Appendix 1

Winterbourne View Initial Findings

1 Summary

The physical and verbal abuse of patients with learning disabilities at Winterbourne View has been extensively reported on previously, following the original Panorama broadcast on 31st May 2011.

This paper provides an update following the publication in August 2012 of a number of reports:

- NHS review of commissioning of care and treatment at Winterbourne View
- South Gloucestershire Safeguarding Adults Board Winterbourne View – A Serious Case Review
- Care Quality Commission – Internal Management review of the regulation of Winterbourne View
- Care Quality Commission – Learning Disability Services Inspection Programme, National Overview

These in turn follow the earlier publication on the 26th June 2012 of the report:

- Department of Health Review: Winterbourne View Hospital – Interim Report

Key recommendations from the interim report are attached as Annex A.

In addition to a summary of the key recommendations from all these reports (attached as Annex B) this paper also outlines next steps and future reporting processes, including detail on the publication of the findings of a number of investigations that have been carried out

2 Key Recommendations

A summary of the collated recommendations from all reports is attached as a Annex B to this report. There are, in total, 115 recommendations in respect of the actions to be taken by the NHS; Local Authorities, CQC; NHS Commissioning Board, Department of Health; drawing on the conclusions reached from all of the reports above.

3 Next steps

The NHS South of England Learning Disabilities lead has established a series of regular briefings with commissioners to manage planned responses to the recommendations contained within the reports above, local commissioning assurance, media responses and requests for information. Bath and North East Somerset is working with neighbouring commissioners and NHS South of England to develop a local action plan to address the recommendations.

All 11 members of staff who were charged with offences relating to Winterbourne View eventually entered a guilty plea, meaning that a trial, set for August 2012 was not needed. Sentencing is scheduled to take place on 22 October 2012

It is anticipated that the DH will publish a final report in October 2012. This review will draw on a number of investigations including:

- Police investigations and criminal proceedings against staff at the hospital;
- Reviews commissioned by the Castlebeck Care Board and shareholders;
- Inspections by the Care Quality Commission (CQC) of all Castlebeck Care units and a wider review of 150 learning disability hospitals and care homes (NHS, independent healthcare and social care facilities);
- The report of the NHS Review of commissioning of care and treatment at Winterbourne View; and
- The Serious Case Review (SCR) established by South Gloucestershire Council.

The Bath and North East Somerset Local Safeguarding Adults Board (LSAB) has committed to holding a 'lessons learned' workshop in October 2012 to ensure that local practice is of the required standards arising from Winterbourne View and subsequent published reports. The LSAB are also reviewing local policies around whistleblowing and provider position regarding whistleblowing and their responses to individual whistleblowing concerns.

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Annex A – Summary of key actions – DH Interim Report

Improve the capacity and capability of commissioning across health and care
Contracts: The Department will work with the NHS Commissioning Board Authority to agree by January 2013 how best to embed Quality of Health Principles in the system, using NHS contracting and guidance
Service specification: The Department will work with the NHS Commissioning Board Authority and the Association of Directors of Adult Social Care (ADASS) to develop National Service specifications
Resources: NICE will develop Quality Standards on learning disabilities and the autism Quality guidelines will be published in July 2012.
Collaborative commissioning: the NHS Commissioning Board Authority will support CCGs to work together in commissioning services for people with learning disabilities and behaviour which challenges. Health and Wellbeing Boards (HWBs) will bring together local commissioners of health and social care in all areas, to agree a joined up way to improve services.
Improve the quality of services which empower people with learning disabilities and their families to have choice and control.
Voice: The Department is establishing Health Watch both locally and nationally. It will act as a champion for those who use services and for family carers, ensuring the interests of people with learning disabilities are heard and understood by commissioners and providers of services across health and social care.
Personalisation: The Department expects the NHS and local authorities to demonstrate that they have taken action to assure themselves and the public that personalised care and choice and control is available in all settings, including hospitals
Providers: The Department expects providers to deliver high quality services and prevent abuse. This includes: • Actively promoting open access for families and visitors, including advocates and visiting professionals • Making sure recruitment practices recruit the right people.
Quality: By autumn the National Quality Board will publish a report setting out how the new system architecture will identify and take action to correct potential or actual serious failure
Care Quality Commission; the Department will look at how CQCs registration requirements could be changed to drive up the quality of services on offer and ensure that unannounced inspections can take place any day and any time of the week
Clarify roles and responsibilities and promote better integration
Integrated workforce; the professional bodies that make up the Learning Disability Professional Senate will carry out a refresh of CHALLENGING BEHAVIOUR; A UNIFIED APPROACH to support clinicians in community learning disability teams to clearly describe how different services fit together to deliver the best outcomes by December 2012.
Professional standards: The Academy of Royal Colleges and the professional bodies that make up the Learning Disability Professional Senate will develop core principles on a statement of ethics to reflect wider responsibilities in the new health and care system by April 2013.
Concordat: The Department is working with key national partners to sign up to a concordat in the autumn committing each signatory to the actions they will take to deliver the right model of care and better outcomes for people with learning disabilities of autism and behaviour which challenges.
Promote innovation and reduce use of restraint
Restraint: the Department will work with the Department for Education (DfE), Care Quality Commission (CQC) and others to drive up standards and promote best practice in the use of positive behavioural support and ensure that physical restraint is only ever used as a last resort
Measuring progress: The Department of Health will work with the NHS Commissioning Board Authority to agree what information and data we need to collect to measure progress