NHS
South of England

Annex B

South of England Strategic Health Authority

DRAFT

Collated recommendations from the following reports:

- **Winterbourne View Hospital: A Serious Case Review**
- **Report of the NHS Review of commissioning of care and treatment at Winterbourne View**
- **Care Quality Commission, Internal Management review of regulations of Winterbourne View**
- **Care Quality Commission, Learning Disability Services, Inspection Programme, National Overview**
- **Out of Sight, Mencap and Challenging Behaviour Foundation**

No	From	For action by	Recommendations
1	NHS Review Page 68 6.13.2	Commissioners of Winterbourne View	Carefully review the actions of staff involved in the commissioning and care coordination process in order to identify if any of the failures to act that have emerged warrant disciplinary action or referral to professional regulatory bodies.
2	NHS Review Page 68 6.13.1	Commissioners of Winterbourne View	Continue to ensure that patients who were at Winterbourne View are supported over the long term to ensure that the effect of any abuse received or witnessed while at Winterbourne View is minimised as far as possible.
3	NHS Review Page 68 6.14.1	NHS	Insist on the use of a standards NHS Contract for all 'spot purchased' patient placements which includes prominently both quality and safety measures, and in particular a requirement for the commissioner to be informed directly of any untoward incident.

No	From	For action by	Recommendations
4	NHS Review Page 68 6.14.2	NHS	Assess the performance of the provider against the contract on a regular basis.
5	Serious Case Review Page 127 Recommendation 12	NHS and Local Authorities	Commissioners funding placements should ensure that they have up to date knowledge of service e.g.
6	Serious Case Review Page 127 Recommendation 12(a)	NHS and Local Authorities	Adverse incidents / serious untoward incidents, including the injuries of patients and staff.
7	Serious Case Review Page 127 Recommendation 12(b)	NHS and Local Authorities	Absconding
8	Serious Case Review Page 127 Recommendation 12(c)	NHS and Local Authorities	Police attendance in the interests of patient safety
9	Serious Case Review Page 127 Recommendation 12(d)	NHS and Local Authorities	Criminal investigations
10	Serious Case Review Page 127 Recommendation 12(e)	NHS and Local Authorities	Safeguarding investigations
11	Serious Case Review Page 127 Recommendation 12(f)	NHS and Local Authorities	The occurrence of Deprivation of Liberty Safeguards applications and renewals.
12	NHS Review Page 68 6.14.3	NHS and Local Authority	Clarify the relationships and respective roles of organisations in relation to the commissioning and care coordination arrangement in place for learning disability and mental health specialist placements. In particular, ensure that there is a formal schedule setting out the arrangements and

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			consistent thresholds for communications between care coordination teams and the commissioner.
13	NHS Review Page 69 6.14.4	NHS and Local Authority	Specify the expectations placed on care coordinator teams and commissioners with regard to their input to the Care Programme Approach process and ongoing communication with families, carers and advocates.
14	NHS Review Page 69 6.14.5	NHS and Local Authority	Ensure that there is clinical expertise available to care coordination teams and that this is being deployed as necessary in order to provide appropriate clinical input to decision making.
15	NHS Review Page 69 6.14.6	NHS and Local Authority	Clarify the routes available for families, carers and advocates to make known any concerns about care being provided directly to the commissioner of care.
16	NHS Review Page 69 6.14.7	NHS and Local Authority	Together with social care partners, review policy and strategies surrounding those whose behaviour challenges services, and in particular ensuring that there is a clear focus on preventing escalation within community settings and develop criteria for situations in which specialist placements outside of mainstream services are required.
17	NHS Review Page 69 6.14.8	NHS and Local Authority	Monitor the length of stay in assessment and treatment units and ensure a clear focus on discharge planning is part of the Care Programme Approach.
18	NHS Review Page 69 6.14.9	NHS and Local Authority	Ensure that the Deprivation of Liberty of Safeguards are being applied systematically in relation to all relevant patients.

No	From	For action by	Recommendations
19	Serious Case Review Page 135 Recommendation 20	NHS and Local Authority	Commissioners should ensure that all hospital patients with learning disabilities and autism have unimpeded access to effective complaints procedures – in the case of NHS-funded care, these arrangements must meet the statutory requirement laid down in the 2009 Local Authority and National Health Service Complaints (England) Regulations 2009.
20	Serious Case Review Page 135 Recommendation 23(a)	NHS and Local Authority	Commissioners responsible for funding placements should be proactive in ensuring that patients are safe.
21	Serious Case Review Page 135 Recommendation 23(b)	NHS and Local Authority	If responsibility for monitoring a placement or the ongoing coordination of care is delegated to nurses or social workers, then commissioners ensure that they are informed about safeguarding concerns and alerts.
22	Serious Case Review Page 135 Recommendation 23(c)	NHS and Local Authority	Decisions about funding placements should be based on outcome data.
23	Serious Case Review Page 135 Recommendation 23(d)	NHS and Local Authority	Arrangements should be in place to share information about safeguarding incidents and alerts between those responsible for monitoring patient safety, the provider and commissioners and this should be routinely monitored through contracts.
24	Serious Case Review Page 142 Recommendation 38	NHS and Local Authority	Organisations providing NHS funded care should be required to demonstrate accountability for effective governance to commissioners and Council Adult Safeguarding.
25	Serious Case Review Page 142 Recommendation 39	NHS and Local Authority	Commissioners should encourage hospitals and assessment and treatment units for adults with learning disabilities and autism to ensure that their employees are signed up to the proposed Code of Conduct and minimum induction / training standards for unregistered health and social care assistants commissioned by the Department of Health.

No	From	For action by	Recommendations
26	Serious Case Review Page 142 Recommendation 41	NHS and Local Authority	Commissioners of assessment and treatment services should ensure that there are pharmacist led medicines reviews both for individual patients and for the service as a whole.
27	Mencap Out of Sight Page 7 Action needed 8	NHS and Local Authority	Commissioners must make sure that provides of care and support demonstrate that they are capable of meeting the needs of people who show behaviour that challenges and that they can provide the right environment and skilled staff.
28	Care Quality Commission Learning Disability Service Inspection Report Page 8 Recommendation 1	NHS and Local Authority	Commissioners need to urgently review the care plans for people in treatment and assessment services and identify and plan move on arrangements to the next appropriate service and care programme.
29	Care Quality Commission Learning Disability Service Inspection Report Page 8 Recommendation 3	NHS and Local Authority	Commissioners also need to review the quality of advocacy services being provided, particularly in those locations where we identified non-compliance with the standards.
30	Care Quality Commission Learning Disability Service Inspection Report Page 8 Recommendation 7	NHS and Local Authority	Providers and commissioners should ensure that there are appropriate quality assurance systems in place. This includes having appropriate: 1 Complaints procedures, assess to and use of: 2 Advocates, welcoming 3 Approaches to visitors and a fundamentally sound and appropriate support 4 and supervision structure of all staff.

No	From	For action by	Recommendations
31	Serious Case Review Page 124 Recommendation 1	NHS, Local Authority and NHS Commissioning Board	Clinical Commissioning Groups, local authorities and the NHS Commissioning Board should be commissioning services with regard to the needs identified in the Joint Strategic Needs Assessment, the priorities agreed in Joint Health and Wellbeing Strategies and where appropriate, the health aspects of the National Planning Policy Framework. The presumption should be to address the needs of the whole population within the geography of the local area, with the aim of reducing the number of people using in-patient assessment and treatment services in line with the policy set out in the Department of Health (2012) Interim Report.
32	Serious Case Review Page 124 Recommendation 2	NHS, Local Authority and NHS Commissioning Board	The principle of investing in and promoting good quality, local services… providing intensive community support **with only limited use of in-patient services** (Department of Health 2012) should be adopted and monitored by Clinical Commissioning Groups and the NHS Commissioning Board.
33	Serious Case Review Page 124 Recommendation 3	NHS, Local Authority and NHS Commissioning Board	Clinical Commissioning Groups should require generic mental health services, as part of their annual contract monitoring, to identify the steps taken to enable citizens with learning disabilities and autism to be supported in their own communities and familiar localities.
34	Serious Case Review Page 127 Recommendation 9	NHS, NHS Commissioning Board and Local Authority	Adults with learning disabilities and autism, who are currently placed in assessment and treatment units, should have the full protection of the Mental Capacity Act 2005.
35	Care Quality Commission Learning Disability Service Inspection Report Page 8 Recommendation 2	NHS, NHS Commissioning Board and Local Authority	The emerging Clinical Commissioning Groups and the NHS Commissioning Board, as well as the local authorities in England need to work together to deliver innovative commissioning at the local level to establish person-centred services. This is much more likely to lead to people being able to stay in their local communities and so maintain

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			important relationships.
36	Serious Case Review Page 135 Recommendation 22	NHS and Department of Health	Clinical Commissioning Groups should explore how Accident and Emergency can detect instances of re-attendance from the same location as well as by any individual. The Department of Health may wish to highlight this to A & E departments, including it in their annual review of Clinical Quality Indicators.
37	Serious Case Review Page 124 Recommendation 4	NHS and NHS Commissioning Board	In it direct commissioning responsibilities and perhaps as part of contractual arrangements, the NHS Commissioning Board should take appropriate steps to enquire hospitals and assessment and treatment units for adults with learning disabilities and autism to publish information concerning:
38	Serious Case Review Page 124 Recommendation 4 (a)	NHS and NHS Commissioning Board	Direct patient related costs.
39	Serious Case Review Page 124 Recommendation 4 (b)	NHS and NHS Commissioning Board	Their service costs.
40	Serious Case Review Page 124 Recommendation 4 (c)	NHS and NHS Commissioning Board	The specific rehabilitation gains of individual patients.
41	Serious Case Review Page 124 Recommendation 4 (d)	NHS and NHS Commissioning Board	The detention status of patients at the point of discharge, and whether or not discharge is to a within-service transfer to a facility owned by the same company, an associated company or an NHS Trust.

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42	Serious Case Review Page 126 Recommendation 7 (a)	NHS and NHS Commissioning Board	Commissioners should commission the model of care as set out in the Department of Health (2012) Interim Report, to ensure that people only go into in-patient services for assessment and treatment where they cannot get the support that they need in the community.
43	Serious Case Review Page 127 Recommendation 7 (b)	NHS and NHS Commissioning Board	Local Authorities should only commission such services where they are the lead commissioner and there are valued services and pooled budgets in place.
44	Serious Case Review Page 127 Recommendation 11	NHS Commissioning Board	The NHS Commissioning Board should seek ongoing assurance that the practice of commissioning of NHS services for adults with learning disabilities, autism, behaviour which challenges and mental health problems is explicitly attentive to reducing inequalities.
45	Serious Case Review Page 137 Recommendation 33	NHS, Local Authority and Care Quality Commission	The Care Quality Commission and the commissioners should ensure that a service is providing care, which is consistent with its Statement of Purpose, i.e. in the case of Winterbourne View Hospital, assessment and treatment, and rehabilitation.
46	Care Quality Commission Internal Management Review Page 46 Recommendation 1	Care Quality Commission	The Care Quality Commission should highlight in our quality and risk profiles (QRP) that services defined as providing regulated activities in residential institutions for people with learning disability, challenging behaviour and mental health needs are inherently higher risk institutions. This is consistent with the Department of Health guidance on models of service delivery for this group of patients. This higher risk status will act as an alert system to our staff when looking at data and information and when carrying out inspections of these institutions. This change should be implemented immediately.

No	From	For action by	Recommendations
47	Care Quality Commission Internal Management Review Page 46 Recommendation 2	Care Quality Commission	The Care Quality Commission should take account of the inherent risk of different types of service provision and the different characteristics of the people using those services throughout it work. This will include collated intelligence about corporate providers as well as individuals locations which will help to identify risks across a provider group as well as at individual location level.
48	Care Quality Commission Internal Management Review Page 46 Recommendation 3	Care Quality Commission	Compliance inspectors should record the outcome of the investigations from safeguarding alerts and compliance mangers should sign off the agreed actions from those investigations. Where Care Quality Commission cannot agree the outcomes from the investigation this should be communicated back to the Safeguarding Adult Team and if necessary to the Adult Safeguarding Board.
49	Care Quality Commission Internal Management Review Page 46 Recommendation 4	Care Quality Commission	Although the Care Quality Commission now have a legislative remit to follow up on action plans, and to take action where there is a lack of improvement, further action should be routinely taken to follow up investigations of incidents which have been notified to the Commission under Regulation 18. These need to be formally recorded in the QRP and where there is limited progress that must be highlighted to the compliance manager by the compliance inspector.
50	Care Quality Commission Internal Management Review Page 46 Recommendation 5	Care Quality Commission	The Care Quality Commission should built new protocols about working with local Safeguarding Adult Teams and Safeguarding Adult Boards to ensure there is timely investigation and intervention of relevant safeguarding alerts, and to ensure that all relevant parties are involved in the investigation of the incident(s) leading to the alert(s).

No	From	For action by	Recommendations
51	Care Quality Commission Internal Management Review Page 46 Recommendation 6	Care Quality Commission	The Care Quality Commission should develop its analysis of safeguarding alerts, to look at particular trends at individual locations, and across service providers. This is particularly important in looking at concerns across chains of providers which cross the Care Quality Commission's geographical boundaries.
52	Care Quality Commission Internal Management Review Page 46 Recommendation 7	Care Quality Commission	The Care Quality Commission should evaluate and embed the process it has commenced of integrated, routine and ongoing exchanges of information between the Compliance Inspectors and Mental Health Act Commissioners and, where appropriate, or joint inspections to take place. This needs to be managed through the supervisory arrangements between the Compliance Managers and their inspectors and the Mental Health Act Commissioner Managers and their commissioners.
53	Care Quality Commission Internal Management Review Page 47 Recommendation 10	Care Quality Commission	The Care Quality Commission should review how it collates information and looks at risks at provider level as well as at location level. This is particularly important for chains of providers where systemic issues could be overlooked because of a focus on location level information.
54	Care Quality Commission Internal Management Review Page 47 Recommendation 11	Care Quality Commission	The Care Quality Commission's Board should receive a report on the whistle blowing arrangements that are in place on a six monthly basis. This should be a public report setting out in detail the scope, volume and actions taken by the Care Quality Commission in response to the concerns raised by whistle blowers.
55	Care Quality Commission Internal Management Review Page 47 Recommendation 12	Care Quality Commission	The Care Quality Commission should audit, on an annual basis, the effectiveness of the case management arrangements in place to ensure that supervision is systematically considering the services with the most serious concerns as part of a quality assurance process. The outcomes of this audit should be reported to the board, and the report should be

No	From	For action by	Recommendations
			made public.
56	Care Quality Commission Internal Management Review Page 47 Recommendation 13	Care Quality Commission	The Care Quality Commission should now develop a protocol about the way in which we will work the Safeguarding Adult Boards and Teams across England. The protocol should take account of what the proposed legislation may set out and also take account of what has worked effectively in Children's Safeguarding Boards.
57	Serious Case Review Page 137 Recommendation 27	Care Quality Commission	The requirements concerning a service's Statement of Purpose and the supporting guidance should be strengthened to aid clarity. The Care Quality Commission, through its Mental Health Act monitoring responsibilities, should consider giving particular focus to:
58	Serious Case Review Page 137 Recommendation 27(a)	Care Quality Commission	The way in which hospital managers (as defined in the MHA 1983) discharge their responsibilities and
59	Serious Case Review Page 137 Recommendation 27(b)	Care Quality Commission	Evidence that hospitals are engaged in their activities they are registered to provide.
60	Serious Case Review Page 137 Recommendation 29	Care Quality Commission	The Care Quality Commission should collaborate with the Health (and Care) Professionals Council, plus the Sector Skills Councils for both Health and Care, in providing advice and guidance on the qualifications and continuing professionals development requirements for Registered Managers and for the practitioners they supervise. It is of concern that managers, registered to operate services across residential, nursing home, hospital and home care, are not required to be distinct registered professionals individually accountable through a governing body and code of ethics.

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61	Serious Case Review Page 137 Recommendation 30	Care Quality Commission	The Care Quality Commission should take appropriate enforcement action where registered managers are not in place.
62	Serious Case Review Page 137 Recommendation 31	Care Quality Commission	Inspection is a term that the public understands and expects to be in pace for an establishment such as Winterbourne View Hospital. The Care Quality Commission's Compliance Inspectors did not identify the abuse.
63	Serious Case Review Page 137 Recommendation 31(a)	Care Quality Commission	Care Quality Commission should ensure that inspections are carried out by sector specialists and experts by experience so that warning signs may be identified earlier (i.e. the approach effectively implemented for the inspection of 150 services for adults with learning disabilities in England.
64	Serious Case Review Page 137 Recommendation 31(b)	Care Quality Commission	Inspectors should be qualified and competent to carry out inspections, and demonstrate that they have sufficient knowledge and (i) the service that they inspect and (ii) the abuse of vulnerable adults, including the crime of assault.
65	Serious Case Review Page 137 Recommendation 32	Care Quality Commission	The Care Quality Commission must encourage whistleblowers to raise the alarm and then securely receive, log and take action when concerns are raised. They should report on actions arising from whistle blowing notifications in its annual State of Care report.
66	Serious Case Review Page 141 Recommendation 35	Care Quality Commission	The Care Quality Commission through its Mental Health Act monitoring responsibilities should consider giving particular focus to the way in which hospital managers (as defined in the Mental Health Act 1983) discharge their responsibilities.
67	Serious Case Review Page 141 Recommendation 36	Care Quality Commission	The Care Quality Commission, in discharging its responsibilities to monitor the use of the Mental Health Act, should ensure that all the requirements of the Act are applied when a patient moves from being an

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			informal patient to being detained under the Act in the same hospital.
68	Serious Case Review Page 142 Recommendation 42	Care Quality Commission	The Care Quality Commission should consider including pharmacist led medication reviews in future inspections.
69	Mencap Out of Sight Page 7 Actions Needed 6	Care Quality Commission	The Care Quality Commission must conduct rigorous inspections, involving people with a learning disability and their families, and not shy away from taking action to deregister or enforce their recommendations.
70	Care Quality Commission Learning Disability Service Inspection Report Page 8 Recommendation 8	Care Quality Commission	Care Quality Commission should determine when it is most appropriate to visit and inspect services at weekends and evenings, rather than Monday to Friday between 09.00 – 17.00. Visits at these times can sometimes provide the additional evidence needed to assess visitor assess, and judge the quality of care, staff, support and supervision.
71	Care Quality Commission Learning Disability Service Inspection Report Page 8 Recommendation 9	Care Quality Commission	We acknowledge that the sample of learning disability providers inspected outside this thematic programme (52) was small by comparison. However, the differences in judgements about compliance and non-compliance warrant further evaluation, to help understand and explain the difference.
72	Serious Case Review Page 141 Recommendation 37	Care Quality Commission and Health Professionals Council	The Care Quality Commission and Health Professions Council should work together to describe in guidance what effective systems of clinical supervision look like in hospitals for people with learning disabilities and autism. The guidance should identify the roles of registered managers and nominated individuals in developing such systems in practice.
73	Care Quality Commission Internal Management Review Page 47	Care Quality Commission and Local Authority	When the Care Quality Commission Mental Health Act Commissioners set out their comments and suggestions for the provider following a visit these should be monitored through an action plan submitted to the Care Quality Commission, and linked with the QRP for the location. There

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	Recommendation 9		should be follow up to ensure that the agreed actions are being implemented as agreed. Where there is failure to do so the Adult Safeguarding Team should be notified.
74	Care Quality Commission Internal Management Review Page 47 Recommendation 8	Care Quality Commission and Medical Staff	The information and intelligence that the Second Opinion Appointed Doctors may capture regarding concerns that they have for patient safety as part of their statutory remit should be systematically and routinely recorded and made available as part of the intelligence and risk information used by Care Quality Commission in its work. Care Quality Commission should review the mechanisms by which SOAD's receive pre-visit relevant information and how they feed back to Care Quality Commission on concerns observed during the discharge of their statutory function.
75	Serious Case Review Page 137 Recommendation 26	Care Quality Commission and Provider Hospital Mangers	The mental health arm of Care Quality Commission should have characteristics akin to HM Inspectorate of Prisons in terms of standard. The hospital managers as defined by the Mental Health Act 1983 have the primary responsibility for ensuring that all requirements of the Act, including all the safeguarding to ensure detention is necessary in the first place (3 independent professionals assessments) and needs to continue. Care Quality Commission and the First Tier Tribunal should ensure that these responsibilities are discharged for all detained patients. All decisions taken on the use of the Mental Health Act 1983 must be guided by the Act's guiding principles, including the purpose principle and the least restriction principle.
76	Serious Case Review Page 142 Recommendation 43	Castlebeck Care Ltd	In the light of the harm sustained by former Winterbourne View Hospital patients, Castlebeck Care Ltd should consider funding (i) Independent psychotherapeutic provision for all former Winterbourne View hospital patients – in negotiation with each

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			person and their families; and an evaluation of the effectiveness of this intervention and (ii) The costs associated with the Serious Case Review.
77	NHS Review Page 70 6.16 a	Department of Health	The extent to which lead safeguarding authorities are able to share information with other commissioners.
78	NHS Review Page 70 6.16 b	Department of Health	Whether lead commissioning arrangements would be beneficial.
79	NHS Review Page 70 6.16 c	Department of Health	Whether the guidance surrounding he Mental Health Act contains adequate safeguards against conflicts of interest arising.
80	NHS Review Page 70 6.16 d	Department of Health	Whether the guidance surrounding the Care Programme Approach could be clearer about the particular role of the commissioners and the retention of responsibility for clinical oversight in situations in which the patient has been placed outside of local services.
81	NHS Review Page 70 6.16 e	Department of Health	Whether existing standards and expectations of independent skilled advocacy support advice are sufficient.
82	NHS Review Page 70 6.16 f	Department of Health	Whether there are adequate checks and balances available in relation to situations in which patients are transferred between two facilities operated by the same provider organisation.
83	NHS Review Page 70 6.16 g	Department of Health	How to achieve clarity on the appropriate balance between checks and assurance carried out by the regulator, the necessary additional checks and assurance that should be pursued by commissioners before making any referrals.

No	From	For action by	Recommendations
84	NHS Review Page 70 6.16 h	Department of Health	What additional contribution families, self and peer advocates can make to monitoring and reporting on experiences of quality.
85	Serious Case Review Page 124 Recommendation 5	Department of Health	The guidance associated with the legislative framework for placing Safeguarding Adults Boards on a statutory footing, and any subsequent review of safeguarding guidance, should reflect the findings of all the reviews associated with Winterbourne View Hospital.
86	Serious Case Review Page 126 Recommendation 6	Department of Health	Adults with learning disabilities and autism, who are not subject to the provisions of the Mental Health Act 1983, should not, by law, be the subject of restrictions in the same way as with patients who are subject to the provisions of mental health legislation.
87	Serious Case Review Page 127 Recommendation 8	Department of Health	The Department of Health should take steps to ensure there is clarity across the health and social care spectrum about commissioning responsibilities for hospital based care for people with learning disability.
88	Serious Case Review Page 127 Recommendation 13	Department of Health	A commissioning challenge is required. There are 51 former patients of Winterbourne View Hospital, some of whom have transferred to other hospitals and secure settings. Commissioners ought to use their best endeavours in relation to ex-patients transferred to hospitals (who are not detained under the Mental Health Act 1983) to return them home or to suitable placements within their local communities. The treatment of those who are detained under the Mental Health Act 1983 should be focused on recovery and support with a view to returning them to their local communities. This will require more than keeping tabs on where they are now – political support, the engagement of generic mental health services, as well as the First Tier Tribunal – Mental Health and capable managers and staff are essential if competent and humane forms of local provision are to develop.

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89	Serious Case Review Page 130 Recommendation 14	Department of Health	There should be a condition of employment on all health and social care practitioners (registered and unregistered) to report operational concerns to (i) the Chief Executive and Boards of Hospitals (ii) the regulator.
90	Serious Case Review Page 130 Recommendation 15	Department of Health	All registered health and social care employers should be required to advise their employees in their contracts to whom they can whilst blow, the response that the employee can anticipate from the employer and what to do if this is not forthcoming. This should include information about provision in the Employment Rights Act 1996 which gives protection to those making disclosures in the public interest.
91	Serious Case Review Page 132 Recommendation 19	Department of Health	The Department of Health should consult the National Quality Board about how to rationalise the notifications which hospitals providing services to adults with learning disabilities and autism should make, and confirm which agency should "hold" this information.
92	Serious Case Review Page 135 Recommendation 21	Department of Health	The Department of Health, Department of Education and the Care Quality Commission should consider banning the t-supine restraint of adults with learning disability and autism in hospitals and assessment and treatment units. An investment comparable to the banning of the corporal punishment of children is required. The use of restrictive physical intervention "as a last resort" characterises all policies and guidance and yet made no difference to the experience of patients at Winterbourne View Hospital.
93	Serious Case Review Page 137 Recommendation 28	Department of Health	There is compelling case for mandatory visits by the Nominated Individual/Board Member reported and brought together in an annual report accompanying the accounts. The Department of Health should consider amending registration requirements to require such mandatory visits and public reporting.

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94	Serious Case Review Page 142 Recommendation 40	Department of Health	Reducing the use of anti-psychotic medication with adults with a learning disability and autism requires attention. An outcome of the National Dementia Strategy (Department of Health 2009) was an investment in reducing anti-psychotic medication for patients with dementia (Banerjee 2009). Adults with learning disabilities require no less.
95	Mencap Out of Sight Page 7 Action needed 1	Department of Health	The government must show strong leadership and clearly set out what each player in the health and social care system is expected to do within an agreed timescale. It must also say who is accountable for the different parts of an action plan.
96	Mencap Out of Sight Page 7 Action needed 2	Department of Health	The government must start a closure programme of all large assessment and treatment units are integrated with local services.
97	Mencap Out of Sight Page 7 Action needed 3	Department of Health	The government must tell commissioners to develop local services that meet the needs of children and adults with a learning disability and behaviour that challenges, including community-based intensive support services. There must be no excuse for sending vulnerable people far away.
98	Mencap Out of Sight Page 7 Action needed 4	Department of Health	The government must carry out an urgent review to ensure that funding arrangements do not work against the incentive to get people out of assessment and treatment units and that 'economies of scale' don't force the continued development or larger units.
99	Mencap Out of Sight Page 7 Action needed 5	Department of Health	The government must ensure that the Care Quality Commission has the power to only register services that are in line with the policy recommendations in the Mansell Report.
100	Mencap Out of Sight Page 7 Action needed 7	Department of Health	The government must strengthen the law on adult safeguarding to keep people safe from abuse and ensure that rigorous action is taken against abusers and responsible organisation when abuse occurs.

No	From	For action by	Recommendations
101	NHS Review Page 69 6.15 a	Department of Health / Serious Case Review	The experience of Local Authorities as commissioners of care at Winterbourne View.
102	NHS Review Page 69 6.15 b	Department of Health / Serious Case Review	The effectiveness of communication within the safeguarding system
103	NHS Review Page 69 6.15 c	Department of Health / Serious Case Review	The extent to which the system of regulation might have provided unmerited assurance to commissioners of care and treatment about the standards at Winterbourne View.
104	NHS Review Page 69 6.15 d	Department of Health / Serious Case Review	Whether issues were considered and resolved appropriately within the safeguarding process.
105	NHS Review Page 69 6.15 e	Department of Health / Serious Case Review	The extent to which patterns and trends in incidents of concern could have been identified more clearly within the safeguarding process.
106	NHS Review Page 69 6.15 f	Department of Health / Serious Case Review	The adequacy of the systems of clinical governance and the quality of clinical care provided by Castlebeck Ltd at Winterbourne View, including the discharge of professional responsibilities by those employed by Castlebeck.
107	Serious Case Review Page 127 Recommendation 10	Department of Health and Care Quality Commission	The Department of Health should assure itself that Care Quality Commission's current legal responsibility to monitor and report on the use of Deprivation of Liberty Safeguard provides sufficient scrutiny of the use of DoLS.
108	Serious Case Review Page 132 Recommendation 18	Department of Health and National Quality Board	The National Quality Board should devise a mechanism for aggregating pertinent safeguarding information for NHS patients with learning disabilities and autism as part of its consideration of actions to correct actual or serious failure (Department of Health 2012).

No	From	For action by	Recommendations
109	Serious Case Review Page 131 Recommendation 16	Local Authority	Council Safeguarding Adults personnel must ensure that hospital patients, subject to Deprivation of Liberty Safeguards and Mental Health Act detention, who are restrained and/or make a complaint, have opportunities to access, in private, independent professionals such as social workers, local authority Deprivation of Liberty Safeguards assessors, Independent Mental Capacity Advocates or Independent Mental Health Advocates and Mental Health Act Commissioners for those detained under the Mental Health Act 1983.
110	Serious Case Review Page 131 Recommendation 17	Local Authority	When a hospital fails to produce a credible safeguarding investigation report within an agreed timeframe, the host Safeguarding Adult Boards should consult with the relevant commissioners and the regulators to identify remedies to identify remedies.
111	Serious Case Review Page 136 Recommendation 24	Local Authority and Care Quality Commission	Local Adult Safeguarding Boards, Care Quality Commission and all stakeholders should regard hospitals for adults with learning disabilities and autism as high risk services i.e. services where patients are at risk of receiving abusive and restrictive practices within indefinite timeframes. Such services require more than the standard approach to inspections and regulation. They require frequent, more thorough, unannounced inspections, more probing criminal investigations, and exacting safeguarding investigations.
112	Serious Case Review Page 137 Recommendation 25	Monitor	Monitor, as the sector regulator of all provider of NHS funded services, should consider the inclusion of internal reporting requirements for Boars of registered provider services in their provider licence conditions.

No	From	For action by	Recommendations
113	Serious Case Review Page 141 Recommendation 34	All Providers	To meet their statutory obligations all providers of residential, nursing home and hospital care should require that their registered managers' normal place of work is one where they can become known to patients/service users and are routinely visible and accessible for the staff who are working 365 day rotas.
	Care Quality Commission Learning Disability Service Inspection Report Page 9 Recommendation 4	All Providers	Providers must ensure that people using services are routinely involved and 'own' their care planning and activities. These must be available in appropriate formats and must be accessible.
114	Care Quality Commission Learning Disability Service Inspection Report Page 8 Recommendation 5	All Providers	There are still lessons to be learned by providers about the use of restraint. There is an urgent need to reduce the use restraint, together with training in the appropriate techniques for restraint when it is unavoidable. There also needs to be systematic monitoring about the use of restraint and ongoing analysis so that lessons can be learned and patterns of use better understood, which should all lead to less use of restraint. The use of seclusion needs to be recorded as a form of restraint.
115	Care Quality Commission Learning Disability Service Inspection Report Page 8 Recommendation 6	All Providers	Providers must ensure that staff understand and can apply the deprivation of liberty safeguards.