children, culture

Introduction

This article explores the multi-faceted nature of violence in the lives of disabled people, with a specific focus on the accounts of disabled children and their families. We start this article with three stories from a project:

> It's finding the people [to look after him] that could actually physically cope with my son. Because if he doesn't co-operate you have to manhandle him, to get him out of the door and, you know, he'll be punching you, kicking you (Roberta).

> My daughter has a good line in hand-biting and hitting people which really upsets the escort on the mini bus. I think at some point, if she actually manages to get the escort, I think he'll say, 'I'm not having that child on my bus ever again' (Shelley).

We will not move forward unless we step back and examine the deep roots of disablism which this violence is the fruit.

Goodley and Runswick-Cole state in their paper that to tackle violence "means not simply targeting those few "evil souls" responsible for hate crime against disabled people but deconstructing and reforming the cultural norms that legitimise violence against disabled people in the first place ".

This will include challenging "normalcy" – the process whereby taken for granted ideas about what is "normal" become naturalised.

When we understand that the world is inherently disablist we can begin to ask questions:

Why are adults with learning disabilities placed "out of sight" at the edges of our communities?

How can we broaden our sense of value to include everyone who might not fit into our "normal" category?

So we ask the question again.

What is safety?

What would safety mean for Connor, Simon and Simone?

In a famous paper by disability activist Vic Finkelstein we are asked to think what would a profession allied to the community (PAC) look like?

Developing a PAC could lead to a new field where professionals would invest less time in pathological views of impairment and more time in challenging the conditions of disablism (including violence).

He believed that a PAC would allow professionals to re-engage with “the aspirations of disabled people”.

By doing so we may yet co-design a safer system.